UFHC 45
Interviewee: Francisco Herrero
Interviewer: Nina Stoyan-Rosenzweig
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S: This is Nina Stoyan-Rosenzweig and I'm interviewing Francisco A. Herrero at the Halifax Medical Center in Daytona Beach. The date is October 22, 2001. I guess I'll just start out at the beginning.

H: There was this big bang, and it got real cold, the dinosaurs all died. [Laughter]

S: I guess that explains it all then. When and where were you born?

H: I was born in Santo Domingo [in] 1934 and my family moved to New York City when I was just six months old. My older brother was fifteen months older and my twin brother and we lived in New York City until 1945, at which time we moved to Miami. I went to college and then went to Gainesville [to the University of Florida medical school] and started that whole thing.

S: You were about ten when you moved to Miami. Did you go to high school there?

H: Jackson High, Miami High. Miami High had a better orchestra. I played the violin, so I went there because they had a good orchestra. My best friends all graduated, so I went back to Jackson and graduated with my brother. Then [I] went to the University of Miami and did pre-med there, four years.

S: What was your family like?

H: My father was a musician. [He played] Latin-American music. Everybody in the family was pretty musical. My twin played the piano, my older brother played the radio, my younger brother played the French horn. It was pretty close, a very close family.

S: What made your parents move to the United States?

H: Opportunity. You go back to 1934, things were bad everywhere, but this is still the best country there was. My parents were not educated, they had [the equivalent of] third- or fourth-grade educations, but they put a tremendous emphasis on education. In my neighborhood in New York, we were one of the first Hispanic families – 109th and Broadway in Manhattan – and many of the Puerto Rican kids never did anything scholastically, got into trouble, bad things happened. Very fortunately, my family placed a great premium on education, doing your homework, doing your work, and consequently there were four boys and three of us are physicians and my older brother is a retired hospital

administrator. All of us wound up going on to higher education, which tells you you can do it.

S: That's really a wonderful story. Did you grow up speaking Spanish?

H: Yes, we spoke Spanish at home and English outside of the house.

S: What made them move to Miami then?

H: The neighborhood was starting to get rough, in the late 1940s there were starting to be gangs, and there were starting to be problems, they just decided [to move]. Things were opening up musically in Miami, Ft. Lauderdale and Hollywood. My father had an opportunity to go down there with a hotel and play. We made the move from the big city to Miami, which was really a small town then.

S: Did your father have a group of musicians he played with?

H: Yes, he had a little band of about five or six that played in nightclubs, dance clubs.

S: Did they ever do any recordings?

H: No. My dad did some recordings, just tapes, that we have, but nothing ever went commercial.

S: That would be fun to hear. So you ended up in Miami, you went to high school there. You went to the University of Miami.

H: Actually, I had a music scholarship. I played the violin and I was able to get my tuition free for being in the University of Miami orchestra. I did that for three years. Then my fourth year, I needed to start to save some money for medical school. I started work full-time at Jackson Memorial Hospital. My brother and I both worked there. He worked the 3:00-11:00 shift in pathology as a histology technician and I worked the 11:00-7:00 in the morning shift in what now is called inhalation therapy, but [was called then an] oxygen technician.

S: Was classical music your focus?

H: Yes.

S: Do you do anything with music now?

H: No. I did until about twenty years ago when I got too busy practicing, or at least I thought that I was too busy practicing. In the last couple of years, I have had

some problems with my shoulder and some physical impediments to playing the violin, so I have not done anything with my music in a bunch of years.

S: You said you were a pre-med student. Did you know pretty much all along that was what you wanted to do?

H: The motivation there [was] my mother's brother who lived in Santo Domingo and delivered us, in fact. He went to school in this country at the University of Maryland and went back to Santo Domingo. She always wanted us to be physicians, she was pushing for that. We were pushing for music and other things, and she was pushing for medicine.

S: Was there anyone in college who was particularly influential?

H: The concert master, Eugene Dubois was his name, [he was a] fabulous fellow from Belgium. I've got a love for cars too, which I have developed over the years, but he drove a 1931 Lincoln. It was a fabulous car, huge car. He was one of my heroes. Also Harry P. Schultz, professor of organic chemistry, was another one of my idols as a pre-med student.

S: Were you interested more in the chemistry side of medicine?

H: I was interested more in music than I was [anything else]. No, as it turned out chemistry was terribly hard for me. I was a zoology major, so I took all those zoo courses. Thankfully, when I got to medical school I was able not to work as hard in anatomy and histology and things that I had in college and [was] able to concentrate on biochemistry, which, in Gainesville, was a bear. I've just never seen anything like that in my life. A lot of us thought we were goners because of biochemistry.

S: How did you end up working as an oxygen therapist?

H: Right. I did that from 11:00 at night until 7:00 in the morning. [I] went to school at basically 9:00, had classes until 2:00 or 3:00, then would go home and sleep from 2:00 or 3:00 until 10:00.

S: Were you still playing in the orchestra?

H: No, at that point, I'd given up the music.

S: That was too much. Did you go straight to medical school in Gainesville after you graduated?

H: I didn't, I spent four years [there, but] I never did graduate. I spent four years

and got all my pre-med at the University of Miami.

S: You went with your twin brother to medical school in Gainesville. How did you all end up going there to that particular medical school?

H: Because it's the only one that took me. Dean [George] Harrell, the man that started [the medical school there,] was a fabulous man. He really turned us on in his vision for a school in Gainesville at the university. We only applied at two schools, Miami and Florida. Miami turned us down, Florida took us. Interestingly, about a week before graduation at medical school, Dr. Harrell told my brother and I to please talk to him [on] graduation day. He had something he wanted to say. Couldn't figure out what in the world that was, but in any event, graduation day we cornered Dr. Harrell and said, you had something you wanted to tell us. God bless him, he said, I wanted to thank you for not letting me down. I want you to know that you were both unanimously turned down by the committee and I pulled rank and I said no. Dr. Harrell said, these two guys are coming here, and I want to thank you for not letting me down. My brother got the Cory award, which is an award for the best overall student to become a family practitioner, and I did fairly well.

S: You were in that first class at Gainesville, the very first group who went through. That was the class that Dean Harrell had interviewed.

H: I wouldn't get an interview today. I had a lot of As and a lot of Bs, but there are a lot of students with much better grades. I forget how I did on the MCAT [Medical College Admission Test]. I forget if I ever even knew. Dr. Harrell fundamentally hand-picked the class. We had a lot of folks in my class who were older guys, guys with master's degrees, Ph.D.s, so a lot of my classmates were fellows that had been around. They'd taught, they'd gotten graduate degrees. I think Dr. Harrell had a strong feeling that you didn't have to be an A student to be a good medical student. You didn't have to make As to be a good doctor. I certainly would agree with that. We're talking about a class of forty-eight. I don't know how many people applied. Today, medical schools have five, six [or] seven thousand applicants, [and have] to pick 150. You know, it's very hard to do. I think all of us owed that to Dr. George Harrell that he saw fit to take us.

S: Do you know what he was looking for or how he made his decisions?

H: He just basically told me, you're not a straight-A student, but, on the other hand, you worked full-time and your brother worked full-time for four years. He felt that was worthy. I think he liked the idea that we were musically-inclined, liked the idea that I played the violin. He just didn't look at the grade-point average and MCAT [score]. It's hard to get in today, I think.

S: It's very competitive. Today there are so many people applying that they try to figure out different standards so they can get through all the applications, and they pay more attention to the numbers.

H: I'm convinced they could fill a class with [students who have] 4.0s.

S: I'm sure they could. You interviewed with him and he was selecting that class. I've read some of the interviews with Mark Barrow about how he really did select a diverse group in terms of ages and things like that. What was he like?

H: Dr. Harrell was really a gentleman, he was just a jewel, he was very soft-spoken, very articulate, just a very quiet man who spoke softly but did great things with himself. After there, he left and opened a school in Hershey, Pennsylvania. Not many people can say they started a medical school, let [alone that] they started and built two medical schools.

S: I guess he had a particular vision, not just for who he selected as medical students, but how the school should be run, the facilities and things like that. Is there anything that struck you about the school?

H: For starters, when they first built the school, [or] were going to build the school, [there was] a lot of criticism all over the state [about putting] the [school] in this little town. If I'm not mistaken, Gainesville's population was literally 35,000. At that time, this is 1956, they had less than 10,000 students in the college. Everybody's concept was that you need a lot of volume, you need large clinics, you need a large patient population if you're going to have a medical school. That brings up names like Miami, Tampa, Jacksonville, today it would be Orlando because they're growing. Dr. Harrell's concept was a small school, that volume wasn't all that important, that you could teach people to become physicians [and] educate themselves. What you lost in not having the volume, you made up with your approach and your ability to figure things out and also take advantage of the rest of the college, take advantage of the fact that you have engineers, sociologists, anthropologists, and all those other folks. There was a lot more to medical school than just a big building. Interestingly, when they first built that place it looked so huge. We thought, my God, what have you done? He was saying [from] day one, you're not going to believe this, but it's not big enough. Today already it's not big enough. I think he was a great visionary about that. I'm prejudiced because I graduated there, but I compare myself to the folks that I've been with at Emory, North Carolina. My brother spent a lot of time at Duke. I think the fact of the matter is that we, and also many of my classmates, performed admirably compared to guys that were in busier schools, bigger schools. I think Dr. Harrell was right, I think his concept was correct. You don't have to have an emergency room that sees 400 or 300 [patients] a day to learn how to do it. I think he was right.

S: Certainly Hershey, Pennsylvania, is not a big town.
H: Is it very similar?

S: I think so, it's a pretty small town. It's not in the middle of a metropolis or anything like that.

H: [Like] Philadelphia, sure.

S: It's not even that close to Harrisburg or other fairly large towns in Pennsylvania.

H: I think personally that his concept was good.

S: The idea of community-based medicine was important to him and he may have thought that you had more of a sense of community in a smaller town.

H: I'm glad you mentioned that because I think in some ways he was a little naive. I can tell you that when they first started the clinical year, he would have a surgeon [work with students]. One of the very first patients I presented was a diabetic patient. The doctor that was making rounds that day was Dr. Bill Wheat, a thoracic surgeon. Dr. Harrell had [an] idea of this congenial small group. I think he was a little naive there. I think the other thing which was great for us at the time [was that] being a new school, they didn't have much in the way of residents, house staff, so the students got involved to a much greater degree than they are today, where they have interns and residents. The focus when I was there, when we first started, the focus was absolutely on care of the patients and educating the medical students. That focus has shifted and changed to not only educating medical students, but educating PAs [physician's assistants] and educating interns, and residents, and all that. One of the trade-offs in being in a small place like that was that you got really individualized treatment. You really got to know the professors. I venture to say that today in many of the large medical schools, a student would never talk to a professor, whereas in Gainesville you could be sitting in the coffee shop and they'd come in and sit down. That part was very good because everybody knew everybody, and it was small enough where everybody got involved.

S: Did Harrell feel that physicians shouldn't be too specialized, that they should also be generalists?

H: I hate to say it, because that's been over forty years [ago]. The amount of material, the amount of information, and the amount of knowledge that you have today, it just mummifies you compared to back then. That idea of the guy that's all-knowing, all-being – it's not a reasonable expectation. I wound up doing general surgery and later plastic surgery, but you wind up specializing and

narrowing and focusing what you're doing so that hopefully you're getting very good at what you do instead of being so-so [at] a lot of things. You're very good at doing a small amount. I think that came later. I think the basic concept was great at the beginning.

S: He had hand-picked the first class, but did he also pick a lot of the early faculty members?

H: To us it was remarkable when you looked back on it. When a professor of [surgery], Dr. Woodward, the surgeon, came, he was forty-two. When the chief of pediatrics came, he was thirty-one, when the chief of OB/GYN came he was thirty-one. These are folks right out of residency. I remember he announced when we were sophomores that he had chosen the chief of ophthalmology, we said, when is he coming? [The answer was,] he's still a resident. He hadn't finished his residency yet, but this fellow was very bright. So he did, in fact, bring in a lot of young folks, which I think was very exciting.

S: He also hand-picked people who he saw as rising stars, and figured that he could get them early in their careers.

H: It was remarkable, the young people that were there.

S: Was there anyone who stood out for you?

H: My hero was Jurkiewicz, my old chief of plastic surgery. Yosh was a plastic surgeon who trained at Barnes Hospital. He started out in the service as a dental officer, then decided he wanted to become a physician and he went to Harvard and went to medical school there, spent four years. Then he went to Barnes Hospital, where he spent seven or eight years doing general surgery and plastic surgery. He was a brilliant guy, one of the best people I've ever known. That's what happened, you meet people like this as a student and you say, I want to be like this guy. That's how I wound up going into surgery and then plastic surgery. The same thing with Dr. Woodward, he demanded a lot of respect and he was one of my heroes also. He was so good with the students and house officers.

S: What was the medical education like there?

H: It was fierce the first couple of years, literally. Another concept Dr. Harrell had was this little cubicle – every student had a little place where he could put his coats and his books, and had a study cubicle. That was nice because you didn't have to haul a microscope back and forth to the dorm. We had to live in the dorm the first year. The amount of work, that was the thing that was incredible, was the difference in how much work there was in medical school as compared

to college. We had a lot of my classmates that were Phi Beta Kappa [academic honor fraternity] in college, that made straight As, but they really worked like hell to do it. When they got to medical school, [they] said, my God. It was awesome. We were there every night til midnight and on Saturday and Sunday you spent most of the day there. The first couple of years, especially the first year, especially biochemistry, was brutal. It was very academic.

S: Do you remember who taught biochemistry?

H: Frank Putnam was the professor, a super guy. Mel Fried was one of the youngsters. I'll never forget the first day in class they passed out this exam that looked like the New York telephone directory. They said, this doesn't count, but we just want to find out how much you guys know, who's where, where we are, an idea of what we're looking at. I guess a week later they came and they announced the grades. They said the grades ran anywhere from twenty-seven to ninety-seven. I think Roger Palmer made a ninety-seven, he was a brilliant guy. He said, anybody that made less than fifty, get together with your tutor because you're obviously going to need some help. I remember Dr. Fried was my designated tutor, so I said, Dr. Fried, I think I made a sixty-one or sixty-two. I'm still very uncomfortable with this chemistry. He said, come by my office Thursday, bring your P-Chem book. I said, I never took P-Chem. He said, okay, bring your Quant book. I said, I never took Quant, I was a zoo[ology] major. He said, what have you taken? Did you take Qual? I said, yeah. He said, then bring your Qual book. I said, no, I sold all of them. I'll never forget Fried, he was a tough little cookie. Biochemistry, for me, was very hard.

S: One of Harrell's ideas was to try to get the medical students more involved with the rest of the campus, but it sounds like you all didn't have time to do anything up on the campus. You were not that far away, but it was enough of a distance to make it a hike to get to campus.

H: I think the other thing, especially in the clinical years, [is that] you do learn of a lot of factual material. Hopefully, what they really teach you is how to become a student. [If you are] given a problem, [you can] look at the problem, and say, this patient's problem is here. You are trained to go to the library, go to the journals, the books, and to educate yourself on an on-going basis so that when you graduate in 1970, you're not a 1960 doctor who just remembered what he learned as a medical student and no more. Hopefully, when you get out you have the ability to grow and learn and solve problems. I think they emphasized that.

S: What was it like to have your twin brother in classes with you?

H: That was fun, but one of the first things they did was separate us. I forget, my

partner in biochemistry and anatomy became Louis Stalnaker. They purposefully split my brother and I. They said, these guys have been together too many years. They split us, if you will, which I thought was a good thing.

S: Where were you living on campus?

H: That was another genius [idea]. They decided that since we were freshmen [medical students], we lived in a dorm the first year. Since we were freshmen, they put us in the freshman dorm, the first year of college for kids right out of high school. As it turns out, it didn't matter that much because we were rarely [there]. We had a little room with a twin cot and we basically never got there before 11:00 or midnight. That didn't matter that much. After awhile, I forget, three or four of us got together and got an apartment the second year and started living a more human life than a dormitory life.

S: Especially with freshmen who are still interested in other things.

H: These guys were worried about fraternities, it's sad.

S: A different world. You'd worked your last year as an undergraduate to save money. Were you working during your medical school years?

H: The third year, yes. Starting in the third year, both my brother and myself and two other folks worked in the blood bank, we were the blood bank technicians. We worked from 3:00 or 4:00 at night until 7:00 in the morning. They had a place to sleep there, but if they needed blood, you are the one who set it up, if you had to get donors, you were the one that did it. Obviously today, that's such a huge thing that it's not a job, that a junior medical student could do with just a couple hours of on-the-job training, but I did that for two years, worked at the blood bank.

S: Your first two years, you didn't need to work?

H: No.

S: Of course, it sounds like it was intensive enough that you couldn't have worked.

H: [It was] murder.

S: Were you taking classes during the summer as well?

H: Between the first two years, [I] went home and went back to work at the hospital in inhalation therapy for the summer. I think I did that two years. After the junior year started, you went straight through, you didn't have a break. Between the first and second, second and third, I worked at the hospital for the three

months of the summer.

S: The first two years were basically classroom learning. Did they have any classes for you in things like bio-ethics? Was that at all an issue at that point?

H: I don't specifically remember a course. I know that we took some pre-clinical stuff in doing histories and physical diagnosis. I've really blocked whether we did that freshman year or sophomore year, but it was before the junior year and at that time, we didn't have a hospital. We went to the Lake City VA [Veteran's Administration] or we went to Jacksonville to Duval County, that's where we learned to do physical examination, do a history and do physical examinations. That used to be fun because that was a trip out of town, get on the bus and drive to Lake City, stop for a beer on the way home and [we got to] deal with the veterans who were a good lot of folk to work with.

S: They probably had good stories.

H: After one guy has been worked up three or four times and the student is examining him, he'll say, listen, you hear that murmur right here? The student says, what? [The patient] says no, you've got to lean forward, put your stethoscope here. The patients got to know what it was that they were supposed to show, what [problems] they had. They would tell the students about it.

S: The hospital opened in 1958, correct?

H: Right, October of 1958.

S: By your third year, then, you did have a hospital. Does anything about the clinical years stand out?

H: My first rotation was OB/GYN with Harry Prystowski. He was something. This man had come down from Hopkins, he was like thirty-two years old, he was a character, would tell more stories, embarrass you in front of patients. This guy was a real looney-tune. By the way, Harry Perstowski wound up at Hershey as professor of OB/GYN. I think he may have passed.

S: I think so too, I'm not sure exactly when.

H: He was one of these geniuses. When he went to intern at Hopkins – he went to the Citadel, I think he went to medical school at South Carolina – he wasn't even twenty-one as an intern [the] first year. He was very young, for everything he did. Loved life, mischievous.

S: Was he being humorous when he was embarrassing you or was he grilling you?

H: It was funny if it was somebody else getting it. It wasn't too funny if it was you getting it.

S: Was [Robert] Cade [developer of Gatorade sports drink] there when you were there?

H: Cade was not there when I was a student, but I got to know Bob Cade. I spent four years here in general surgery. I got to know Bob after [I was a student], but Bob wasn't there before 1960.

S: Did you know Jape Taylor?

H: Absolutely. The Fang, we used to nickname him the Fang. He was fabulous, he was a great clinician, great teacher, embarrassed the students, [would] almost bring you to tears in front of the patients. I'll never forget one time – this is a situation where Dr. Taylor was making rounds on a surgical patient who had an ingrown toenail – Sam Smith, one of my classmates, was a brilliant guy, absolutely. He knew more about ingrown toenails than anybody in the world. I think he read every article, every book, everything to know about ingrown toenails. Dr. Taylor was the attending [physician], the man making rounds. Sam was just ready for him on ingrown toenails. He presented the case and did all that. Dr. Taylor says, Sam, talking about nail beds, can you give me thirty pathogneantic nail bed changes. He said, what? He never asked him to think about ingrown toenails, he just took that as an opportunity to talk about changes of the nail bed and different diseases: clubbing, spooning, misshape, diabetic ridges. He was fabulous. Sam was just dumbfounded. He stood there like a fool. But Dr. Taylor was fabulous, he was a fabulous teacher, great clinician.

S: He was famous too for his ability to use his stethoscope and detect different conditions and things like that from sounds.

H: Physical diagnosis, I guess they still teach it. I hope they still teach it. Now folks get an X-ray, a CAT scan, an MRI, one of the last things [doctors] do is talk to a patient and examine a patient. Dr. Taylor trained at Duke and his mentor was Eugene Stead. Stead's forte was [to] come on rounds and the house officer will present the case. Dr. Stead would walk over the patient, run his hand through the patient's head, and all of a sudden [he] is saying this guy has got a disease, we don't know where it's coming from, he's got metastasis to his lung, we don't know where the primary is. Dr. Stead and Jape, the same way, would say, here's a nodule right here, why don't you biopsy this thing here and find something that nobody had [found]. I'm sure a lot of them looked for it but they weren't quite as thorough, as complete. Dr. Taylor was very good at history. He said if you listen to a patient, ninety percent of the time, he'll tell you what's

wrong with him.

S: A lot of times doctors don't listen hard enough.

H: You get in a hurry and you have all this technology now.

S: I guess you can even attach a Doppler to a Palm Pilot so you can see what the heartbeat looks like, instead of listening to it.

H: Sure, that's old-fashioned now.

S: How about your classmates in that first class?

H: There were some stand-outs. Roger Palmer, a very very bright guy who enjoyed drinking home-brew. I'll never forget we'd sit in the student lounge eating. The married guys would be complaining about what [they had to eat]. I'll never forget one time Roger had a spaghetti sandwich, he said, can anybody top this? A spaghetti sandwich. He was very, very bright. Mark Barrow was very bright. Probably the smartest guy in the class was Sammy Smith, who sounded like a hillbilly and talked real slow, but dang, he was really smart. Ed Wesmark was another guy that was very, very bright. We had a character named Marvin Baker. He was funny because he liked to be called doctor and he would call the residents by their first name. Charlie [Park], chief resident of surgery. Charlie, this is Dr. Baker. No, it's Dr. Park, this is Marv. He was a character. [We] had some good people in that class.

S: Where did you do your internship?

H: I interned at Emory, did a straight surgical internship at Emory which was okay because I got an opportunity to see a lot of first-rate private surgeons operate. I took care of a lot of patients, didn't do as much as I would have liked to have done myself, individually, but saw good surgery. Still, I felt that Gainesville was better. Consequently, I left Emory after the internship, went back to Gainesville for my general surgery [residency] for four years. Then I went in the Air Force for two years, I was in South Carolina, then came back to Gainesville for a year of plastic [surgery], then I went to North Carolina for a year of plastic, Chapel Hill, then I came back to Gainesville on staff for a year.

S: What year was that?

H: 1969 to 1970. I enjoyed medicine. I enjoyed doing histories and physicals and doing things. My disillusion is that I was not a researcher, I wasn't doing any research. I was strictly a clinician. It's not to say that they didn't need clinicians or want clinicians, but I was disenchanted at that point with some of the house

staff. There were some that were fantastic, then there were those who were lazy and didn't read and didn't study. After a while, I said, I really enjoy taking care of folks on a one-to-one [basis]. That's when I decided [to move]. I was the first plastic surgeon in Daytona Beach in 1970. That's when I decided that I was going to leave the university. I've got no regrets. Dr. Woodward treated me like a son.

S: Was that during medical school, or residency, or the entire time?

H: Well, [the time I was] with them. Actually, I was fortunate, my third year of general surgery residency, I spent the entire year with Dr. Jurkiewicz on his service. At that time, he didn't have a plastic resident. As a senior resident on service, I got to do all the stuff that the plastic resident would have done. That year was an unbelievable year. I did everything in the way of general surgery through plastic surgery. It was a absolutely fabulous year. Then I spent six months the next year as chief resident, six months at the VA at Lake City, where I had near one hundred beds and did an enormous amount of work there, and then came back to Gainesville for the last six months as Dr. Woodward's chief resident on his service. He let you do a lot of work.

S: You would say your interest in surgery was guided by these people?

H: Absolutely. Mainly Jurkiewicz and Woodward, those two, but then others. Tom Bartley in thoracic surgery, Bill Wheat taught me a lot. He wasn't very charitable when it came to praise and he was very critical, but he was a good doctor and taught me a lot.

S: You were doing general surgery, so what types of surgery did you perform?

H: Hernias to stomachs, thyroids, breast, colon.

S: What would you say made you more interested in plastic than general surgery?

H: I think there was an opportunity in plastic surgery to do things that weren't just rote. Sometimes when you take out tumors and do things, you wind up with a defect or a problem. It's different for every patient. I always enjoyed being able to analyze the situation and say, what can I do to make this work? When I was in the service, I hate to say it, but in the military I was doing ten or twelve hernias a week and operating on a lot of young people and that just wasn't very challenging to be quite honest. At least, based on what I was doing in the Air Force, I really looked forward to getting [to do something new]. I always enjoyed doing kid surgery, cleft lips, cleft palates. I always had a huge interest in cancer surgery, the head and neck, which Dr. Jurkiewicz was very good at. We did most of that surgery at the hospital. I think you did more as a plastic surgeon,

different than general surgery.

[End side A1]

S: I guess in a way, plastic surgery is more creative. How do you plan or conceive of a reconstruction? Let's say you've removed a tumor and there is a scar.

H: If you have a tumor or a scar, a bad scar with a contracture, one of the basic concepts there is you recreate the defect. If somebody was burned and they had this defect, then it was allowed to heal by just scarring. The first concept is recreate the defect, so you open everything up and say, now what do I need? There's some things you need. You may need just skin cover, or if there's nothing underneath there that's very thick, you may need skin and fat. If working inside the mouth, we need skin, muscle, and mucus membrane. That leads you to figure out what you're going to do with local tissues. At the time that I trained, we didn't do that much with distant flaps and free flaps, the micro-vascular flaps was not something that was being done when I trained. It is the concept of finding what's missing and where we can find it. What can we do to bring it into the area?

S: Do you also have to think about how tissues are going to shrink or expand as they are healing?

H: The point is if you put in muscle, or fat and skin, a nice thick piece of tissue, the chance of that contracting is very small as opposed to putting in a little, very thin skin graft which can shrink. If you put something there that's the closest to what was there, yes, sure.

S: What years were you in the Air Force?

H: 1965 to 1967.

S: Were you in South Carolina the whole time?

H: It was a little air base, called Shaw Air Force Base in Sumter, South Carolina. There was an eight-five bed hospital. Even though I was just a captain, I was chief of surgery because I was fully trained. I had a junior surgeon who had a year of internship and one year of residency, and was going to get drafted and he wound up joining. The two of us [were there]. Then we had several pediatricians, three OB guys, ENT [ear, nose throat], orthopedics. The beauty of it is, every one of us there had just gotten out of a residency. So everybody there was young, anxious to do their thing. We had a chief, the colonel there was very good. He pretty much left us alone as long as the job got done and nobody complained. He was very good to us. That was a good two years. [I]

did a lot of common surgery, a lot of work. For the first time in my life, [I] had twenty bucks in my pocket. It was a very good experience. In fact, my junior surgeon, Jim Cather, when I came back to Gainesville to do plastic, he came to Gainesville to do general surgery, which he finished there. Excellent guy, and then he went on to the Watson Clinic to work, where my brother had been for years. The service experience was excellent. I see so many guys who were unhappy and complained about the service. I can't say that, we had a great two years.

S: Was that during the Vietnam War?

H: It had just really gotten cranked up. In fact, when I first got there, we were a reconnaissance base. The flyers there were picture-takers. They flew fighter planes, but they took pictures. When I first got there, they were going to Vietnam on what they call TOY, temporary duty. They would go for maybe three months, something like that. Their families stayed at Sumter, stayed on [the] base. By the time we left, they were on PCS, permanent change of station. It was a training base for that, but when you left there, you left full-time. Your family didn't stay. I got out in 1967, it was over in 1972-1973. It was just getting really cranked up when I went in, and it was going on full-force. In fact, when I went back to Gainesville, a group of residents, tremendous bunch of guys, everyone of them got drafted that year. All but one got sent to Vietnam. Things had really escalated then, compared to what it was when I first went in.

S: Were you working while you were an intern?

H: No, that was a full-time job. I took a good-paying job. Emory at that time was fabulous. I made $185 a month. I rented a room there. They had a house staff kind of a place for $50 a month, so I was making $135 a month which was a fortune. My twin was at Duke and the interns there got paid $50 a month, but they got to live there, and they got their meals and uniforms. Heaven help you if you ever gave them any of your regular clothes. They'd be so starched they could stand up by itself. Back in those days, I'd venture to say that the majority of house officers were single. A lot of the house officers were single. You had nowhere to go. He didn't have anywhere to go spend his $50, he was so busy.

S: What was his speciality?

H: Internal medicine. He wound up in internal medicine, and then GI, gastroenterology. Actually, he did an internship at Duke in internal medicine. He worked in pathology for years, a tissue technician. He always loved pathology and he was very good at it. He wanted to do some time in pathology, because he was still torn between becoming a pathologist and becoming an internist. He went to Hopkins and did a year of pathology. Then he got drafted

and because of the chief there, Dr. Bennett, got him a job, it's interesting now, at the chemical warfare plant, doing pathology. These guys were working with anthrax, botulism, Agent Orange, all of these things. He spent two years doing that, and then he decided he really didn't want to be a pathologist. He went back to Duke and did three or four years at Duke in internal medicine, gastroenterology. Then he went up to Yale, spent a year with Flatsen doing hepatology. Pathology came in because of looking at liver biopsies. I always say he's the world's most trained GP [general practitioner], because he really had a very general kind of a practice at the Watson clinic.

S: You did a residency at Gainesville and then you were back in Gainesville from 1969-1970. Was there more of a research focus at that point?

H: No, the deal was that they did have a place for that. The old saw: publish or perish, or if you don't do that, the odds are you're going to do real well as a pure clinician and not doing research in an academic center, the odds are stacked. It's fundamentally an interest. Now, there's no question there's a need for clinicians, people like Jape Taylor. I don't remember how much research Jape did. I think my problem was I used to get disenchanted. If I made rounds, told a resident, debride that wound, do something, then the next day I'd come back and it wasn't done. That didn't make me happy – to have to deal with people. I prefer to do it [myself]. If something needed to be done, I didn't see it as a big chore to do it myself.

S: Certainly, that would be the case if you're trying to talk to someone who wouldn't take the responsibility for it.

H: Now there were some stellar residents. I had some residents there that would just knock you down, they were so good. I supported those guys, I let them do things that were beyond what you would think a first-year resident should do because they were so good. They worked so hard, and they studied, and they deserved the [opportunity] to do that.

S: What did Gainesville pay you as a resident?

H: It was good. I think my first year back, my first year of residency, I think was $300 a month, which was after $185, then by the time it was chief resident, it was up to $500-600. That was an enormous amount of money. Today they pay internist residents $40,000 a year. It's been 40 years ago, times have changed.

S: After your year, from 1969 to 1970 in Gainesville, what did you do?

H: Then I came here and opened my practice in plastic surgery.

S: You've basically been here ever since.

H: I've been here since. I quit practice a little over eight years ago. I practiced for twenty-some years, went through a divorce. Medicine has changed. It really has changed. It's not the fun it used to be. Government is more involved, third parties are involved. The practice of medicine became not as good as it was. The CEO [chief executive officer] here approached me because I had been doing this job part-time for a couple of years. He approached me and said, we're getting big enough now, we have over five hundred or six hundred doctors on the staff, would you consider doing this job full-time?

S: What is it that you're currently doing?

H: My title is director of medical affairs. I'm liaison between the hospital and the medical staff. [I] fundamentally run the medical staff aspect. Credentialing, looking at new doctors who apply, making phone calls, that sort of thing. If guys misbehave, it's my pleasure to have to sit down and talk to them. It's purely an administrative job compared to [what I did] before, but I call it chapter two, after having gone through my first family. I've got a nine-year old now, a little over nine. Life is good. I get here at 7:00 [or] 7:30 in the morning and I'm home at 4:00.

S: You don't get called in the middle of night or anything.

H: No night calls, no weekend calls, it's a different deal.

S: When you came here to Halifax, it was 1970. How many physicians were there on staff?

H: I don't remember but I think they had [about] 150 or 170. I think it was less than 200.

S: And now they're 500, you say?

H: Over 600, yeah.

S: Well, that's quite a change. What made you choose Daytona Beach?

H: Basically, here I was a plastic surgeon and saying, who needs a plastic surgeon? I love Gainesville, I think Gainesville's one of the greatest places. I went down and talked to a fellow who was in practice at the time, Bruce Walton, and I was naive enough that when he said, oh no, this town couldn't support [another plastic surgeon]. At that time he was the only private plastic surgeon in Gainesville. Lenny Furlow and Yashow, everybody else was at the university. I

would have loved to have stayed there, but I believed him. I said, what do you think about my going into practice here? [He said,] God no, [it's] terrible, there's not enough work here for me. I was looking around and [it] was felt that it took about 70-75,000 people to support a plastic surgeon. I wasn't crazy about Miami, going back to Miami or a big city. I liked [about Daytona that] we had a huge number of fellows who had trained at Gainesville. Jim White, we lived together for a year, was a pediatrician who was here in town. His partner trained in Gainesville, who I knew, an ophthalmologist who I knew, a general surgeon. I had a lot of friends and knew a lot of people in Daytona. At that time, the greater Daytona area was about 85,000, so I figured I [could] make a living there. Interestingly, when you talk to guys, a lot of them say, I never send anybody. A lot of times they don't send somebody because there is nobody. Plus, my wife at that time was from Daytona Beach, she was born and raised in Daytona Beach. That was a natural.

S: When did you get married then?

H: I got married my chief year, just before we finished general surgery.

S: You never considered heading back to New York?

H: Oh God, no. I've talked to a couple of the guys that I grew up with. I've got to laugh, because this is twenty-some years after I'd left. It's a strong New York accent. I think to myself, I can't believe if I stayed up there, I'd be talking like those guys. No, I never considered going back to the big city. I'm basically a small-town guy, I like small towns.

S: You have never considered leaving the south or Florida?

H: No, [it is a] great place to live, I think.

S: How did you build a practice in Daytona?

H: My first month here was almost the busiest month I had. A lot of the fellows, general surgeons, pediatricians, and people that I knew had some cases that lined up for me when I came to town. All of a sudden these people came in to see me.

S: So most of it was referrals.

H: Referrals from people that I knew. Then you start getting referrals from patients, which is the best referral, the patient referral. [It] just worked out.

S: Did you do more reconstructive than cosmetic surgery?

H: I did general, I didn't do that much cosmetic. I did some breast surgery augmentations, face lifts, but I did a general practice. I think my first year here, I did like six or seven cleft lips, some cleft palates, did a lot of skin cancer, there's a lot of skin cancer in Florida. At the ocean, people [are in the sun a lot] out here. I'd say that what I did most of, more than anything else, was skin cancer. Most of it minor, but a fair amount of it major. I did what I would call a general practice of plastic surgery. It wasn't a cosmetic practice.

S: Did you see more skin cancer as time went on? I'm just thinking about the ozone layer depleting.

H: I don't blame it on the ozone, it's just people being out there. The one cancer which I really think has increased in numbers is malignant melanoma. I previously saw four or five, certainly less than a dozen patients with malignant melanoma in a year, [whereas] my last couple years in practice, [I] would see a couple a month. There's no question in my mind that there's a definite increase in the number of malignant melanomas. I don't know that I blame it on the ozone, but I blame it on people that buy tanning beds and want to just live. In fact, one of the first cases I did when I came to town was a twenty-one year-old lifeguard who had a malignant melanoma. A young, strapping kid with a million freckles on his face and a melanoma. I think we're seeing more melanoma than we used to see, I know we are.

S: Is that always related to the sun? An aunt of mine lives in southern California and she had one on the sole of her foot.

H: The sun never shines there, I know, but that's the exception.

S: I'd just wondering if she'd gotten too much exposure in her skin and then the disease showed up somewhere else.

H: Usually you see these things on the face, in the trunk, on the back, the arms, areas that are exposed.

S: Did you do much burn reconstruction?

H: No, fortunately we didn't see that many burns. We weren't really set up at that time and we still don't have a burn center here. That's very intensive work. Basically, the major burns got sent to burn centers, either to Gainesville or the military. Kids would go to the Shriner hospitals. That was fortunate that we did not have a huge number of burn patients.

S: Is that the hardest kind of reconstructive surgery do you think?

H: No, I don't think so. I am trying to think of what is the hardest.

S: Or maybe the most challenging?

H: I think if you take care of them right at the first get-go and avoid contractures and avoid those problems, that keeps you from having to correct them.

S: Not meaning to change the subject, but are those your cars? I notice you have two pictures of two cars.

H: Salvador Dali did those [cars]. Those are cars I used to own, I used to own a limousine and a convertible, that's when I used to live down on the river. Now, I've got a 1949 coupe.

S: That's beautiful.

H: My brother and I drove a 1949 coupe, drove it to Gainesville, drove it through four years of college and four years of medical school, an internship, and one year of residency. Drove that car for ten years, best car I ever owned. Took me twenty-five years to get another one. Cost a whole lot more than the first one which we bought in 1952.

S: Do you collect cars?

H: I've only got one. I have had as many as three or four, two Cadillacs and a couple of other clunkers, but I finally have tried to make my life easier than spending all my time in a garage getting a car fixed. I'm down to my Cadillac, that's the only collector car I have.

S: It also makes me think about Dr. Cade, who has cars.

H: Studebakers.

S: Nobody seems to know how many he's got.

H: I don't think I've seen Bob in five or six years, but it seems like the last time I asked him, I think he had twenty-seven or twenty-eight. It got so bad that his wife made him buy some land out in the country and build a warehouse for them, a barn to keep them in. She said, this place is looking like Sanford and Son [television show about a junkyard owner], all these cars in the yard.

S: What is the most challenging reconstructive surgery? You were saying burns, avoiding contracture.

H: Yeah, that's a good question. What is the most challenging? I would have to say an ear, only God can make an ear. Many tests have been made, there's been some real advances, but they didn't hold up over the years, they just shrink up and shrivel up. It's hard to make because of the fine detail of the cartilage. I am talking about people born without an ear or [who] lost an ear. I've seen some ears, I hate to say it. God, don't quote this. I've seen some ears where it looked like somebody put some cartilage under the skin, raised it up and pulled it out a little. It's looks like a pork chop, it doesn't look like an ear. I think only God can make an ear.

S: I remember now seeing something about they're trying to grow ears in petri dishes, where they would try to make some sort of cartilage.

H: [A] framework, sure.

S: I don't know what happens after they attach them.

H: They have a way of shriveling up after time and not growing with the patient, with the body.

S: If it's a child, it doesn't grow. That's interesting, an ear that's the hardest. What else were you working on, reconstructing with cancer and dog bites?

H: The dog bites you take care of initially. Fortunately, if you scrub them out real good and give them antibiotics and take care of them, the infection rate wasn't that great. On occasion, you would lose a portion of a lip or something [and] you would then use adjacent tissue, bring over what's missing – mucous membrane, muscle, fat, skin, and use like tissue to bring that in.

S: You were saying that you feel medicine has changed. Did that change affect your practice, did it affect your ability to work as a surgeon?

H: As far as I'm concerned, several things [affected my practice]. It seemed that pleasing people got tougher and tougher. People saying thank you got less and less. Now we're talking about cosmetic patients. To me, one of the most important things in the cosmetic cases, to have a reasonable expectation and hopefully the patient is on the same page you're on. To have somebody come in and think, I'm going to look like Linda Darnell or some movie star when this is done, there's no way in the world you can accomplish that. To me, that's an important part of patient selection. Hopefully, you can predict some of those folks, and those folks you don't operate on. You say, I just don't think that I can do this. Having said that, other patients where you think this patient is

reasonable, she has realistic goals, and then you operate upon them and then it's not quite [they expected]. You find yourself showing them the pre-op pictures and saying, look at what you looked like before and look what you look like now. They get to the point where they say, don't go get that picture, I don't want to see that now. Then you wind up doing little revisions and trying to please them. It's bad. I was fortunate, I was never sued to the point that I went to court. I never had any great loss of money as far as that's concerned. That's in the back of your mind all the time. If somebody's unhappy, you're going to be sued. We see more and more of that. In my position, I'm involved in the medical incident committee, and we look at suits. That's frustrating. Doctors are not infallible. In a sense, we've set a standard that may be way too high. People think if somebody died, somebody must have screwed up because in 2001 people don't die from being hit by a train. Somebody did [a] bad [job]. There's that aspect of it. There's the aspect that you got a call for permission to do things to folks and certain tests, can we do this? You're not really in control of the patient. I comment that my brother-in-law who works, it seems like the company he works for, they change insurance carriers every two years. Every two years I find him coming to me and saying, Frank, here's a list of the doctors for this particular insurer, who do you like? I don't think he's had the same doctor for more than two years in the last ten years. The insurance companies, HMOs [health maintenance organization], they're controlling the patients, they have control of the patients. They're not yours. Thirty years ago, twenty-five years ago, everybody worked hard, everybody made reasonable money. You very rarely heard guys complain about charity patients or service cases. They felt that was the dues you paid for being on staff. I'm allowed to work here, so I'll do that. I can tell you that not only at Halifax, but nationally, [it] has become a real problem with who is going to take care of the uninsured patient – people that have no insurance and have no money. Historically, it's the doctor, you're expected to do that. I must say I've changed considerably on this. Twenty-five years ago, if I heard of a guy that didn't operate on somebody because they didn't have the money, I'd think less of him and say, what the hell is wrong with that guy? On the other hand, as the practices have gotten smaller, as the reimbursement has gotten less and less, where twenty-five years ago, you didn't know who was pay and no-pay, you didn't care, you just took care of folks. Now all of a sudden, doctors find themselves responsible for the care of people with no insurance and no money. It's a societal problem, you know. They expect you to come in at 2:00 in the morning, operate on this guy for nothing and if you're lucky, you didn't get sued. That's changed. I've gotten to the point where – I hate to say this – but you can't go to the restaurant and order a paté and the duck and say, all I've got is two dollars, or I don't have any money, catch me next week. The plumber isn't going to your house and do something for you. Your TV is not going to be fixed. The only guy I know that is expected to come out and take care of somebody for nothing is a doctor. Doctors are getting tired of that. I don't want to put the bash on lady doctors, but in our class of 1948 we

had four ladies. Now, it's fifty percent and rising. Again, I'm not smashing them, but a lot of those folks say, I want an organized life, I wanted to be primary care, I want to come to this clinic 8:00-4:00 five days a week and then I don't want to be called after 4:00. I don't want to be bothered at night, I don't want to be bothered on a weekend. I've got my other job, which is my family. I think that's very sad. I think we see guys now who are more concerned with the money, more concerned about the bennies [benefits]. I can't think of one of my classmates that was in medicine because of the money, because he knew he was going to make money. It's just getting tougher and tougher.

S: Do you think patients' expectations of plastic surgery have risen over the years?

H: No, because there have been unreasonable expectations [all along]. If you see movies from forty years ago, they showed this scarred-up thing and all of a sudden here's this beautiful girl. Plastic surgeons are miracle workers. The expectations are higher. Marcus Welby, [television show doctor] fortunately he only treated one patient a week. That TV show was [about] one patient, that's all he saw. He didn't see fifty a day like he does today and everybody got well. He sat there at the bedside and worried about them. The expectation is that in the year 2001, if you don't get well, if something goes wrong, somebody screwed up. Sometimes that's true, sometimes it's not true.

S: It seems that people are now more willing to undergo cosmetic surgery for any part of their body that they want to change. Is that a fad, do you think?

H: We push it, we advertise, something that didn't happen thirty years ago, plastic surgeon advertise. You're getting thin, you're getting bald, you're getting this, you're getting that...I've got the answer. You're going to do better, you can't compete in your job because you don't look as young as the other guy, or you're not as young as the other guy. If we can make you look younger, you're going to do better. The lady that comes in with a sixteen-year-old girl with this terrible big hook nose, says she's a wallflower, doesn't go anywhere, her self-esteem is zero. What you can say is [that] the odds are great that if we do this, she's going to feel better about herself, but I don't expect that it's going to change like throwing a switch. All of a sudden you're going to take a homely, quiet person who is a wallflower and all of a sudden she's going to be Miss America tomorrow. It just isn't going to happen. That's where we get in trouble. We, the patients and doctors, get into trouble when the expectations are not something that you can really do. Somebody comes in and says, I'm having a problem with my wife, she's cold, she's frigid. I know that if you do an augmentation mammoplasty that my sex life is going to be better. We say, listen, we accomplish one thing when you're doing augmentation mammoplasty and that's to augment the size of your breast. Hopefully, if you feel better about yourself or whatever, maybe there will be some corollary things that take place, but that's

not what we're doing this for.

S: That's not the promise.

H: Yes. The other problem is that everybody and their brother wants to be a plastic surgeon. We have GPs in this country that do cosmetic surgery, we have oral surgeons now that do cosmetic surgery, we have dermatologists now who are doing cosmetic surgery. I find it interesting that something I spent seven or eight years in training to do, all of a sudden somebody thinks that they can do that with one year of cosmetic training. There are some terrific ear, nose, and throat doctors that do cosmetic surgery, that train or do it. They do it well, it's fabulous. We're now seeing dermatologists doing liposuctions and we're seeing dermatologists doing blepharoplasties [eyelid reconstruction], doing more and more cosmetic surgery. Beware.

S: Would you recommend that people look for someone who's had the eight years of training?

H: I look at it this way, people will tell you that I know some board-certified surgeons that are terrible. And I do, and I know some board-certified surgeons and I wouldn't let them operate on my dog. However, if you take one hundred board-certified guys here and one hundred non-certified guys here, your odds are going to be extremely better dealing with this group [the board-certified group]. It's not say that there aren't exceptions, which means a very bad guy over here, or an unbelievably talented guy over here. People's ability, in general, reflects their background, their training, and their experience.

S: You mentioned how the insurance companies are controlling what the doctor does. When do you think that started?

H: Basically ten years [ago].

S: When HMOs started up?

H: We had one of the first HMOs in the state here, twenty-seven years ago. It's not so much the HMO, it's just the other providers, they want to approve everything. If you want to do an MRI or a CAT scan, you've got to have pre-operative or pre-hospitalization approval. I wound up talking to a clerk on the other end from an insurance company or – I hate to say it – I may wind up talking to a pediatrician who is a part-time medical director. You say, what's your basic background and they say, I'm a pediatrician. I've got a hard time explaining to you, I think you have a hard time understanding, where I'm coming from as to what this patient's needs are. Not to say there aren't some pediatricians that know a lot about [plastic surgery]. We're seeing more and more of [how]

somebody else gets into the act to make a decision as to whether something is going to be done or not done.

S: What about the number of patients that a physician sees? Was that an issue for you?

H: No.
S: You had more autonomy.

H: Yeah. I shouldn't call myself lazy, but I think a doctor basically controls his practice. You show me somebody that doesn't get home until 9:00 every night and I'll show you a guy that doesn't want to go home until 9:00 at night. With exceptions. There are times when you've got emergencies, bona fide emergencies do come up. Basically, doctors have the right to say, I can only see x number of patients, x number of new patients a day. That's it. I can't see more than that. Leave me space for an emergency. What you hear is I am seeing forty or fifty a day. That shouldn't happen.

S: That should be within the doctor's control.

H: Yeah, within reason.

S: Let's discuss the change in attitude of the doctors themselves. Do you think then that more doctors are in it for the money?

H: I can tell you that when I was an interning resident, my professors, Bill Wheat thought we were a bunch of wusses. They talk of the iron man, the guy that's on seven days, never takes off. They used to think that we, my generation, were lazy. I don't know how you could say that, because I can tell you that fundamentally when you're on the chest service, you were there seven days a week. I walked in on January 1, I walked into Shands and the first time I walked out of the hospital was the 13th. As a second-year resident that was rotating through thoracic and telling a fellow one of three things: I either come to work naked tomorrow, I got to go wash clothes, or I got to go buy clothes. I'm out of clothes. [They say,] go buy some. Then every generation looks at itself as we were really hard, tough guys and we did this. The fact of the matter is that we're seeing more and more residencies now. Many of them in New York, they went on strike, they decided you can't work a guy any more often than every third night. I think there are extremes. I think you can overdo it. I think that making a guy work five days in a row or seven days in a row is brutal. I think it's wrong and I don't think that's very good. On the other hand, to quote Gene Stead, you don't see PND in the daytime. PND is nocturnal dyspnea, which is shortness of breath at night. You don't see it in the daytime, so if you're not there at night... you've got to be there to see it. You take a guy that's worked at a place and

trained at a place like Duke where they worked them unmercifully, compared to a guy that trained at a resort that took off every third or fourth night...I just got to tell you who I want to be my doctor. Doctors pay a hell of a price in their training. It's gotten better, I think it's gotten a whole lot better.

S: Do you think it was excessive at one point?

H: I think thirteen nights in a hospital in a row without a day off is excessive. I think anybody would agree that's excessive. Whether thirty-six [hours] on and twelve off [is too much, is another issue].

S: Is too easy?

H: No, that's a lot too. Dr. Woodward, the way he put it, he said, when you guys go into practice, if you operate on somebody and something goes wrong four days later, that's your patient, you've got to take care of the patient. I'm a big believer that the guy that did the surgery should be the guy that takes care of the complication. For these patients, you're basically available. It's not to say that [if] I'm going to take a vacation, go out of town for three days or five days, I'm signing out to this guy, sure we do that. But other than that, you're expected to be responsible for your patient's welfare, twenty-four hours, seven [days a week]. That's the way it goes.

S: That's just the bottom-line.

H: Really. We see fellows now that want to work at an HMO. I guess I can't blame them, they basically want to work a forty-hour week.

S: Do they still expect to get paid as well?

H: Oh, yeah.

S: They don't see the hours as part of the doctor's salary?

H: That's the thing. Realistically, thirty years ago, forty years ago, [if] a fellow came into town and he's well-trained, did his job well, took good care of his patients, he could expect to live on the river, and he could expect to buy a Mercedes, and he could expect to send his kids to private school. Today you can't say that. A guy that comes to work for an HMO, who is making $135,000 or $140,000 a year, he's not getting on a river. The cheapest river-front house in this town is about $500,000 now. He's not buying a $60,000 Mercedes. His kids are not going to some private school where the tuition is $28,000 a year. To me, that's a fundamental change. Interestingly, a lot of guys are saying, I don't need to be on the river and I don't need a Mercedes, and I don't need to send my kids to

George Washington [University] or wherever the tuition in $30,000 a year. It's changed.

S: What about the character of various physicians? In terms of how people choose their particular specialization, are there personality traits that define a surgeon versus another type of physician?

H: People define a orthopod [doctor specializing in orthopedics] as [having] a strong back and a weak mind, which isn't fair to some of the brightest guys I know are orthopods. There's tendency to think in terms of the internist [being] brightest guy around, the guys that go into surgery. There's no question there is a surgical personality. There's a guy that wants to do something now and he wants to see the results now and he doesn't want to wait a week or ten days and see little changes. He wants to go in there, the house is on fire, put the fire out and it's over. Look what I did. There's no question. Thoracic surgeons seem to be more that way than neurosurgeons or what have you. The other problem, I believe, [is] the way guys are trained and the way they're brow-beaten. It's a miracle that they come out as well as they do. Doctor's attitudes of being mean to nurses and abrasive – I'm not making excuses for it, because there is no excuse for cursing and carrying on – but when you're raised in a situation where you never hear thank you or please and all you hear is [bad attitude], you have a tendency to be that way yourself.

S: Do you think that's more the case for surgeons?

H: Yes, I think it is. The requirements of time, time is highest for surgeons.

S: The pre-anesthetic surgeon was selected for a particular personality. Somebody who could ignore the screams.

H: That was good if you were very fast, if you could take the leg off in twenty seconds. It's less pain than if it took ten minutes. That's true.

S: That's certainly changed. In your situation, how much patient contact do you get?

H: Some. Unfortunately, my patient contact mostly comes [from people that are unhappy with results]. I've never gotten a letter saying, I want to tell you how nice Dr. so-and-so was. I want you to know that this guy is a jewel. He was so sweet and kind to me. What I get is, this doctor was nasty, he treats me very poorly, he's obnoxious. I want his liver. Unfortunately, in my position now, I'm more prone to be hearing complaints than I am [compliments].

S: Do you ever get someone saying I want to recommend a certain doctor?

H: When [patients] get discharged, they do have a [survey] where they get back to them. I've never gotten a letter from a happy patient, but I've gotten plenty of letters from dissatisfied patients. Not just [about] the doctors, but the cafeteria, the nurses, whatever. When people are sick, they're not really very happy. They're not here because they want to be here. If it takes them ten minutes to answer a call, that ten minutes seems like forty minutes. If you gotta go, you gotta go. Or if you're in pain and you need a pain shot and you don't get it for fifteen minutes, that fifteen minutes seems like an hour.

S: No one can come fast enough.

H: The younger doctors, I marvel [at]. They're bright, articulate. I'm willing to say they're probably a lot smarter than I was coming out. Very good.

S: Do you think they are as well-trained? [End of side 2, tape A]

H: We have a family-practice program here and I know they get good training here.

S: Did you do any teaching here?

H: I used to give a couple lectures a year on how to sew up lacerations. What to do and what not to do. I haven't done that in years.

S: Are there any sort of other experiences that you wanted to talk about in terms of medical experiences or patients? For instance, do you have any clinics where folks come from the developing world to get plastic surgery?

H: I've not done any of that. You pretty much have to have a partner or somebody where if you go off and do something, somebody's taking care of the homework. I've not done that.

S: Have you done much traveling?

H: No. Again, when you're in a solo practice, just getting away is hard to do. No, I never even took much in the way of vacation.

S: Did you ever consider getting someone else to share your practice?

H: You made a good point. The biggest mistake of my life was in not getting somebody to join me, instead of just saying, I want to do it my way and that's it. I think I screwed up there.

S: Was it a conscious decision, though, to do it your way?

H: Yes, everybody wants to be the boss.

S: You moved here where you were the only one and set yourself up as an independent operator.

H: Well, I was the only one for seven years. Without being heroic about it, even though the guys now tell me it wasn't nearly as busy, it may not have been as busy as thirty years ago, but I was on twenty-four seven [twenty-four hours, seven days a week] for seven [years]. When I went out of town for a meeting – I did go to a couple of national or local meetings for four or five days at the most. Never more than two weeks in a year and for practical purposes, I was the plastic surgeon, twenty-four seven. I have to laugh now when I hear guys complaining [about how] taking calls is terrible, I don't want to take service calls. Well, try that for all [your life].

S: What happened when other plastic surgeons started coming to the area? You said you were the only one there for seven years. Did the population grow or did someone else just come?

H: Somebody else came. Maybe they looked it up in a computer or something that says, what towns need plastic surgeons? Miami had 150. Well, [Daytona] looks good. A fellow came when I had been here seven years. Then about a year and a half later, another one came, then another one. Now we have six or seven.

S: What's the population of the area?

H: The county I think is close to 500,000 if you consider [surrounding areas]. Daytona per se is only like 45,000-50,000, but you've got Daytona, Holly Hill, Ormond Beach, Ormond by the Sea. Then you start going south. It's much, much bigger than it used to be.

S: It's all started filling in. Certainly in plastic surgery, there are changes in the field. What sort of things, educationally, did you do to keep up with what was happening?

H: I kept up with some of the things. I never did do microvascular [surgery], which would not have been hard to do, but it would have meant going somewhere for at least several weeks or a month. The reason I thought I didn't do it is [that] I was in practice. I couldn't close down my practice and go off and do that. Not getting somebody was a mistake and I think I could have done a better job of the new technology.

S: I've read recently about how they have gone back to using leeches when they reattach fingers and things like that.

H: That's if you've got a venous drainage, if you put a flap in, you do a re-implantation or you do a free flap where you bring a flap of tissue in, or even if it's not a free flap, if you do a flap and it gets very congested, the venous system isn't working to get the blood out. You put leeches on it, over a period of days to weeks, until the other circulation gets better, [then] you can pull it off.

S: Have you used them personally?

H: No, I never used them. I've also never used maggots for cleaning up wounds, which they still do in Europe, in Spain.

S: That's what I've heard. About eight years ago, you stopped your practice and went into more administrative work. You're also raising your second family.

H: Chapter two. See this picture of this little girl that's everywhere, that's my latest love, I've got four other loves. That's my Hannah. She's nine.

S: You have four other children. How old are your other children?

H: They're [in their] 30s. Reed was born in 1966, what does that make him? Thirty-five. Then Renny was fifteen months later or fourteen months later. Yes, thirty-five is the eldest and I had three boys and a girl who was born in 1970, she was born here. She's hitting thirty. Like I say, chapter two is nine years old, nine-and-a-half years old.

S: Do your older children, do they live in Florida as well?

H: Yes. My oldest son is in Miami, he's an attorney. My number two son lives in Daytona. He's a bio-med detail man, he does hips and knees and implants. He works in all the hospitals around here. Number three is in California and he's in computers doing something. Unfortunately, [he] just lost his job with all of this negative stuff going on, so I don't know what's going to happen. Then my daughter just graduated from college and she's looking for a job right now and lives in Daytona. No doctors.

S: Did you want them?

H: No. I wanted them to do whatever they wanted to do. I supported them. I never pushed them and I never really said no, either, I never pushed them out.

S: Since you changed to the administrative side of medicine, do you miss not seeing patients?

H: Oh yeah, every day. I miss operating on folks and taking care of folks. Then I think of some of the coconuts that I've had and it passes. No, I do miss it. Sure, you miss it. There are a lot of them that I don't miss.

S: There are a lot of things that you're happy enough not to deal with. You certainly must get coconuts in your current position.

H: Oh, you get them everywhere. When you're dealing with folks that you've operated upon, that becomes a very personal problem. When I'm dealing with people who are really unhappy because another doctor did something or didn't do something or a resident or a nurse or whatever. I take the gas, but it's not the same thing as being in the direct line of fire.

S: I guess it's less personal.

H: Right.

S: In your present position are you in charge of hiring?

H: No, I don't do that. I don't hire or fire.

S: Do you check credentials?

H: One of my biggest jobs is when new physicians come and apply and ask for privileges to do things, as far as I'm concerned, my most important job is making phone calls, talking to people where they came from and ferreting out what I can, what they've actually done or not done, because if you can keep somebody off your staff, it's a heck of a lot better than letting somebody on and then start doing battles six months later or year later.

S: Do you have trouble firing people?

H: I don't fire, nobody works for me. I don't have trouble looking at problems. I don't have trouble sitting down with somebody and saying there's a problem here. I'm not crazy about it. It's not the most fun in the world, it's a dirty job but somebody's got to do it. No, you gotta do what you gotta do.

S: Do you find it difficult, in legal terms, to fire people for incompetence?

H: It's tough. Doctors have gotten the complaint that you guys take care of your own, you don't do this, you don't do that. Let me tell you, it's another world when you start to take somebody's privileges away. Of course, they're entitled to legal counsel. It's just a hell of a job. It's much easier said than done. I

hate to say it but the university, if Dr. Woodward had somebody in the department of surgery that didn't please him or didn't do the job, he had the power to say, see you [meaning, to fire the person].

S: He had more power that way.

H: There's no committee. Also, this was thirty years ago. That's changed. It's difficult.

S: You deal with the credentials and things with physicians or everyone, including: PAs and nurses.

H: Not nurses. PAs are credentialed. They come through the credentials committee and they are credentialed and I do deal with that. Independent nurse practitioners like the CRNAs [certified registered nurse anesthetist] come through the credentials committee and we look at their credentials before they get privileges to do things. Hospital employees, nurse hospital employees and what have you don't come through the credentials committee.

S: Do surgeons and cosmetic surgeons have higher-priced malpractice insurance than others?

H: Right now, the highest, I think, is neurosurgery. OB is still pretty high, plastic surgery is still pretty high. When I started my practice in 1970, my malpractice for $1,000,000-$3,000,000 coverage was $1,700, when I quit eight-and-a-half years ago, it was in the $40 [thousands] or approaching $50,000. Neurosurgeons in south Florida are paying over $90,000-$100,000. Some of the OB people are paying $45,000-$50,000. It's immense. It's an immense amount of money that has to come from somewhere. That's part of the overhead. Liability is still a big problem. I was going to mention some lawyers by name, but I won't. They advertise on TV, they advertise in the paper, they have billboards. Lately, they jumped on a bandwagon and [have] gone after nursing homes. If you got a decubitus, somebody did something wrong, call us. Again, I don't cover the sky and say that all doctors are perfect and that doctors never make a mistake, but it's out of control, it's absolutely out of control.

S: Is it the lawyers or is it the combination of expectations?

H: It's everybody. I've been involved in a couple of auto accidents. One very recently. Somebody said, did you talk to an attorney? I said, what the hell for? I got hit in the back. My neck was a little sore for a day or so. I'll be all right and I am. I am all right. I could have gone to an attorney and he could have sent me somewhere and run up a couple of $10,000-$20,000 bills in physical therapy and X-rays and built a case and gone after somebody. People just are that way and they're aided by the attorneys that do that kind of work.

S: There are some attorneys who are working on getting families to sue for the World Trade Center [destroyed in terrorist attack, September 11, 2001].

H: It wouldn't surprise me that somebody's got to sue somebody. I don't know who it is they're suing, the Taliban [ruling group in Afghanistan, 1996-2001] or Osama bin Laden [leader of terrorist network, Al-Qaeda; son of wealthy Saudi-Arabian businessman]. I don't know who.

S: When you started in private practice, what was your daily routine?

H: That has changed tremendously. When I started practicing, basically everything was done as an in-patient [procedure]. If you had a patient for a face-lift, you admitted that patient the day before and they got lab work. If they were old enough, they'd have a cardiogram and chest x-ray. Then they'd have their face lift the next morning, [which would] take four of five hours. The average patient would be in the hospital two days after with ice packs on their face and all of this good stuff. A breast augmentation, that patient would be admitted the evening before, have surgery the following morning, spend that day, that evening in the hospital. The first thing you did in the morning is make rounds, you'd come in at 7:00 in the morning and see the folks you've got in the house. You never had less than three, four or five in-patients. You went to the operating room at 8:00 or 9:00, depending on what time you were scheduled. Basically, did that until noon, then went to the office at 1:00 and saw office patients from 1:00-5:00. That was basically the day. If you had somebody that was serious enough, a big enough problem, you might go back and see them in the evening, stop by the hospital to see the patient before going home, otherwise you went home. I think my last year of practice, I admitted something like five or six patients in the whole year. Everything is same-day surgery: face lifts, breast augmentation, everything is done as a same-day surgery. It's really changed.

S: Is that for the better?

H: In general, it's for the better. On the other hand, the last thing I want to do is a tonsillectomy on somebody or do a palate procedure on somebody and send them home, then get a call 10:00 at night in the trailer park where they live that this kid's vomiting blood and having trouble breathing. I don't like that. That I wouldn't do as an out-patient. I've got some friends that do ENT that still don't do tonsillectomies as an out-patient [procedure]. They're old-timers on the basis of, if they get in trouble the first night, I want them where I can get to them. As it turns out, it's unbelievable what you can do to people on a same-day surgery basis, and send them home. It used to scare me at first, you've got a sixty-something year-old lady you've done a face lift on, this huge operation, got the big dressing pads over their eyes, and you're sending them home.

S: Are you thinking about infection and other complications?

H: No, the things you worry about early on are hematomas. The most common bad thing that happens is they bleed. You've got to take them back to the operating room, get the blood out and fix it. Do something with it. That's changed, the practice of medicine has changed unbelievable from in-patient to out-patient. By the way, hospitals' incomes show that difference.

S: Have the hospitals' incomes declined?

H: Yes. We were in the business of doing all this in-patient work. Now all of a sudden, you're not doing it. You've got to be sick to be in a hospital today.

S: That's true. In a way, the role of the hospital is going back in some ways to what it was before, where on the whole, people really didn't go to the hospital unless they were extremely sick. They would have someone care for them at home.

H: The other problem is that we have an emergency room that sees 300-350 [patients] a day. There are a lot of people that use the emergency room as their primary care. They work all day, don't feel good, but they tough it out, they go home, then they show up at the ER. By 7:00-8:00 at night, the kid's howling and carrying on, bring him to the ER. It's unbelievable what's being done now in the emergency room. I think they do over 90,000 visits. It's [about] the third biggest ER in the state here. That's changed.

S: I'm curious as to why the number of visits is so high here. Is it the socioeconomic situation? Is it people who can't afford a primary-care physician who come to the emergency room?

H: We have a lot of people here who are minimum-wage earners and a lot of them don't have insurance. They just don't have the benefits.

S: If they go to the ER, then it's covered.

H: No, they go to the ER, have it done and they don't pay. The hospital loses so many million [dollars] a year.

S: Do you see that anything will change that in the future?

H: I hate to say it, [but] I think it's a societal problem. Not that I want to pay any more taxes than I'm already paying, but the local politicians can't sit back and throw bombs at the hospital. They want to know [why] we spend so much money and we get some tax money. Yet we still provide much more service than the tax money we collect. Part of the deal is, the doctors are free. These

folks that show up with no insurance and no money, there is no doctor bill. It's a freebie. What I'm saying and so many of my colleagues are saying is, if you commit a crime and you've got no insurance and no money, they're going to provide you with a public defender. There's a guy over there that works for the county, his salary is to take care of people. We don't have a comparable public doctor, if you will. The [Health Department] is supposed to do that. They quit seeing patients, I can't tell you how long ago. They're just saying, no, we don't have the [staff and facilities,] let them go to the ER. When I say societal, I can't tell you at what level, whether we're talking city, state, county, or fed[eral], but something has got to be done to provide those services.

S: They should spread out the costs so that one person or one hospital doesn't get stuck with it.

H: Yes. Like I say, the doctor's part [to] come in here 3:00 in the morning, do an appendectomy. If it's a Medicaid patient, you come over see the patient, take him to the operating room, operate on him, take care of him for a couple of days, send him home and you get $125. I don't think you ought to get $2,000 for an appendectomy, but I think $125 from Medicaid is pretty lame.

S: I've heard the 1950s referred to as the golden age for physicians.

H: Of course, they all say that about us. To a degree we were. Everybody looks at [the] 1950s because they also look at when Medicare came in. Some good things happened when Medicare came in and some bad things happened when Medicare came in. Before Medicare, doctors were doing hip fractures on old people for nothing, for people who couldn't pee, urologists were doing TURs [transurethral resections] on old people that didn't have any insurance, didn't have any money, for nothing. All of a sudden, here comes Medicare. They say, all we want to do is help the patient pay their bills, we don't want to get in between them and the doctor. The fact of the matter was, there was a golden age. The goose got throttled. There was a golden age when all of a sudden all the stuff the doctors are doing for nothing, all of a sudden now we got Medicare. People being what they are, we're not perfect. People abuse the system. A lot of doctors made a lot of money on Medicare patients. Of course, now they're beefing because Medicare, at one time, [was] paying $2,400 for a cataract. Now they pay $675. If you're used to making $2,400 for a cataract and now you're making less than $700, you're kind of unhappy about that. Although they tell you, you were doing fifteen a day. What does it take to make you happy? The point I'm making is that was called the golden period. Twenty-five years ago, doctors were doing well, they were working hard, they were getting paid, Medicare was paying [well] then, there weren't that many public or uninsured patients. They didn't know who was paid and not paid, they didn't care, they just took care of the problems. As things have been contracted, as the pie has

gotten smaller and smaller, now all of a sudden, these freebies, all of sudden are a real problem and nobody wants to take care of the freebies. Should we criticize the guy? I used to be very critical years ago, I never wanted to hear of a guy that wouldn't see a patient because the patient had no money. They said, bring $150. If you don't have it, don't come. That used to make me crazy. Where is it written that doctors have got to take care of folks for nothing?

S: Especially when they are the only ones who are making that sort of sacrifice. How long did it take to perform various surgeries? How long does a face lift take?

H: What constitutes a face lift? If you're going to do the eyebrows, the eyelids, the face, the neck, if I did all of that, on average, that was about a four-hour procedure. I've got some friends that did that, [and] it would take six, seven, eight hours.

S: You are on your feet the whole time.

H: And in many cases, the patient is asleep. You put a sixty-five year old to sleep for six or seven hours, you may see some problems. Augmentations mammoplasties average somewhere between thirty minutes to a hour.

S: How long does it take to operate on melanomas and other cancers?

H: If they're straightforward and not big, radical cancer operations, you're talking about forty-five minutes to an hour-and-a-half. If you're doing a big, radical cancer operation, you're talking about three or four hours. A long time in the hospital.

S: You did major skin cancer surgeries?

H: Yes. Tongue cancer, inside the mouth, palate, head and neck, jaw cancers.

S: Is there anything general that you want to say about the medical profession?

H: I immigrated to this country, so I'm an immigrant. I'm a foreigner, if you will. Although I figured I came at six months and that was sixty years ago. One thing that has changed tremendously is the number of foreign medical graduates practicing medicine in this country. It's very, very large. Anywhere from a third to a half of the medical staff are trained overseas. A lot of these folks are very, very good. Some of them are not very, very good. Here we are, they're here. You get involved with quality of care issues. Some of the best doctors I've known, some of the best doctors on our staff are FMGs [foreign medical graduates]. On the other hand, some of the worst are FMGs. That's a problem

for the future.

S: Is there anything else you would like to discuss?

H: No. Thank you.

S: Thank you. That's the end of the interview with Francisco Herrero.

[End of interview]