INTERVIEW WITH PAM BENTON
MARQUETTE MI
APRIL 22, 2009

SUBJECT: MHS Project

MAGNAGHI, RUSSEL M. (RMM): Interview with Pam Benton, Marquette, Michigan, April 22, 2009. Okay, this afternoon we'll discuss your background and then the role you play in the foundation office and the connections you have with the hospital and so on. As we're going along here, this is mostly for the transcriber as you know, since you've transcribed. If there are any words you feel have to be spelt out, just say them and spell them out, so that I don't have to ask. The first question I ask as you know, what is your date of birth?

BENTON, PAM (PB): 10/31/1958

RMM: Can you give us a little of your background? Where you're from and a little about yourself?

PB: Oh absolutely. Born and raised in the U.P., in Dickinson County, Kingsford. Graduated from Kingsford high in 1976 went right into Northern Michigan University, graduated with a Bachelor of Science Degree in '81. Met my husband while I was there, got married. I actually did my internship at the hospital from Northern and was hired from that. So, I went right from college to the working world here at the hospital. So, actually, this is the only job since I graduated that I've actually held. So almost thirty years now. Thirty Years in October. I started in the personnel office. Went to the pay roll department then back to the personnel office, then I went to the administrative office. That's where I was for gosh almost 20 years. So that's why Dan Mazzuchi wants me to be interviewed because he thinks I have all that knowledge from that or at least some really good stories from that time. There were 3 different CEO's from that time. It was interesting.

RMM: Were there any developments or something that occurred while you were in that position, in terms of the development of the hospital?

PB: Oh absolutely. All kinds of advancements, new buildings, just the largest building on the hospital's campus the '81 building we call it. Which really I think kind of defined the facility; it came just a couple of years after I started. So, that was a big project just after I started in '79. That was a real big project, and the planning for that, what departments, as you know its huge laboratory services and all kinds of things never seen before in the UP. That was definitely a defining time, that '81 building which was followed by the '84 building which houses the MRI. It was right on the heels, so there was a lot of building going on at that time. Then the parking ramp after that and the '91 building or the North building. There was definitely a focus on building and expanding.

RMM: What was it like working here at that time with all the activity?

PB: Definitely an exciting time. There were so many new and different types of programs developing. The emergency department advancing to what we have now in trauma services. Imaging from X-Ray to MRI, and CT scanning was huge. We have behavioral health, the development of behavioral health, the mental health hospitals in the UP were closed at that time to so there was a big influx of activity for that program. How they were going to address that UP wide as we were the only with certain things, you know, psychiatrists, substance abuse professionals. It was just really an interesting growing time. For

most of the time it was under the same administrator, Nelbert. When I started, it was Elwood Matson; Harlan Larson was chairmen of the board. That was one of my big responsibilities, working as a liaison and working with the boards. Both Harlan and Elwood were such civic minded people, active in the hospital.

RMM: The way members of the board looked at it the hospital was not so much as a private corporation, I mean it was that, but they saw it more as a community service.

PB: Oh I think so. At that time too, we still had Sulk. The Jacobetti Center. I think Dr. Wright talked about that in his interview too because we used to be two separate facilities. Then the hospitals merged, St. Wilson, and Mary's merged in '73, and for a while we had that facility before we sold it to the Veteran's Facility. It was quite spread out in the community and you know it just played an important role in the community, because there are so many people and so many employees, even at that time, employees and physicians and probably one of the larger employers in Marquette.

RMM: As this was emerging how did the administration or board view the services as, just serving the Marquette and Marquette County community or were they looking at a larger area of service the central UP and beyond?

PB: I think starting from way back, Marquette just became the place where certain specialist came because they could be supported by others. So it was like the natural medical hub. It always had the we're serving the local……we have two roles, the community hospital and the regional center. As far back as I can remember we always had some of the only things in the UP. You have a different focus when you're serving that type of population. There are always, I would say, mindful of that.

RMM: Was there ever an undercurrent of some other in the UP trying to take on a similar role, becoming a center or did they pretty much leave that in the hands of Marquette General?

PB: I don't think it was a conscious decision to leave it in the hands of Marquette General. I think a lot of them would like to be what they can be you know. But they just can't support doing open heart surgeries, cause if you don't do enough to maintain your competency then what good is that? So, I think those are limiting factors for some of the communities that would like to grow. There are even things that we don't do, you know, burns, organ transplants, not cause we don't want to it's just we don't have enough to do.

RMM: So it's really a rational decision on the part of the different hospitals around the UP and Marquette general as well, that certain areas work and develop.

PB: You can't support it. You can't dabble in it.

RMM: Were there any interesting, humorous developments when the hospital was going up that you can recount?

PB: You know Russ, I'd like to say yes but there is just nothing that just jumps out at me that would be worthy of or appropriate for a …….hahaha. Certainly the growth, the technology.

RMM: Now you've been here for some time before this development, well you kind of came in when it was going on, but was that kind of the defining moment in terms of technology and equipment that was coming on the scene.

PB: With the merger you mean?

RMM: Well, at the time of the merger and all but also with the development of the hospital that all sort of came together. It was like they expanded the hospital and then ten years later they had the development of certain types of technology. The technology seems to have come in at the same time.

PB: I think contrary to what some people would say there actually was a long range planning committee for years. There probably still is. I'd like to say that was always part of the bigger picture, staying on top of the technology, because what's current today isn't going to be current next year. So that was always changing and always a challenge. The other thing that really just stands out was the information technology. The IT, just huge over those years when I first started, things were done on the manual type writer, I know it's funny when you talk to people about carbon copies, what is a CC, a carbon copy? That's actually carbon, haha, they don't realize that. I was there when some of the first computers came on and word processing systems was kind of how it started. Yeah just a huge expansion of technology. I had the luck or advantage to take a tour of our Lab and I've been here for 30 year and I just had no idea of the technology, the computerization the barcode reading, the skill you know, it's unbelievable what goes on in little ole Marquette, Michigan. Just unbelievable, actually I do tours with my job here at the hospital - different organizations, or donors or VIPs or whatever. That is always the one common thing they say is that they had no idea what goes on here. The same thing at Northern in the Upper Michigan brain tumor center with some of the research that goes on there. It's unbelievable. If you talk to people about the hospital, I don't think they have any idea. It's just "the Hospital".

RMM: Or they have an old idea, they think it's a white room with doctors or whatever.

PB: Yeah, doing whatever they want, when they want.

RMM: So, you're one of those transitional people that came in at the time of typewriters and whatnot. All of that, we'll call it technology, and you were involved in the carbon copies, and the white out material.

PB: Oh yeah, the white out, absolutely the white out.

RMM: Having to scrape it, demographic.

PB: That's exactly right, when I was at Northern in lab that's exactly what we had to do, was run the Mimeograph machine and if you make a mistake out comes the razor blade. I know I'm dating myself, aren't I?

RMM: I'm just going to add to it. I had a newspaper article that went back to all of the old time gadgets, the things you're talking about, and then bring it to students attention and they're in a state of shock. That you would have to retype the whole page.

PB: Absolutely.

RMM: With computers today, you can make some changes to the footnote, print a final copy and you're done. And they have no idea that it was….even us looking back at it, it's rather crude.

PB: It's hard to believe, but oh yes, we did retype those pages.

RMM: Now do you find with the new technology that things get done more efficiently?

PB: Oh, absolutely. No doubt about it. When you think about it, when I first started one of the things, my responsibilities, was to take minutes at medical staff meetings. And how I did that was how I was taught at Northern, which was short hand - which they don't even teach that anymore. So you'd sit through the meeting in short hand once. Then you'd sit through the meeting again when you transcribed it. Then invariably there's editing or changes that go on, so you have to change it again. Like you said, many times. You're retyping these pages, cause they're the documents that are going to be kept, a lot of it would be peer review or whatever.

RMM: So this would be at least 3 typings?

PB: Oh, easy. Two to Three.

RMM: Because then someone would review it and maybe make additions or edit it. And then the final copy.

PB: Exactly, now you know they just sit with their laptop computers and it's typed as your sitting it's almost like a court reporter.

RMM: Verbatim?

PB: Exactly.

RMM: Is there anything I didn't ask about your job?

PB: One of the things we talked about some people don't realize what goes on inside a hospital or you know they just think doctors come and do whatever they want to, cause it's a hospital and that what doctors do. But one of the jobs I had was credentialing positions. What that means is, basically that you verify that they're trained to do what they're asking to do. That's how it started. That would be done yearly or every two years. Positions would have like a check list thing. Then as regulatory agencies got more involved with licensing, they were starting to look more into how physicians were practicing and their outcomes. I'll never forget the medical staff meeting four times a year and I think this is still true of the medical staff. The entire medical staff gets together as a whole and have required attendance.

RMM: So that's how many people?

PB: Oh my goodness. 100-150, depending on which meeting it is. They brought up the issue of the fact that the joint commission on accreditation on health care organizations JCAHO is now requiring in the credentialing process the physicians to divulge any malpractice activity that they might have had. I had one particular physician came up, I mean I'll never forget it, I mean I can relive it to this day, he was so upset. How dare I, "Who in the hell do you think you are, asking me for this information?" You know I was a recorder so I was up front, because I was also like the medical staffs secretary. He was just

incensed; he could not believe that I would have the audacity to ask him for that. The chief of staff at that time was trying to intervene and take some of it for me. I had to come back to the office and produce the regulation in writing, so that he could see it in writing and that he had to give it to us. It was the start of scrutiny into the physicians, not only at Marquette General but also nationwide. I mean they were really starting to look at, what are you doing, you just can't come in and do whatever you want to do, you have to be qualified, you have to have good outcomes. Shortly after that the physician report card came to be, where every time they asked to do certain things, every couple years from their credential. The report card from our quality assurance department comes out and says you know, okay Dr. Russ had this kind of outcome in this, great you know or maybe you should look at why he's doing this. That I think is really advancement, doctors looking at what other doctors are doing.

RMM: Does that also, kind of…..well it keeps everybody tuned-in to what they're doing but does it also in the process expand the knowledge of what the different positions are doing?

PB: Absolutely, not only the positions but too they have what they call tumor board, for example for cancer patients. Cancer cases go before a board of all kinds of specialist from the surgeons to the oncologists; my goodness there's a whole variety of them. That is beneficial for the patient and for the practitioners sitting around a table talking about a case what could be done.

RMM: How did you have, well you had one particular physician who was upset, but how did the other physicians take to this policy settle into your expectations?

PB: Part of it I think he was just so loud and vocal about it that they just sat back waiting to see what was going to happen because they all had gotten the memo. You know you need to start doing this. In hindsight it was beneficial that it actually happened that way because it was a public flogging.

RMM: The messenger almost got shot.

PB: Haha, that messenger was darn near shot, I hope you don't think I was sweating coming back to the office. You know, I hope I can find that regulation. For the most part they comply. They just want to understand, "why do you want that? What are you going to do with it? Who's got access to it?" They just want to know, just like your credit card password.

RMM: I think you have going for you that you're in a scientific mode so you can explain it so they will see very quickly that this is going to mean an improvement.

PB: And if you're watching Dr. X you're also watching Dr. Y, you know there is some comfort there.

RMM: Now do you notice, just as an outsider, not that I pay much attention to it. There seems to be fewer stories about…..

PB: Cutting off the wrong arm?

RMM: that and then even doing crazy things actually not crazy but like marking with a felt tip pen, this arm comes off or something, but …physicians being sued for malpractice and what not unless it becomes part of the culture which it has. Do you think these regulations have sort of tightened the situation so you don't have these problems as much?

PB: I think we live in a litigious society, I really do. I think that people will sue….of course you need to talk to a practicing physician about the current climate but my perception is that people sue a doctor at the drop of a hat. They'll do something and the doctor will say; now go home, bed rest, come back and see me in a week. Well they go out and cross-country ski the next day and it opens up and then they sue the doctor.

RMM: But now do you think that these regulations and what not, do you think that physicians could also see that this is protecting them?

PB: Oh, yeah and the Hospital. If there is a lawsuit it's not just the physician, the hospital is sued.

RMM: The hospital can also produce you office or something at that time could also produce all the documentation. Here we are?

PB: Yep, this is what we've done. We've looked at it, but it's not us really looking at it. We just compile the information and the peers are the ones that would decide if it was appropriate or you know, additional training and there were physicians who applied for privileges who weren't allowed to come on because of, you know.

RMM: But if they had been they could have had a problem and then you'd be up for…..

PB: You talk about society, they've got the national practitioners databank. That was a big development in the medical staff office and the administrative office where hospitals are required to report any kind of actions taken against a physician, or if a physician resigns because actions were contemplated. At least you have this national databank because you'd get where physicians would jump from state to state to state to state. If they had a problem in one state they'd go to another or you know you have some of these smaller hospitals in the UP where the secretary for the administrator was also the secretary for the quality assurance department and probably also runs the admitting department and probably in her spare time she credentials physicians. They don't have the time to spend investigating and they'll probably say "thank goodness we have a physician who is licensed, who wants to come and practice in our community, we'll take them." That I think, this databank was huge, because it prevented them from jumping around from state to state and hospitals had someplace they could check into a physician before they encountered problems. It's one thing to know he has problems in a certain surgical area versus waiting to experience it yourself.

RMM: Now anything else you want to add in that part of your experience?

PB: No, I don't think so.

RMM: Then how did you get into and you're gonna talk a little about the Foundation and your perspective on how that got started?

PB: For a long time the Hospital board viewed the Foundation as a sign of weakness and I don't understand it so don't, I really don't understand it but that's how it is viewed. So Marquette General never started a foundation. There were many people who suggested it, you know you remember I suggested this that you start this foundation, you know 20 years ago I told you, you should start this foundation. But it never was. Then in 2003 the hospital retained a consulting firm to come in and see if it was something that was even feasible. They interviewed 100 to 150 people throughout the

community, throughout the UP to see what they thought of the hospital starting a foundation, starting fundraising activities. So this firm did a really comprehensive study. It came in a three ring binder and proposed that there was definitely the support there in the UP for the foundation. So Marquette General should proceed in certain steps to develop the foundation. The CEO at the time Nemachek asked me if I had seen the study yet and I said "yeah I saw it come in, in the three ring binder." He said, "I think you should take it home and look at it. Just read it." He said, "you might find this interesting." So I did and in there was like an operations manager position and it was neat. At the time I didn't think that just anybody could do it, you had to know people and having been there for 25 years, I thought well this would be something different. Something new, I don't want to say I was in a rut but I couldn't get fired up about the joint commission surveys coming in every 4 years. It would be like, ho-hum big deal, here's what you got to print out. I like the people I was working with, I loved the physicians, because that's who I worked the closest with. I was just looking for a new challenge. It was taking something from the ground level and building it. I knew it wasn't gonna be easy, because Marquette General was always viewed as the giver of money not the receiver of money. So I was the first employee of the foundation.

RMM: What year did that take place?

PB: The foundation was incorporated in October 2004. Our first director was hired that following spring.

RMM: In the spring of 05?

PB: Yeah, she was here for almost two years. I can definitely say we have grown in these last five years

RMM: And so has the foundation been received? You said, "people have commented and so on."

PB: It's an education thing, because I think that the hospital has always been so private. I could ask when the last time you saw a community reporter, other than this last one we did. The hospital always kept things quiet, it was always private. You know? If there was a financial thing they never talked about it. The only thing you read about the hospital in the paper would be if there was a union problem.

RMM: Or expenditure or something?

PB: Yeah. What can I say. The community would see the hospital as this big guerilla. "You don't need money, look how big you are you're just constantly growing. What do you need money for?" Then you try to talk to them about…."Do you know that the hospital gave away 14 million dollars last year in free care?" "What do you mean you're giving away care? Why are you giving away care." See they just don't understand how the hospital works. What the challenges the hospital faces. For me making sure this foundation is successful is really important. It's kind of a legacy building. What we're doing now, the groundwork we're laying now, if this foundation isn't successful where is that going to leave the health system 20 years down the road? Like I said it's building the, continuing to build this.

RMM: You mentioned the first Jan Philman, was the first director?

PB: The current director is Patrick Bree.

RMM: He's the second one?

PB: Right, there has just been two.

RMM: what are some of the activities that the foundation has been involved in?

PB: Ongoing educational opportunities, that's our inside joke. We have three major events that I personally focus on. Our annual Gala, which is held in the fall, we'll have our second one this October and it's a major fundraiser. We raised enough money to purchase a new needle intensive care unit transporter. Then another event we have is the paint the ring pink with the Marquette Rangers hockey team. It's a fundraiser for the Cancer Center held in Breast Cancer Awareness Month, October. The other one we have is the Upper Michigan Brain Tumor Center, cycling challenge. It's a joint effort between NMU and Marquette General. Their big fundraiser is the day before Mother's Day, it's a cycling challenge, a long ride and short ride. Why anybody would want to do the 40 mile ride, I don't know. For me those are the three big events, which are pretty much all consuming to me. We're also trying something new this year, which is kind of neat, getting information out to the community. We're doing a breakfast with the president. We're inviting 300 community leaders to sit down with Gary and have breakfast and kind of talk about what's going on at the health system. What they've heard, where he's taking this place, that kind of stuff. We have not yet had a capital campaign, but that's on our horizon for sure. That will be exciting. The health system is definitely looking to the foundation to provide for some of the improvements that they just can't afford, that will take us to or keep us at that cutting edge.

RMM: Now you think, has the technology sort of developed to such a degree that, and there's so many new things coming out that you need foundation money to get some of the equipment, cause there's just so much coming out?

PB: Absolutely.

RMM: Where in the past, you had a hospital and just basic equipment.

PB: The old days when employees got 16% pay raises. That's the old, old, old days, yes. But you know, money wasn't an issue.

RMM: But then there wasn't any new technology coming in or more equipment. Well you might have had some but…..or it'd be some procedure that would….

PB: No it kind of seems like when computers came on that really changed the face of everything. From the office, the way offices were run to the labs and the…

RMM: Now, is the hospital gearing up to digitize records and what- not?

PB: Oh yeah. The emergency department actually has a paperless record system right now. There kind of rolling it out unit by unit. (Inaudible). But definitely the bedside computerized is definitely the way to go. With barcode readings, in the pharmacy, you can just scan the bracelet on the patient and right away know if there is going to be any drug- food interaction with medications or if there's any kind of medication errors, who gave a lot. You know, I mean, it's just all the employee scans their badge scans whatever their going to do. There is the record, there is the billing. Plus the restocking that has to occur because that one piece of whatever was used. It's just so technological.

RMM: So also just to note in a huge facility like this, it's probable you could be operating without the [issue].

PB: It's exciting times. Like you said it takes money to do that. In one to two double spaced pages look at the phrase stated in: Social Entrepreneurship: Creating new business models to serve the poor.

RMM: So, do you find that another part of the foundations activity is the educational process?

PB: Oh, definitely. That's a huge part of it right now. Like I said people are just not used to seeing Marquette General in that light. We've never done that before. We've never had a foundation. Never asked for money. Just never done that and people question. They don't understand, the changing of the old administrator retiring and new one coming on. There's a lot of questions about what went on and what happened. "Are you in financial difficulty?"

RMM: It was just a process of the old administration retiring?

PB: Yeah, a new one came in.

RMM: That immediately set things, or started some new things?

PB: Well, yeah and it was probably the right time for a change because it seems like there was that rut again, but you do things the same way you promote people who do things the same way and no one really steps back and looks at why are we doing this? Could we be doing this better? Then the new administrator Gary Muller came in and that's exactly what he did. You know, why are we doing this?

RMM: No one had really thought about it?

PB: Is there a better way we can do this? Right. He's all about communication transparency. It's refreshing. It certainly helps us to do our job.

RMM: So, I guess, kind of what you're saying, the hospital, the whole community, is kind of an organic community that's growing and developing. It should be looked at as a growing and developing community, rather than something you would see, like I think about, there's down behind the St. Peters cathedral, there's the original St. Mary's hospital which I think is a house. Now you look at and you say, yeah, okay, that's probably an operating room and so on. But the hospital is a very, as we said, a very static entity. Today, it's really growing with many parts.

PB: Yeah many parts, changing parts. Who would have thought 5 years ago that bariatric surgery would be so big? You know, weight loss surgery. Who would have thought? It's just so different. A good thing and a reduced length of stay. I mean when I had my boys 25 years ago, gosh I think I was in the hospital for about a week. You know now, you're in and out so quick. And that gets into how hospitals are paid, you know? It used to be paid for a week, but not anymore. How do you afford that when the payment mechanisms are constantly changing and the technology is constantly changing? You know, the regulations are constantly changing? Then you have to communicate that to everybody. Cause now we're going to go out and do fundraising.

RMM: We kind of talked about it. I don't know if we answered the question, but the educational process. Do you have any things that you do?

PB: Well, like this breakfast with the president thing is what we consider and educational opportunity. We're into the service clubs and the organizations and the retired nurses clubs. We're in there making our presentations but it's always educating them from the ground. Father Capo used to say "repeat, repeat, repeat! Then repeat, repeat, repeat!" So, you know, people have questions because they hear things you laid off 120 employees last year. Well, no. That's not what that was. You have to give them the forum to ask those questions. People say to us all the time at the foundation, oh I bet you, you hate that when people ask about whatever? No, we don't, we welcome it, we want them to. First of all that tells us they're comfortable enough talking to us about things and then it's that educational opportunity. There are not too many things that we don't like people to ask about.

RMM: So, now how many people are connected with the hospital?

PB: When you say connected?

RMM: Well I mean working in the hospital community?

PB: There's about 2500 employees alone. If you look at the position offices

RMM: You mean the staff in the position office?

PB: Right, right.

RMM: I'm saying with the 2500 that includes all physicians?

PB: No, that would include the employed positions, yes, but not all physicians are employed by the hospital. A good number are not.

RMM: Would you like to explain that?

PB: Sure, it's just a matter of--I personally have this thing. It really shouldn't matter how a physician gets paid. A physician is a physician. Some physicians choose to not be involved in the business aspects of running a practice and those are the type of people who come and work for the hospital. The hospital runs the business part of their practice and they do what they've been trained to do. Others prefer to remain independent and not get their paychecks from the hospital. They want to run their own business and they run their own. For example Dr. Wright and Dr. Wright's practice were all independent. Where there is another internal medicine group who chose to work for the hospital. It's just they do the same kinds of things, they're still internal medicine, they're still the same kinds of doctors they just get their paycheck differently.

RMM: So, it's like going into private business. Then you have to have your bookkeeper and all that type of thing. The other doctor, like I'm teaching over at Northern, I'm working for Northern, I get my paycheck.

PB: Exactly, you let them worry about doing the billing or keeping the records.

RMM: Now, do those physicians have offices in the hospital or outside the hospital? Do they see patients?

PB: Both the independent and employed physicians see patients in the hospital. Some have offices in the hospital; some have offices in both locations. You'll have people like the cardiologists who see patients here. They're using hospital facilities to do like, cath labs or stress testing or certain procedures or test that they do here at the hospital, but they also have their office over in the medical center. Now they are not employed physicians. They are independent.

RMM: But then, if they're employed, do they have just the office in the hospital or they can also have an office outside the hospital?

PB: Yeah, some do. There are some employed physicians who have, who are hospital dependent, like a radiologist. They have to have the imaging equipment or the emergency physicians who have to have the emergency room or the pathologist who have to have the lab for autopsy and all of that. There are those physicians who have to have an office here, but there are also physician who are employed like family care doctors who don't have any offices here. Their offices are in the medical center.

RMM: It's interesting to think of the different doctors and all. When you go there you don't think about-

PB: How they get their paychecks?

RMM: Yeah, It makes sense. A lot of these things like the cardiologist and so on whose equipment, for the use they would get out of it, they could purchase that kind of equipment in the hospital.

PB: It's kind of like win-win situation. The hospital has to provide the equipment, then they have to provide the specialized staff to run the equipment. Neither one of those are any good if you don't have the physician doing it there. So it's a win-win.

RMM: You were talking about 2500 directly connect with the hospital?

PB: Right employed by the hospital.

RMM: And then you're saying?

PB: I was just saying the impact health care even across the U.P. oh my goodness sakes. I f you think about how it's almost a domino effect.

RMM: Then you have the staffs of the physicians over at the medical center.

PB: Then from all that you have all the pharmacies and home help and the medical equipment. It would be an interesting question to see. U.P. wide what the impact of health care would be through Marquette General.

RMM: No one's done that?

PB: Not that I know of.

RMM: Probably hard to figure out?

PB: Yeah, a challenging undertaking.

RMM: Then Marquette General has connections with other hospitals? Does Marquette general have any, like satellite hospitals that are part of the system in other towns.

PB: Not hospitals. We have partnership agreements with different hospitals.

RMM: So, you don't get into running a hospital in town?

PB: No, we for example, I can think of in my years here, it happened in Munising in happened in Ontonagon, for whatever reason their administrator left or retired and they had trouble recruiting another one. We lent them one of ours to run it for a while. One of our assistant administrators went over and ran the hospital program until they found someone. We've never purchased another hospital or you know run it, the whole hospital program. We definitely have clinics in certain areas like in Hancock, or up in Portage, that type of thing. Where our doctors would go and…

RMM: Specialized?

PB: Certain specialized areas.

RMM: So, then as you were saying, the influence of the hospital and its involvement is very widespread. It's not just people coming from a position in Hancock sending someone down here, but you have staff from here providing services.

PB: Then there is something interesting that will happen, we'll get somebody say like a urologist. A urologist from Marquette, even goes up to Ishpeming enough. So then he'll hold a clinic maybe once a month, then it turns into a couple of times a month, then it turns into once a week. Then before you know it, now the area has enough business built up to support the recruitment of a physician. How good is it for that area to have, to have you know. Now there is enough business in that area for a urologist and there wasn't there before. What is the impact of Marquette there? Of course now you look at that poor physician who just spent five years building up this practice in this outlying area so another physician can come and pick it up and he's out bucked. You've developed a relationship obviously. That's another behind the scenes influence that a lot of people don't realize. They build it up and now that place can have their own whatever.

RMM: And so you see a lot of that occurring?

PB: Oh yeah. You also see a lot of our family practice residents who go grand physicians staying in the UP which was the intent of the program when it started.

RMM: And that was the one when Dr. Mazzuchi was involved in?

PB: Exactly.

RMM: Now with physicians that way connected with the hospital then they can't just go out and freelance and decide they're going to spend Friday afternoon doing some work in the iron range region?

PB: If you had a hospital employed physician, where the hospital is paying your malpractice insurance that probably would not be allowed unless it was at the hospitals request or direction. That you go out

and do that, you'd have to pick up your own insurance in some fashion. That's not to say, I don't know if this still happens but there would be family practice residents those that are getting near graduation would go out and cover some of the emergency departments freelance on the side and do a few shifts in the emergency room in Iron River or in wherever. In Manistique or something. I'm pretty sure that still happens, but that's good too. You get in there, you start to form relationships and help them out.

RMM: They would be doing this on their own basis. You don't really have people freelancing on their own?

PB: Not really.

RMM: Kind of running out of control I mean?

PB: No gosh, heavens no.

RMM: I mean physicians I don't want to say--It's like the old medieval guild, they're monitoring, as you said earlier their monitoring everyone, government agencies and so on monitoring all of that. The other thing is that they are storing what physicians do so they can't jump from hospital A to B to C and malpracticing all along the way. Where now, that is tightening up.

PB: I had one time where I was doing credentialing for physicians it was at Ontonagon Hospital. His name is Jim Richards. He was on our list of people to be interviewed. He was an administrator at the time and he was going up running Ontonagon. And he came back with this physician file. He put it on my desk and said there is something not right about this guy. He said, "I'll be damned if I can figure out what it is," he says, "you have at it, see if you can figure out what it is. Everything is….the I's are dotted the T's are crossed but I have this feeling." So I went through ran the information going through the national practitioners databank. It was the son who had lost his license using his father, copied off his father license. Copied off his father's DEA so instead of John Doe II it was John Doe the III. He had submitted all of his father current licensure and everything and Ontonagon didn't catch it.

RMM: But they had the same name?

PB: John Smith II, John Smith III.

RMM: But they didn't have any numbers at the end of it?

PB: Nope, and that's what--he actually tried to pull that off. The son, who had lost his license for I don't know what, in another state, um, they were all set to take him. Some of these places you need them, you got to have them, and it turned out to be the son. It was, that could have been awful, just awful.

RMM: So somebody was able to catch that, or somebody caught it? Was it simple to do or?

PB: Well, if you put the time into it, because we would call up primary source verification. You don't take anybody's word for anything. You go right to the source and you verify it with the source and that's where it was discovered. Instead of taking copies of the transcript or copies of a license whatever. Primary source verify and then red flags start.

RMM: Now you're saying this new system it would have been much easier?

PB: Yeah, oh yeah.

RMM: But still that's?

PB: But still, that's what I'm saying you know. Poor Ontonagon, the poor person trying to credential that doc probably had three other jobs that they were trying to do. In small communities, you wonder how they're overworked. When you hear about somebody's wrong arm being cut off or some… you wonder. My first thought is what was the training and the competency and the experience and what went into this physician who you know? Or was it like another small hospital where, you know, they shouldn't have been doing what they were doing?

RMM: So you've kind of gone through the--You're a real transitory person, I mean you hadn't been here since 1950 like Dr. Wright but you've been here during major change.

PB: One of the big things that happened too was when Nelbert retired, the CEO, there was this community wide effort to conduct a nationwide search to replace the CEO. Don't promote from within. Nepotism….go out and conduct a nationwide search for this so. I sat on the search committee. I was the coordinator. I took in all the applications and made sure all the search committee saw them. So long story short, we ended up hiring a gentleman from Wisconsin. His name was Bruce (climet) _____. He lasted for about 9 months. That was an odd, awkward time. Like I said he was the result of a nationwide search and worked with a recruitment firm to bring him in. And he just thought nothing good of Michigan. That was a really difficult time in the health system. I don't know that he really wanted to be here and he wasn't embracing the area, he wasn't embracing the people. So he lasted for about 9 months then they went to Bill (Nemicheque)_____. Will you at least function as an interim. We're gonna let this guy go. So he was let go. (Nemicheque)_____ stepped up and I thought that he was…..he deserves a lot of credit for that because he was kind of looked over in the beginning for this nationwide search but yet he stepped up when they asked him to run it. Then they ended up giving him the position in '97.

RMM: This wasn't the latest, you're talking about a search back in 1997?

PB: Right when (Nelburt)_____retired I think it was in like '96, he was here for 30 some years. Then they did the nationwide search. Then they brought in Bruce (Climet)_____and he lasted maybe 9 months. Then he was let go.

RMM: Oh, and so Nemicheque was….?

PB: As soon as Nelburt retired Nemicheque wanted the job and he didn't make any secret of that. They said no we really think we should do a nationwide search. So they did and that didn't work out. Then Nemicheque stepped up for almost ten years then. Maybe a little longer.

RMM: He did get the position?

PB: Yeah he did ultimately get the position.

RMM: Well that was just a debacle?

PB: Yeah without a doubt it was just rude, very strange. Very strange time in the health system. There was even a community, I'm trying to think of what the name was. An organization in the community was formed, People's Choice, UP Choice, Citizens for the Improvement of our Hospital or something. There was a community outcry about what was going on in the hospital. Was there nepotism going on? Oh there were all of these horrible rumors about what was going on, but again it comes back to that secrecy and no transparency. My goodness you certainly couldn't discuss financials. You didn't discuss private stuff but that just perpetuated the misunderstanding that we face now. So many years…

RMM: Do you think things are changing now?

PB: Oh God yes, oh God yes, Yes. Yeah I would definitely say our current CEO, President Gary Muller, he's all about transparency, communication, partnerships and I think he's done a lot of good things for this place.

RMM: So he's been here how long?

PB: A little over a year. He's turned it around financially, we've got 12 month under our belt now of positive cash flow. Before that it was loss after loss after loss. But Gary Muller will tell you he comes from New Orleans, one of the three hospitals that was open after Katrina and they lost you know $30-40 million in a fiscal year. He jokes that our measly few million that we lose is nothing, in the big scheme of things. He's a good one. I think he's on our list of people who should be interviewed annually. He's a good one.

RMM: I do an annual interview with President Wong at Northern. It also helps as long as the person is here ten years or twenty years.

PB: It's almost like a diary.

RMM: Yeah, it's a nice summation of what happened here during that time. I know I did it with President Bailey, now president Wong. And I think they appreciate it as a way of pulling it together and we have it in written form and they have it in their office and can go back and look at it.

PB: Yeah.

RMM: So it's kind of a whole new area?

PB: Oh definitely. I'd say for the better. The new administrator Gary has brought in experts in their field in MIT, Information technology is definitely the future. It's not something we can have somebody dabbling in when they have the time.

RMM: So in this area, we're talking about the foundation and the present and future aspects of the hospital and hospital community. Is there anything I've left out I didn't mention. Something you'd like to add.

PB: Not that I can think of off of the top of my head. Russ (wik)_____ reserve the right when I'm transcribing to edit and type freely. Oh I should have said this.

RMM: No, no. that's we'd like to go and take the interviews and send a rough copy. In the new era where we're not retyping, to the individual to see if they want to add or elaborate or anything. Just to give them the opportunity for a complete interview process.

PB: I can tell you how interesting Charlie(Last name)_____, he works for me, he says something and it's like oh that's right I forgot that happened. He's got an amazing memory that man.

RMM: See now once the project gets done we'll have all these interviews we'll have all this wealth of information, that would otherwise have been lost. It's sort of amazing when you do this and sort of look back how people then pass away and say ahhh, got their memories. Then that becomes an asset to the organization to have then and then you also have the misunderstanding that goes on, you know. And you can listen to it or what you get is people that are writing about someone and it helps pull the story together by looking at the history or the aspect of the hospital showing up in the Marquette monthly publicly. So all of this kind of builds into the realm of transparency, which is what is going on today at the hospital. No more of this era of secrecy. Not talking about some issues and so on.

PB: In an absence of fact people make things up.

RMM: Okay very good. Thank you.

PB: Thank you Russ.