Interview with Dr. Stanley R. Cohen - Vice Provost, Health Professions Division

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It is the 22nd of June 2010 and I’m speaking with Dr. Stanley Cohen. Tell me when you first got involved with Nova and I suppose in your case with Southeastern.

SC: Yes. It was actually in 1980. Although officially I believe it was recorded as 1981. We were just, we bought a house in 1979 and I retired from New Jersey in higher education and I didn’t do so well in retirement. I hated retirement. In fact, I got an F in retirement. So, my wife said to me one day, “Either get a job or go to a psychiatrist.” And, I walked over to this place, I saw them building a building over there and I walked over with my poodle and I went in and it was Mort Terry and Arnold Melnick, they were the only two people. I said, “I need a job, my wife says I’ve got to go to work.” They said, “Well, we can hire you, but we can’t pay you.” So, I did that. They really save my life, because I was, I was a mess.

JP: Now, was this in Miami?

SC: This was in North Miami Beach.

JP: Yeah.
SC: Yes.

JP: And, at this time it was called Southeastern?

SC: It was called SECOM, Southeastern College of Osteopathic Medicine.

JP: Okay.

SC: That was the only college we had at the beginning. We started with 40 students.

JP: And what was the general concept when Mort Terry was beginning? What was their goal? What were they trying to achieve?

SC: Well, he wanted, he was a very successful internal medicine doc. He had spent a long time, he had a great reputation, he wanted to give something back to his profession and he thought the way to do that was to educate some young physicians that he could influence and he had a passion to do that. Actually, at the time, he owned a hospital, he and a group of other men owned a hospital right there at the medical school across the street and they decided to use that, to sell that and to use that money to open the school, which they did.

My first involvement, they told me they didn’t have any money so they needed some startup money and I started writing grants for them. I wrote the AHEC grant and pre-
doc grants, which they got quite a bit of money from those
to open, to continue the operation.

JP: So, in what 1982 they start the medical school?

SC: Um, actually it started in 81’. We took our
first class, I’m trying to remember, I want to make sure
about this, they graduated in 84’, so it would have been
81’ I think.

JP: Okay.

SC: Yes.

JP: And so, in the first class there were around 40
students?

SC: There were 40 students, absolutely.

JP: And what were their physical facilities like?

SC: We had one lecture hall, one. And, across the
street there was a, it was a building that used to, where
they used to put the nurses, it was a nursing home of some
sort, and they converted that into offices and gross
anatomy was in the first floor and it smelled like you know
what because they didn’t have the proper ventilation in
there, you know, but that was it. It started with one
lecture hall and we had it rewired for television so we
could watch what was going on from our offices across the
way. We were able to monitor every single classroom.
JP: Well, in the beginning there is a difference between a traditional medical school and this medical school, could you sort of explain the different circumstances?

SC: Sure. First of all, osteopathic physicians are hands-on people. They believe in touching patients. They believe in sitting down with patients and really listening to them because they know they’re going to get their diagnosis from the patient. There’s a lot of, they get their traditional medicine too, you know, the sciences and all those things, but in addition to that they get manipulation training, which is different from chiropractors. It has to do with the neuromuscular system and how to adjust those things so they can do a lot of things without pills, but the emphasis is on humanism, compassion, empathy for patients. That was what, in fact, Mort Terry said to me, “I want to make sure this instruction stresses that because I want them to be people docs,” what he called “people docs” and that was the idea.

The first 40 students took a terrible risk. We were not accredited at first. We had to, we got temporary accreditation, but until you have your first graduation class you don’t have full accreditation, so they were
spending their money in a school where they had to take a chance that we would become accredited.

JP: Now, what kind of faculty did they have at the time? What was Melnick’s background?

SC: Arnold Melnick was recruited by Mort Terry. He was a pediatrician in Philadelphia, retired. A very bright man and Mort Terry knew him. They were students together in the Philadelphia College of Osteopathic Medicine, and he called him up and said, “You’ve got to come down here and get this program started. I want you to be the first dean.” He took, he picked the right guy because Melnick was extremely bright and he’s just an incredible guy to work with. He also happened to be a great teacher, by the way. He was just superb. He taught, he was an administrator. Most of the faculty, in fact, all of the faculty were volunteers. We had local physicians, mostly all DOs who came in and we only, if they did a lecture we paid them $50 I think it was for a lecture and then we asked them to donate it back. We sent them a certificate that said, “We are low in money, will you donate back the $50?” That’s the truth because money was-- In fact, I’ll tell you a funny story about it.

I was writing these grants for Melnick and I wasn’t getting paid, but I went in there one day, I ordered a
dozen pencils, okay, and he’ll tell if you speak to him, this is true, he called me in and he said, “How many pencils do you use at one time?” I said, “One.” He said, “Well, I’m going to give you one pencil.” I said, “Oh no, I want a dozen pencils.” “Nope, you’re getting one pencil.” That’s the truth. That really happened. That’s how tight, but you know because of that, because we were so careful and not squirreling away money we were able to put some money together in the next ten years that built a good bit of these buildings here on Nova campus. I mean, we literally had over $90 million that we were able to accumulate with investments and so on. The grants that came in, the one grant, the AHEC grant, which we started, was less than $1 million. I wrote that thing. It turned out to be $68 million today, that’s how much money came in from a single grant from the federal government and from the state government. So, and some of that money was invested at 17%. Mort was a good businessman and over the years that money grew and grew and grew and when we married Nova, I think it was in 1994, somewhere in there, Nova donated the ground, but we paid for all those buildings over there, including the dental building.

JP: Let me go back a little bit.

SC: All right.
JP: And talk about the beginning. Now, when you are starting a medical school you have to have I guess local and state approval.

SC: Yes.

JP: People must inspect, I mean not just accreditation by osteopathic medicine.

SC: Absolutely.

JP: But from the state as well. Was that a difficult process?

SC: Yes, it was. When Mort, Mort tried to first get the charter it was 1979. The first time he tried he was turned down. I don’t remember what the reason was. I wasn’t really there at that time, but that’s what he told me. But, it was another year or so when he reapplied and was able to get the acceptance to go ahead, that was the state approval for the school. It’s not easy, you’re right. You have to get the state, actually the state and the local people too had to approve it and they were kind of tough because we were trying to build things as we went along and they were-- Boy, the inspections were incredible. You know, he worked it out. He built the garage and that kind of thing.

JP: Well, of course it should be. It’s medicine.

SC: Yeah. Absolutely.
JP: So you have to make sure that it’s not--

SC: Absolutely. We had some good things going in those days. The first class, we had them riding the ambulance on Saturday morning. The hospital across the street, we assigned, we only had 40 students, and I was able to schedule those students so they could be on the ambulance Friday, Saturday and Sunday. They got experience out there with seeing some really bad things happen, accidents. It was great exposure. As we got larger, we weren’t able to continue that because we went from 40 to 60 to 80 to 100, 120 up and now we have 240, but it just got to be impossible to schedule that kind of thing.

JP: Was there some distrust of osteopathic medicine as opposed to what people would consider traditional medicine?

SC: Absolutely. In fact, the history of that is incredible. You know, osteopaths couldn’t even write prescriptions, some of the states-- What happened in the Second World War, the MDs were drafted, the DOs were not drafted. So, what happened, the hospitals needed patients, so all the DOs were home taking care of patients and many of them wouldn’t admit DOs to the hospital, except they needed money, the hospitals needed patients, so all of a sudden across the nation many of the hospitals decided to
admit DOs to the hospital and, of course, at that point, they were allowed to write prescriptions in most all the states. In fact, I think of all them, but there was no question there was prejudice. When I went to Washington to try to get the AHEC grant, I had to go before a peer review there, an all MD peer review, they didn’t even know what a DO was. I had to get Marty, one of our guys to make a film of, what was it, Oak Harbor or someplace, Belle Glade, some of my students were taking care of these little black children and they were, they made a film in our lab, of our science labs, and I showed it to those people in Washington. I said, “Hey listen, this is a legitimate school. It’s not a storefront operation.” They thought it was some kind of a, you know, a storefront thing, but I convinced them. And, we were the first osteopathic school in the nation to get an AHEC grant, that’s “Area Health Education Center.” We were the first. Now, of course, there are many of them. And we were competing with the University of Miami, the University of Florida, the University of South Florida. When I was in Washington, I asked them to get together with us, let’s have one proposal. “You’re an osteopathic school, what are you talking about?” They wouldn’t even talk to me. They went out to dinner without us. They wouldn’t even invite me to
dinner, that’s how, you talk about prejudice. It was really bad. As it turned out, we got it and they didn’t.

Now, the rules were only one in a state. So, the following year the University of Miami called up Mort and said, “If you don’t support us, we can’t get it now. Will you support us?” And my opinion was, “Don’t do it Mort.” But he said, “Look, we’ve got to be friends with these people.” So he said, “Okay,” and eventually UM got one, the University of Florida got one, Central Florida, they all have them, and now there is a statewide program of AHEC, which Dr. Zucker runs. I hired him because when I wrote the AHEC grant I put myself down as the director. We didn’t have anybody else. But, I couldn’t do that, I was doing a million things already, so I called up the people in Washington and said, “We need an aggressive guy who can raise money.” They said, “Well, there’s one over in West Virginia. His name is Steve Zucker. Go get him.” I called him up and got him down, his mother was here and he wanted to relocate anyway because he wanted to be near his mom so Mort and I and Arnold, we hired him right away and was the director and he’s been the director, he still is the director. He is an incredible person. That program has developed now into this huge statewide AHEC. We’re taking care of sick people all over the state, people just
walk in, they have babies, everything possible—Belle Glade and places like that, and he has gotten that program to operate, $68 million as of this year.

JP: What would be different in the curriculum for a DO, as compared to an MD?

SC: Basic sciences are the same. They get the gross anatomy, they get microbiology, physiology, pathology. All those things are the same. The clinical work is a little bit different. We send our, we believe that people, students should be out there rotating into real offices. They need to be in the hospitals, they need to be in doctors’ offices, they need to be in the community. So, what we did was schedule these 24-25 rotations they’re called. Every student was required to be in an area that was disadvantaged for two months. We wanted them to get familiar with those people. They did a rotation in surgery, in dermatology, you name it they would get at least one month.

JP: And, where would they doing this?

SC: They were doing it in doctors’ offices around Miami, they were doing it across the street in the hospital when we were down in the old school, they were doing it in—What happened, interesting, in Jackson at first they wouldn’t take our students because they were DO students.
JP: And this was Jackson Memorial?

SC: Yeah. They wouldn’t take our students and Mort got on the phone with the director down there and said, “You get federal aid?” “Yes, we do.” “Are you familiar with the law about discrimination?” Boy, he was, “Oh, well, Dr. Terry, we’re awfully sorry. We’ll take your students.” Because he threatened to sue them, see. They took our first group of students out of the 40 and they were the best they had because our students were, they could go into a room with a patient and they could do a workup, they could take a history. The Miami students didn’t have that exposure yet. They didn’t have their rotations. So, they loved our students then and they said, “Oh, send us more.” In a few years, they couldn’t get enough of our people and they not only put them in the emergency room, but they had them, they wanted them in other, in the dermatology, and they wanted them in ear, nose and throat and all that other stuff because they were outstanding. They could really function.

JP: Well now, if they finished their medical degree, did they do traditional internships and residencies?

SC: Yeah. They did one year of internship required. By the way, the MDs don’t require that anymore. They don’t require an internship. But they did one year, it’s a
rotating internship and then three, depending on the specialty, internal medicine is like three years, surgery is four or five years and so on. Otolaryngology, ears, nose and throat is four or five years.

JP: So, if they would do a surgery residency, let’s just say they go to Shands in Gainesville, would that be a traditional residency?

SC: Some programs are traditional in the residency. Some are a combined residency. My son Andrew was one of our graduates. He went to Allentown, Pennsylvania, which was a combined MD/DO program and there were a number of those around the country that were starting up. It was a trauma hospital and he wanted that exposure up there, that’s why he went there, but he was sort of, he was accepted as a DO, he was the first DO student at Allentown to do that. After that, a lot of them, they wanted more because he did well up there and they asked us to send more students.

But, across the country now there are a number of places that they don’t, they’re MD/DO residencies. In fact, one time the Vice President of the AMA, American Medical, came to my office and said, “For God’s sake, how do you get these people to do family practice residency?” They open these, a new huge number of family practice
residencies, medical, MD residencies, they couldn’t get students to select them. They wanted the, you know, the surgery and that, and our students were filling those slots. So, he said to me, “How do you get, what kind of a student do you get to do this?” And I said, “Well, you’re taking the wrong ones.” You know, they wanted the ones with the 1% on the MCATs up there with these huge MCAT scores. We wanted people who are people, people. It’s not necessarily true the higher your scores on those tests that the better doctor you are. I mean it’s really not. There’s no correlation. So, the type of students, we would interview every student. We never took them by grades and MCAT scores. And to this day we still interview every single student that we admit and the kinds of questions we ask them dealt not with their scores, but how they would deal with people, how they would communicate, how they would make a patient comfortable for the first time they see them, how to bond with the patient. Things of that sort.

JP: Well, this looks like a perfect background for what the new Obama medical plan is.

SC: Absolutely.

JP: They’re going to need more and more practitioners.
SC: Absolutely.

JP: At the rural and local levels.

SC: Absolutely, and our model for that community base, okay. In fact, incidentally, I’ve been involved in writing some of that Obama thing. I’ve been involved with that and I, some of the things that I put in there were based on our experience in AHEC and our community-based stuff, yeah. These community-based health centers that are designed in that program came from our AHEC model.

JP: Is there still a certain, I guess, distrust on the part of the traditional medical schools and MDs?

SC: There is some of that, but so much, you know, you go back to 1945-50, it was pretty bad. Today, some people just don’t understand, they don’t even know what a DO is. They’re in the minority. But if they go to one and they see how they’re treated, very often they won’t go to anybody else because they know they sit down with them and they talk to them. You know, sometimes they go to doctors and they want to work on their computer, not even looking at them, sitting there, you know, they’re putting all this data in and all of a sudden they have somebody who will sit across from and say, “Tell me what’s going on. Talk to me.”
JP: So, in terms of training, let’s just say I wanted to go to a DO who has a specialty in neurology or whatever, would they be as well trained, just different approach to medicine?

SC: Yes, they would be, they would take a residency in internal medicine or nephrology or whatever it is. Yes, their training, in fact, many of them go to the MD residency programs. Yeah, the training is the same, but the approach is quite different.

We had a DO when we lived in New Jersey, our doctor was a DO there, in fact he was a good friend of ours, Dr. Green, and I just loved that man. He was the first doctor I went to who would talk to me like an intelligent human being. You know, if I asked him about the drugs or asked him what he knew about so and so, he would tell me. When I first moved down to North Miami Beach in 1979 I interviewed five doctors. I wanted to make sure I had a doctor who was up to date in the medications. I had some issues I needed to take care of, so I went to three or four around Miami and, what’s his name? Bob Auer. Bobby Auer was in practice right near the old medical school and I walked in there and he was the first one that didn’t throw me out. When I said, “I would like to talk you,” he said, “Yeah, I’ll be happy to talk with you.” He told me his
background. He told me, I asked him about some drugs I was
taking, he knew about them. He seemed, I saw some journals
on his desk that he was reading and I said, “Okay, you’re
my doctor.” As it turned out, we tried to, he used to come
over and help me with teaching students how to do
interviews, how to do initial interviews, a history and
physical, but we couldn’t afford to hire him. But years
later, he’s now on our staff. Bobby Auer is the head of
our clinics all over Nova Southeastern now.

JP: So, part of the issue was, if you look back, is
this manipulative process that some people were a little
disturbed by that, they felt, “Well, these are
chiropractors, not MDs.”

went before peer review for AHEC, they equated them to
chiropractors, they called them “rub doctors.” They didn’t
understand and it’s not that at all. It’s, you know, it
has to do with the relationship between organs of the body,
the muscles, nerves, all of those things are integrated and
when one part gets knocked out, if for example, if you’re
at L5, S1 your back let’s say had a problem, it wouldn’t
just affect that, it would affect everything. It would
affect your chemistry.
JP: And, in the medical profession that’s really changed now because most MDs recognize that, do they not?

SC: They do. In fact, the University of Miami has a course now in the medical school called, “Physical Medicine.” They wouldn’t call it “Osteopathic Medicine,” but they called it, and it’s taught by a DO. It’s called, Physical Medicine, yeah.

JP: Explain what went on, let’s say from 82’ to 94. Explain how Southeastern grew because by the time the merger comes clearly Southeastern is financially solid and has physical buildings and all of that that they didn’t have when you started.

SC: Okay. First of all, the 40 in the first class of medical school became 60 in the second class, and in the third class they became 80, and the fourth class 100 and we increased, we got permission from the AOA to increase it by 20 each year. We got up to 120, it might have been 140, I’m not sure about that, but until we moved up here, but in the meantime, Mort was interested, he wanted to make sure that other professions, health professional people understood each other and he said, “You know what, we need to have a school, we need a pharmacy school, we need an optometry school, we want these people to be,” and he wanted them close together, he didn’t want one school to be
ten miles away and another four miles away. He wanted them closer to get an understanding because he thought that in the future medicine would be a team approach and boy I think he was right about that. We got our, I’m trying to remember which school came next. I think it was the pharmacy school. I hope I’m right about that.

JP: So, here we are just getting started with the medical school and already he is starting the pharmacy school?

SC: Yeah, here’s the thing-- We didn’t have a bureaucracy to fight. I was in a state institution in New Jersey. If we wanted to build a building, five years later we’d get it built. You know, we had to go through all the, all that stuff with the state. But we were a private school. When Mort said-- Boy, in one week Arnold got a committee together, a need study for pharmacy, a need study later for optometry and so on, we were able to get things done fast. That was important because once Mort decided we want a pharmacy school we had it the following year, you know, we opened the pharmacy school.

JP: Where did you get the money?

SC: Well, a lot of it came from Mort Terry’s pocket, Arnold Melnick’s pocket, Danny Finkelstein’s pocket. Most of the auditoriums we built were named, if you go over
there you’ll see our auditorium names came from people who
donated money to the schools, it came from the grants that I wrote, it came from—

Oh, here’s another story. We, I went up to Tallahassee to get some capitation money for each pupil we had and I went up with several people, I’m trying to think, well anyway, we were just really discouraged because they said to us, “Look, Miami is written into the law. Their name is in there. They’re the only private school in the state that will get state money, state capitation.” And we said, “We need it, we’re taking care of poor people. We need money.” So I wondered, and so I walked down the hall and I saw this, it was a nursing liaison person for the State of Florida, she was a liaison for the nursing school and I walked in there and I said, “You know, I’m kind of discouraged, we, Dr. Terry is trying to get the money.” And she said, “Dr. Who?” “Dr. Terry, Mort Terry.” She said, “Sit down.” I said, “Oh my goodness.” “You mean Dr. Terry from North Miami?” “Yeah.” “Tell me what you need.” “Well we need, if we can get $5,000 per pupil it will save our necks because we’re in a hole.” She said, “Give me a few days.” Okay. I don’t know what she did. I don’t know what she did, but the following Friday I get a call from her, we’re getting the capitation money. I said, “Will you
tell me why you’re doing this?” “Well, I just want you to know that Dr. Terry was the first physician,” (she was a black lady) “he was the first doctor that allowed my grandmother to sit in a white waiting room.” I said, “Are you serious?” She said, “Yes. She sat in a white waiting room. You can’t imagine how important that was to her and I would do anything for Dr. Terry.” So I go walking into Mort’s office and I say, “Mort, do you know why we got state capitation money?” He remembered her name, he remembered that woman, okay. He didn’t know he was supposed to have a separate waiting room. He came from Philadelphia. He was broke and he had enough money to open, he borrowed money to open this little office over here in a black area and he had, he didn’t know he was supposed to, he had one waiting room. The truth about it, he was the first doctor in Florida to have one waiting room. I don’t know, there was a lot of discrimination then even back in 1979-80 they had separate toilets for whites. They were sitting in the backs of buses, you know, it was still pretty segregated.

JP: In this case, he’s going to go through the process of first pharmacy, is that right?

SC: Yeah, I’m not sure. I think it was pharmacy and then optometry. I’m not sure which came first.
JP: And then eventually there’s a nursing school?
SC: No, that came later up here.
JP: Up here, okay. So, his idea was, the concept was this unified medical care program.
SC: Absolutely.
JP: Which would start with osteopathic, then pharmacy, then optometry and eventually dental.
SC: And eventually, dental came up here.
JP: That was much later?
SC: Much later, and nursing just recently in the last few years, yeah.
JP: What I’m asking is, was all of that part of his vision?
SC: Yes, absolutely.
JP: Yeah. So, he intended--
SC: And every time they said, when he said, “I think we need,” the only thing that we didn’t do was a veterinarian school and the reason we didn’t do the vet school was because he asked me to research that and I found that every vet school in the country lost money except the University of Pennsylvania and Cornell and they made their money with these prize bulls, they would go out and service all the cows every year, that’s the only way they survived.
But, you also have to have a separate building for each animal, you have to have a huge farm for it.

JP: It’s very costly to start up.

SC: Yes. Startup was huge and I said, Mort we’re in big trouble financially with this kind of thing.

JP: Now, did you have any trouble with the accreditation for pharmacy and optometry?

SC: We went through all the steps we had to go through, you know, the higher, no matter what they threw at us we were going to do it and we had committees to work on that kind of thing. We went for it. Again, each one of those programs, we had to have our first graduating class to get fully accredited, but we started with partial accreditation and we worked it through, we got all our requirements and we got fully accredited on every single program, absolutely.

JP: Talk a little bit about Mort Terry. What made him such a good, successful leader?

SC: I think first of all he cared about people. He was really, he just had a bond with almost everybody. It didn’t matter what they were. He just, he had that magnetism about him. You would sit down with Mort and he made— I know the first time I met him I fell in love with the guy. I liked his drive. I liked his ambition and he
and Melnick got along really well. They were a good team together because he would say to Melnick, “Develop a pharmacy program.” Okay. He stayed out of that. “Develop optometry” and so on. “Develop a science,” we had a basic science program. I forgot to mention that. Howard Laubach was one of the first people we hired. He is now our Dean of Basic Science. We had, he just, he was a good business person too. He used to invest in things for the school. They all turned out well. I mean, he owned a dog track one time. He invested in a dog track in Palm Beach and tripled the money. He opened one of these travel, you know, these travel trailer places in North Miami. He owned that, he bought that thing for almost nothing and all of a sudden, three years later it was worth $2 million.

JP: And he put that money back into the school?

SC: Back into the school. Absolutely. Back into the school. And he just had this, the only bad thing he did, he was president of a bank in North Miami Beach and we deposited some, I don’t know, $10 million at 17%. I don’t know if you remember when the interest was way up, that was his bank. He said, “We’re going to put this in my bank.” Okay. We didn’t realize, that he took a real bath on that one because, you know, all of a sudden, a couple of years I think, we invested that at ten years, ten years locked in
and wow, that became $40-50 million. So, from his personal standpoint, but for the school it was great because we got a great amount of money from it. He had a good business sense.

JP: He also, obviously, had, and I know this is an over used term, but a certain vision and goal that he wanted to pursue and that he was determined enough to figure out how to get there.

SC: Yes. He knew how to get, he wasn’t just a dreamer.

JP: Yeah.

SC: But he knew how to take action and-- See all of the people that taught for us were volunteers. They all knew Mort, they worked with him in the hospital. They were the people that came in to take care of patients in all different specialties and they had a great admiration for him, a mutual admiration. So when he would ask them to do something, “Oh, sure, right away.” They would come in, they would help, they were tremendous. In fact, the problem was none of them were teachers. They were good doctors and my job, my degree is in education, EDD, and he wanted me to make sure that their methodology was good for students. So, I had quite a challenge. I mean, they didn’t know how to write a lesson plan. They didn’t know
what a syllabus was. I was teaching ED101, you know, to these people. They wanted to, they had good attitudes, but no exposure at all in the classroom.

JP: Talk about the physical facilities and how they changed, say from 82’ to 94’.

SC: Okay. First of all, we had a, Mort believed in a library so we opened our, right in the nursing home we opened a little library and, in fact, Geri Terry, Mort Terry’s wife, and Mrs. Snyder and my wife, Joan Cohen, they ran the, they brought, most of the doctors sent books in. That was the beginning of our library and we got them free and we would call up companies and ask them to send us books. When we had to sell books to students, we would open a temporary place to sell books and again those same people, including my sweetheart here, would sell these books and collect the money and pay for them. The initial library when we opened it was manned by volunteers, all volunteers. Nobody got paid.

The science labs were really pretty good considering we started up from nothing, but we had, I mean we didn’t have an electron microscope and that kind of thing, but we had a good microbiology lab, we had a good path lab. We were doing some studies with dogs. We got picketed one time because we were using dogs as test animals.
JP: Now, is this in one building or are there several buildings?

SC: It was basically, the lecture place there in our nursing home that was where gross anatomy was. It was a three-story building. Gross anatomy was on the first floor and I always avoided that. I couldn’t stand that smell, but it would come up to the third floor. I’ll tell you, my office was on the third floor, and Arnold was on the second floor and Mort was on the second floor. Joe Namey, who was one our people who helped us with accreditation, we hired him for that reason, he later became a dean after Arnold stepped down, they were on the middle floor, but everything else, the sciences were all in that building.

JP: Okay. So, over a period of time, how many buildings did you build?

SC: Well next, we built another building for the sciences. We built a, after the, the one lecture hall was first and then we built that one next to it for the science stuff and housed our basic science program in there. And, I’m trying to think, I guess the pharmacy offices, no they were still in the nursing home building. We only had, we had the big parking garage, we had the science building, and we had the lecture hall and we had the nursing home. That was it. That was it until we moved up here.
JP: Up until 94’?

SC: Right.

JP: So, this was pretty crowded?

SC: It was crowded, except you’ve got to remember that our students on their third and fourth year were out in the community.

JP: Okay.

SC: So, we only actually had the first two years of medicine, the first, even the other programs they were, they were getting community exposure.

JP: So, when you come to the merger, what you have at this point, you have science programs, you have pharmacy, you have your medical school and you have optometry.

SC: Optometry.

JP: Those are the four areas.

SC: Yes.

JP: Now, from the beginning was the administration and I would say here Mort and Arnold Melnick, were they looking for a merger or were they looking to expand? What was their goal?

SC: Well, when we got to the point, the city was starting to give us a hard time. We couldn’t really, we didn’t have any ground. We bought one of the, a little tiny house there, we bought a number of houses there to
house students, but they were, they were difficult to work with and Mort said, “You know, we’ve got to get more,” and we actually approached the University of Miami first, but the board and they, the president wanted us but when it went to their board for approval there were MDs on the board and they didn’t like the idea of merging with a DO school, so Miami turned us down.

JP: Well, in the relationship with Nova, the story that I have heard, when Feldman was president and when he was inaugurated, Mort Terry had come to the inauguration and had in essence sort of jotted down--

SC: That’s right. That was after we were turned down at Miami.

JP: At Miami, yeah.

SC: Yeah, that happened. Yeah, you just reminded me, that’s true and he wrote a little thing about, “Maybe we should get together,” and out of that came a number of meetings and it-- We didn’t know at the time though that the cash flow of Nova was so, it wasn’t very good. We didn’t realize that. We were in good shape in terms of our own operation.

JP: Yeah, the figure I had was something like $90 million.

SC: Yes.
JP: Is that close to the number?
SC: Yes. Oh yeah. I think it was like $94 million, but close enough, yeah.
JP: And part of what the advantage for Nova was the cash, obviously.
SC: Oh yeah.
JP: And the advantage for Southeastern would have been the space at an established university.
SC: And the chance yeah, to really grow into other areas. We didn’t have dentistry at that time. We didn’t have nursing, allied health. We didn’t have the PA program, which was allied health. Oh, I beg your pardon, we started a PA program just before we moved up here.
JP: A what program?
SC: Physician Assistant program.
JP: Oh, PA program, okay.
SC: I forgot about that. Yeah, we moved, we did have that. Right, I was the first dean of that school. Again, we didn’t have anybody. I became the dean.
JP: That would have been at a time before physician assistants became more prevalent and more accepted.
SC: Yeah. Johns Hopkins had the first one in the country and they were starting to grow around the county, you’re right, they weren’t really that well established.
They certainly were not, today they’re actually I think a level above nurse practitioners. They can write scripts and things of that sort, but you’re right, it was, it was a risky thing, but we had a great number of people apply to that program.

That’s another, you know, we never thought, everybody was saying, “Oh, you don’t need more dentists, we don’t need this.” But, every time we opened a program our applications were huge, just huge. I mean, our medical students--

JP: So, at this point, most of your money would be coming through tuition?

SC: Yes, we were getting, our tuition started out at a pretty low level and we were able to raise it each year. Tuition raised money. See, we were putting a couple hundred students in an auditorium with one professor. We didn’t have, like most universities, you know, have a set up where you have to have one professor for 35 students that kind of stuff. So, we had one professor for 200, you know, and the people coming in weren’t getting paid, I mean they were just volunteers. So we were able to, with the tuition, we were able to put together that money to build some of the stuff there, the garage and so on and then invest money so that’s how we got the $90 million.
JP: Now, as I understand it, the first discussion about the merger was in 1989, but at that point Mort Terry and Nova really were not ready to resolve some of the issues, it’s going to take a couple of years before they really get into serious discussions.

SC: Yeah. That may have happened. Okay. I’m not sure about that, but I know this, the first option-out came from Miami. They had the first right of refusal. Okay, and once that happened then Mort decided well, he got angry about that because the president down there said, “We want you,” and the board said no.

JP: Well, I do know that the first, I guess articulation agreement was 1992 when there was dual admission.

SC: Right.

JP: For the medical, pharmacy and optometry, so that’s not the merger, but that’s a fairly significant step.

SC: Yes it was.

JP: Now, were you involved in any of the negotiations with the merger?

SC: I sat in on the meetings that we had. I didn’t have a whole lot to say because really Mort was in charge,
you know, it was Mort Terry and Arnold pretty much. I was there.

JP: Well, did you, I guess Ovid Lewis did most of the work for Nova.

SC: Yes. I remember Ovid coming down to our school with somebody else with him.

JP: How difficult were the issues to resolve? One of the immediate issues was, what’s going to be the name.

SC: Yeah, the name was an issue, but it was resolved. Actually Melnick wanted to make sure that we didn’t lose the Southeastern part of it and so they agreed. It was pretty, I mean it came to closure pretty quickly on that that we would change the name to Nova Southeastern University.

JP: But then there are other issues because you’ve got two boards of trustees, you’ve got different organizations for your workers and students.

SC: Absolutely.

JP: All of that. So that, in terms of the details, that might have been more difficult.

SC: It was except Mort signed a five-year contract with Nova, which said he would be, we maintained our own board of trustees. They still raise money for us now. But that we would-- and we needed some people on the big board
appointed from our place. I don’t remember the number, but he stipulated a certain number about that and for five years, he would be in control of the Health Profession Division, that is in terms of hiring and firing and money and, you know, things of that sort. Now, he had to report to the president of course, but he was the, he became the chancellor of the Health Profession Division and he was in charge for five years.

JP: What happens after five years?

SC: After five years, we are part of the whole university. We have a chancellor now.

JP: So that was the five-year transition period.

SC: Yeah.

JP: Now, there were problems with bylaws, fringe benefits, faculty salaries-- Did you all have any kind of tenure at all?

SC: No.

JP: No.

SC: I never even had a contract. I had a handshake. That’s the truth. I still haven’t, I don’t have a contract now. I’ve been here 29 years. It was just a handshake and anytime I said, “Mort,” you know, frankly I didn’t believe in tenure. In New Jersey we had tenure and I saw a lot of
misuse of tenure. I thought people were too comfortable. I didn’t even want tenure, frankly.

JP: Now, Southeastern at this point had an endowment, did they not?

SC: Yeah.

JP: Was that fairly substantial?

SC: Well, it was raised by our board. The endowment was raised. Yeah, it grew. Roy Jonas was the guy who invested our money. He’s an attorney and he picked out the places that we were going to, some of his choices were really good, some weren’t so good. He bought Eastern Airlines and it went down.

JP: That was not good.

SC: Yeah, but he invested our money and the endowment, that’s how we got that, all that money went into the endowment, $90 million or plus.

JP: Well, in my head my figures are at that point the endowment was $35 million and the annual profits were about $3 million. Does that sound--?

SC: I think it was more than that, but it might be right, I’m not sure.

JP: Okay, but this is for Nova an opportunity to expand as well.

SC: Yeah.
JP: In other words, they were still struggling financially so it was a financial benefit, but even beyond that, and I’ve talked to all the presidents of Nova, they saw this as the opportunity for Nova to become a multiversity. I mean it wouldn’t just be--

SC: Absolutely. They didn’t have any of the health professions.

JP: None.

SC: They had all the other stuff, except they didn’t have engineering. But yeah, it became a real university and you know when we came up here, I guess it was in 94’ we were giving Nova somewhere between, I don’t know $5 and $6 million dollars a year from our take in our school and that money really, I think it saved Nova because they weren’t doing so well financially at that time.

JP: They were not, no. And, as I understand it, all the employees for Southeastern were protected. Nobody was fired or that was not changed at all, right?

SC: That’s right. The same people, that’s right, their jobs were secure even though they didn’t have tenure. That doesn’t mean that if they were incompetent, I mean we, there were some people we had to fire because they weren’t doing their jobs.

JP: But not due to the merger.
SC: Not due to the merger.

JP: Yeah.

SC: The nice part about the employees as far as the merger it was the first time they got a retirement program. We didn’t have one. We didn’t have one in the old school.

JP: So, in terms of the fringe benefits, Southeastern’s were better.

SC: Yeah and that was incredible. In fact, that 10% the university gave, I thought at the time it was the highest in the nation. When I was working in New Jersey in higher education, I think we got 5% or something. You know, and you had to match it, but this was really great.

JP: Now, the figures again I have that what Southeastern spent was like $30 million for the buildings, the garage, paid for the moving and the equipment and that all was paid by Southeastern and not by Nova and part of all of this had to do with the selling of your facilities in North Miami Beach, right?

SC: Right.

JP: Was that done without too much difficulty?

SC: A lot of difficulty. In fact, Mr. Bush, who was in the real estate business at that time in Florida, was trying to sell our buildings and he didn’t. We weren’t able to sell them. We still have them now because we
really couldn’t sell them. We couldn’t get a customer. I mean, those buildings were worth a lot of money, you know, and nobody wanted them.

JP: Did the Fischler Educational Center, did they take over any of that?

SC: Yeah, they took over the one, that’s right— they took over the one building. There’s some, we still have clinics down there. We have medical clinics and we have, I think we have a dental clinic down there now too and they get pretty good business from the community, but we still own all that property, or Nova Southeastern owns it now.

JP: Yeah. Now, is the development of this merger, this is going to change how Southeastern operates? Or, are you in the Health Services Center operating essentially as you did before?

SC: Pretty much. We have our own chancellor in the Health Profession Division. We have a vice chancellor. I’m vice provost over there and we operate, the deans pretty much run their schools, we have a dean in each school. Budgets are handled, you know, centrally and submitted. Now, the first five years were a little bit different because we pretty much just did our budgets and we sent them over and said this is what we’ve come up with and now there’s a different process, but which is okay.
But, as far as relationship with deans—same thing. We don’t have quite the autonomy we used to have, but we have enough I think to operate the program and it’s doing well.

JP: But you had to change your accounting and bylaws and all that stuff to merge with Nova.

SC: Yes.

JP: Obviously you can’t have two computer systems for that.

SC: Exactly, and we changed that.

JP: So do you now see that this was very beneficial to Southeastern?

SC: Absolutely. I think it was a great move for both schools because we were stuck. We couldn’t really grow. We had no way to put in a nursing program or a dental program down there and other things. We were able to, you know, when we built these science labs we have probably the best science labs in the nation here. I was involved with that a little bit. We have, I mean anybody that walks in and does a tour of our science building they go crazy over what we have here. In our dental school, for example, we have a microscope, if you have a root canal done this microscope watches the nerve come out. I had one done. I couldn’t believe. The guy said, “Watch the nerve.” Three of them, wee. In the olden days, you had to go in there
and guess. This microscope cost us $52 million. Yeah. No, that’s not right, $52,000.

JP: I was going to say that’s a little heavy for any microscope.

SC: $52,000. It was from Germany, but it retailed for $150,000. We got it, they wanted to put it in as a model see, so we got it and now our dental students can rent those when they graduate with intent to buy them.

JP: The decision to open the dental school was very controversial.

SC: It was.

JP: Because dental schools around the country were closing.

SC: Absolutely. Emory closed and many of the schools closed. And they said, “You guys are crazy. You won’t get any patients. Nobody needs any more dentists.” Well we did a, we had our team go out and do a need study again. We found thousands of people that weren’t, didn’t have fluoride. Most of the Haitian population grew up without the fluoride. We had older people here that needed bone reconstruction, you name it and Mort said, “Don’t listen to them, we’re going to open a dental school,” and as it turned out, honest to God, we have a three-month wait now for patients. The day we opened that, we had 2,000 people
come in that wanted to do it. We have 100 chairs on one floor there to take care of these people. We also have private, we have a fee-for-service thing on the clinic side, but boy has that turned out right.

JP: And what about the nursing school? When was that decided and how has that worked out?

SC: Oh, about three or four, maybe five years ago. I might-- We started again with a small program, 50 or so. We’re close to 1,000 nurses now. We’ve got them in Jacksonville. We’ve got them in Fort Myers. We’ve got them in our main campus. Nighttime, daytime, weekends, you name it. It has grown. I can’t even keep up with it. I go out to do workshops for these people in these different centers on their methodology and I’m amazed at the buildings we have. Nova’s got a building in Fort Myers, an exquisite building there that they have these programs in, the PA and the nursing. The same in Jacksonville. Just, and they keep growing.

JP: I was talking to George Hanbury yesterday and one of the things he was talking about is his Academical Village and in that village he had intended to put a hospital, which apparently got turned down.

SC: Yes.
JP: How did, were you involved in that? Did you support the building of the hospital?

SC: Absolutely I did and I was really amazed because I thought Fred, see Fred Lippman, our Chancellor, had been in the legislature for a number of years and had a lot of influence. He still had a lot of friends there. We did a need study for this, okay. The other hospitals though really fought us. They said they didn’t want competition for rooms. They said they had empty rooms, they weren’t filled and they nailed us at the meetings in Tallahassee. So, we were turned down twice actually. It’s a shame because we were only, what we were doing was not increasing beds, we were taking some beds out of the Broward General and putting them over there because they weren’t, and we wanted to have them here, and it was growing. The area, the western part of, west of University is just growing like crazy, you know, Weston and all those places, and we could see that potentially as a tremendous resource. We documented the need, but you know how politics are. You have to go through the hoops and so far we haven’t been able to overcome that. I still think we need it. I’d love to be able to do rounds. I teach medical ethics in the medical school and in the old school I used to take them across the street to the hospital and do rounds with them.
I’d love to be able to do that here if we had that hospital.

   JP: So that’s somewhere in the future?
   SC: Yeah. As far, I don’t know right now if anybody is doing anything with that.
   JP: Well, it’s off the table right now, as I understand.
   SC: It’s off the table, yes.
   JP: You know, there just not going to be, they’re going to go ahead and proceed with phase 1.
   SC: Right.
   JP: But they will not have a hospital, so that’s settled.
   SC: I think it’s unfortunate.
   JP: Well, that’s what the president said yesterday.
   SC: Yes.
   JP: He had thought that it was a needed thing and it would have been a good anchor for the development of that Academical Village.
   SC: That’s actually the first thing we’ve been turned down on I think.
   JP: Let me ask you a little bit about teaching medical faculty how to teach.
   SC: Okay.
JP: And one of the things I noticed that you do, you go to their classes and observe.

SC: Yes.

JP: And then you sort of make comments. Now, having been a professor for all my life and having done some of that, I know you’re dealing with egos here and they don’t like to be criticized.

SC: Absolutely.

JP: And some don’t take that kind of suggestions very well, so how did you get past that?

SC: First of all, we separate classroom instructional improvement from hiring. I do not hire and fire anybody.

JP: Yes.

SC: I do not report to the deans. They know when I--

JP: It’s just one-on-one.

SC: Yeah. When I go into their classes to observe, they have the criteria ahead of time. We worked really several years developing a huge criteria for teaching. They have that ahead of time. We do workshops with them on those criteria so they know what the, what we’re talking about. When I go in there, I observe for an entire class, I then write up a report, which goes back to them. Sometimes I videotape it, which goes back to them. They are the only ones that have access to that. Nobody else.
Unless they ask me if they want it for continuing contract or that kind of thing, if they ask me to send a report to their dean I will do that, but they have to ask me.

JP: That takes a little of the sting out of it right there, yeah.

SC: Yeah. I’m not there to judge them. I’m not there to get rid of them.

JP: Just to help them.

SC: I’m just trying to, you know, and boy you know I see a tremendous improvement in many of these people. I mean, I remember times when professors would walk in they didn’t even introduce themselves, didn’t make eye contact, all of a sudden just started talking up there, writing, you know, and the students don’t even know who they are. You know, I mean, and so I had to get down to the basic stuff like that, how to begin and how to--.

JP: So, the criteria would be you had an organized lecture, you had whatever technology, you had a syllabus, you had an outline, contact, getting there on time, answering questions, all of the basics.

SC: Some of them had a syllabus, some of them had a lesson plan, some of them didn’t follow the lesson plan, you know, some of them didn’t know how to evaluate students, how to assess students. We had workshops on
writing multiple choice questions because the first questions we had years ago were just, they were terrible. Students many times didn’t even know what the question was and you know, so we had to do everything. I mean it was like, but I’m real proud of that. I think that has developed into, we have some great teachers. I didn’t, I wasn’t responsible-- We hired some great teachers too by the way. We are careful when we hire new people now to look at their background as far as teaching is concerned and what we try to find are people who know their medicine or their pharmacy who have done some teaching. One time I tried to talk, when we first started I asked Mort, I said, “Mort, save me two seats. I want to go out and recruit high school science teachers, teach them the medicine and then guarantee they’re going to work for us, because I figured they’d have the teaching background.” He thought it was a good idea, except it would cost too much money, we’d lose the tuition from two students, but he didn’t do it. But now, we try to select people like that.

JP: There is this sense that there are “born teachers” who have innate ability to communicate and relate and that there are people who “can be trained” to that, so I presume you see both types.
SC: I see both and I also believe that born teachers can be better. Look, I’ve been teaching some 60-some years and I still, every year that I teach, I don’t have one year 60 times, okay, but in my own classroom I look at my own videos, I sit down and figure out how I can change it the next time. I don’t use yellow notes. I really don’t. So, I don’t care how good you are, I’m sure, you know, I think I’m pretty good I’ve got to tell you, I have a strong ego, but I can always get better and I think the born teachers can always get better. They can strengthen what they’re doing because they get a— I had my son evaluate me one time. I had him in class in medical ethics and I remember him saying, I said, “Andy, give it to me, really give it to me.” And he said, “You know what, three times when you were talking, you were on the thing with pictures, the transparency machine, you know, three times you went like this when you were talking and I couldn’t hear you,” and he was right.

JP: Of course, you were totally unaware of it.

SC: I was unaware of it. I swear I was.

JP: Oh no, you don’t know that.

SC: I didn’t know it and a couple of times I walked in front of the machine and the pictures disappeared. He pointed that out to me. He said, “And besides there were
two guys that had their hands up you never called on.” I missed them and this is the kind of stuff. So, you know, it doesn’t matter how long you’ve been teaching.

JP: Well, the essence seems to me from what I’ve read is that the concept that you want to get across is a positive learning experience.

SC: Absolutely.

JP: And I know that you and other people don’t like professors who demean students or ignore questions or say, “That’s a dumb question.”

SC: You’re right. We want a positive environment. These people are under enough pressure. It’s hard to, boy Harrison, which is internal medicine, is thick. Every one of their courses, they get 40 pages of handouts. It is not an easy program. None of our programs, our programs are rigorous, but they’re rigorous, but they’re rigorous for a purpose. We want them to know what they’re doing. We want them to pass the boards and we do well on board examinations, national boards. We don’t compromise those, they’re good programs.

JP: Well now, do they teach to the boards or do they teach to creative positive thinking?

SC: Both.

JP: Both.
SC: They do both. We put a lot of emphasis on environment, learning environment and it’s not what the teachers do, that’s a process. It’s what the students do that makes learning. Teachers can do a lot of things.

JP: They’re facilitators.

SC: Yeah, and it was hard, some of them have been used just to pure lecturing, you know, what I call antiphonal lecturing where you stop and you throw out questions and you get back and forth with students, antiphonal. Many of them were not comfortable with that.

JP: For example, I talked to a law professor yesterday, it’s almost all Socratic, you know, I mean there are no lectures, per se, they just bring up issues and respond based on what the students do. I would imagine medical school would be different.

SC: Well, what happens is this— I try to get them after about 25-30 minutes of a lecture when the learning curve drops way down, we have evidence—

JP: And then you stop for a minute.

SC: You start and structure time, the race, not at the end of the time, because at the end of the time if you do that the students they want to get out of there, but actually structure five or ten minutes, open it up and say not, “Do you have any questions?” but “What are your
questions?” “What are your questions?” gets a different response because it means, “I expect you to have them,” see and if they don’t have them, allow enough wait time, that’s another issue. If you throw out a good question to students, a conceptual question, they have to think about it. You know, it’s not like, “Who discovered America?” You’re asking some kind of a concept, you’ve got to allow at least 15 to 18 seconds of wait time and by the way, we have evidence to show that, so it’s hard for them because 18 seconds--

JP: Sounds like forever doesn’t it.

SC: It sounds like forever. So what they wind up doing, they answer their own question, they short-circuit the process, you know, and the students— we have these clickers now too. You know, I ask a question and the students can click their answers, they get immediate feedback upfront of how many say A, B, C and D. They can see who has misconceptions, they can then say to the students okay--

JP: In other words, they ask the entire class the question and everybody--

SC: Everybody has a clicker.

JP: A, B, C, D and you’ll see that half of them got it wrong.
SC: Yeah, and now you say, “Well, I got a problem here because either they have a misconception, so all right, you guys pair up, negotiate your answer and prove to the other person there that you’re right.” And they will take a couple of minutes to do that and then they reclick the thing and they say, “Ah ha.” Now we got, we’re way up there in the right answer, see.

JP: So, is the academic portion of medical school teaching dramatically different from other kinds of teaching?

SC: Well, I think other kinds of teaching have adopted these things before medicine ever did. The only other worse thing I saw, I went one time when the middle states had accreditation of a law school in Chicago, they were worse than anything. They were really bad. But no, I think other schools have long, when I was in, I was a public administrator at one time, I was the principal of a school way back, I’m talking about 1955 or so, we were doing those things even then in the public schools. We were doing team teaching.

JP: So, the dissimilation of information, regardless of the type of information is pretty much the same?

SC: I think so, yeah. Yeah, I think so.

JP: I mean, obviously, the subject matter--
SC: It’s new in the health profession except for—Because traditionally, I visit a lot of medical schools, I’ve been all over the country and it’s pretty much lecture, most of these schools just lecture-test, lecture-test, that’s not the model, we try, we try to change that.

JP: The measure of the real teaching is in rounds where you’re one-on-one, right?

SC: Absolutely. It wasn’t until my son became a third-year resident in Allentown where he called me up and he said, “You know, after 6,000 patients, I think I know what I’m doing now.” You know, this is where you’re with patients, you see congestive heart failure and you see the ankles swollen, you see they can’t breathe. Reading it from a book or learning it from a lecturer is okay for background, but the real stuff is out there when you get into it with patients.

JP: So, that’s the emphasis for the medical school here?

SC: Medical school is you give them a basic background and the basic sciences, that’s important, microbiology and so on. You get them exposure in clinical, you get them learning how to make patients comfortable and so on and then get them exposure in all these different areas—nephrology; dermatology; surgery and all these
things so they have some spread of knowledge and then, you know, I think it’s a good model. Schools that don’t have that, they graduate— For example, I have an aunt who is an OB, obstetrics, she went to a medical school where she did, she only took obstetrics courses basically. She knew how to do C-sections and all that stuff, but she never had any, you know, she gets patients in there who have other, I mean they’re women and I don’t think she can recognize those things that those women have because she’s never had any exposure in some of those areas, you know what I mean?

JP: Yeah.

SC: I think a well-rounded doctor--

JP: So, holistic medicine.

SC: Yeah. You should be a doctor first who knows, who has a comprehensive view and then specialize fine. We need specialists too. I’m not saying we don’t, but I think they should be a doctor first.

JP: When you deal with student learning in medical schools, is the essence the positive feedback?

SC: Positive feedback— also, we have, last year I had eight medical students who were failing at least two courses. I wrote a book three years ago called, “I’m a Tree, I Can Bend,” which has to do with learning style—teaching style. What I did with those students is change
they way they study. I have found that many of them will study the way they did in college and it’s based on their personality kind of thing. They could read a couple of hundred pages and think they know it, they’re familiar with it, but they really aren’t familiar. I mean, they’re familiar, but they don’t know it well enough to be tested. So what I do--

JP: They don’t understand it.

SC: It’s like, I’ll give you an example-- I had an operation on my shoulder this past year, Dr. Uribe was down in Miami, and my wife drove me down there every time, I did three or four visits and I was familiar with the route, you know, I know you go down 95, somewhere down there, you know, and one day she wasn’t feeling so well and she said, “Why don’t you drive?” I got on 95 okay, but I made four wrong turns. I forgot about this street or that street and she had to steer me because I didn’t, I was familiar with it, but I didn’t really know it see, and what I try to do with these students, I get them shoeboxes with drill cards, 1,100 gross anatomy terms, 800 micro terms are put in a drill box and every morning I do a ten-minute drill—Strep A—Rheumatic fever; Strep A—Rheumatic fever until they don’t even have to think about it and what I found with those eight students, by the way all eight of them passed
all of their makeup courses last year. I’ve got a similar number now I’m working with. I’ve done that through the years, in fact, I based my book on that, they try it and, it’s not really changing their learning style, it’s changing their skill, their study skills.

JP: Are you Skinnerian?

SC: Skinner—Sort of, sort of, yeah. Yeah, I am. I think if you look at the course, see the courses they fail are the courses that have a huge amount of knowledge of facts, they’re really facts, I mean they’re level 1 factual, okay? And so, when you have that kind of a course you’ve got to memorize, for example, in the micro course, they’ve got 500 microorganisms to know, they’ve got to recognize 500 microorganisms, that’s my fear, I was originally a bacteriologist, okay, and I knew those and that was my fear but I did graduate, you know, but medical students have to know, dental students have to know those microorganisms. They can’t do it by just sitting down and reading a handout. They’ve got to, they’ve got to learn it by, you know, the way they teach first grade reading with flashcards, so you look at the word and you know it, you don’t have to think about, supraspinatus is right up here in your shoulder, you know, all those things.
JP: Let’s get back to these students who are failing. Part of what helps them is positive reinforcement, so their attitude is better, they think they can achieve their goal, in other words, they need a little pickup.

SC: When they first come in, they’re in bad shape—some of them are depressed. I have to go send them for counseling. They think they’re a failure. They failed the course, you know, and their world is coming to an end, their whole future is at stake, they’ve got all this money invested, “What am I going to do?” And the first few sessions I have them, I say, “Listen, I tell med students I’ve had before, I tell them about them, they’ve been successful. Now, you’ve got to, if you do what I tell you you’ll be okay,” you know, and try to get them into a positive frame of mind. They work hard. These are not—These students are bright. They’re not—it’s not a question that they don’t have the brains, it’s just a question that their study skills are different from what they should be and, you know, they tell me I treat them like babies and “I’m not a first grader.” I say, “I know, but you’ve got to learn this stuff.” You know?

JP: Well, let me ask you about, have you worked with Ray Ferrero very much?
SC: I love Ray Ferrero. He’s a, are you talking about the third?

JP: Current Chancellor.

SC: Oh, okay because we have his son over in our place.

JP: Oh, I didn’t know that, okay.

SC: Yeah, Ray Ferrero, III is one of our faculty. He’s a super guy.

JP: Okay.

SC: I think he’s tremendous. What I like about Ray is, he used to come over every Thursday. He wanted to sit down and have lunch with our students and he would sit there and mingle with students and talk to students about our programs. I thought that was really good. I also liked the way he knew faculty names. When he would meet a faculty member, I don’t know how many, maybe once or twice, he would know their names and that’s important to faculty because, you know, you call somebody by name it’s not you, it’s just like students in a classroom, you know? I think he’s a straight shooter. I think he’s done a great job for this school. He’s, you know, he has vision. I just like the guy I think and I’ve had, I’ve been in several institutions with a number of presidents and I think he’s probably the best I’ve seen.
JP: What about George Hanbury who will take over in a year?

SC: Well, George came in later. He was from Fort Lauderdale and I haven’t had a whole lot of contact with him because I’ve been mostly with Ray Ferrero, but he, I’ve seen George a number of times. I respect the guy. I asked him, they had messed up my starting date and I asked him to change it because it was wrong and he went along with that. He talked to Human Resources and they got it straightened out. It wasn’t that big a deal, but it was important to me because they had me down starting in 84’ and it wasn’t correct. It was based on the money thing.

JP: Who is the current chancellor of the--

SC: Fred Lippman is our Chancellor at HPD.

JP: Right, and so what do you think of him? He is not a medical professional.

SC: No. His background--

JP: He is an attorney, right?

SC: No, no. Fred was a pharmacist.

JP: Oh, okay.

SC: He was a pharmacist and he had, he was a very successful pharmacist. He had a number of drug stores in Florida. I have to say I think he’s done a remarkable job. He came in and, in fact, I had a number of talks with him
about why I think, what could have been changed when Arnold was the, Arnold Melnick was the Chancellor. Arnold tried to micromanage a lot of things and it wasn’t working. He was successful at that when we had the smaller operation because we could save, by him micromanaging we could save a lot of money, but when I talked with Fred about this, I said, “I don’t think that’s a good idea,” and he tried to change that by saying, “Okay, the deans are in charge of their school. They will develop their own budgets.” They had to submit them to him and to our finance guy, but he moved a lot of decisions away from the chancellor’s office to the dean’s office.

JP: So, within the health-related professions, the dental school and Pharm School are sort of semi-autonomous?

SC: They are. They come over if they want to hire people and expand their budgets. Budgets are always a concern. They have to go in and see Fred and he meets the new people and so on, but they are the ones, they’re pretty much the ones to decide if they want a person or not, yeah and he’s done a good job with that.

JP: What’s the future for health-related professions at Nova?

SC: That’s a good question because I think at some point there will probably be a reorganization. I don’t
know what George Hanbury wants, but I have a feeling that there will be some decentralizing, you know, I’m not sure we will ever have another chancellor over there, I don’t know, but my gut tells me we probably will not have when Fred decides to retire, I don’t think we’re going to have another chancellor. I think what will happen is that the deans will run their schools and report to the vice president like the other schools do. Right now we have, I hope it doesn’t change. See, we use common facilities. We have one library, a medical library for all the programs, we have one cafeteria, we share classrooms and because we can do that we save a lot of money. If everyone of the schools had to have their own library, which the accreditation groups want, by the way. We were able to get away with that because we made sure our library had comprehensive programs in there, but if we had to go to that, our expenses would go up a lot. So, I think there’s something to be said for keeping HPD together in some ways, but I’m not sure about at the higher level if that’s going to take place— I don’t know. I really, I’m going to jump, I don’t know.

JP: Do you think it’s going to expand a lot? Is there a potential now for a vet school say?
SC: I don’t think we’re ever going to have a vet school, even though, you know, we bought the ground at and there’s a lot of ground there, but I just don’t think the vet school—The operation of vet schools is, first of all, to hire a veterinarian, that was another thing, when I did the research on this, I couldn’t believe the salaries that veterinarians make in medical school. You’re talking $300,000 or $400,000 each veterinarian and then you have to have a building for horses, a building for cows, a building for birds. Yeah, like 50 buildings you’ve got to have, you know, and they tend to be— I called the accreditation people and they said, “If you don’t have that, we won’t even talk to you.”

JP: That’s one of the reasons there’s not many vet schools.

SC: That’s right and there’s a monopoly. They don’t want, hey, I think it’s a monopoly to tell you the truth. They don’t want more veterinarians. They keep their money, their salaries up that way.

JP: And so, do you see an expansion in the size of the schools, that you would have more pharmacy students, more dental students?

SC: I hope we don’t get more medical students. We have reached a point-- We don’t want to lose quality.
We’re up to 240 and it’s been quite a challenge that we, you know, to move, when you get to some point you can be too large. I think our pharmacy school is up to 120 now. I think it’s big enough. I think our dental school has been expanding. I think it’s big enough because now we’re having some trouble. When the students do their clinical work, they have to look for a chair that’s open because we’ve got all these thousands of people coming in. And, we’ve reached a point where we’re really saturated there.

My personal opinion is that we’re large enough in all these programs, including nursing because, you know, but the demand is there. I don’t want to lose the quality of our product and I think we’ve reached a point where we ought to stay where we are. That’s my own personal opinion now, okay. I don’t make--

JP: No, no, that’s fine. Is there anything we have not discussed that you would like to talk about, anything I haven’t asked that you would like respond to?

SC: Well, I would like to say this, I think that, I get to see probably six or seven hundred classes a year. I think we have a good bunch of great teachers now, I really do. I can name them if you want me to. I don’t think I better do that. We have good, we have some adequate people and we still have some people that need to strengthen what
they’re doing, but I guess that’s true in all schools, you know, I don’t know. We have workshops once a month to work on methodology. We have, we send them to take courses. We have a number of our people who are taking EDD programs now at the university, a number of dental faculty and a number of medical faculty. I encourage them to do that because they get a one-on-one course, not just me, you know, and we have, that’s coming along well. In our PA program, we have a number of people that have done that and are taking EDD education courses. They know their stuff in their field pretty well. This was their big, their deficiency was in methodology, but it’s coming along and I think I see a lot of growth there. I’m real happy about that.

I don’t know how many more years I have, I’m 82 years old and I don’t want to fail retirement again, which I did. I got an F in retirement. I was not a golfer. I didn’t, you know, I hate cards and to sit all day long and talk about your ailments just didn’t, I mean we lived in a condo on the beach and all I heard all day long was how sick they were and, you know, their heart attacks and--

JP: Anything else?

SC: I don’t think so. I’m trying to think. I just hope I live a few more years to enjoy this.
JP: Okay. Well, on that note, we’ll end the interview and thanks very much for your time.

SC: My pleasure. It’s been fine.

[End].