ALTER: This is Judy Alter and I'm interviewing Dr. David Richards on August 31, 1989.

RICHARDS: The first question is what attracted me or interested me in Texas College of Osteopathic Medicine. The thing that interested me most was, in 1980 when I first reviewed here, is the fact that it had the most potential of all the osteopathic schools in my opinion. It had funding, it had legislative support, it had facilities and it was associated with an emerging state university, North Texas State University, at that period of time and it had the potential for expanding, the opportunities, in the pure sense of acadamia. As you know, there are different types of osteopathic medical schools in the country.

ALTER: And you were at Ohio at the time?

RICHARDS: I was at Ohio at the time. In fact, I helped start the Ohio college. I was the second position hired. I was on the planning committee to help establish that. But what I saw was a young institution that had the full committment of the academic base and the full committment of Texas Osteopathic Medical Association and close proximity to the primary teaching hospital and I saw nothing but potential for the institution and I wanted to be a part of that growth. And the strengths of the institution are some of those that I have just mentioned. The weaknesses at that point in time were that we did not have a research base, per se, and one of the first things that I did was to establish that and, by the way, I named Joe Lawler, the chairman of the committee. I remember Joel. I didn't see a lot of planning, I didn't see a lot of direction.

ALTER: In the overall institution, not just in research?

RICHARDS: Right, in the overall institution. I equated this hospital, after I made my initial assessment when I was on board, as an institution that, the analogy was a proprietary hospital in the 50s that was established by a surgeon, then an internist and whatever. It was a family hospital. We had 30 beds.

ALTER: Mom and Pop.

RICHARDS: Mom and Pop. They knew everyone. They took care of things. They socialized and it was a family, in essence. But now, in 1978, with brand new facilities and a prolifery of faculty and staff coming on board, the communications link did not keep up with the sudden growth of the institution. And that related not only to the relationship with the private sector across the street but within our own family.

ALTER: Let's back up to research for a minute. Is it not traditionally hard to start a research program in an osteopathic institution?

RICHARDS: It is, because many of our graduates and those even in a residency training have not been trained in academic health centers where they had responsibilities for being a part of research programs. On the other hand, our Ph.D. colleagues have had that experience and they took off running. There are very few osteopathic medical schools in the country that have external funding. In fact, some of the osteopathic schools have very little external funding.

ALTER: Even today?

RICHARDS: Yes, but some of the state schools do have. I think that we are among the leaders in research. We started with an insignificant amount of dollars back when, and are approaching almost $4 million a year in aggregated research. That's a long ways in comparison.

ALTER: And that is not just basic science research but also clinical.

RICHARDS: We're into clinical research which includes some funding for the Kellogg thing which is a landmark for the institution.

What are the problems? The problems are as I just mentioned. But also the problems were, at that point in time, and I predicted in 1981, that with the growths of the institution, in spite of the facilities planning that we had, that space would be a problem, and we are at that point at this point in time. We are running out of space. Major, major concern is that. Some of the other concerns that we have is our lack of quality graduate education programs, a prolifery of these programs available to our graduates now that they are competent and are receiving national recognition to their credentials. What are the other problems that I could think of: it's a global problem that relates to the single most important factor that we face as medical educators in general, is where medicine is going; the high health care costs and the perception in high health care cost is the single most important factor as it relates to where medical education is going. DRGs are cutting back in terms of graduate medical education programs. Small hospitals are closing and small hospital are, in fact, one of the differentiating factors in the osteopathic profession. Many of our graduates have trained in community hospital throughout the United

States in 100-250 bed hospitals. Much of the graduate program in the osteopathic profession has been in those kinds of hospitals, but they are closing. So now, we as medical educators have to plan for that closing, open up new avenues of opportunities in order to insure and enhance graduate medical education. The profession is looking to the colleges for support and committment to graduate medical programs which is something new.

ALTER: When you say lack of quality graduate education programs, then that's not really a TCOM problem, it's a D.O. problem?

RICHARDS: It's a D.O. problem. There was a study done recently by the Americal College of Internists in the last Osteopathic News Journal where they surveyed a 156 graduates who have gone into alopathic residencies and what they determined was that it was not just the stipend, it was the lack of patient volume and it was the lack of structured quality graduate programs in certain areas and what we have now is, we have competitive graduates. They can stand on their own.

ALTER: For the first time?

RICHARDS: I don't know that. But consistently, they can stand on their own with any graduate from any medical school and they are wanted and they are being recruited. Now is not only this school but other schools as well.

ALTER: Back up and tell me about the Kellogg grant. I obviously have heard but I don't know totally.

RICHARDS: Kellogg grant is a unique grant. We were told that we, as

an institution, needed to have funding from a major foundation and Kellogg and Ford Foundation are some of the biggest ones in the country. So, back a few years ago the initiative was taken to get in to some planning mode to find a niche so Kellogg would fund us. We started out with something that was wellness and prevention and that never worked. We started out with two or three other initiatives and that didn't work. Charlie Ogleby came up with the idea of community oriented primary care perspective, at which point some of the people here contacted Ph.D. in nursing, Dr. Rene Courtney, from U.T. Arlington Nursing School who worked together with Dr. Balwin and some others here and came up with a proposal. At which point it went to Kellogg. Kellogg made some site visits and they funded us fo $1.1 million to be given on matching of another $1.1 million. The reason that they did not give us the full money is that Kellogg felt that the Texas foundations are very protective of funding Texans, but yet this is a Michigan foundation and they felt that we should raise money internally because of the attitudes of the other foundations. I don't know if that's something you want to publish, but in reality that's what happened. At which point, this was to involve the inner city. This involved a research program to determine that really it's a community partnership in the health care delivery system. If we cooperate with the medical students, with nurse practioner student and the nursing student and osteopathic physicians, that we in fact can influence health care delivery in a significant way by that partnership. For example, if you're into a community, like the Northside community and you find that diabetes is prevalent or you find that hypertension is prevalent or you find that scabies is present, whatever it may be, that there is a mechanism to involve that community in helping solve that problem through awareness. We recognize that the single most important preventive factor which we have in the AIDS situation is prevention.

So we are very excited about that, and we think that the Kellogg proposal will continue and expand.

ALTER: It's going to start on the north side?

RICHARDS: It's going to start on the north side and Dr. John Peckham has got the responsibility to make that happen. Remember John Peckham?

ALTER: Yes, I've talked to him recently and frequently.

RICHARDS: It's exciting and we are a player.

ALTER: It is a major step for the institution?

RICHARDS: It is a major step for the institution.

Okay, what else on this? What was your background in osteopathic medical education? Okay, I'm a D.O. I graduated from the Kirksville College of Osteopathic Medicine in 1960, interned at Doctor's Hospital in Columbus, Ohio in 1961. I practiced in a small town north of Columbus, a town at that time of about 5,000 people, Worthington, Ohio. I practiced in that vicinity until 1976 at which point I helped start the Ohio College of Osteopathic Medicine. I was put on the original curriculum committee to establish the college and I was offered a job as a founding chairman in the Department of Family Medicine in 1976 and I took that and then I became the Associate Dean for Academic Affairs and Associate Dean for Academic and Clinical Affairs and left there in 1981 to come here.

ALTER: I remember having dinner with you and Joel and Jay. We were

all in the Century II Club.

RICHARDS: That was in 1980.

ALTER: When you came to visit.

RICHARDS: I came to visit. I was invited down here to be Chairman of the Public Health and Preventive Medicine Department by Dr. Baldwin and decided that it was not my niche and went back and continued doing what I was doing. I interviewed again. There was a job opening and I was called and made aware of that, for Associate Dean for Academic Affairs and interviewed for that and I started April 1, 1981. I became the Dean for Academic Affairs and remember that I was not the dean of the college at any time. I've never been dean of the college here.

ALTER: Did we have a dean of the college at the time; but we didn't have a president?

RICHARDS: We had a president in 1981. The president maintained the title as dean of the institution and president. A very important point. He was president and dean. All academic decisions were made by the president. One of the first things I did when I became the acting president was to separate the deanship from the presidency. We have a dean, we have a vice-president and dean for academic affairs.

What do you see as particular strong points of the educational program at TCOM? I think that we have a particularly strong liberal arts of medical education curriculum. People don't like me to use that term. They think it's not a good term, but I can't find any term that's more descriptive.

ALTER: Does that go back to John talking the other night about we went through a spell of accepting people without the strong scientific background because we wanted people with other kinds of skills. Is that all part of this making a rounded physician rather than the tunnel vision scientist?

RICHARDS: Yeah, I think it is, but it means more than that. The analogy that I would use is the fact that let's say we have a lecture that's on pediatric oncology, pediatric cancer. The major of those lectures, if it does exist as a lecture and I'm using it as an analogy, would be given perhaps perhaps by the pathologist, the pediatrician and the oncologist, not the pediatric oncologist. So the approach is different. The other thing is that our program does not say to the medical student, look you've been here two years at medical school now it's time to make your choice. I've got a slew of electives here. If you're going to be an internist then take our electives in internal medicine for the next two years if that's what you want to be, versus do you want to be a surgeon, take your electives in surgery. We have a core rotation which is required and we do have a few electives, but we do not ask them to make a decision on where they're going to be after a period of two years. So in fact, they will go through pediatrics, they will go through internal medicine, they'll go through surgery and I've had students come and say they'd like to be an internist and they go on pediatrics and they want to be a pediatrician and I here them say that they want to be a surgeon and they go on into surgery and they want to be in something else, and we feel that's good because we're producing, at the end of four years, the community physician. That doesn't preclude the fact that that community physician that's trained after four years, will then take an

internship which again is twelve rotations and then go into the specialty of his or her choice. That's an important point that I feel very strongly that anyone that's graduating today has to be residency trained in order to have privileges down the line.

ALTER: In alopathic schools today, do they make their specialty decisions soon?

RICHARDS: In my opinion they do?

ALTER: In other osteopathic schools?

RICHARDS: I don't know that. I feel that they have core rotations as well and at least the philosophy that's emulated by the other osteopathic schools is the well-rounded physician and then they can take their graduate programs. What is particularly the strength? The fact that we have a location where there is so many unmet health care needs: inner city, rural, and suburban right here in Fort Worth. The latest Tarrant County health surveys were 90,000 individuals this year do not have health insurance of which 45,000 are children and where 59% of the people polled were not aware of any wellness or prevention aspects upon advise of their physician puts us at the right place at the right time. I think that as an institution we could not be in a better place at the right time. Meeting with one of the senators at breakfast a couple of months ago in Washington, he was sitting there with representatives from the American Medical Association, from Physical Therapy Association, from the Ophthalmological Society, and whatever, there were about 15 of us with Senator Hiess of Pennsylvania, and he said, you know 85% of the medical school graduates do not know anything about wellness and prevention. He said with the rising health

care costs and the state of the medicare and medicaid and the insurance industry there isn't anyone on the Hill who doesn't recognize that fact and that could very well be an issue that will relate to this, something to that effect. They recognize that 85% of the graduates are not trained in nutrition, health assessment, and aware of wellness components as a measure to help reduce health care costs. On the other side, third party pay does not recognize that, which is a problem. You're feeling well and you want to go in and get a check over this or that because of whatever, the third party won't pay for this.

ALTER: I thought to some extent they would.

RICHARDS: Very little. You can ask John.

ALTER: I think I just thought that because they paid for mammograms.

RICHARDS: There may be a few exceptions, but certainly not for nutritional survey or lifestyle inventory or those type of things. I was told by one individual that they brought together Forbes 500 Companies, 10 of them, to Washington, and behind closed door. I was told this by the head of the Medical Service Corps who was asking me, I was giving a speech at one point, he said what do you think of health care costs. And he said in this meeting those people told him that they wanted a physician that would take care of the majority of the problems and not have to refer to five different places for 10 different tests, that's what is raising health care costs. Well, the reality is that we're producing that kind of physician; however, malpractice and the Tort Reform and defensive medicine fits into that aspect. That has to be changed in order to reduce health care costs. I think the strength of the educational program is the committment the

institution has towards excellence and I think that there isn't any faculty here who is not fully aware that we're striving to be the best and I think that relates to students as well. It's contagious.

What distinguishes the clinical program from other osteopathic institutions? I think that the three months in general practice, I think that we are training in community hospitals, I think that in all reality we do not have as strong a clinical program as we should, but it will continue to grow and we'll continue to grow by continuing to hire outstanding faculty who are committed and expanding our affilitation base and more graduate programs which means better teaching programs and residencies.

What distinguishes the research program? I think that we are generating about $75,000 per individual in our research area, that is each Ph.D., which is probably very high in comparison to the other medical school. I think that what distinguishes us is the caliber of our faculty. For example, Dr. Bob Gracy received $3 million over the next ten years for his work in aging. Significant cancer research. In fact, our people are working very closely with Alcon Laboratories in a partnership level. We're teaching there in some programs. We are internationally know researchers. Our people are going all over the world lecturing on their areas of expertise, particularly in biochemistry and physiology and pharmacology. These are national figures with an international reputation. We are starting to have some of those people have joint appointments in our clinical departments in order to assist our physicians in developing that clinical base.

ALTER: What does a physiologist do in a clinical department? In teaching you mean?

RICHARDS: Helping with the research projects and also teaching. Much of internal medicine in pathology and physiology and pharmacology and we have several Ph.D., one biochemist and another research grant writer, Dr Shields, physiologist in there, and our cardiologist, Dr Fisher, is doing things in cardiology based on his training that are very much related to physiology, developing that research base. There are three schools of academia that differientiate the physicians here from the physicians in private practice. One is a committment to teaching. I feel very strongly we don't teach much, we create learning experiences. Two is the area of scholarly activity. At a state institution in 1986 when the governor said that the state is in trouble economically, Governor Hobbie said that the oil and gas windfall is over, now it's high technology and research which is going to take the place of those gifts that higher education got from the oil and gas money which gave us direction and initiative to do some things that needed to be done. I'm not sure I have at the top of my head any other answers to that researc program but I do suggest that you meet with Ben Harris to explore that a little further and that's an important area.

What are the significant sign posts in the history of the school? I can't speak before 1981 because I don't know.

ALTER: You know there have been interviews done up until about 1984 and I have really a pretty good bunch of material up until at least 1980. When did you take over as president?

RICHARDS: I became executive vice-president on November 16, 1984. The first sign post was TCOM created a president for the institution. That was an important step in terms of giving us the opportunity to do some

things, Ralph Willard and whoever succeeds ms as relating to other people with the same credentials throughout the United States.

ALTER: When was this?

RICHARDS: It was in 1981, I don't remember the date. It was in May. The Board of Regents was created then. Remember that the reporting lines that I report to a Board of Regents of the University of North Texas through Chancellors. The Chancellor is the President of the University of North Texas and he is chancellor of us. In terms of the sign posts, I think that the establishment of the research base in 1981 was very significant.

ALTER: What one event marks the establishment of the research base?

RICHARDS: The committee that was established. One of the first things that I did, I felt that I had the authority to establish this committee. I got in a lot of controversy because I established it. That was important, and what it did was make a needs assessment of our institution in comparison to our resources that we should be moving in a separate direction.

ALTER: And I assume it was a committee of D.O.s and Ph.D.s.

RICHARDS: Right, chaired by Joe Walter. The second thing is that we negotiated at that point that there would be an Associate Dean for Research and established a search committee and Ben Harris was named as that Associate Dean for Research. Given that license it just took off and we started to hire people who were well-qualified in that area.

ALTER: What year did we occupy Med Ed II?

RICHARDS: About that time, about 1981 or 1982.

ALTER: Did the physical facilities also help with the hiring of qualified people?

RICHARDS: Absolutely. The physical facilities gavethe individuals par excellence space for them to conduct research in an organized fashion.

ALTER: And made us more attractive to the caliber of people we wanted?

RICHARDS: No question. The other sign post was, in 1984, we were in deep straights. For a period of time we had taken in students who did not have good MCAT's who were wonderful people who did not have the GPAs and we had had for a period of years had 11% and 12% failure rate down the line, and all of a sudden we had a 21% failure rate and the legislature and the Board of Regents asked a series of tough questions on why. They wanted it resolved and that's when the 39 points came out, and those 39 points are the template for academic excellence that was approved by the Board of Regents November 16, 1984, along with the restatement of the Goals Statement. When you're taking in students with 23 and 30 MCAT's and you're competing against institutions with 50 and 60 MCAT's, it doesn't work.

ALTER: So it really was an admissions policies problem.

RICHARDS: The most significant problem was the admissions policy, the liberal admissions policy. There were students, wonderful people, who were very osteopathically oriented.

ALTER: Yes, but there were also theology majors, etc. I remember that, looking at the list when I worked here and thinking, golly.

RICHARDS: Well, taking a theology major, there's nothing wrong with that, providing that they have the GPA and you have the science GPA and they can read. If you'd ask me today, in looking at this over a period of time, the most significant factor that we have that is consistent in failures on external exams is the reading factor, reading comprehension.

ALTER: You have a person here who is skilled in teaching that, do you not?

RICHARDS: Peggy Dancero.

ALTER: Is that not unusual for a medical school?

RICHARDS: To have a reading specialist? I think that other medical school certainly have support and we have a variety of support systems. THe decision was made at that point in time that we would raise our academic standards to the minimums and this has been a major controversy with the profession, even today. "Why don't you take my son and daughter who is a wonderful person and committed to osteopathic medicine?" We face this continually and our decision is to uphold the standards of the Board of Regents and so far it's paying off.

ALTER: I somehow think that's a more difficult step to take in the osteopathic profession because, although we're going away from it, we're still a family profession.

RICHARDS: "My son or daughter deserves to be in a state institution for which I pay taxes and they will do fine." But they don't have a 40 MCAT. A 40 MCAT is a minimum. That's the lower 20% of all medical school applicants in the state of Texas.

ALTER: Is the pool shrinking? Are there less applicants now than there were?

RICHARDS: There are nationally there are less applicants. And particularly in minorities; major problem in blacks. But this is a national problem, however, we were very fortunate in we think being in the right place at the right time. The initiatives and incentives for primary care nationally are going to put us in the right place. All these studies on health manpower that there is an oversupply of physicians, in my opinion, is a bunch of malarky. In fact, Eli Gensberg, in Health Issues that came out about a month ago, said that in the original data that they used to determine that there was an oversupply in the Jeminack study which was the first one that came out in the late 70s, in fact the error was like 250,000 in terms of the count. So he is probably the expert on health manpower in the United States, the former dean of Harvard Medical School and has had federal appointments and stayed tuned to this. His feeling is that you can't predict that. Look at the nursing profession. There has been an oversupply of nurses. Headlines: we have an oversupply of nurses. Now we have an undersupply. At one point we had an oversupply of engineers, now there's an undersupply. There's an oversupply of teachers, and now there's an undersupply of teachers. What goes around comes around. I suggest to you that if you take a circle around Fort Worth and go 50 miles in any direction and you're going to find

significant needs that are unmet in health care as well as in the inner city for our type of physician.

The other signpost; that was one, and the other one was about a year ago, two years ago there was a special committee in higher education looking at the role and scope in institutions - do we need as many institutions? what are their qualities? Well they couldn't deal with medical schools and allied health programs and nursing schools so the governor and lieutenant governor and speaker selected a committee to review medical schools, dental schools and nursing schools and they spent a year going from campus to campus and asking questions and looking at them and that was a significant what I call tiering of the institution. We tiered up a level because it created a better understanding with the other medical schools, it created a better understanding in the legislature that we were, in fact, credible, we had a unique perspective in relationship to the other medical schools like Baylor, and Southwestern perhaps, are research institutions. Well our mission is to produce community physicians for areas of need in Texas and that's unique. That was a major stepping stone and the Chancellor was the one that said, "When the history books are written, David, that will be the single most important factor" in his regard to the institution.

The other thing I think that's significant is the fact that we cut a deal with Carswell. I received an award on behalf of the college at Keesler Air Force Base a couple of months ago by the Head of the Medical Service Corps of the Air Force for taking the ball and running with it; seeing that there were needs at Carswell and creating a community partnership which is the envy of many installations in using our resources and trading for educational opportunities.

ALTER: So that gives our students a whole clinical body for practice, right?

RICHARDS: And our residents and we are doing surgery there, too, and these people are being taken to Fort Worth O. and doing surgery. It is significant. The other thing is, the relationship with the VA.

ALTER: When did the Carswell deal go through?

RICHARDS: I cut that deal about a year ago with them. The VA: I sat on a federal committee, a special medical advisory committee of the Veterans Administration, and cut a deal through our legislative people, Jim Wright and Craig Roth who was a former Board of Regent, and cut a deal that would involve ambulatory care base here in Fort Worth with the Dallas Medical Center and VA Medical Center in Dallas. We also were approached and we will sign an affiliation aggreement with Sam Rayburn Veteran's Administration Hospital in Bonham, Texas, which is two hours away from here. So now we have our foot in the door for an educational base in the Veteran's Administration which is significant because the osteopathic profession has not had a long history in establishing these kinds of affiliations and the reason that we are having that opportunity is the fact that we are being recognized as a national figure now in medical circles as a whole. We are players in the system.

ALTER: That's the whole thing, isn't it, to be a player in the system, to be part of it and it hasn't been that way. Twenty years ago it wasn't that way.

RICHARDS: We are a player. I think that the other most significant thing that has happened is that for the first time the state of Texas recognizes us as a player. Our budget was 14% increased this year, higher than any other medical school. Why? Because they recognize the contributions we've made and the job that's getting done. They came to us and said, would you like to be part of paternity testing? This is a landmark. Why is it a landmark? It's a landmark because now we're in the DNA business. We will be doing paternity testing for the Attorney General's office because there's such a need. There are 50,000 cases in the state of Texas of illegitimate pregnancies of which there is a backlog of some 400,000 cases in the court system which relate to paternity testing. When you're living in a town which in 1985 had the highest infant mortality rate in the nation... The significant thing about paternity testing is that now instead of being a training program for medical students and residents, we are asked to be of service directly to the state of Texas in a very interesting, far-reaching potential program which is DNA testing. Now DNA testing has an academic base, a research component, let alone the potential for diagnosis and treatment in certain cancers. It is a state of the art and not to mention the fact that the University of North Texas has a criminal anthropology component which has identified the remains of bodies that have been out in the field for months and years. It gives us potential to be involved in the aspect of criminal investigation, and you do know that we have a partnership with the forensic Tarrant County Medical Examiner which in on our faculty half time. So we are now into a different arena.

ALTER: Does the Tarrant County Medical Examiner not have facilities on the campus?

RICHARDS: No, they are now at John Peter Smith.

ALTER: They did have at one time, didn't they.

RICHARDS: For many years and they asked us at one point if we wanted to give them land to put the building and I said no. But we still have a relationship and that relationship will continue to grow. Those are the major signposts since 1984.

ALTER: As the school grows the signposts become less tangible and a little more complicated. It's not simply moving from one building to another.

RICHARDS: The greatest strength that we have, as I see it, is in the people who are here - the students, the faculty, the staff - the committment. We have a very low turnover rate as an institution, attrition rate. People don't leave, or very few people leave according to our personnel group. The greatest strength that we have is that we are a young medical institution that has flexibility to initiate change. We are in that situation. We aren't established in 50, 75, and 100 year traditions of what or how.

ALTER: That, of course, is the point that I tried to make, that even in the early years of the institution it was the people who overcame and I think there's a tradition of that flexibility because there were some very creative solutions.

RICHARDS: Yes, and there has to be. We don't want to have people saying that, "well, it's not like it was when I trained in the 50s". It's people who are saying "Here are the variables that we have and

what can we do in our strategic planning." Strategic planning is another milepost in terms of the institution because the institution does have direction and I want to give you documents today which, in fact, is the template for the institution and which we have had published. It's called "Directions to the Future of TCOM" and all of these include a goal statement, service statement that worked through the faculty and worked through the staff and administration and was approved by the board, and a research statement. So the direction of the institution is very clear for the next 5, 10, or 20 years. It's in place and now we have to find the people and we have to allow our students and our faculty and staff to believe that we are good because we are. Many of us find the warts; we're not looking at the great things that are happening.

What accomplishments during your administration have brought you the most satisfaction? I guess that the ratification of those three documents; the reinforcement of the goals statement which was done in 1980, was redone in 1984 by the Board of Regents, the service statement and research statement that was put in place. I think that the economic impact statement which has demonstrated that we have produced $50 million per year n revenue for Tarrant County and I think that the seeing the turnaround in attitudes of the students and watching them share their pride in the accomplishments on external exams, watching the growth and proliferation in clinical opportunities for the college and noting that we are a player at the federal level and at the state level and looking at our stature grow consistently in the osteopathic arena. I also feel that I'm most satisfied that we are looking critically at those who we choose to become our colleagues in administration, faculty, and staff. In other words we now can be selective to pick the cream of the crop throughout the country and

we've done some of that recently and we will continue to do that; look for the best people to become a part of where we are because bricks and mortar are wonderful but those aren't programs. The people are the programs. I think that I have tried very hard to change the fiber of the institution and I think I've got a little bit of accomplishment there. We put the EAP plan in place this year; the Employee's Assistant Plan for students and faculty and staff, which allow, because the workplace is changing. We have significant single parents working here. They have special needs, so we have in place a program where, if they need legal counsel, or if they need psychological counseling, or if they need financial counseling, and anonymity, we've signed a contract with a private vendor and with anonymity they can receive that help to have them continue to be in the workplace while they are resolving these problems.

ALTER: It sure goes along with the wellness concept of the college, doesn't it?

RICHARDS: Yeah, but more importantly it's an attitude that I hope will pervade through the institution, that we do care. It doesn't do us any good to have a well-trained employee who gets into financial difficulty or their son or daughter is on drugs or major divorce thing and have them quit and go out of the workplace. On the other hand, if we don't recognize that problem and if they don't recognize that problem early and deal with it because they do not have the financial wherewithall to deal with it, they end up not being able to do their job, quit, and then we have to train a new employee which is more expensive. I'm very proud of that program and I'm proud that people are starting to hear that the most important thing we have are our people. I've said many, many times to our administrators, I've said "You know we all have to

make some decisions about people and how things are done oftentimes are more important than what is done." You need to talk to John about that because he and I and other people have gone over that many times. It's trying to have the humanistic approach to dealing with people and people's problems. I'm particularly proud of the institution, the fact that we've taken the leadership probably in the nation of being one of the first if not the first medical school to have a complete ban on smoking.

ALTER: Although some of your faculty spend time outside the door.

RICHARDS: I took that to the students. I did a medline search on smoking and I took it to the student body and the student leadership and said "What do you think?" They came back and said "Dr. Richards, if we're who we say we are in a health related profession, there is no choice that we have but to ban smoking." I took it to maybe seven or eight other committees with the same data and that information, led by the students, and they came back and said "Dr. Richards, you have no choice." So on October 1, two years ago, we banned smoking and received a commendation from the Surgeon General on the leadership that we've given in this regard. I don't know of any employee that is retiring because of the nonsmoking situation.

What problems have had the most difficulty? I think that the overall problem is attempting to have individual staff and faculty and administration believe that the most important thing in our life as an institution is our students. I say to the janitors and I say to the people that I meed with, and I meet with every section at least once a year, have coffee with them and so on, I say to them "I won't be satisfied until you share with us our commencement in May or June and

you will say, I am a janitor, I am a truckdriver, I am a physical plant individual or I am a secretary, and I really feel that I have made a contribution to this individual or this group collectively that crosses the stage and receives a D.O. degree. And my job is that, and I'm making a strong contribution and I do care and I do believe and I'm proud to be part of the Texas College of Osteopathic Medicine because what they're doing nationally, their reputation nationally, and what contribution that they make within the state of Texas." That's the most difficult problem we have, because if I can get 75% of our faculty and staff to understand that that's their mission, then many of these other problems will be lessened, because we will have a full committment of why we're here and that certainly is an altruistic task but it's not inconceivable and that relates to making decisions on how we treat each other and how we treat other people, particularly the students and our graduates. I guess that's the biggest problem I've got.

ALTER: Will you discuss the Institute for Human Fitness? That wasn't a philosophical idea?

RICHARDS: No, that was an implementation phase. The Institute for Human Fitness ws an implementation phase. The committment for the institution continues to be (1) the Department of General Practice (and not necessarily in priority but there are three areas that have to grow in order for us to continue with the mission that we've got), (2) the Department of Public Health/Preventive Medicine, and (3) the Department of Manipulative Medicine. There has to be a symbiotic relationship between those three departments as to where we are and the uniqueness of this institution. Every one of them has a mission that relates to why we exist and they cannot be a single entity going in different

directions, beating to a different drummer. There has to be an opportunity for them to contribute not only to the health care needs but the educational needs of our students and our residents. They have to take leadership in the profession and they have to contribute in a scholarly sense to core knowledge, and there's a deficit there. That has to grow and that relates to the goal statement and that relates to everything that's in the research document and our service mechanism. That doesn't mean that they grow in spite of other departments, but you have to have a foundation to continue that primary care base. We can't graduate 10% of our students that are going to primary care area by 10 to 15 years from now. We have to continue the foundation and that means there has to be leadership in that foundation who feel that sense of committment and are willing to buy into that dream. Now how it's implemented is only as good as the leadership and their creativity and their ability to dream what could be. The template is there. The curriculum is still headed in that direction.

ALTER: Why is there no Institute for Human Fitness any longer or was that just a phase that you went through and it's not the most effective way to implement the goals?

RICHARDS: The reason that there is not an Institute for Human Fitness is the fact that the state of Texas told us that we could not continue to use state funds to rent space at River Plaza. We didn't have the thousands of dollars per month of private money to do that. The people involved in the institute did not choose to raise that money so we had no choice. With the fact that we had a Department of Rehabilitation where the physiatrist chose to leave, we had to regroup. So we regrouped in the consortium of putting together, which was the original design of the Institute for Human Fitness to begin with,

putting together three areas: (1) the relocation area, (2) the public health area, and (3) the Institute. Half the functions of the Institute are still in existence. They're doing wellness assessments and contracting with the city and the Police Department. We are doing wellness assessments in terms of contracts for those in other private industries. The implementation phase of the Institute has been taken over by a prolifery of wellness centers all over Fort Worth. Within five minutes from where we are here there are at least five different wellness centers.

ALTER: And they spend an enormous amount on mail. Don't you get it at home. I do.

RICHARDS: Yes, I get it all the time. You've got the YMCAs, the YWCA, you've got the Harris, you've got the St Joseph, you've got the Hugeley, you've got the President's Fitness Centers, those are implementation areas.

ALTER: So you can say that we were a leader in that because IHF was first but there is not a community need for it now as such.

RICHARDS: There probably is a need for it but we can't use state funds on it and Texas is unique in terms of some of the funding. For example, we can't use state funds for students or alumni. Other states can. So we're restricted. On the other hand, the potential for us to do scholarly activity in relation to those hundreds and thousands of people who come through here to get their assessments, the opportunity to use that in some scholarly base and publish findings down the line which will contribute to core knowledge can, in fact in my opinion, give us the recognition and leadership that's necessary, very similar

to our friend in Dallas who received his notoriety not on the basis of specifically his runners but from the basis that he has the data to support that the quality of life improves, you get your lower cholesterol, you get your lean body fat, and you increase your cardiac reserve, all of those things have had significant impact on persons' longevity and the quality of life, but the data he produced gave him that recognition. I'm saying that we our leadership here that we can and should have the quality people who can enhance that and give us the leadership again in the direction that we need to go.

And what are the particular concerns for the future? I think the concerns for the future as I mentioned some of that: where is medicine going? will we have a socialized system? will we have rationing of health care? will the health care costs continue to be an issue to the fact that it influences what happens with medical education? I am concerned that as a profession we come together with an understanding that we can work cooperatively with other health care agencies and we are symbiotic in that relationship and take the advantage that we are leaders and will make a significant contribution in the health care delivery system, not only in the state of Texas but nationally based on the quality of our programs.

ALTER: Can you convince people that that can be done while maintaining the distinctiveness? Can you overcome the we're-as-good-as and the we-want-to-be-like that has plagued the osteopathic profession?

RICHARDS: That's a matter of attitude. I don't know that I can convince people of that. I can only say that leaders lead and leadership starts at the top, and my message is that we're second to none in terms of our contribution. We're second to none in the things

that we're doing and we can hold our own in any health care endeavor and can make a significant, unique contribution in a variety of different ways.

ALTER; I think unique is the key. As long as we keep saying that what we do is different.

RICHARDS: If we're the same as there's no need for us to exist, because we can't compete in the same areas. We also have to take risks. We have to open up new avenues. We have to take that risk to open up new avenues and where we're not willing to take the risk, and there are certain individuals who say "Why are you doing that, we don't have the manpower?" You're not going to get the manpower unless you open these things up. You're not going to get the space unless you have those needs. It's the chicken or the egg. On the one hand individuals will say, "Well, Dr. Richards, we need more graduate programs." Okay, I agree, I can get those, we can create a paper trail for a new graduate program, but where are you going to get the patients to assure that there is quality to interest our students and our graduates that we do have a strong program, we do have consortiums. And you do that by creating a clinical base. The VA and the Carswell have the potential, like 350,000 potential patients. You've got to think of those things in order to get the clinical base which gets more faculty which gets more state funds, which gets more graduate programs which has more quality. Some individuals will say, "Why should you go out here, why are you doing this, Dr Richards? We don't have the manpower to do this?" I get the manpower through state funds and you go to the state and say "Here are the needs that are unmet and we need 10, 20 new faculty to do this, Mr. Governor and Mr. Lieutenant Governor and Mr. Speaker of the House."

ALTER: You mean when you started in with Carswell, people said to you "Wait a minute, don't do this, we don't need to take on any more projects."

RICHARDS: I've got it right now. "We don't have the manpower. We can't do this." But if you have the patience and a quality education program, you will have residents, who are licenced. But you need more faculty. How did the other medical schools build their faculty base?. What we do is we look at ourselves and we say isn't is awful, isn't is terrible. We don't dream on the potential of where the institution can be. I think the vision for our institution for the next 20 years - you can read the book. I think that our vision is to become an academic health center in conjunction with the assets of the University of North Texas where we can in fact play a significant role not only in the economy of Tarrant County but a significant role in the training of those individuals who will relate to health care delivery in the state of Texas and I would hope at that point in time that we have a full affiliation with John Peter Smith.

ALTER: Would you back up and tell us something about core today? John just mentions core and I don't understand it. I have Kent's interview about the establishment of core and to me it's like at TCU we talk about teaching writing across the curriculum. To me it sounds like you're teaching osteopathy across the curriculum.

RICHARDS: Core has organizationally changed because the original function under which core was established was never full implemented, particularly in the area of the interdisciplinary aspect of things and particularly in the aspect of scholarly activity. We're not competing

with the other osteopathic schools in terms of what we're doing in osteopathic research. Based on our resources, based on our budget, based on the number of faculty that we've got, we're not the leaders in that area. So what we're trying to do is bring core back into manipulative medicine and charging them very clearly that part of their responsibility is to do scholarly activity and take the leadership of where we are because what happens is: we got a visit about six months ago from a physician, an M.D., who runs the Medicaid program in Texas, and he asked the question of Dr. Dickey and John and myself, "Tell me, I've got a patient here with carcinoma of the colon. Tell me Dr. Dickey, what data do you have to support what does anything for carcinoma of the colon?" No answers. There are no answers. Now certainly we feel that as a practicing osteopathic physician that are things that can be done to help that patient, not necessarily cure the cancer, but help that patient's total well-being during that process. But I can't tell you anything that's been produced here at this school that in any way directs any answers to those questions, and we have to have a leadership to be able to do that. We say we are unique in terms of the osteopathic concept. Fine. We say we're unique in producing general practitioners and primary care physicians. We've got a track record of that.

Core was an interdisciplinary group that would bring together the people to continue the education of our faculty and to use the leadership in interdisciplinary approaches to fulfill the osteopathic concepts in four years and it had a research component, very clearly, of which we had zero in research and we had little in interdisciplinary areas, but let me make a point. When you got into our hospitals and you see patient's with asthma and they are laying over the bed and people are cupping them, the respiratory therapists are cupping them,

and you ask the question: why are they not getting rib raising, and why are they not getting lymphatic pump and why are they not getting what we think are the techniques that are necessary? Then I have to go back and say: the reason is because someone wrote an article someplace, somewhere on double blind studies on the effectiveness in respiratory disorders of cupping and postural drainage in order to improve asthma or pneumonia or so on.

ALTER: So we need the article that says rib raising is effective?

RICHARDS: And lymphatic pump has in a double blind study of 300 patient who have these diseases that they have been effective and have such a quality that that is published in prestigious medical journals.

ALTER: It would make a difference.

RICHARDS: It would make a difference. For our people to say: you know, I've had 30 patients in my practice and they've all gotten better by doing these things to them and students respect that, truust me, believe me, and go with God, and then they go and meet with our general practicioners, our internists and they say "Dr. Richards, I don't belive that you're treatment of diabetes is acceptable here. I think that you should be doing whatever and whatver." And I say to them, "Let's go to the library. Let me pull out the latest that we have in this journal on the treatment of diabetes." "Oh, okay, you're right, I'm wrong." You have a data base. But the guru aspect and the laying on of hands aspect with the quality of students that we have at this point in time, they won't accept "trust me, it works" in my last 30 patient's. Unless they've experienced that themselves. So there is a need for us to produce the educator in osteopathic medicine that can

and will publish those results with double-blind studies. I am convinced that they work.

ALTER: That has been one of the goals of the college?

RICHARDS: I have given a clear message to this college to give leadership in that direction. And the higher those people who have that initiatiave, who have that ability, and will give that committment because that's what we need.