HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

George Bugbee

GEORGE BUGBEE

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

Produced in cooperation with

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Hospital Research and Educational Trust
Chicago, Illinois

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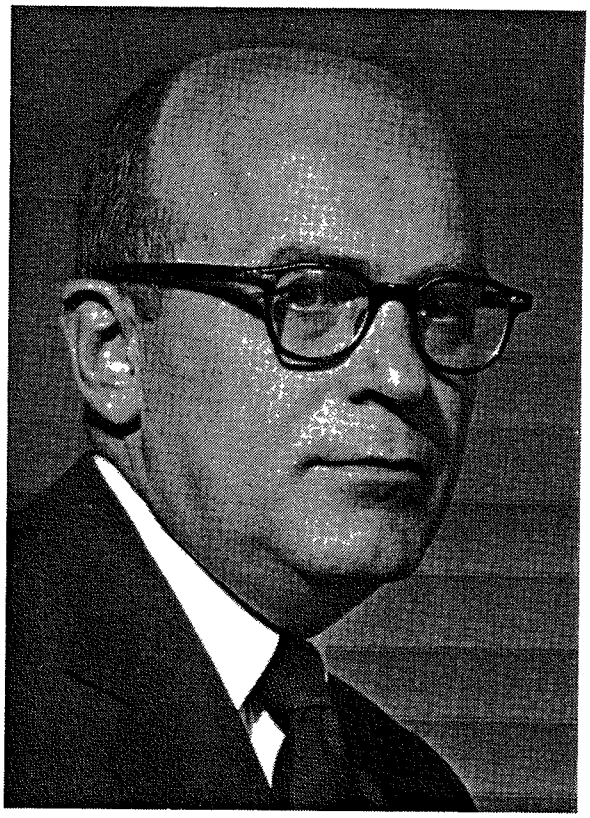

George Bugbee

CHRONOLOGY

1904	Born Waukesha, Wisconsin
1926	University of Michigan, B.A., Phi Beta Kappa
1926-1938	University of Michigan Hospital, Ann Arbor, Michigan resigning as Assistant Director
1938-1943	City Hospital, Cleveland, Ohio, Superintendent, later Superintendent Commissioner
1943-1954	American Hospital Association, Executive Director
1954-1962	Health Information Foundation, New York City, President
1962-1963	Health Information Foundation, Chicago, President
1962-1970	University of Chicago Center for Health Administration Studies, Director
1962-1970	University of Chicago Graduate Program in Hospital Administration, Professor and Director
1970-1978	University of Chicago Graduate Program in Hospital Administration, Professor Emeritus
1970-1972	Department Health, Education and Welfare, Consultant
1970-1972	Association of University Programs in Hospital Administration, Consultant
1971-1978	University of Washington, Consultant
1972-1973	Georgetown University, Consultant
1972-	Veterans Administration, Director VA Forum

MEMBERSHIPS AND AFFILIATIONS

Alpha Delta Mu

Honorary Member

American Association of Medical Records Librarians

Honorary Member

American College of Dentistry

Honorary Fellow

American College of Hospital Administrators

Fellow, Member of Council of Regents

American Dietetic Association

Advisory Committee Member

American Hospital Association

Member, Executive Director

American Public Health Association

Fellow

American Hospital Service (Blue Cross, New York)

Member of Board

Association of University Programs in Hospital Administration

Past President

Commission on Dentistry

Member

Commission on Financing Hospital Care

Technical Consultant

MEMBERSHIPS AND AFFILIATIONS

(Continued)

Commission on Hospital Care

Technical Consultant

Commission on Survey of Dentistry

Member

Committee for Study of Human Relations in Hospital Organizations

Member

Convalescent Care Study Committee of New York City

Chairman

Council on Survey of Medical Education

Member

Federal Hospital Council

Member

Hospital Club of Northwestern University

Honorary Member

Hospital Council of Greater New York

Member of Board

International Hospital Federation

Member of Board of Managers

Joint Commission on Accreditation of Hospitals

Member of Advisory Committee

Joint Commission on Graduate Education in Hospital Administration

Member of the Board

MEMBERSHIPS AND AFFILIATIONS

(Continued)

W. K. Kellogg Foundation Hospital Advisory Committee

Member, Advisory Consultant

National Commission Studying Medical Education

Member

National Health Council

Past President

Phi Beta Kappa

Member

Who's Who in America

AWARDS

1948 American College of Hospital Administrators

Award of Appreciation for Remarkable Achievement

1951 Federation of Hospital Executives

Citation

1954 American Hospital Association

Distinguished Service Award

1980 Georgetown University

Doctor of Science, Honorary

PUBLICATIONS

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"About the New Bill for Voluntary Health Insurance." Hospitals. 23: 37-9, May 1949.

"Statement (to) Senate Committee on Labor and Public Welfare in Support of S.1453, June 7, 1949." Washington, American Hospital Association, 1949.

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"Multiple Screening for a Variety of Diseases; Can Hospitals Adopt It?" Hospitals. 24: 38, May 1950.

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BUGBEE:

I think an interesting question always is: How does one get into hospital and health administration? It was pretty random in my day, and I don't think it drew a random sample of the best people. In fact, we used to complain about the ability of those who were in the field. It led me to be very supportive of the graduate programs in health administration, and I have had something to do with many of the early programs. Anything I could contribute in the way of support, I tried to give.

My own entry in the field came May 1, 1926 when I accepted a job in Ann Arbor, really in the University of Michigan controller's office. He sent me to the University Hospital. I got the job because I had taken a good deal of accounting in the business school. Nonetheless, the only degree I have is a bachelor of arts. In any event, the accounting courses were what got me my first job.

When I got to the hospital where I was assigned, they had just opened up a whole new 800 bed unit, and the accounts receivable had piled up as they often do. They were my first job. At least it taught me how to dictate, for there were many letters to write.

I won't go into the details of Ann Arbor except to say that I went through

various administrative jobs there over a period of 12 years, resigning as Assistant Director in May 1938 to accept the position of Superintendent, later Superintendent Commissioner, of the 1500 bed City Hospital in Cleveland. I was 33 years old which made no impression on me then, now it seems rather good. I succeeded James A. Hamilton, who was one of the leading administrators in the country.

City Hospital was an excellent public hospital, at least comparatively, and it gave me contrasts with the University Hospital in Ann Arbor. I was surprised it was nearly as good as the University Hospital and spent much less money. It didn't have any money to spend, so I couldn't take much credit for it--that was the truth. I stayed there five years.

About that time--going back a bit--there was the question of my involvement with the American Hospital Association. I joined the Hospital Association at an early date, thinking if that's my career, I should be a member--and I attended the Michigan Hospital Association. I also became interested in the ACHA a little later. The American College of Hospital Administrators was organized while I was at Ann Arbor. My boss was Dr. Harley A. Haynes. He seemed to have a reasonably low opinion of its development. Actually, I think it was sponsored by nonphysician administrators and perhaps encouraged by Dr. Malcolm T. MacEachern of the American College of Surgeons. Certainly much of the ritual came from that source. In any event, I did not join as promptly as I should have, but after I was at the American Hospital Association the college waived some of the requirements and "grandfathered me in," which was still possible under their bylaws.

One of the reasons I was pleased to go to Cleveland was because of the hospital council there, which was, undoubtedly, the best in the country at

that time. It did really an outstanding job from group purchasing to community planning under the direction of a man named Guy Clark.

Jim Hamilton resigned from City Hospital to go to the University Hospital in New Haven. A search committee was set up to find a new Superintendent. In any event, I ended up with that appointment.

Jim, by that time, was very active in the American Hospital Association. He drew me into various activities including, eventually, appointment as Chairman of the Association's Council on Hospital Planning--or Construction--perhaps Hospital Planning and Construction. That job, with Jim at the helm as President of AHA, precipitated an evaluation of the staff of the Association.

Dr. Bert Caldwell had been the Executive Director for a number of years. After I assumed that position I came to the conclusion he really was very hard working. But he set up a pattern where he did most of the work with some clerical help. As the war came along, hospitals needed representation in Washington, and they needed many other services, but Dr. Caldwell was resistant to changing his staff so he could increase his service or take care of the Washington office. It came to the point where the Board asked Dr. Caldwell to retire. Then there was a search for an executive, and I was eventually the selection of the Board, and appointed. I took office in May of 1943.

Bert Caldwell's conservatism was understandable if no longer pertinent. The Association just prior to the Depression had purchased what had been the Boys' Latin School building at 18 East Division. The Association did not have reserve funds and purchasing was only possible with a substantial mortgage. With the Depression of 1929, the Association's income decreased and it was thought it would be impossible to maintain payment on the mortgage. The

situation was saved by the sale of bonds to members of the Association. Institutional dues were initiated in 1919, but the membership had not conceived a role which led to dues which yielded much income. Then also, hospitals were smaller and often not members of the Association. The Depression led to loss of some of those which were members. Undoubtedly the danger of losing the building and of the collapse of the Association was very much on Bert Caldwell's mind and supported his objection to all the new plans of the "Young Turks."

Prior to my being in office, Jim Hamilton with a Committee on Association Resources had gone to the Board and recommended that the dues of the Association be quadrupled. The amount would be rather inconsequential compared to present dues, but the size of the increase was startling in the field. The Board recommended it to the House of Delegates which approved it. That they did at the first convention that I had responsibility for, which was in September of 1943.

In anticipation of their approval, and because there had been a great deal of interest in expanding the role of the Association, I was asked to begin planning what should be the Association's program. This was pretty short notice since I hadn't had any association experience, but there was a core of people who had worked with the Association far longer than I, led by Hamilton. John Mannix had been very fundamental in the reorganization of the Association a few years earlier, and O. G. Pratt, who was at that time in Massachusetts administering the hospital, I think in Salem, was very active. Bob Buerki, Dr. Robert Bishop, who was the administrator of--well, I won't go into all the locations they were in, but they were in important assignments in administration in the field and they had ideas about what the Association

should be doing.

The first thing, of course, in support of the dues increase was money for the Washington office. It would have taken almost as much budget as the Association had up to that time.

They went further, of course, and suggested that the councils of the Association other than the Council on Government Relations, which was in charge of the Washington office, should also be staffed and have funds for travel. The travel--that sounds inconsequential--but the councils weren't meeting because there wasn't any money for travel expenses and staff. Staff, of course, could greatly expand the productivity of the councils. So that was a second major budget item for which to use the quadrupled dues.

The accomplishments of the councils can easily be evaluated by reference to the annual transactions published by the Association. This was a verbatim transcript of everything said at the annual convention, both the papers delivered and the proceedings of the business meetings of the Association. These transactions were discontinued a few years after I was appointed, because both the number of program sessions at the convention and the detail of reports to the House of Delegates became so lengthy that all could not be published in one volume. Only the deliberations and reports to the House of Delegates were printed.

An aside--this perhaps is incidental, but it interests me because history, of course, does repeat itself. Just within the year the American Hospital Association has voted a substantial sum for public relations or public information. Hospitals and particularly hospital administrators always think the public doesn't understand their problems. I wrote Alex McMahon, the current President, I believe his title is--but the position I onetime occupied

in a smaller sphere--complimenting him on an ad in the Wall Street Journal which I thought was about as dignified and effective public relations as there could be. I haven't seen another ad, although they undoubtedly have done more.

However, one of the things to be done with the quadrupled dues was to finance a public relations program. Jim Hamilton and I arranged an appointment with a Vice President of American Bell Telephone to see what his advice would be, thinking that that corporation had done an unusually good piece of communication with the public, perhaps primarily in service. We were used to seeing in advertisements how Bell Telephone people met emergencies locally in one way or another.

In any event, we made the appointment and saw him in New York City. He was very kind and visited with us for a while and asked us how much money we had. I don't recall exactly, but it was around $150,000. He tried not to laugh, but we got the idea. He said it would buy just about one page in the Saturday Evening Post, which was then, probably, as good a medium for reaching the public relations as there was.

I don't mean to say they still are amateurs at AHA just because the drive is the same: the feeling that the public doesn't understand their problems. Currently AHA has a particular problem, namely cost containment. At that time it was a more general hope that people would realize the things that hospitals needed in the way of public support.

We finally ended up hiring a public relations director and working with staff internally to furnish materials to member hospitals so they could utilize them for local public relations. I think this met with some success for those hospitals that wanted to do it.

I think I have mentioned the three recommendations that were taken to the

House of Delegates as examples of what to do. In fact, I had to budget for them. Then there was the question of employing help--by help I mean associates. I think Kenny Williamson was the first. At the time we hired him he was Secretary of the California Hospital Association and the Western Hospital Association. He was experienced. He had worked for Blue Cross also. He was a good addition to the staff and always productive.

I became editor of Hospitals when I took the job as Executive Director and insisted on not having a separate editor, calling whoever ran the magazine, managing editor. The model I wanted to avoid was Dr. Olin West and Dr. Morris Fishbein at the AMA where the editor of the American Medical Association journal, Dr. Fishbein, was more powerful than the Secretary. It wasn't a matter of power play, I just didn't care to have a division. I also insisted that the director of the Washington Service Bureau, as we called the Washington office, report to me rather than to the Council on Government Relations. If I were going to run the association, I was going to try to do it.

I didn't do very well in staffing the journal. I got a very honest, able fellow named John Storm, but John was not a flashy publisher. At the time I employed him--and I think this is a part of history that has a certain interest--Dr. Otho Ball, who was the owner and editor of Modern Hospital, had recommended another whom he later hired as his editor. I should have hired him because he was a better man, as time was to prove, but I didn't want Ball to control the Association. At one time the Association had been a desk in the Modern Hospital offices. Ball was a powerful man, and I wanted to avoid having him think he was going to continue to play an important role. So I got John Storm and then built up the staff, advertising agents, and internal

editors.

Up to that time Bert Caldwell had been the editor of Hospitals, but really all he did was publish convention papers. It was hardly a sparkling journal as the library would show, but I think we did improve it. I never thought during my time at AHA that we were quite as good as Modern Hospital, which always hurt my pride. On the other hand, that's the way it was, in my opinion, as I said from time to time to the editorial staff.

After a few staff members were accumulated and on duty, we began to think about the future of the Association: whether the budget that was formulated a few months after I got there was a sensible one. I recall we had what is somewhat pretentiously called a "retreat" where staff talked over what the functions of an association were. We were very pleased with ourselves because we had never read of this formulation of association functions being done anywhere else.

Of the functions of the Association, one was education--running all the way from institutes to the convention to the journal.

Again I suppose it's kind of a digression, but I had no idea the annual convention was a carousal. It was a terribly expensive thing for the hospital field with all the travel expenses of the thousands of people attending. The convention had the potential of being one of the most educational activities of the Association. So one important function was education.

A second function, little understood, I think, by many people, was research moving toward standardization. How much could we help the field develop best practice? We spent a great deal of effort bringing in the most knowledgeable people in a given field, asking them to formulate what might be a manual or a discussion of a procedure, and getting this information out to

the field. It might be any group: directors of nursing, or physicians in some specialty or laundry managers or purchasing agents. So standardization was the term we used for formulation of better practice.

The third function was representation. The obvious representation, of course, is with government, but government at more than one level. Representation was needed also with the professional associations of which there are many all the way from the American Medical Association to the National Fire Protection Association which impact on hospitals. If AHA doesn't work with the professions closely, they proceed with their own interests without any attention of what it may do to hospitals and hospital care.

Having formulated those three functions, we began to structure the staff organization to accomplish those purposes.

We never did away with public relations, but primarily tried to standardize procedures for individual hospitals to do their own public relations. I suppose there ought to be some humor in life. I won't have time to tell much. However, on public relations there had been a contest in which each hospital could submit a scrapbook of all its newspaper publicity. I think there was a prize given; I have forgotten what the prize was. It was a venture started before my day, but we continued it. Perhaps it had some merits. In any event, there was a high point for me in it, but I let the contest wilt thereafter. I found that St. Luke's Hospital here had the biggest book. In glancing through the book, I found that one of the articles was about a patient jumping out of a window and being killed. I hope most public relations activities or articles are better than that, and I am sure they are.

Incidentally, hiring a Director of Public Relations for the Association was not easy, especially so since the most talented, with proven talent, were far too expensive. One try was a man named John Jonkel. He was very smart indeed, but, it turned out, not a hard worker. In fact, after about a year I found he was doing very little but think up work for me. It was finally necessary to let him go. Eventually the director was C. J. Foley, the son of the Foley who made the magazine Hospital Management an important force in the field as it was under him. C. J. was knowledgeable about the hospital field and a very good Director of Public Relations.

Perhaps an amusing anecdote about John Jonkel is warranted. When I decided to let him go, I asked him to come to my office and discuss his finishing at AHA. When he went out he told one of the staff that he was not sure whether he had been fired or promoted. This was a smart alec comment. Later I was reminded of it by Odin Anderson. He told me of a comment by Nathan Sinai, his mentor in the School of Public Health in Ann Arbor. Nate was one of the first academic health services researchers. He told Odin that an administrator should be judged more by how he fired than whom he fired.

Anyway, what about the Association and the distribution of hospital care? What was its philosophy? Prior to the Buffalo Convention (1943) and at the St. Louis Convention the year after, the House of Delegates passed a resolution which had taken a great deal of work. It was called the Bishop Resolution. While it didn't say it was opposed to national health insurance, it was an alternative. The resolution essentially recommended voluntary health insurance, federal aid for the construction of hospitals where they were needed, and government aid at all levels as necessary for those who can't pay for care. It's interesting that's always the proposal made contrary to

national health insurance. You either have entitlement for everyone, or you only give it to those who need it. The Association took the conservative side. You could always argue whether it should have or should not have. That's a different story and a philosophical dividing point.

It is important to remember that the political perimeters for the hospital administrator are a conservative board and a more conservative medical profession. Well, I always get very impatient with criticism--the last report was the report of the Kellogg Commission--the Kellogg financed Commission on Education for Health Administration--published about two years ago, in which they exhort the administrator to take more leadership in solving the health problems of the nation. I agree with that. I did my best during the AHA days to do it, but if they think they are going to recommend a national health insurance--any administrator that I know of that did it won't be in office. Everybody is limited by his setting and there is a conservative setting there.

However, after the Buffalo meeting, the Bishop Resolution was embroidered somewhat but retained the essential features that I have just described.

On Thursday, the last day of the convention, a group of us were in what I suspect was Jim Hamilton's suite. He was President of AHA that year (1943). I don't know who was there except Hamilton and E. A. van Steenwyk, one of the very early pioneers in Blue Cross (he thought up the name Blue Cross), and myself, but the room probably had eight or ten people in it.

I remember van Steenwyk saying: "Now that the Association has a policy, what are we going to do about it? There isn't any use sitting here, we'd better do something!"

That resolution, in a sense, gave me authority to move. I thought: He's right, I'd better move. I had been in office only two or three months, but

action was indicated. You will recall that one of the three items of policy was: Build hospitals in areas that don't have them and/or need them.

To digress for a moment from that philosophy of the Association--Jim Hamilton and I working with him--I think he was the primary leader although Graham Davis was high in the Association's councils and he was in charge of the hospital division of the W. K. Kellogg Foundation--were a part of an effort made to create a Commission on Hospital Care. It was hard going to raise that money. Kellogg pledged a certain amount, and we solicited many other people. I can remember going to Carnegie. I think Gardner was then Secretary, though I may do him wrong. Anyway, the man said all you are doing is trying to measure leaves in a whirlwind. We were talking about the need to plan for postwar. This was 43 and 44 (1943 and 1944). However, largely by the help of Morris Fishbein we were able to get to Basil O'Connor, who was the dictatorial chairman of the March of Dimes or polio foundation. He gave us some money, and there was, I believe, a very little from a third source. It didn't amount to much. Later the Public Health Service supplemented the funds.

David Wilson, a Public Health official, who 20 or 30 years later (1968) was President of AHA, was assigned and spent a year on the Commission staff. The last I knew he was administrator at the University Medical Center in Jackson, Mississippi.

The Commission was chaired by Thomas Gates, the President of the University of Pennsylvania, a very public-spirited gent. We spent a lot of time, some with Mr. Gates who was to do the appointing, trying to figure out who should be on such a commission. I would say there were about 25 members. It became a pattern for foundation commissions, including, a few years later, the Commission on Financing of Hospital Care. Maurice Norby, who was the

staff member that probably did the most work on the Commission on Hospital Care, and I consulted with quite a few people on how you establish such a commission. Well, the ingredients we wanted were representatives from all walks of life. We wanted labor and industry and farmers, who, at that time, were more powerful because their numbers were a great deal greater. We wanted providers, blacks, whites, and women, etc. We had really quite a representative commission. It was important, because later the fact that it was representative was very helpful in the passage of the Hill-Burton Act.

The question came up as to who was to be the Director of the Commission, because it was clear that his wisdom and experience would be the report.

(I suppose this is another semihumorous thing. Rufus Rorem, who has always been a wit, at that time said: "You know what all commissions are. You decide what you want to say then spend the next two or three years documenting that that's the correct answer." There's a certain cynicism, but not wholly wrong.)

Eventually we persuaded Dr. Arthur Bachmeyer, then Associate Dean of Biological Sciences at Chicago and Superintendent of the University Hospitals and Clinics--and the title was "Superintendent," they kept it for a long time, that old-fashioned title--to become the director. He said he would do it, but he couldn't spend more than half time. It was then that we persuaded Maurice Norby, who was an employee of Rufus Rorem at the Blue Cross Commission located in the headquarters that the Association owned, to take the staff job. The orderliness of the Commission's report and its success was partly Art Bachmeyer, but a great deal Maurice Norby. Someone told me just recently they reread it and it's still very pertinent--not all accomplished yet, needless to say.

Following that experience with the Commission on Hospital Care I have been involved with the organization of the three studies of graduate education for hospital and health administration financed through grants from the Kellogg Foundation. Though I have not been a member of any of them, I was a member of the national commission studying medical education during the 1950s and of the Commission on Dentistry which was organized shortly thereafter. My memory is that the Commission on Medical Education, which had many reasonably wise things to say, was one of the first that identified the functions of the medical school, not only as teaching and research, but significantly as patient care. In dentistry I think the primary contribution was an urge to dentists to increase their ability to serve the public by the use of ancillary workers.

While at AHA the National Health and Welfare Retirement Association reorganized to make a drive toward providing basic retirement security for hospital and health agency employees. I was made a member of the board and became active on the executive committee after I moved to New York City. The AHA, at that time, recommended this program to its member hospitals. The organization did not have all the flexibility it should have had and was slow in offering wide varieties of retirement coverage. As a result the hospital market was, and probably still is, less than it should be.

It may be false modesty, but I have never kept scrapbooks or records of articles and speeches and other involvements I may have had. Now when I try to think and talk about the many activities I have been involved with in my life I must fall back on memory more than I wish were true. Perhaps if I had kept better records I would have found the positions with the five different organizations I worked for more or less easy to evaluate now. I don't see

though how I could have had more interesting jobs. This was how they appeared at the time and this is true in retrospect. The fact that I have received various honors always came as a surprise, not that I failed to accept them with pleasure, but they seemed an unexpected and unnecessary bonus.

I won't go through much of it except one part. There's always been a question whether the Commission on Hospital Care and its findings and report led to the Hill-Burton Act. Well, having been there, I am inclined to think they related, but hardly as direct a lead-in as later the Public Health Service said. They were the ones who indicated that as its source and I don't feel it was.

One of the ventures of the Commission on Hospital Care--and Graham Davis from Kellogg was not modest about telling the Commission what he wished they would do--one of their ventures was to set up the primary, secondary, and tertiary districts of care in the State of Michigan. I can see the map now. It followed the Mountin pattern--Mountin and Hoge had written about regionalization. I think it had been better formulated in Britain than was true here. You put a big circle in the middle and a triangle or two off to the side, then some little dots--your three levels of care. They became so enthusiastic about that in Michigan that the pattern was recommended to all the other states. Many of them began by the governor appointing a postwar planning committee to think through their needs in the state. That became a powerful pressure for the passage of the Hill-Burton Act.

WEEKS:

May I interject something here? Coincidental with this, wasn't there a great change in what hospitals were like, how they were organized, and what services they were offering--after the war particularly?

BUGBEE:

I think so. However, by then I was out of hospitals. I have taught the hospital survey course, the practicum, here in Chicago since 1962. I just finished with students; I am going to do their final class today.

I keep seeing a good deal of resemblance with University Hospital in 1926. Residencies were beginning to appear, qualifications for specialists were beginning to be developed. I think it is true that a number of things happened in the war. I wonder about the firmness of many medical procedures. California went into shortened length of stay, early ambulation, during the war because they didn't have any beds. Population increased tremendously, there weren't any beds. How do you cope with that? Well, get patients out sooner is one way. All of a sudden instead of two weeks for obstetrical care it turned out that you could do it in a great deal less. Of course, we know it's about four days everywhere in the U.S.A., but that was a pretty shocking change.

Certainly there were much more complicated procedures brought back from the war, and equipment, too. So there were those changes. The fundamental structure of the hospital was preventing infection, a majority of the patients having surgery of some sort--at least a major number of them--many familiar things. The x-ray department and clinical laboratories were both well developed and busy, though, of course, the volume has compounded in recent years. The degree of change at the end of the war could be hard for me to state.

I am going on about the Bishop Resolution and the need for aid for construction of hospitals. The establishment of the Commission on Hospital Care was only one expression of the intent of the Association to drive for

legislation. One of the major issues in that legislation was whether nonprofit hospitals should be eligible for grants. There had been major work relief programs for years prior to war, and only one of them permitting grants for nonprofit hospitals. Since nonprofit or voluntary hospitals were doing most of the short-term care, it seemed not right. Certainly the nonprofit group didn't like it.

So a planning committee was set up under the Council on Government Relations--Postwar Planning Committee was its title. It met in Washington. It began trying to figure out what might be done to see that the nongovernment hospital was considered in any postwar building program, public work relief, because the presumptions then were that there would be a depression as there was after World War I. A very faulty one, thank goodness. This planning committee tried to see what to do.

I remember one of the patterns that gave them a little encouragement, not only on the nonprofit, but also on the hospital building side was the work of the road builders. I suppose the road industry had patterns. For work relief projects you could put down one pattern and it might be 10 billion, or if Congress wanted 20 billion they had another grid of roads. We have seen them all built, on federal aid, too. It's certainly been a bonanza for the road construction people.

So there were ways of planning what was needed. Here was the Commission on Hospital Care trying to plan what was needed by the states.

During the war, under President Roosevelt, there had been a proposal for a hospital construction program. It was prior to my time, and it was opposed by the leadership in AHA, because they said it was a hospital post office building program. They'd build everywhere they shouldn't, particularly small

rural hospitals which the teaching hospitals thought were butcher shops. I think perhaps they underrated them, but they were against a lot of small hospitals being built. It turned out that Hill-Burton built a lot of small hospitals, but that's a different story. Anyway, those interested in legislation in the Public Health Service had proposed that bill, undoubtedly, to Roosevelt. More hospitals and doctors were needed if national health insurance were enacted. AHA started over again (with the Postwar Planning Committee).

On the Postwar Planning Committee was Dr. Vane Hoge. He was one of the early graduates (1936) of Art Bachmeyer's from the University of Chicago Program in Hospital Administration. He had been sent there by the Public Health Service as an officer. He was close to Art and he was close to the Commission. I think the action was due to Vane and his boss, Surgeon General Dr. Thomas Parran, who was one of the very strong Surgeons General.

Parran thought: Things are coming together. Let's draft legislation for aid for hospitals. He brought the draft to the Postwar Planning Committee. Graham Davis and Vane Hoge were on the Committee. The Committee said this was just what they had been looking for. The essential points were that each state have a plan, pick the neediest areas, and federal aid was to be varied between the states according to need. The aid was to go within the state to government and nonprofit hospitals by priority of need. This in a way is what Hill-Burton turned out to be with considerable embroidery, one way or another. The bill required the first country-wide planning of hospitals.

The bill as first drafted by the Public Health Service seemed good. Then the question was: How to get it introduced? I won't go through all of it, but about that time I became registered as a lobbyist. I intended that we

pass that bill. It was one of the successes of my life, as a matter of fact, that it passed, but I certainly was an amateur. In fact, I thought it was rather good for the status of hospitals, and still believe so, although others might think it is not as effective as it might be.

In any event, we had the bill, and who were we going to get to introduce it? When I went to Cleveland to succeed Jim Hamilton, I was appointed by the mayor, then Harold Burton. Harold Burton later became United States Senator, and after that a justice of the Supreme Court. At the time I am talking about, 1944, he was in the Senate. So I went to see Harold Burton, whom I knew fairly well from that experience. He agreed to introduce the bill with one reservation, and that if Senator Robert Taft, the other--the senior Senator--from Ohio agreed. I did see Taft, and he did agree. He was getting ready to run for the Presidency. He said "I have a labor bill, and I have this and that--education bill--I need a health bill." He later rewrote the bill, because he said he was going to make it a model of federal grant-in-aid, and, perhaps, did in his opinion and other people's, too. The bill was introduced January 10, 1945.

Then there was the question of someone else to sponsor the bill. We wanted a bipartisan introduction. I asked Harold Burton. He suggested Lister Hill. That was the move that really led to success with Hill-Burton, because Lister Hill took it on. I think he would consider it one of the great accomplishments of his life. Certainly it was a great accomplishment for the state of Alabama, because the bill ended up with a weighting toward the South that was tremendous, and still is in effect--and probably is currently excessive. I saw one Senator in the last few days making a speech to that effect. I think it was on educational television. I thought: there's still

too much going to the South in some areas. Senator Hill spent a great deal of time on the bill and it was his time that was needed. His family were doctors, his father named him after Lord Lister, of course.

Things then fit together. I don't think I said this before, but we called on members of the Commission on Hospital Care for support. The representative of the Farm Bureau was terribly key in getting support in the House on the bill. With the labor man, Golden, we immediately went to Nelson Cruikshank, who was on the staff of the Health and Welfare Committee of the AFL-CIO. He was very supportive and so was his industry, so we had a good group.

When I went to the AMA, they had been so against everything that they essentially said they needed something to be for. So they agreed to support it and they did testify in support of it, but reluctantly as far as the inner circle was concerned. I remember Olin West when I went to see him. I was kind of young and certainly naive, but I knew what I wanted there and got it. He made a point to me and said: "You know Blue Cross"--I suppose I talked about the Bishop Resolution--"Blue Cross is going to lead inevitably to national health insurance." As far as I know he may be right. He may have been right, for he has gone to his reward.

It was about two years before the Hill-Burton Act was passed--with great authority to the states to do as they wanted. Taft was thinking that what the states did wrong would be less bad than what would happen if it were a national program. That was his philosophy and I could even subscribe to it at times.

Now, later on we got into one of the other activities that I thought was important and an accomplishment, namely the standardization program, they called it, of the American College of Surgeons. The history of that--there

are plenty of books that write of the history, but the surgeons found they were doing surgery in pretty poor hospitals. I suspect they found some pretty poor surgeons, also. Anyway they always tell of the first 50 hospital inspections. They were meeting in New York at the old Waldorf. It was so horrifying that they took the inspection reports down to the furnace in the basement of the Waldorf and burned them up.

They decided to go into a program of hospital improvement, setting minimum standards. They hired a Canadian obstetrician, Dr. Malcolm MacEachern, as Secretary of the College. Mac devoted a lifetime to do just that. He was a character, he worked all the time. He didn't want to do anything but work, at least mostly work. He liked to travel, he loved to be on the platform. He had a special way with Sisters, they thought he was--I never saw such appreciation as they seemed to give.

Well, the time came for Mac to retire. He had run the College's standardization program on a shoestring. It was a fairly rich College but the number of surgeons qualified wasn't endless, and, of course, increased costs hit them. The college reluctantly decided they were going to get out of the program. Then the question was: What's going to happen to it? I knew one thing, that, if it were going to go on, the hospitals better jump in and be in favor of it and keep it alive. So then I proposed to the Board that we get in. The American Hospital Association decided to take over the program of hospital inspection. One could say the fat was in the fire. The AMA was in a state, and they said so. They gained pretty good support from everyone, particularly from the general practitioners, who have always been threatened by the standardization program. They (the GPs) were probably doing too much surgery, for all I know still are, but the inspections tended to keep that

down, require consultations, and various other things. The criticism of the AMA didn't bother me, I thought it added stature to the Association, but I think I have to admit we were wrong. The resolution of the argument--and there was plenty of argument--was better than if the American Hospital Association had taken it over alone.

The Board of Trustees of the AHA and the Board of Trustees of the AMA met together and then appointed a committee which met repeatedly. The President of AHA at that time (1951) was Dr. Charles Wilinsky of Boston, a wonderful man who had been President of the American Public Health Association and most everything else. He was deaf, but he heard enough so he did better than most who heard everything. He was unusually adept with the physicians. On this committee were representatives not only from the AMA, but also from the College of Surgeons, because up to that moment they had the program. I don't recall that the College of Physicians was there in those early meetings, but they were discussed.

Budgeting was a problem. The only one there with any money was the AMA. They had inspections, but for residencies. The College of Surgeons, in addition to inspection for accreditation or approval, had inspectors for their cancer programs. AHA was willing to put some money up for inspectors. There was a feeling to put together enough to get around more often that the College had under MacEachern. It got down to the point where it would be five years or more between visits. Mac was inclined not to cause a fight either if he could help it, which may have been good.

The arguments, of course, were how much medicine and how much hospital on the Commission (Joint Commission on Accreditation of Hospitals). The AHA by that time, with people like Wilinsky, were not worried about doctors, they

were worried about the AMA and the attitude of the general practitioner either emasculating the program or killing it. They thought it was a program primarily approved by specialists, rather than generalists. So, AHA insisted that there be representation from the College of Surgeons and the balance from the College of Physicians. It ended up with six hospital, six AMA, three for each of the Colleges. Then somebody said: What about Canada? The Canadian Medical Association was given one, and, since there wasn't a Canadian national hospital association at that time, the AHA had seven. That was the early texture of the Commission.

Then the next question came up: Who is going to be the Secretary? That was pretty touchy. My memory is not good enough to be sure of the sequence, but I believe Ed Crosby had been President of AHA by that time. (Not until 1953.) In any event, I remember persuading him to leave Hopkins if he were offered the Commission's job. He was the first appointment, and a very fortunate one. He carried it through two or three fights in several cities where there was a great deal of fee splitting and poor care. Then Dr. Kenneth Babcock succeeded him when I retired from AHA in 1954 and Crosby was appointed to that job.

Babcock was certified by the Board of Surgery and had been a hospital administrator, Grace Hospital in Detroit, for many years, so it was a logical appointment.

I think it has gone along pretty well, all things considered. It's a voluntary program. How far can you go with such a program? It now charges for inspections, that's given it a much firmer income than it once had. I think they now send a team for a couple of days to each hospital. That's not complete knowledge. Within that there has been trouble from the first. Who

do you hire that's willing to travel two-thirds of the year? It's not an easy life. Interesting in some ways, repetitive, I guess, in others. So sometimes the quality of the people who are surveyors, as well as the time they have to work, limit the thoroughness with which the inspection can be made. On the other hand, I think it's had a great effect on maintaining quality in hospitals. Currently I think it's being pushed to do even more.

What will happen to it in face of pressure for the government to take over, I don't know. If one were to compare the effects of state licensing of hospitals--which we recommended at the time of the Hill-Burton Act in order to have state control of hospitals that were to get aid (it was to be a state licensed hospital, at least, in order to get Hill-Burton aid)--if one were to review the effectiveness of the state licensure, I suspect that the Joint Commission on Accreditation has made a much greater contribution than licensure. The state has the same problem of money, quality of inspectors, political pressure not to rock the boat, so I think the voluntary program has been the better. It was certainly high time that hospitals be involved with that.

WEEKS:

Going back to Hill-Burton, do you think that the formula for providing a higher percentage of aid for the poorer states set a pattern for later federal programs such a Medicaid?

BUGBEE:

Whether the favoring of poor states and localities as provided for in the Hill-Burton formula--as whether it set a pattern--I think it certainly did, and I'll tell you why. How much of a previous pattern there was, I don't really know. I sat in on the executive sessions of the Senate committee which

rewrote the bill. On that committee were: Senator Murray, who seldom came and deputized Lister Hill to chair the committee; Taft; Robert LaFollette, Jr.; a Senator from Missouri; and another from Louisiana. The consequential ones were Taft and Hill. Hill tended to give Taft anything he wanted within reason. I think Hill felt that help in passage by the Republicans and the priority he would get for the South, which was logical at that time, were what he needed and they probably were. I respect Lister Hill tremendously. To me he was a statesman in the finest sense of the word.

I suspect that during the Depression there had been some weighting according to need. We did not want Hill-Burton to let need be determined by Public Health Service regulations thinking it would be a political business. How do you weigh need? Almost anybody can define need--possibly that's wrong. I know it can be manipulated. We wanted a fixed formula as is spelled out in Hill-Burton.

When Oveta Culp Hobby became Secretary of HEW under Dwight Eisenhower she someway was able to persuade the administration and Congress to make the Hill-Burton formula apply for all HEW grants. The cities certainly got a blow when that happened. That's what I heard somebody complaining this week, but it's hard to change.

WEEKS:

We know that Oveta Culp Hobby was the first Secretary of the Department of HEW appointed after the department was established under Eisenhower. However, somewhere I recently read that Nelson Rockefeller as the Under Secretary of HEW at that time was really the moving force in the department. Would you please comment?

BUGBEE:

Under Mrs. Hobby as Secretary from Texas as Under Secretary was Nelson Rockefeller, who was certainly down there looking over the political setting, and making such political profit as he could.

I was very protective about the Hill-Burton Act once it was passed, which was in 1946, as I recall. (I used to have the pen that Truman used to sign it. In fact, I had two pens. It was said Truman originally threatened to veto the bill.) Really my antagonist in the Senate committee hearings was I. S. Falk, who is now at Yale. He sat in on it, and I beat him on an issue before the committee that I think he deeply regretted. He thought he would worry me a little by saying that Truman might--leaked to the hospital press anyway--that he might veto it. He wasn't going to veto it by any means.

What happened after the bill was passed--I know I got two of the pens--sort of a consolation prize from friends. I wasn't invited to the signing, which was, I imagine, a calculated insult that I was too naive to care about anyway. I had gone back and forth between Chicago and Washington so much I was delighted not to make another trip. I'd seen it voted and thought he (Truman) would inevitably sign.

Once the Act was passed and turned out to be a success--in its time it was considered ideal federal grant-in-aid legislation--there was a tendency to tinker with it. Lister Hill always said that once you open it up you'll never know what will come out, so he resisted amendments.

When Mrs. Hobby came in, I think Ike had a Republican majority, as I recall it. Nelson Rockefeller, trying to think up something--you see, the Republicans weren't for any health legislation under Ike--sort of understandable as far as I'm concerned, but they had to have a health program. So Ike said he was in favor of research. Well, Lister Hill and a

few others of his cronies doubled and tripled the research money. It was really that which led to moving research from 100 million to practically a billion.

The other thing was that they were going to improve Hill-Burton by making amendments that would give priority--not priority--they separated out the money and put a little bit in nursing homes and outpatient departments. It was nonsense stuff because under Hill-Burton you could have priority if a state wanted it.

That made me mad, so I went to see Nelson Rockefeller and dusted him off as well as I could, because it was very clear to me it didn't make any difference what I said. He did listen. He was nice and polite and what not, but as far as I'm concerned, that contribution to national policy, if it came from him, was nonsense. So I told him. I think he did have a terrible job, because neither he, Oveta, nor the President wanted any health legislation. But for them to monkey up Hill-Burton was hard for me to take. They passed the amendment too--useless legislation.

Going back to the issue and I. S. Falk, whom I had known for years and who actually is a friend, indeed, I have a joint honor with him from the Association of University Programs in Hospital Administration. He, Vane Hoge, and I sat in on the executive sessions of the Senate Committee. I imagine that committee met 25 times. They were well served. They had an attorney--Congress always has an attorney working on a bill--but also, of course, HEW had one, Alanson Willcox. The American Hospital Association years later hired him. There would always be a draft of the bill with the parts struck out that had been changed and the new wording printed so you quickly could see the changes. The committee met only every two or three days because

it had to go through the two lawyers looking at it, and printing, and distribution. So I suppose it was once a week that the committee met. I know I spent most of that year in Washington.

I. S. Falk and I see things about as different as anyone could, politically and philosophically. One of the provisions in the bill that meant a lot to AHA and the AMA was that the regulations which must be developed under the Act--because no one could put everything in so complicated a procedure within the law itself--would be made by the Surgeon General. What was the Federal Council, which also was advising? What were their rights? It was our contention that they should have approval of regulations. It was I. S. Falk's that they should be advisory on regulations. That's what irritated him. The committee sustained our viewpoint.

I have been on the Federal Council. I tell you, I wasn't on for a number of years. I should have been put on right away, in my opinion. I thought so at the time; it was an added insult. I had two terms on the Council, as a matter of fact, much later (1959-1967), but I don't think the authority of the Council ever amounted to much. Over time it got in new people who weren't involved with it, they didn't know. PHS staff came and told them--and staff knew more than the Council members. It became rubber stamp. I thought it was just an exercise in discussion after the fact.

WEEKS:

Much has been said about the close relationship of Blue Cross, the AHA, and hospitals in general. What is your view?

BUGBEE:

The connection between hospitals and Blue Cross has always been hand in glove, I should say. From my years in AHA I certainly was, and still am,

defensive for hospitals. Every so often I read that hospitals supported Blue Cross because it was a time of Depression and people couldn't pay their bills. Well, I always thought it was nonsense, because Blue Cross went so slowly it paid few bills in the Depression. I prefer a much more altruistic description of their reason. I think in some degree it's true. In fact, for the people who went through it, I think it is true. They thought people ought to have protection against high cost bills.

Among the early leaders of Blue Cross: Rufus Rorem had been involved with Michael Davis on the Rosenwald Foundation. Basil MacLean, a Canadian physician, was one of the leaders. I think he was an administrator at that time of Touro Infirmary in New Orleans. He was Chairman of the Commission (Blue Cross Commission). They were drawing in the executives of those Blue Cross plans that were organized--at that time there weren't many--van Steenwyk in Minnesota, Mannix in Cleveland, McNary in Colorado, Colman in New Jersey. I can't remember the name of the man in New York, who shortly nearly bankrupted the plan with open individual enrollment, frightening everybody in Blue Cross affairs. Offering of space in the AHA building was indicative. When Rufus was appointed the executive of the Blue Cross Commission--they didn't have much, didn't have any statistics, much as you can imagine. The insurance industry, which paid no attention for the first few years, all of a sudden realized that Blue Cross had stolen a march on them, and what's more, the medical profession preferred the insurance industry indemnity toward the bill. They didn't want Blue Shield to give the whole service on a fee schedule, if they could avoid it. Individual Blue Cross plans did not like Blue Shield. They were hesitant to turn their data over. I suspect it's still fairly privileged, although I think that the Blue Cross Association is

now in a very different role. They put in programs--exchanges--where you can be hospitalized anywhere--a whole series of things that now makes the central organization large and strong, which it wasn't in early years.

I think there was a great deal done to help Blue Cross get off the ground. They needed hospital support in the face of competition. Hospitals were told it was a good thing by their leadership, over and over again--almost a religion. It still (the Blue Cross idea) takes some support, because insurance pays the bill. Here's a hundred dollars, you owe twenty more, but the hospital gets its rate. In other words, insurance, in these times when people mostly have money, pays what the hospitals ask for. Blue Cross would say they (the patients) are poor and couldn't pay the added amount. I think when Blue Cross first started that was an argument in their favor.

On the other hand, most administrators now--well, I have just been going through a survey of hospitals where the amount that is charged pay patients, including commercial insurance, is so much larger than is paid by Medicare, Medicaid, and Blue Cross that the differential sometimes is 10 to 20 percent. So administrators like commercial insurance.

I think it's affected Blue Cross enrollment over time. However, at that time I think it had a great deal to do with the growth of Blue Cross that hospitals, and certainly hospital leadership, supported it. The Blue Cross pioneers made a special point of being hand in glove with hospital leadership. van Steenwyk then in Philadelphia--I remember when Bob (Robin) Buerki was there--there was no question that Bob thought van Steenwyk was doing a good job, and more than that, that Blue Cross was the solution in face of proposals for national health insurance. It was always put in the savior role, and has been.

As Executive Director of the Association, I tried to be supportive. Support was one of the three points in the Bishop Resolution. When I had been there seven or eight years, and Blue Cross had grown as it did after the war--the minute income tax acts were passed to make it possible for the industry to pay it (insurance and Blue Cross premiums) as an expense, and not have it considered income by the individual, it grew with leaps and bounds. Then came the question I really never faced up to because I didn't realize exactly what was happening. I don't know, with the leadership of the Association as it was, that I could have done anything. I think Blue Cross outbargained the hospitals in many places. I am sure they did it in Philadelphia. So at times there was a question of what the relationship should be between AHA and Blue Cross. It's still talked about. Are hospitals dominating Blue Cross? I am sure in Michigan every time the rates change, that comes up.

Again a digression on a thought which may be inconsequential, but amused me. While trying to explain third party purchases of hospital care for the students at the University of Chicago, I suggested three methods. The first was to pay whatever charges the hospital established. The second, was to pay the hospital costs. The third, was to develop a formula so complicated that no one could understand it. This tended to be the easiest for the third parties in arguing with hospitals about reimbursement. I have always thought that discussion between third parties and hospitals on reimbursement was difficult as union bargaining between the employer and the employee.

The facetious comment on third party payment using an un-understandable method almost inevitably develops as an effort is made to perfect the fairness of payment to hospitals. A whole series of variables can be thrown into the

computer relating to case mix, age of patients, the building, salary levels, etc. etc. to produce a rate of reimbursement for the individual hospital which is beyond argument. It is beyond because there is question that the right variables are used, for example: the fact that such data as case mix may defy quantitative expression.

On the question of whether Blue Cross was an agent of the hospital, the issue came to the AHA Board of Trustees. It was argued by the Blue Cross Commission representative that it was not, and I argued they were. I was beaten in the Board. That's the worst beating I ever took on a major policy issue. If I had won, it probably eventually would have been changed.

By that time I was convinced that Blue Cross was really in many instances not paying what they should to the hospitals. I think it was true. I think they have gone beyond that now with the temptation not to.

We haven't at all discussed the advantage of Blue Cross. I have talked about a negotiated rate, which may be very favorable to Blue Cross, but, almost more important to its growth, has been the contract which has permitted direct billing. Awfully nice to go out of the hospital and owe only for a phone call or two.

Had another fallout I never liked. I'll tell you, I am not going into any two-bed rooms if I can help it. I think it's a horror that this country has almost nothing but two-bed rooms as wealthy as it is, but Blue Cross didn't want to pay the top rate. Some people thought they ought to pay what was known as ward rate on the East Coast, but they ended up paying semiprivate. The net of that is that we have built mostly semiprivate beds. I don't think we need to have done it.

Through the years many people have seemed to misunderstand the different

definitions of such terms as ward, semiprivate and private. On the East Coast in the large teaching hospitals these terms meant that the patient paid no fee to the doctor when in a ward, while in semiprivate, which well might be a multibed room, the doctor could charge a fee, while in private rooms the sky was the limit to some degree on charges both by the hospital and the physician. However, elsewhere throughout the country, ward has meant an area with more than four beds; semiprivate has usually meant a room with two to four beds and a private room as indicated, means a single bedroom. Physicians may charge in any one of those types of accommodations. Usually ancillary services are at the time rate irrespective of the accommodation the patient occupies, while they are variables on the East Coast for ward, semiprivate and private.

WEEKS:

The Wagner-Murray-Dingell bills were active attempts at health legislation during the 1940s. Did AHA take a position on these?

BUGBEE:

You will remember that I mentioned the Bishop Resolution. It was really quite fundamental. I think I could indicate that it is fundamental now in policy decisions nationally about health insurance. The three issues, as I stated before, were: construction of hospitals when needed to provide resources for care; support and development of voluntary health insurance; and assumption by government at all levels of responsibility for those who couldn't pay for health services. It was in many respects a counter resolution to the Wagner-Murray-Dingell bill which came up in Congress year after year. When President Truman made that bill essentially an administration program which he wanted passed, I think everybody in the health

field thought it was going to be passed. They took sides--most of them in the field in opposition because of their conservative background.

I had worked with Lister Hill. He developed and I worked with him on a bill which was called the Voluntary Health Insurance Bill. It provided for a division of the country into regions with support for an inventory of health insurance coverage and support of health insurance--tied into the Hill-Burton Act. When we were able to get enough people as sponsors of that bill, it was clear Murray didn't have enough votes in the committee to pass his bill. I don't think national health insurance has been a critical threat since. There was a good deal of feeling that it might be passed when Johnson was president, but certainly as we come to it now no one thinks it's going to happen. Though, it could change overnight--that's (the uncertainty) been true since World War II.

In fact, recently (summer, 1978) the Secretary of HEW sent a memorandum to President Carter on health insurance that to some degree presents two approaches: one might be called the Wagner-Murray-Dingell with very comprehensive benefits and coverage for everyone; the other approach might be looked at more in the light of the Bishop Resolution with special attention to financing care for those who can't afford it and mandatory coverage under voluntary health insurance by employers. So we are back again to that division.

WEEKS:

About 20 years ago you wrote an article about European health systems in which I believe you said the governments usually overcommitted themselves. Would you comment?

BUGBEE:

You mention that I've said in the past that governments overcommit themselves as to benefits. I think there is more consciousness of that in this country right now than there has been in the past. It was clear at the time Medicare was passed that they were far underestimating what the cost was going to be. All records since passage prove that point. Now there is a great deal of concern about the amount that can come out of the federal budget. They don't dare overcommit as much as they did. The overcommitment is chronic; we don't have to go any farther than our Social Security program. Congress, year after year, has added benefits. Now, all of a sudden, the income is not equal to the commitments that they have made in spite of tremendous increases in taxes. Now there is talk of drawing on general revenue.

WEEKS:

Did you or AHA actively work for the passage of health legislation other than Hill-Burton?

BUGBEE:

As I think I mentioned, I registered as a lobbyist. The Association was very much opposed to "compulsory" health insurance, as a loaded word in opposition to complete coverage.

There was other legislation the Association was interested in. I suppose as consequential as any was the addition to the Taft-Hartley bill of an exemption for nonprofit hospitals. Ed Crosby was the administrator at Johns Hopkins Hospital at the time. He had a board some of whom were well-connected politically. We talked to one of these men on the board--Ed did primarily--and he arranged an appointment with Senator Robert A. Taft. Taft wasn't very interested in the amendment we wanted (exemption of nonprofit

hospitals under Taft-Hartley). I think he was worried whether he could pass the bill. It really was quite an important bill for conservatives in somewhat reducing the rights of organized labor in their bargaining. He proposed it, and eventually passed it, but he didn't want too much added to it.

We then went to Congressman Fred A. Hartley. Hartley was much more interested, and eventually within that Taft-Hartley Act was exemption of voluntary hospitals as there was already for government hospital employees. A number of the states passed state legislation that took away that exemption, notably New York State with Rockefeller. Of course, the exemption was taken out (at the federal level) a year or so ago. I realize that employees have rights, and should have rights, but, to me, the thought of a strike in a hospital--which is the ultimate tool or weapon for labor--is very distasteful, terrible! I think it's proved to be. On the other hand we see strikes--right at this time firemen, policemen--vital public services are being disrupted by strikes of public employees. Perhaps voluntary hospital employees are entitled to the same rights. It is not anything I would support. Indeed, I was very pleased to have the exemption for some--well, it must have been 20 years. That exemption delayed hospital unionization for many years.

There were other legislative activities, none of them terribly consequential. Protection of Hill-Burton was almost a full-time job because it was regularly described as model legislation of federal-state grant-in-aid (which many were tempted to ride).

I don't think I talked to you much about Taft. There was an amusing aspect of his decision to rewrite the Hill-Burton bill. The draft had been prepared by Alanson W. Willcox, an attorney in HEW, and which was first introduced by Hill and Burton. It was not the act that was eventually passed.

Taft, when he agreed to work on it, said, "I'm going to rewrite it." He did rewrite it. He considered it model state-federal legislation. He believed (and, I believe, too) that states in such a program should have some independence of action. His interest was fueled by the fact that under the Social Security Act the State of Ohio about that time had done something that caused the federal government to hold up millions in grants under Social Security for benefits of some sort because they said the state was not administering the way it should be. Taft was furious at that. He was going to fix the Hill-Burton bill so it wouldn't happen with that.

For example, under the Social Security Act the federal government paid the salaries of the state (SSA) administrative personnel. The minute they (the federal government) stopped paying, the very people they were arguing with had no salaries. So the Hill-Burton Act initially did not have one dollar for administration, but some said this led to poor administration. The states that wanted the benefits had to put up the money for administration. There were various other aspects of it that were calculated to make it particularly a states rights bill.

I talked about protecting Hill-Burton a little before. The bill was so well accepted that not only was it used as a model of states rights legislation and a model of weighting of federal grants to the poorer states, but also people wanted to keep amending it and adding their own ideas of what it should do.

I never liked the lobbying. I think some of the most disagreeable jobs I was confronted with were hanging around outside the House or Senate waiting to catch some person, who didn't want to see me, to ask how he was planning to vote. Or going to his office and trying to get in.

I remember a man named Brown in the House from Ohio. He was opposed to the Hill-Burton Act. Well, on the Commission on Hospital Care had been a man representing the Grange, the farm Grange, who lived in Brown's district. It was a rural district and that Grange man's intercession was pretty powerful stuff. When the bill came up for a vote on the floor of the House, although Brown had said he was going to vote against it, he stood up and didn't say a word in favor of it, but he said he wouldn't oppose it. That was enough to let it get by. That sort of lobbying I felt neither experienced nor understanding about. I thought it was an unpleasant activity.

WEEKS:

You have touched a little on educational activity being one of the major functions of AHA. Would you talk some more to that point?

BUGBEE:

Maybe we can go back to the early meeting at AHA where we came up with the three functional areas for an institution. (I think probably in attendance were: Kenneth Williamson, Maurice Norby, C. J. Foley, possible Ann Friend.)

One functional area was relationships. I've just been talking about relationship with government. There were other relationships: AMA, for example. That was a restless relationship. We've talked about their finally agreeing to support the Hill-Burton Act, which they did, and also negotiating with them on the Joint Commission on Accreditation.

I am digressing a bit. I never knew what the relationship should be. They would have been very glad to treat AHA as "be a good boy, Sonny!" That type of thing. Well, I kept away from them. I thought the fact that we occasionally showed some claws probably got some respect, and was a more practical working arrangement. Ed Crosby, on the otherhand, I think, showed

the claws but was closer to them.

One time when he was favoring--I think it was the AHA's proposed approach to national health insurance--they got to the point of threatening to go to the AHA membership and suggest they not pay dues. That's never been tested but I should say it would be a serious threat, knowing the political interests or political stance of most board members and medical staff. AHA is particularly vulnerable with dues as high as they are currently. So relationships are important.

We have already talked about the research and standardization function.

I think the educational function was tremendously important--and difficult and not necessarily with immediate payoff from the standpoint of membership thinking. By the way, I early came to the conclusion the Association must have some quick payoff projects for members to hold their interest for longer projects with delayed results.

I am not even sure--well, I used to be unsure--that many members thought of the annual convention as an educational opportunity. Some of them never went to the so-called scientific sessions, but salesmen at the exhibits of the convention are educational, too, hopefully in a constructive fashion. The educational ventures of importance--at least visibility--were the convention and publications.

I certainly saw the publications proliferate, including Trustee magazine which I think had an important force. This was Kenny Williamson's brain child. I wasn't at all sure it would go, but it certainly did in short order. Incidentally, there was always a question about how much literature sent out by the AHA was being read. There was a tendency to discount reading. My experience seems to show that while the membership was selective

in its reading of association literature, the mailings were not ignored. Equally consequential was a series of institutes.

When I went with AHA there were two institutes that had gone on--one of them regularly, but neither really an AHA venture. Dr. Malcolm MacEachern had an institute in the International House on the campus of the University of Chicago that had gone on quite a few years. He ran it; he chose the speakers. Occasionally people still talk about it as being an educational venture they were exposed to. Then there was an occasional accounting institute, which was popular.

With the development of staff for important councils and committees--Council on Administrative Practice, a committee on accounting, purchasing, several others--we began to have institutes and they were well subscribed. I don't know how many AHA has now. It got to a point then when there were 30 or so a year. There was no question they were a learning experience for the people there. Learning for the staff, too, because it was a way they acquired knowledge of problems, acquired knowledge of people and promising individuals in the field.

The development of talent in an association such as the American Hospital Association is difficult. In my day it was the President who had appointing authority for the important council chairmen, nominating committee members, etc. No President really knew the membership in the then 48 states. He knew them in his own. I think I have seen since then some of the symptoms of what can happen. If your President's from Texas, you've got more Texans than I can bear all at once. It's not really political so much as that's all he knows. How is he going to know anything else?

Well, I was talking about institutes. Out of the institutes emerge people

of talent. Then you get them on a committee, and they move on up to the councils. Really, when they go to the Board, they probably should have been a chairman of a council and have demonstrated knowledge of the Association and its objectives.

The Board of Trustees in my day was relatively small--as I recall, 12 or 13. They were very consequential in setting Association policies--much more than the House of Delegates, although the House had veto power. While I was at AHA the bylaws were changed so that while the House of Delegates could veto an act, they were required, if initiating action, to refer it to the board. It was my impression, in contrast, that the House of Delegates of the AMA was out of hand repeatedly reversing and hamstringing the AMA board and staff.

I thought it was part of my job to keep track of people coming up. I am not very crazy about socializing, nor am I a backslapper, but I did try to attend state associations regularly enough to see who people were. I kept a key staff member to watch for emerging talent. I remember I had a list I kept. At one time it had about 500 people around the country who either had been important in state association work, local councils, or national affairs.

Incidentally, that list helped me evaluate my memory for names and faces. Everyone I ever talked to regrets his inability to remember names. Certainly I thought I was poor at it. However, I once took the list of 500 and was able to remember the faces of almost everyone on the list. Probably most people could do the same. Also, review of the list before a convention made it possible for me to greet many more people by name than was otherwise true. After that review I was not startled when I met a person into no memory when I had just seen the name and thought about the person a few days before.

The list was useful when the President wanted to look at people. I tried

not to tell him who to appoint, but to say I had no influence would not be true. At least, I always hoped to have influence. The AHA needed members to work on committees, councils, and relationships. Many members like to be invited to participate, but would not work. An ingratiating quality of Ray Brown, while I was at AHA, was no matter how many times I called him for help, he accepted the assignment.

I suppose it would fit here: One of the troubles of an elected official for an association is the tendency for those who campaign for a job to be people who are in trouble at home. I remember Ed Crosby saying one time: "What would you do? My President has just been fired!" That's not unique with them. The office is a way to get visibility and get the next job. On the other hand, the hospital administrators who are very adept at operation often stay home and operate.

I remember at one stage in our search of names for that long list we tried to have every member of the staff get out and visit so many hospitals a year. Somebody went down in Indiana--I can't tell you any more than it was in that state--and came back to tell about a pretty fair sized hospital there. It was run by a fellow, who as far as they could see, was doing a wonderful job. Everything was going just right, but we had never heard of him before. He just stayed home and ran a good hospital. Probably that's the other end of the spectrum.

At least in my day, every so often somebody would campaign for election to an AHA office. There wasn't competition for election, so the person insecure at home, if he really worked on it, was likely to have some chance to be elected.

It always raised the question of what should be the texture of the

nominating committee. You have a committee of great importance to the Association whose members don't really know people. They would often ask my advice, but the important thing was to put people on the committee who knew the membership. In my day, each President had the appointment of one member, as I recall. The last three presidents, skipping the immediate past president, were members of the committee, ex officio. At least they had been around to a lot of state meetings and they had some idea of who people were and who had worked for the association. The logical place to draw candidates for officers is from the board and the chairmen of important councils. The committee knew them because they had seem them operate.

Ed Crosby made many changes which I have no way of evaluating. He enlarged the board; I liked the small board. In fact, I often thought the discussion in the board was about as healthy as one could possibly have. Usually someone expressed a very liberal point of view and someone a very conservative point of view. They talked it out and arrived at a consensus in a very healthy fashion. I think I was often accused of dominating the association. I suppose in some degree I did, and intended to. What I tried to do with the board was see they had all the pros and cons as near as I could get them. Then they discussed and made their decision and, I thought, really very wisely. I also tried to meet with all important councils and committees, because, for some of the reasons I have given, staff was not always productive in developing with those groups on important standardization or association positions.

One of the things I thought would tear an association apart would be to have an important council-recommended policy decision which the board would reverse. It almost never happened. I think I only lost once, I believe I

mentioned, on a Blue Cross issue. That's the only time I thought the board voted improperly on an important issue. Needless to say, they many times voted differently than I would, but not on vital issues. Incidentally, almost equally bad is for an association committee to meet with nothing to do, because of bad staff work.

WEEKS:

What other sources of financial support were there internally for the Association besides dues? The convention? Publications? Headquarters real estate?

BUGBEE:

I have never looked up the precise date when the association was reorganized to provide for institutional membership. It was before I came to AHA. The model was the Ohio Hospital Association. The architects of change were John Mannix and Monsignor Maurice Griffin, and, I think, Jim Hamilton among others.

Monsignor Griffin occupied a unique place in association activities. He had his own parish in Cleveland. Certainly his responsibilities were much broader than that. The church is not one to tell you everything. He was on the board of the Association for years, and as I would guess, was by the Council of Bishops designated to be their representative with AHA--although he never said so. He was very helpful in legislation.

The Council on Government Relations, on which he served after he left the board, met in Washington. It was at the Statler Hotel, which at that time was new. It was new, but they didn't have the ventilation right, and I doubt if it is right now. He, Griffin, would call about 9 or 10 o'clock and come down to my room and want to visit a little while. I wouldn't be surprised if we

even had a drink. But he'd smoke a cigar. I'd never get that cigar smoke out of my room for the rest of my stay in the Statler. You can see it is still on my mind.

But coming back to financing: It was that change to institutional dues that completely refocused the Association. You can see the difference with the American College of Hospital Administrators and the AHA. The membership to some degree is parallel, and AHA still has a personal membership. I think rightly so, but personal membership doesn't generate any amount of dues.

One reason AHA is as important as it is is institutional dues. The quadrupling of the dues was quadrupling of the institutional dues. I'd have trouble citing exactly but I'd guess the dues varied by number of patient days. The institutions were billed once a year on the patient day annual total that they submitted for calculation of dues. I'd guess it was at the top around two or three hundred dollars. It wasn't very much.

The journal, Hospitals, was an expense until advertising was added. For a time it had some net income, but not very much. It was especially so since everybody on staff was considered a source for input to the editorial side of the journal, while Storm and his associates were responsible for writing it up and making the decision on content. Nonetheless, I don't think we ever charged to the journal the expenses we might have. To some degree that was true of the convention.

The convention generated a net income of substantial size that helped support the association. Maurice Norby and a man named John Williams (Jack Williams, we called him), who was the advertising manager, developed a philosophy on how to handle the exhibitors at the convention. The exhibitors were represented not by the presidents of companies but by somebody quite a

few echelons down. They were always anxious to have less in the way of program and more time in exhibits. Furthermore, they were always arguing about how much they ought to pay. We listened carefully to what they had to say, but we knew that in the long run it was the quality of the program that made it an educational venture and that brought the attendance, too. So we never paid much attention to the arguing. We charged what we thought it was worth. The halls we had for the exhibits filled up at those prices. If they didn't like, they didn't need to come.

The hospital industry association had at one time run the convention, or essentially that. Again, I suspect Otho Ball was not unrelated to it. While that might seem very critical of him, Modern Hospital, in addition to being a very good magazine had back of it Otho Ball's guidance to many beginning industries. It was a time when there was much happening in the development of hospital products...well, hospitals were developing. He helped many a small company with developing of its product and merchandising it. They were very appreciative and expressed it to him. They gave the hospital industry a dominant role. I may be critical in some ways of Otho Ball. I think overall he contributed greatly to the health field.

In being critical I am talking about his relationship with AHA, where I thought he had served his purpose.

I thought we had a fair amount of money and the dues were raised, from time to time, while I was there. Incidentally, there was a man named Harold Prentzel from Pennsylvania. I never did understand what was the matter with him. I think maybe his main claim to fame was that he had visibility by always objecting to any dues increases. It always bothered us, but he would get up in the House of Delegates, which had the authority for dues changes,

and make an impassioned plea to hold the line. The increase wouldn't be any amount of money in the hospital's framework. The House would promptly vote him down. To that degree it was a healthy thing, rather than pass the increase on almost a rubber stamp basis.

I think one of my many faults is planning too narrowly. I remember one reason I liked Monsignor Griffin--we were talking about plans for the association. He said they were not big enough, plan them bigger--what the future's going to be. I thought, he's right!

When I was at the University Hospital in Ann Arbor back in the twenties and thirties--this was in the thirties really--it was decided to build a neuropsychiatric unit attached to the main building as a "T" out the back. The architect was Albert Kahn of Detroit, one of the great architects of his age really, and the psychiatrist a man named Wagner. It's always embarrassed me thinking about that thing, because it was too small. The space was squeezed up in spite of everything Kahn could do. That's the way we ended up.

I probably was guilty of the same thing in financing of the Association, particularly about the headquarters. I talked about the AHA having bought the Boys' Latin School on Division Street. It had a gymnasium two floors high. We put in a floor so we got added space. The gymnasium was two-thirds of the building from front to back, so a floor added quite a lot of space. There was a three story small apartment next door that had been rented. We got rid of the renters, knocked a hole through and used the added space for offices. Everyone who worked there laughed about how crowded it was. I had kind of a small cubbyhole. It's great advantage was that it had a window that looked over the lake. You could see the lake, although it was from the second floor and wasn't a major view. But I enjoyed that part. My room, I don't think,

was 10 by 10; it might have been 9 by 9. Anyway, it seemed adequate to me. The members had nothing to be proud of at 18 East Division. Certainly there is merit to having an impressive building such as the one built by Ed Crosby. It gives stature to the Association.

It was obvious that we were growing and needed more space. We rented a couple of other buildings. We needed some greater change so I--. I say "I" although it was an awfully smart staff. We did have regular staff meetings where they all did throw in their ideas. I can't remember whose was one idea from the other. I threw in mine, they threw in theirs. As we talked about locations, the first question was: If you were getting rid of this building, where would you locate? We came to the conclusion there were three cities in the country--Chicago, New York, and Washington, D.C.--any one of which was a possibility.

I began to look around Chicago. We had various offers. I went down to the University of Chicago. The President, Lawrence A. Kimpton, later Vice President of Standard Oil, probably coached by Ray Brown, was very welcoming. They were razing buildings across the Midway and offered us space. I think it is now occupied by the Center for Continuing Education. The University had just given space to the American Bar Association, which is out there. The analogy was obvious, but the neighborhood is still there. If you have an operation that requires a great deal of clerical help, it's difficult to get any. The local residents often are not qualified by education and training. Those who are won't come down there, so that part is difficult and crucial. Also, there is the question of staff and whether they will come down there.

So I equivocated. Then someone urged looking out in Cook County near what is Pres.-St. Luke's. It was a great open space with bricks lying around on

top, and, again, a neighborhood that was difficult. Then Northwestern University offered space. Well, between Northwestern and Chicago I thought there were many arguments for the University of Chicago, but obviously the Northwestern setting was more attractive.

About that time--in fact, we were coming back on the train, I think from St. Louis. I remember Karin, my wife, was with me. I think we had a drawing room. Other members of the staff were in the train; C. J. Foley, I know he was there. I don't know who else. We got to thinking about location and we got to thinking about... Oh, I am going too fast.

We got to thinking about affiliating with other universities. Prior to the train ride, I had been down to Baltimore and talked with Lowell Reed. Reed had been Dean of the School of Public Health, was one of the great biostatisticians of the country, and at that time was President of Johns Hopkins University. He and I discussed at some length the idea of having a school to train for management in several categories: management in engineering, and public health, and hospitals, perhaps. We talked about a building on the campus or at the hospital, whichever one--the campus and the hospital, as you know, are separate. That was appealing. Lowell Reed was a very smart man.

You mind my digressing? One of my concerns, following over time the development of programs in hospital administration--as they were then called--was that they were being taught, particularly those in business schools, as if the problem of management of a hospital was similar to the problem of management in business. While both needed facilities and people, I thought they were very different, as indeed I think they are. I think what is analagous to the hospital with predominance of skilled professionals might be

a university. A great argument could be made for this--and with some industrial research units.

When eventually I had on my Health Information Foundation board the presidents of some of the large ethical drug companies, I'd say to them: "How do you get along running your research units?" It's the trickiest business to get productivity. You certainly don't handle that type of professional the way you do an office worker or a factory worker.

I thought: They are training these young men in many of those H.A. programs and they'll go out and the first thing they'll do is lose their jobs because they don't realize professionals are different.

I found, indeed, that there was quite a literature on that particular problem of productivity in an organization of professionals, even some in higher education management at universities. I finally got AUPHA (Association of University Programs in Hospital Administration) to have a session on it. I helped plan the program. By that time Lowell Reed had retired and was up in New Hampshire somewhere. I wrote him and asked him if he could be on the program. He said "no," that since retirement he was so busy he was thinking of taking a permanent job, which amuses you as you get older more than when you are young.

Incidentally, on that business of studying problems of management at universities, at that time James G. Conant and Harold W. Dodds, President Emeritus of Princeton, were studying management in higher education. I talked to Dodds. I tried to get him on that program, and didn't succeed either, but he told me that he and Conant had come to the conclusion that the nearest analogy to management in higher education was the voluntary hospital.

I am coming back to the location of association headquarters. The idea

that Lowell Reed threw into it was intriguing. In fact, I had thought that with a staff of skilled individuals in a variety of--it could be called disciplines, I should say activities within the hospital would be a better designation--that the group would be useful as a faculty in a program in hospital administration. Therefore, if an association were located adjacent to a university and affiliated with it, that might be worthwhile. Lowell Reed thought so too, as I talked with him.

Well, on the train--coming back to the train ride--we began to talk. C. J. Foley was a friend of Jack (John W.) Kauffman, who was administrator of the Princeton (N. J.) hospital and later President or Chairman of the Board of AHA (1973). He told us that the Westminster Choir College in Princeton was for sale. C. J. had seen it and said it really was an ideal facility. They were talking about selling it for a million dollars. Our thought was that we some way could locate there and maybe not have an affiliation--we doubted that Princeton would affiliate. The facilities of Choir College would be ideal for an institute setting as well as for the association staff. That's fine, but how's that going to be arranged? We came up with the idea of--not an Institute of Hospital Affairs--it was a little better name, but that's essentially what it was. We thought of the millions needed. We needed some money for endowment, and staff, and expanding the office space.

I went to see it. It was a very attractive campus we were talking about. It was a red brick Georgian quadrangle with a front building that had classrooms, on the sides two dormitories for 50 boys and girls, and the chapel and dining room on two different levels in the back building. There was much space back of that which could be used for an office building.

The board met in Princeton. We discussed this Institute of Hospital

Affairs. It appealed to them. I suppose it was the expansive planning that Monsignor Griffin had recommended, although he wasn't on the board at the time. They voted to go ahead and buy the building. It was on the Pennsylvania Railroad, easy to get to New York, easy to get to Washington--it seemed equally accessible to both.

I then proceeded with negotiations for buying it. It turned out that the Chairman of the Board of Choir College was a very old man who had been head of the Princeton Theological Seminary. The President of Choir College, who had great ideas of expansion, wanted to go out to the Lambert estate and build one of those performing arts centers that would draw people from all over the area--and it's a very heavily populated area. There really was nothing wrong with the idea except the President was old--he was over 65. The Chairman of the Board said the College was not going to be sold because that man was too old to develop such a plan. When the chips were down, the offer to sell was withdrawn. It was too bad. It was such an attractive community and attractive building. It would have fit in so well.

However, the idea of an Institute of Hospital Affairs continued. At the same time I had been negotiating with the Sloan Foundation for a grant of five million dollars to finance this venture. Several times I saw old A. P. Sloan, who in his years at General Motors had built it into a great corporation. He was interested in hospitals, education, and in management. He almost single-handedly had supported Memorial Hospital for Cancer in New York City. In fact, his foundation was disturbed because he was supporting it so, if he stopped, the hospital and its research would collapse. I imagine the foundation still supports it. When he and Mrs. Sloan died they had about a hundred million each, and I suppose it's worth a great deal more now, so it is

not a small foundation.

My access to A. P. Sloan was not the best in the world, because it was through Ray Sloan, his younger brother. I think Ray and A. P. at times--they were brothers in close contact. They hadn't always agreed on things. I think that old A. P. treated Ray as a younger brother. A. P. was deaf as a post. He'd listen for a while, then the first thing you know he'd turn off his hearing aid. Ray all along told me he didn't know we would get a grant, but we were encouraged because A. P. had given a large grant to M.I.T. for a school of management. He was convinced that hospitals needed better management. Ray said the grant could easily go to Cornell.

Indeed, it ended up that A. P. gave a substantial grant for the Sloan Institute of Management at Cornell and we did not get the Institute of Hospital Affairs.

As a sort of consolation prize, I was made a member of Mr. Sloan's Advisory Committee to the Sloan Institute. We met once a year at the University Club in New York. He would open the meetings by deploring the state of efficiency of hospital administration. I never remember our being asked for advice. Incidentally, the Advisory Committee was largely made up with his cronies who either had, or still ran the financial world. However, Ray Sloan and Jack Masur, later President of AHA (1962) were members. Chester Barnard, who was a member of the committee and had been President of the New Jersey Bell Telephone Company, at the last meeting protested that he thought hospitals were one of the most difficult institutions in our society to manage. Since Mr. Barnard had written some of the most pertinent literature on management, this comment was impressive. He was also President of the Rockefeller Foundation.

Later I invited Mr. Barnard for lunch at the University Club to discuss his impresssions of the difficulty of managing a hospital. I have always thought that criticism of hospital administrators related more to the difficulty of managing the hospital than the ability of administrators, or at least they were entitled to some discounting of criticism. I was hoping to persuade Mr. Barnard to write about this problem. However, he died before he had the opportunity to do so.

As an AHA executive I was always protective of hospitals and hospital managers. I suppose that was my business. In any event, I have thought their problems were not well understood and criticism too easy and often not fair. Once I looked through Who's Who to find as many prominent Americans who were on hospital boards as possible. I matched perhaps twenty. I wrote them asking their impression of the degree of difficulty of hospital administration compared to other management jobs. Very few replies were received; six, as I recall. I judged this was the result of their not really having much idea. Of the six, I got what I always thought was a poor answer, namely that it must be easier because it was not necessary to make profit in voluntary hospitals. This reason I thought was only a dodge. Later I found in reading one of Chester Barnard's books on management a statement that the worst worry for managers in business was not the problem of making a profit, but the danger of a deficit. This certainly sounds familiar.

WEEKS:

You had an outstanding record at AHA. How did you happen to leave the Association to become President of the Health Information Foundation?

BUGBEE:

About the time of the Sloan episode I was offered the position of

President of the Health Information Foundation. I don't for a minute mean to imply that I left in a tiff because we hadn't gotten the grant. We were very operative and there were other possibilities, as Ed Crosby demonstrated. HIF, the Health Information Foundation, was an interesting venture. Before they started the Foundation they held meetings around the country to find out what the pharmaceutical industry could do to be helpful to the health field. I didn't attend the meeting held in Chicago. Ken Williamson, as I recall, did. He was impressed with various people they had. They had been putting quite a lot of money in a committee whose names escapes me. I always called it: "The Committee for the Prevention of Cruelty to Physicians." It was initiated by a man named Cary, as I recall, in Texas. As far as I could see their major program was, if anybody mentioned compulsory health insurance, beat him on the head. It proved to be a rather impractical approach.

The pharmaceutical industry decided that money was not well spent and then they had the hearings. They decided to make a venture as far divorced from their interests as an industry as they could. It was supported primarily by the ethical and proprietary drug companies. They had the best resources, but the wholesalers and retailers all contributed--not everyone, but there were substantial numbers of both.

They decided to try to do research and public relations particularly in relationship to the advances in medicine that had been useful to people--also research in problems where research might help in the solutions.

The first thing they did was look for a national figure as president. They appointed Admiral W. H. P. Blandy who had been in charge of the Atlantic fleet. He was a man of national stature. They set up an advisory committee of equally important people. (The reason I could get to ex-president Dodds of

Princeton was that he was on that HIF Advisory Committee.) Herbert Hoover was Chairman of the Advisory Committee. While he didn't do much, he did function. I saw him periodically after I became president of HIF.

Then Blandy came to me and said: I've got to have somebody who knows the health field. I mentioned Kenny because I thought Kenny might be entitled to a break if he wanted it. He hired Kenny Williamson. Then after about five years, and they were a difficult five years from all I have heard, Blandy died.

Well, Jack Searle (John G. Searle) who at that time was president of the company of the same name (G. D. Searle & Co.) which was thriving under his leadership, plus good luck, I would guess. Their first find, as you would speak of a gold strike, was Dramamine for seasickness. It built the company overnight. He had taken over the company from his father who was a physician and, I suspect, had merchandised a few compounds he had found.

Jack had been fundamental in the organization of the Health Information Foundation. I think he was particularly enthusiastic about the idea of a positive program, more in the national interest and practical than the physicians' committee. I think he felt it was very near collapse at the time Blandy died. Though he never said it to me, I think it was without any question true that he was not used to presiding over failures. He had decided he wanted me to be president. I suppose he wanted whoever he could get, but eventually I looked the most--I was who they wanted.

I often wondered whether AMA wanted me out of AHA too. If so, nobody ever told me. We had just been through the accreditation fight (JCAH) and AHA was burgeoning in a fashion that was a potential threat.

Anyway, Kenny Williamson was there (HIF), but I had just hired him as Associate Director to run the Washington office of the American Hospital

Association. It was one of the embarrassments of my deliberations on whether to take the job.

Well, why should I have taken the job? First, in AHA the most interesting parts to me were national policy issues. In a way the Association had been most productive there, but it's big stuff--I suppose a little Washington-Potomac fever as they call it. National health policy was intriguing. After all, that, in a sense, was the role of this (HIF) foundation. Needless to say, they offered me a great deal more money.

Family had always been the primary interest of Mrs. Bugbee and me. I think our hobby had been our family. We both had large families in Wisconsin. We spent what time we could with them, and they spent quite a lot of time with us. Part of the HIF offer was that I could spend summers there and operate from there, which I did. I used another reason, but I think it was rationalization in part.

When I was hired for the American Hospital Association as the choice of the board and the president--Jim Hamilton was president--he told me of one of the engineering associations which hired an executive for a ten year term with the promise that they'd get him a job at the end of ten years, on the theory that that was about as long as an executive was productive. That might be true.

The other reason for leaving was more pertinent: I never could find a way to run that Association easily. It seemed to me that I almost had to be the center of contact between the membership, the councils, the committees, the Board, and the House. I don't mean decide everything, but communication was very important if you weren't going to have a revolt of one sort or another. I got to the point where really every waking hour was occupied, and too much

from the standpoint of my family. I would have continued, because it was the only way I could see to do the job properly. I told Ed Crosby that when he succeeded me, but he said, "I am not going to work so hard." Of course he did. He did things differently than I did, but he worked equally hard. Incidentally, one of the things he did that I didn't do was become involved in international hospital affairs.

WEEKS:

You did have some connection with the International Hospital Federation, didn't you?

BUGBEE:

I was on the board of the International Hospital Federation. When Dr. Donald Smelzer was President of AHA (1945), we both worked on rescuing the International Hospital Federation. It had fallen apart at the time of the war, the Germans having logrolled it in some way. I don't recall the circumstances, but it was blamed on them. If I know the British, they didn't lie supine. In any event, it broke up. The Germans were hardly a factor right after the war. We got IHF started and appointed a fellow Honorary Secretary, which, I believe, is the executive in British terms, a man named Ted Stone. He functioned for years and it worked all right. Ed moved much more aggressively than I and became president of IHF. He spent a lot of time, I think partly as relaxation and as his contact internationally. I went abroad once or twice while I was there, but for social reasons. I attended the International Hospital Federation, but that was all. Kellogg (W. K. Kellogg Foundation) invited me to go to Australia, and I think I was also offered a trip to Latin America. My own feeling was that I'd better stay home and tend to my knitting. I don't know whether I was right or wrong, but

that's the way it was.

WEEKS:

Didn't you serve on an advisory committee of the Kellogg Foundation?

BUGBEE:

Talking about Kellogg: I've been a grantee for years, starting with the Commission on Hospital Care. I think Kellogg would have certainly--Graham Davis, who was in a key staff role--would have evaluated it as a major success. It was a precursor of many other commissions financed by the foundation in everything from dietetics to public health.

I can't recall the exact date, but I suspect it was about the time the commission was completed, probably about '45 or '46, I was added to the advisory committee of the foundation. I found the committee one of the most stimulating experiences. On it at that time were: Bob Buerki, Dr. Robin Buerki, who by that time, I think, was administrator of University Hospital in Philadelphia; Jim Hamilton, who was administrator of the Grace-New Haven Hospital, the Yale Hospital, a teaching hospital; and Jim Dixon, James Dixon, who, I think, was still in Denver as a health officer and a city hospital administrator, but he may have been in Philadelphia at that time in a similar job.

We would meet for two days, maybe two, or maybe three times a year. Our assignment, never written or verbalized, was essentially how should the foundation spend the allocation of money to the hospital field to be productive. We used to kid the staff that we were called an advisory committee, but they never followed our advice. They felt no compulsion to do so, but they certainly listened to what we said, and periodically did follow it. In any event, whether they did or not, it permitted us, a small group of

about six, to discuss the field as to its major problems and from different vantage points--a very knowledgeable and talky group of people.

Interestingly, over a period of time we gave the highest priority to better preparation of hospital administrators. Andy Pattullo and I wrote an article in Hospitals on priority selection. If they were going to give money to improve the hospital field, they had the highest priority.

Equal priority was given to some way translating the evaluation of medical staff performance into understandable terms for the governing body and administration. From that, and I think it was before I was on the committee--just before, they had asked Art Bachmeyer whether there was a young internist who could come over and look at the quality of medical care in the southwest corner of Michigan. That was then the initial geographic district of foundation concern. The internist was Dr. C. Wesley Eisele who later went to Colorado, and who has initiated those very productive trustee-physician training centers. Out of this work came the professional accounting service, Professional Activities Study (PAS), which is run by Dr. Vergil N. Slee at the Commission on Professional and Hospital Activities in Ann Arbor.

So that was one of the ventures. I remember at the time we thought--well, the foundation put a lot of money in that service. This is one example of where we weren't followed, but we didn't have all the facts on money. When it came time to charge for the professional activities service, we strongly urged that they not charge, and continue to research whether the data accumulated by PAS would be utilized by the hospitals. Well, maybe they didn't have the money. Anyway, Slee, tail over dashboard, increased his enrollment of hospitals and income. My own impression is that the effective use of it (PAS) in the individual hospital has never been accomplished, with minor

exceptions. It's too bad. I don't know that further research would have helped. It might have, it might not have.

I found the meetings of the Kellogg Advisory Committee exciting and one of the things I missed when I accepted the Health Information Foundation job. Incidentally, I resigned from the board of the IHF, recommending that Ed go. I did a number of such things I considered generous. On the other hand, from the AHA where people had a series of assignments and then went out of the field, some hung on. It always was embarrassing. I tried not to do that.

Bert Caldwell, after he resigned, was unusually good in not continuing to participate in association activities which would, or least could have been embarrassing. I don't think I did as well as that with Ed Crosby. My intentions were good, but Ed, from time to time, drew me in and occasionally I suppose I meddled in association affairs, so that I did not really follow my own precept, though it is my conviction that the delicacy of relationships with one's successor and predecessor is only surpassed by marital relationships.

WEEKS:

Will you tell something about your work at HIF?

BUGBEE:

When I got to the Health Information Foundation I found the staff was small, and rather in a state, if the truth were known. Odin Anderson was the key person and was called Director of Research. He had just come out with his findings from the first family survey of medical care use and expenditures. He was attacked by the AMA as left wing. One of the first jobs given me by the board was to evaluate his political stance. Not an easy thing to do. I think Odin now is more conservative. Just how liberal he was--he was

acceptable to the liberals, and, I think certainly in his early days had been very liberal. How liberal I don't know. He wouldn't have been very good as Director of Research if he weren't open-minded. He once said to me: "You know, when I try to be neutral, as I always do in my research, then they say, 'Whose side are you neutral on?'"

Social and economical research is touchy business. I finally found the statement I had been looking for when I came across an article written by Milton Roemer. I had known Milton Roemer from Hill-Burton days when he and Fred Mott and others were in the Department of Agriculture group. I have thought it was their pressure that put the rural priority in Hill-Burton, which should never have been there, in my opinion. It led to the construction of a lot of hospitals that otherwise wouldn't have been there. Without that rural priority Hill-Burton would never have passed. I think it was their pressure that developed that setting.

Anyway, Milton had been set up in Saskatchewan running their compulsory hospital insurance system very well. Tremendous worker, and, astonishingly, he turned up on the staff of the Sloan Institute at Cornell. I wonder what A. P. would have thought if he had known of some of Milt's antecedents.

Milt did an article on social research. (I never quite understood: I think Milt did a Ph.D. in sociology or some such thing, because besides his medical degree he did have considerable knowledge of social research.) In this article he said social research really was essentially three steps: You gather your data. You analyze your data. You interpret your data within your plausibility. I thought: That's generally true, Milt. Your plausibility and mine are quite different. I like Milton, he's a tremendous worker. I have benefited from his writings, but it always goes a little into his plausibility

beyond mine whether he is writing on how physicians get paid or whatever it is. Anyway, I wrote Milt a few years ago and asked him for that article. I never got it. I don't know whether he thought I was pulling his leg, or whether he forgot it, but it was some years ago he wrote it.

The plausibility of the researcher is consequential. What really was being questioned was Odin's plausibility. It was touchy, that family interview study, you know. Odin cited it as a replication of the five year study of the Committee on the Cost of Medical Care in the early thirties. It was, although done with modern family interview and sample drawing techniques.

It has always interested me to see how members of the study groups emerge as knowledgeable individuals useful to the field. For years those who were occupied in the five year study of the cost of medical care, in the early thirties, occupied many important policy positions in the health field. At one time I could list at least a dozen. Currently I think of I. S. Falk, Rufus Rorem, and Michael Davis.

Odin's figures, let's say were right. Goodness knows, the National Center for Health Statistics on a much bigger sample, and on a rolling sample, keeps such a study going on. The data could be used for or against the drug industry sponsoring HIF. The amount spent on drugs was pretty startling to some people. It was cited when Senator Estes Kefauver was investigating the drug industry for monopoly and excess profits. It was cited--that's not very much fun to support a project and then have it used against you. However, I thought they stood up reasonably well under it.

Their objective--maybe I was able to verbalize it better than it had been. I remember Jack Searle being delighted when I finally put in written form what I thought was the purpose of the foundation. I think it was the

original purpose, but I don't think they had ever got it clearly.

Just what I said earlier: First, they didn't think the public understood what wonderful things were being done in the health field. Second, there were problems which could be helped or corrected by research. I got them to agree to it.

Now the question of how you educate the public. Well, I have already talked about the American Hospital Association and the Bell Telephone fellow having a hard time not laughing when we had a hundred fifty thousand to spend. The budget of the Health Information Foundation was about a half a million in total. We had to have a staff including a well-paid president, I might add. So, what are you going to do to educate the public? Well, they tried everything. They tried hiring a public relations director. None of it had been worth anything. In the same way they had hired a research director before Odin--a nice enough fellow who is around the field somewhere now. I don't know as he has ever burned up the field, but what he got into was health inventory. Cecil Sheps had done a health inventory in Salem, Massachusetts. Someone else at Michigan State University had done one in Hillsdale, as I recall it. They were all right, but they didn't show anything. The Hillsdale one was remarkable in that they had no consciousness of sin. Anyway they were not calculated to solve any problems particularly. So on both functions they stone-walled.

Odin had come on. He had testified before Congress. He got columns in Time with his Family Interview Survey. Further than that, it was perfectly obvious that it was consequential data. It illuminated such problems as: that the incidence of medical expenditures fell very unevenly, and was very hard on rich and poor alike; that the proportion of income represented by

medical expense was greater the lower the income was; and that voluntary health insurance was not universal by a long shot. So there was plenty of work to be done.

It was the AMA--you know--it was the old "Committee for the Prevention of Cruelty to Physicians" who said, "Don't tell the public anything, and, if anyone says anything, say they are conducive to Communism." Wasn't that the word Morris Fishbein used?

Later I got to know and admire Morris Fishbein for his many talents, though it was hard to excuse some of his past positions while with the AMA. Some would say, however, that he reflected the membership and essentially voiced what they wanted said. Whether that's true or not, he was a man of many talents. He wrote voraciously. I once asked him what his methods were. He had two secretaries. He dictated to them. He had a dictating machine which he used from time to time and he wrote longhand. I envied him his ability with words.

Well, on the public relations side, I got rid of the remnant of public relations. Odin and I, between us, developed a mailing list and a small publication which was issued ten times a year titled Progress in Health Services. I came on a bound volume of all the copies up in Genesee Depot where I now live, just last week. I was reading some of my deathless words. As always, when I review anything I have written, I think: How could I have written so badly?

Essentially what we did was hire Monroe Lerner. He was the best. Monroe is now the head of the Health Administration Section of the School of Public Health at Hopkins. He was a tremendous worker. What he did was compile the data available on any given subject. One thing we looked into was time lost

due to illness, also changes in morbidity and mortality. After the polio vaccine, which goodness knows the ethical drug companies had had hard enough time producing, where deaths in an average polio year, as I remember were 5,000 in a few years were down to two or three. The incidence of disease and paralysis from 50,000 was down to an inconsequential amount. As an example of modern medicine, it was pretty dramatic. I recall many other things which were astounding to me.

With the reduction in death rate among the very young, productive years increased tremendously. Even with the added years of older people, the productive years, the working years (of the young) were greater in proportion. So there were more years to support the aged than there were when the death rate among the young was much higher.

I think Monroe was pretty good statistically. Because you couldn't make the statistical sections accurate and not a little difficult to read, my contribution was to summarize the material and state its implications. Incidentally, we also used Progress in Health Services to summarize and report on HIF research projects. So the publication was a feeder for public understanding of our research and what it meant. That went on for quite a few years. Indeed, we published a few issues after we moved to the University of Chicago in 1962 with a short-term support from the Ford Foundation.

WEEKS:

How did the Health Information Foundation happen to move from New York City to Chicago?

BUGBEE:

What happened to HIF is hard to explain in a few words. In any event, I don't feel that it's worth recording.

First, Kefauver began to investigate the drug industry. It really had just emerged from a cottage industry--I guess that's the modern depreciation of things--into really a very large industry. It had never developed national statistics. When the Senator attacked, the industry had little to answer with. So one of the things suggested by the backers of HIF was: Here we're supporting a number of corporate creatures; that money ought to all be going into a trade association. That's the way it turned out. That's what they did.

It was equally true that the leadership had changed from those who established the Foundation. Young Turks were in. They asked: "What is this HIF? What good is it?" It's one thing to start something, and understand it, and believe it's worthwhile. It is another thing to think your predecessor probably had done something wrong. Considering those two points there wasn't enough support for HIF, really. Not everybody had been educated, not all research had been done, and not all problems had been solved. In fact, it was almost impossible to evaluate what had been accomplished by HIF. So, when they raised that issue, you'd say, "Well, what!"

The drug industry ran the Foundation with great altruism. Once I had a president--I won't name him--. (After we began to percolate Searle felt able to leave the presidency and they rotated among the leadership of the board.) The new president wanted to use HIF a little bit. I forget, it wasn't to advertise the drug industry, but it leaned a little in that direction. He was voted right down by the board.

When it was decided that the Foundation would not continue, the board offered two possibilities. I think they thought it could simply be dissolved. On the other hand, it could affiliate with a university. I had suggested this because Odin and I had always thought it could be more

effective in a university setting. There was training potential. Also, Odin would have preferred a university affiliation. He was quite active with Columbia when we were in New York, but it was an adjunct relationship, so we chose the university affiliation.

Then the question came: What would I do in the university? I thought I might be able to head a program in hospital and health administration. There were two positions open. Walter McNerney had just left Michigan, and Ray Brown had just become Administrative Vice President at the University of Chicago, so I went to both places and talked. There were many reasons why Michigan was attractive. Odin would have preferred it. It was a pleasanter place to live. My friends from my early years were still alive and there. Those were all reasons why it would have been good. Walt had established that research unit, the Bureau of Hospital Administration, which would have melded very well with the Foundation, or vice versa. On the other hand, I didn't get much enthusiasm from the Dean of the Business School. I don't think he handled it very well, to tell the truth, though I may be overly critical.

I went to Chicago and there was great enthusiasm. I must say Ray Brown, who was an operator, moved in fast on that. He pointed out where we could have our offices, and what not. I remember one of the Michigan problems was that I thought that Odin should have tenure, but the Dean said no. When I discussed things with the Dean in Chicago I said I wanted Odin to have tenure, I thought it was important for him to have it. (I didn't care whether I had it, although I think they should have given it to me--but they didn't.) I had a term appointment. It was all right. It gave me an excuse for never being terribly close to the faculty. I don't think it helped the Foundation, but it was easier for me.

Chicago also was nearer Genesee. I tried not to be terribly influenced by that.

After the fact, Lew, and with all your loyalties, you might not agree with this, but Chicago is a very elegant university. The academic standards are high. It made running the program more of a problem than I knew when I went there. The core curriculum in the business school was tremendously attractive.

Where was I reading in just the last few days? Oh, a column in The Wall Street Journal yesterday or the day before. Milton Friedman, with the way things are going, is--Milton being one of the leading conservative economists of the country--is receiving more attention than he probably ever has. It's because of the way things are going with inflation and his predictions of what's happening to the economy, largely following predictions he had made for some time.

So there isn't any question that that core curriculum and the fact that students got an M.B.A. where very attractive to them. I think--as I checked with Larry Hill and later with John Griffith, who succeeded Walt McNerney at the University of Michigan--that the two programs attracted probably the best students in the field at one time. On the quality of the core curriculum, I think, there was a difference--incomparably better at Chicago--and is now, in my opinion. I don't know if John Griffith might argue, but he's had to construct his core curriculum in a fashion that's always difficult and impermanent as a rule, whereas at Chicago it's not necessary.

WEEKS:

Before you begin to discuss your Chicago days in more detail would you talk about some of the voluntary jobs you held while with HIF in New York City?

BUGBEE:

Yes, before I talk more about the eight years at the University of Chicago as director of the program, perhaps I ought to go back and talk about extracurricular activities in the years I was in New York. John D. Hayes, who had been administrator of Lenox Hill Hospital, was a very old friend, and had been president of the Association (1947)--that's why he was a friend.

To digress: One of the very attractive aspects of association work for me was that the president and I had to be so close that we developed friendships that continued in fashion that doesn't happen to adults as a rule. John--I know his family and I still send Christmas cards to his wife and what not. He has been dead a good many years.

When I moved to New York, John inducted me into the activities of the city. One of the things he did--I am sure it was his recommendation--I was made a board member of the Hospital Council. It wasn't a council as it was in Cleveland, but rather the hospital planning council, though it wasn't so called. It was the first of the voluntary hospital planning councils in the country, and it had been going for some years. Then they made me chairman of what was pretentiously called--embarrassing to us all--the Master Plan Committee. In effect it was the technical committee that reviewed applications. That council had authority to recommend to the state agency on Hill-Burton grants--that in itself was interesting--but also it had turned out to be in a way a nonprofit consulting group. For example, the Diocese of Brooklyn might ask what should this borough do about its hospital problems. The staff would then do as detailed a study as it could make. The studies were able to generate quite a lot of statistical material. The staff and Master Plan Committee then formulated a recommendation, and the board of the Council went over it. THe board was broadly representative of the whole

community, a fascinating community. I found the years in New York very exciting. As a city, my own opinion would be it is the most exciting city in the country to live in, even with all its difficulties. Part of what makes it exciting is that there are such tightly organized ethnic, financial, labor, and religious groups: the Jewish group; the Catholic group; the blacks. They all...any decision is hewed out with active interest by all those groups and others. Of course, it was true also in the hospital field: the blacks being concerned with the city hospitals; the Jewish had quite a few hospitals of their own; and the Catholics also with many of their own. So trying to... Well, the part was, how do you plan?

Herbert Klarman, who was a senior member of the staff of the Hospital Council, did a number of excellent studies. One was a study of municipal hospitals. It was published in book form. Herb, as usual, was resourceful in finding statistical material. A table which intrigued me, and I well remember, was a comparison of municipally, or publicly, operated hospital beds in a number of large cities. On a ratio basis New York, as I remember, had about double of the number of the other cities. It has always been difficult to account for so large a hospital system there. Those defending New York attribute it to the many immigrants. On the other hand, this was not a unique situation in New York. Others have looked at it as the result of political contests and promises to gain votes. Recent financial stringency has tended to reduce the number of municipal hospital beds, though strong employee unions fight any such decision.

I began to review the problems of planning as it was developed by the Commission on Hospital Care for the state of Michigan using the Mountin-Hoge grid of a tertiary care hospital surrounded by three or four secondary

hospitals and then smaller hospitals. That was fine (for Michigan), but it has almost nothing to do with a thickly populated metropolitan area.

Issues arose: How far should a hospital be travel-wise in Manhattan? Is a half hour too long? It makes a lot of difference what you think. There was a hospital right at the tip of Manhattan that the community insisted they have. It should have been closed. It was worn out. The mayor went down there after the council said we won't have one and reversed us. Well, they have finally closed it after many years, I see. There was financial pinch--costly-- should have been closed years ago.

I remember one of the hospitals wanted an obstetrical unit. There were too many OB beds on Manhattan and not many babies left. Well, to have a well-rounded residency training program and a group of specialists--we talk about group practice, we want specialists there. Should they or should they not have the obstetrical unit? Well, what do you do with the question? Those were the issues in planning that began to emerge in that Master Plan Committee which I found fascinating.

The other side was that the board, which in my memory was about 30, had the Welfare Commissioner and the Health Commissioner on it. Also, there were representatives of the Jewish charities, Catholic charities, the United Hospital Fund, and so on--the top charitable people in the community giving support for it. Their representatives were always there. It was the only city in the country that raised millions annually for day-to-day support of hospitals--through the United Hospital Fund.

The attendance at the board meetings was tremendous. As I recall, they met at 4 o'clock and would go 4 to 6. They would have done their homework, they would argue, and eventually would vote a recommendation. It was a

stimulating experience and a place to learn about planning.

The experience gave me a feeling that the authority of the planning agency should be very circumscribed. There isn't any straight road to heaven. Nobody's going to know how to do it, and I don't know if this planning act (P.L. 93-641) will survive. They'll monkey everything up. They are wanting more money. You can't get any statistics that resolve the issue. It becomes an opinion--a judgment related to how well oriented your staff is. Everyone is in favor of planning. It seems so logical. On the other hand there are so many variables in medical care and in the politics of satisfying various groups that the results of mandatory planning may be far from satisfying. Herb Klarman once said, in what may have been a low moment, that while without planning we make small mistakes; with planning we make large ones.

I remember when we refused the obstetrical unit for Roosevelt Hospital. They went ahead and built it anyhow. Somebody gave them money. Maybe they should have built it, for, before the fact, we didn't know which way to vote. We finally had said "no," but were not sure we shouldn't have said "yes." As I said, they didn't take our advice, so the planning that's going on under the health systems agencies will be very clumsy I am sure.

Appointment to the Federal Hospital Council in 1959 came while I was in New York and President of HIF. The public health service officer in charge of the Hill-Burton program and other public health construction programs was Dr. Jack Haldeman. It was clear at that time that one of the major problems in the hospital field was renewal of obsolete facilities in central cities where were located our best hospitals. The question arose of how to consider overall planning for hospitals for a metropolitan area and the assignment of priorities among many projects in cities like New York, Los Angeles, or

Chicago. It really turned out, after much discussion, that the only way to make such decisions was to have a local planning agency made up of local citizens and providers from the community decide. This led to a nationwide drive to create such hospital or health planning councils.

As part of the Public Health Service activities there was created a Joint Committee of the American Hospital Association and the Public Health Service on Areawide Planning of Hospitals and Related Health Facilities. I chaired this committee, which produced a widely distributed report drawing its title from the name of the committee. To butter me up, it was sometimes called the Bugbee Report.

This project alone, developing such a report, took a great deal of time. Further, the organization of such councils countrywide was a substantial project. The Hill-Burton Act permitted support of such planning groups. After 1962, when there began to be a substantial number of new planning agencies, training sessions at the University of Chicago in the Center for Continuing Education were developed. These training institutes were an annual affair for a number of years. Initially, the staff of planning agencies occupies its time thinking about structure; who should be on the board; where is the money coming from to finance the agency; what data needs to be collected; what staff needs to be employed. The institute did more beyond that to discuss the issues in planning, particularly in urban areas.

With the passage of what was known as the Partnership for Health Planning legislation, the decison was made, though never announced, that all of the old voluntary agencies should be phased out. It meant that such experience as had been gained, and it was fairly substantial, was lost. At the University of Chicago we had one institute for the new planners, but it was clear that

someone in the public health service had other ideas.

The other important contact during my New York days was the New York Blue Cross plan. It had four or five million enrolled, doubled any other plan. I was invited to be on the board at the same time three organized labor union officials were added--three or four who had never been on.

The plan had been under public attack. Stanley Resor was the head of Blue Cross. He also was head of J. Walter Thompson, which was the largest advertising agency in the country. He had been president of the United Hospital Fund and with that fund it had to be some citizen who was a prominent citizen and a good fund raiser.

During the years before I went to AHA, I don't know just when it was, the fund decided New York should have a Blue Cross plan. Resor, as president of the fund became head of that plan, that Blue Cross plan, and was a member of the board while I was at AHA. Blue Cross nationally was going through the throes of whether it gave them a commercial aura if they advertised. There were many who thought they should not advertise. Stanley Resor, or his minions, were in the process of persuading them that if they wanted to get enrollment, they'd better advertise. As you know they do advertise now.

I think his point was: Look at New York, we've got you all backed off the map in enrollment!--which he did. He didn't also say they'd kept the premiums low because the benefits were low-- disgracefully low really--compared to other plans, but it's easier to sell a low premium. I imagine he and the industries he dealt with didn't want any higher premiums to be bargained on.

Anyway, they were under attack. First, it was said that the then president of Blue Cross and his sales people, I think mainly the vice president for sales, had either rented or had a yacht which he took out to

sell prospects. The inference was that they relaxed a good deal. Second, that Stanley Resor had a big contract for advertising with the plan--which he did have. Third, that the attorney who was on the board had a very handsome retainer. Resor and the attorney resigned, as did the president of the plan.

I was invited to become a board member. Stanley Resor got in touch with me and wanted to see me. (Incidentally his son has just been appointed Secretary of the Army, or some such thing.) I wanted to go on the board, I thought that would be interesting. They were paying a tremendous salary to a full-time president. At HIF I was getting a fairly good one, but it put that to shame. I found the reason I was being offered the job on the board was that they were offering me the presidency of the Blue Cross plan. Well, I really didn't want that, and refused it, but I went on the board. That was all right, I don't think I was taking advantage of the offer.

The past president, the man who resigned, was a man named Garside. He was a very able fellow, but it turned out that he had been somewhat of a henchman of Governor Thomas Dewey. The practice had been to put into that presidency someone who was well-connected politically. I remember Garside didn't know anything about Blue Cross. He thought he did. In the councils of the Blue Cross Commission and the AHA he was the first one to tell what should be done, but he didn't know anything much about Blue Cross. In addition to being president at the time of the criticism he was Chairman of the Board. This raised an interesting question as to how you get rid of somebody who is both Chairman of the Board and President. He resigned, however it was done.

A committee was appointed to find a successor to Garside. The chairman was president of a bank--smallish bank. The members of the committee, if I remember it, were well listened to in the monied community in New York City.

They came up with the recommendation that the Commissioner of Sanitation of the City of New York, a deserving Democrat, be appointed head of the Blue Cross plan.

Well, the hospital representatives on the board were not for having such a thing as that, nor the head of the United Hospital Fund, nor Monsignor James H. Fitzpatrick, a fine fellow from Brooklyn, the Director of the Catholic Charities--he wasn't for it. None of them could as well confront the opposition, so it became my--at least, I chose to do it. (I often wondered how much that caused trouble with my board in the foundation because they were all pretty well in the big money area). Anyway the committee brought in the recommendation and the board voted it down.

The then chairman of the old nominating committee said to me: "You are so smart, we'll make you Chairman of the Search Committee." Also, they put on a labor fellow and two or three others.

I thought I would talk to the Chairman of the Board of the Hospital Council (of Greater New York) about it. He suggested a placement agency, which he said was one of the best. Incidentally, his name was Thomas J. Ross. He was the head of the firm of Ivy Lee and Ross. Ivy Lee was the one who taught John D. Rockefeller, Sr. how to give out dimes. I don't know how much good it did; it got him in the papers anyway. Ross had a gilt-edged public relations business. I remember when Chrysler--didn't some of the officers line their pockets? Some such thing. Anyway, he was there to carry the company through. I don't know what he did. He certainly had clients that must have paid him well and appreciated his advice, so I went to him and he suggested the placement agency. It cost a little more than the rest and didn't do anything either. At least it gave us support with what was supposed

to be objective advice.

The question was: Who should it be? We talked to two or three people. I remember it was offered to a couple of people who were outstanding in the hospital and health field, who you would know. In spite of the fact that the salary was probably double or triple of what they were getting, they finally decided not to take it. It was a time when rising costs were causing Blue Cross a terrible problem. This was particularly true in New York State where the adjudication of rates was with the Insurance Commissioner as it is in the state of Michigan, but as it is not in many other states. So, they didn't care to get into that anymore than I did.

Basil MacLean was President of the Blue Cross Association then in New York City. He had hired (as Vice President) Doug Colman, who had organized the New Jersey plan, one of the pioneers. He then had run the Maryland plan. He became Vice President of Johns Hopkins University. I don't think that went very well, so he'd taken the job with Basil. He is the fellow that beat me on that vote with the AHA board. Doug was a very pleasant fellow with kind of a silver tongue, but he didn't gain my admiration by that operation because I thought it was done as a rather under the cover way.

I went to see a man in the Blue Cross movement, Jeb Stuart, whom I respected greatly. He had run the Cincinnati plan for many years. I asked him for ideas. He didn't want the job, he had retired.

I said, "I think the best fellow we have come up with is Doug Colman."

"Well," he said, "if that's the best you've got, why don't you recommend him?"

That was such obvious and sensible advice. We promptly did.

Doug Colman, with considerable adeptness, ran that plan 'til he died.

Tremendous venture it was. Heavens, I don't know how many employees--hundreds. A steady controversy--political, really--with the Insurance Commissioner, as the rates went up.

The New York job--the HIF job--gave me lots of time for related venture. I enjoyed that. I moved around, did a great deal of talking, sometimes to pharmacy associations, sometimes to medical associations, and often to hospital associations.

At HIF I had enough money to have anything that would facilitate my work. I tried to be sensible about that. We did have a part-time public relations adviser--helped somewhat. When I went there I thought: I am going to do a lot of talking and writing. I want someone who really knows editorial work.

At AHA I had hired Michael Lesparre as he graduated from Northwestern after he came out of the army. He ended up managing editor of Hospitals and was good. He resigned because of various family things. He didn't want to live in Chicago, so he went to New York and took a job with Medical Economics. There is no question in my mind that Medical Economics pandered to the biases of the medical profession, but it made a lot of money and was well edited. To work there was a drill in writing performance. Mike didn't like it, and I didn't blame him. I don't know, maybe he--Mike was a very mild fellow, I don't know that he would have fought back. In any event, as I got to New York he was free, so I hired him. He was a great help in all our publications. He was equally great with my writing. When I would write a speech, he'd often put the last paragraph first and the first paragraph last. He even taught me a little about editing--or how to write. That was one of the privileges. One time I was talking so much I thought: Maybe I'll tell Mike and he'll write it. I tried that one or two times; it did not work at

all. I don't know whether that was that I didn't have enough to say, or Mike didn't have the knowledge. I found it very embarrassing to get up and read somebody else's remarks. All of a sudden I'd be reading along--and I thought I read pretty well by that time and I was quite proud of it, because neither Eisenhower nor Truman could read without stumbling around--I'd think: My heavens, did I say that? I could read it all right, but I wasn't sure it was true, or that I wanted to say it. Nonetheless, Mike was a great help.

He came to Chicago with HIF, but in the Chicago budget there wasn't money enough. Anyway, he didn't want to live in Chicago. Ed Crosby hired him for the New York and then the Washington office of AHA, and he still works there.

WEEKS:

Would you talk a little about your work at the University of Chicago?

BUGBEE:

Going to the University of Chicago led to the university assuming the assets and liabilities of the Health Information Foundation. Further than that, the main supporters of the Foundation contributed an added year after I got there, so that gave a fund of about a million dollars, which did not escape the notice of the university principals and gave a certain freedom for what eventually we called the Center for Health Administration Studies. We needed that money. That money permitted us to buy the unpaid mortgage, as it were, of the building that had been occupied by the National Center for Opinion Research. They had a grant for a new building on campus. Then I, working with Odin, applied for a seven year project grant from the National Center for Health Services Research and Development for basic support. It was really from the research funds of the Hill-Burton Act, and we got it. That money, plus the revenue from the million dollars, gave us a pretty fair base

and staffing--not rich, but useful.

My mind goes off in different directions. After our experience--my watching and, in some degree, participating in granting of funds, and establishment of research objectives with Odin Anderson--I came to the conclusion that it was very difficult to assemble a research staff. First, there's only so much methodology useful for social research. Second, there are only so many people of ability and plausibility--acceptable plausibility. Thirdly, they don't care to do contract research. They want to choose their own projects. So, in New York, while we had about a quarter of a million for research grants each year, those three factors I have mentioned were limiting, although we could go anywhere in the United States or Canada. Odin and I always heaved a sigh of relief when we made grants that seemed sensible as well as initiated intramural projects that had been approved by the board. For another year we could begin thinking about what to do. It was difficult to place research money with assured payoff.

I think the reason the National Center for Health Services Research has had such a rocky course is that they have had too much money. They gave regional center grants. When they evaluated those grants, they decided to stop the support grants. The regional centers had not been productive. They have now made four or five more, focused on a certain objective rather than leave it to the regional center to decide their research focus. I would predict that the money will be enough so they will find those centers are largely nonproductive, although they made the best choice they could in the country. There are few I think might be productive because there is a good base to build on.

It's a terrible job to assemble a health services research staff,

particularly on an ad hoc basis. It's worse than trying to make grants in many respects. We didn't have a very big staff in Chicago. They were primarily in sociology, although all the time I was there I tried to develop an economist. Medical economists were hard to come by. Often they were unacceptable as evaluated by the economics faculty of the business school. It really came down to the fact that the best economists were not specializing in health economics and wouldn't. Yet we were looking for somebody in health economics. So, the research group tended to be sociologists and to be Ph.D. students, with a cadre of staff.

There should have been a physician. I went over the need with the Dean and the powers that be in the Division of Biological Sciences, which encompasses the medical school, and told them the view of the future was community medicine. There was a very able fellow at Cornell, an internist. He came out, we offered him a job. He didn't take it. The faculty at Chicago was focused on the science of medicine, not interested in community medicine.

We finally got a very able psychiatrist to take the job. Then he was offered the job of Chief of Psychiatry in one of the leading university departments of psychiatry in the country, and away he went. The staff was never as broad as it should be.

My own feeling was that the staff of the Center for Health Administration Studies, one element of which was the Program in Health Administration, should house the disciplines needed for properly teaching health administration. To some degree we accomplished that with the limitations I mentioned. We have always had somebody teaching health economics who was able, but never involved to the extent I thought he should be in research.

I am going around in a hit or miss fashion about the Chicago experience.

I have said--it is not modesty, but I truly believe--of the five positions I have held in my life the most venturesome thing I did was to think that I could teach in a top-flight graduate school, beginning at age 57. I think I attracted students and maybe I occasionally passed on an idea in the practicum, but that's not the kind of teaching I think should go on in a graduate program in health administration.

I like a core in management. Often in discussing it with others in the field of health administration, they talk as though it were health, but it's also administration. I don't mean to separate them, but I think our curriculum in Chicago is about the proportions needed: about 2/3 was administration; 1/3 was orientation to the field. The specifics of the locale for administration comes when you get on the job. It can't be any other way.

At Chicago I still carry the practicum where the student is assigned a hospital and is not there the second year. It was to let them see the most frequent big administrative assignment in the health field on a local basis. In that way they will know terms anyway, and see administrative limitations in a health delivery unit. I think it does that.

In our curriculum with 2/3 management, the balance is 1/6 orientation to the health field as a whole and 1/6 tends to be the specifics of the setting. That's oversimplification, but that's about the division.

WEEKS:

While you were at the University of Chicago, weren't you active in the AUPHA?

BUGBEE:

At the University of Chicago I was drawn into the Association of University Programs in Hospital Administration, as it was then called. It had

an unsatisfactory existence. I don't know why.

Ray Brown was an enigma to me. He once said to me: "You know I am the best known administrator in the country," and no apologies for what was a fairly immodest statement. The fact is, it was true. He was in great demand in that role. He rationed his time carefully. He gave a series of lectures to the students on management behavior which they liked and I think were good. He wrote a book about it. At least he had great influence on them, I think.

During the time Ray was director of the Chicago program, Jim Hamilton, who had been on the faculty of Tuck at Dartmouth, went to Minnesota and established, in my opinion, a far better program in hospital administration than Ray had. It was the prototype for many programs, but by the time Jim Hamilton went to Minnesota, it should have been changed. Chicago had very few courses in the business school. However, they managed to maintain students getting an MBA.

The students essentially sat eight hours a day in a conference room and somebody talked to them. It could be the medical records librarian up to Ray Brown and visiting firemen. As I said, when I was at AHA, I always went out once a year. He had a whole cadre that came and talked to the students. However short of academic depth the program may have been, Ray made up by his adept placement of graduates.

Ray very carefully fixed it so the alumni had almost no--he avoided a strong alumni association. None of this did he ever tell me. The fact is he avoided ever getting involved enough with the business school so that they would take over and set the quality of what he did. He was important enough and articulate enough and associated with that faculty so they let him alone.

He protected his own line.

One of the first problems I had when I got to Chicago was to cope with the student body who were disgusted with the program. They were an able group. Ray had recruited the group. I was faced with trying to make something of the situation. One of the first things I thought to do was to get more of the core curriculum in the business school. I negotiated with the school and we shortly put that together. I did it using a Ph.D. student who had been out in his internship. He was Joel May. To begin with, I didn't know what was in the core curriculum. You know you can read the description, but I had no idea of its quality, or the demand on the student, or it's usefulness, or how to relate it to the hospital sequence. What the hospital sequence should be I didn't know.

Joel was smart and aggressive. With him I talked about the idea that we should be using the research people for a special course, each based on their discipline, even if they tended to cover the same ground and overlap. They would all be covering the health field, they'd be analyzing it each in a different fashion. Then I would move in on the description of the field and the practicum. That's how it worked out.

I guess what I am saying is there was a lot of time spent in restructuring the curriculum--complete revision of the curriculum.

There was a fault that Ray foresaw and one reason he didn't do anything about it. The business school put no money into the program at all. It was all financed by the University Hospital (of which Ray Brown was head). Anyway, there wasn't any expense to it to speak of because it was all volunteer faculty, and the one shot visitor stuff. As I said, when I was at AHA, I went out on my own time and didn't get anything for it. Drove my own

car. Not far, but that's the way it went. It didn't give the business school much of a handle. It didn't matter, it didn't cost them anything.

Ray appointed who he wanted, but problems arose when he became Vice President of the University. He had just appointed one of the alumni as associate director when I came. Part of my embarrassment was that the man had to be handled. It was hardly gratifying to him.

One result of getting into the business school was the beginning of control of faculty quality and that was all right. It was terrible to cope with, but that is what it should be. People carry on about how terrible the horror is that young faculty go through proving themselves good enough for tenure. Well, they do go through that horror at Chicago, probably worse than most places. The fact remains that, in general, the process selects outstanding faculty, in my opinion, as far as Chicago is concerned.

With my resignation in 1970 and then Joel's a few years later the whole question...I was on the search committee for a successor to Joel. It really ended up with a compromise. It wasn't ideal with the school unwilling to give tenure except to somebody who had a Ph.D., etc., acceptable to them. While we had one or two that were--they were young and were not ready to change jobs.

So Ray protected his rear there, but it was not the best program by the time I took over.

WEEKS:

I can assume the early days at the University of Chicago, which you have just described, had a connection with your later involvement in AUPHA?

BUGBEE:

When I'm talking about Ray being far-sighted about avoiding trouble, I think he controlled AUPHA with the same idea. No use having that out there

setting up an accreditation program that'll flail us, and they didn't. They never got off the ground. He usually had somebody in his organization act as as secretary and treasurer of AUPHA.

The Kellogg Foundation was not very happy about the situation because they were working in other related fields. The School of Education at the University of Chicago had been a great help to the Foundation in their work in the field of educational administration. While I never followed it completely, many of the things that were put together for a program for AUPHA were things they had tested in that field. Logical, if you had thought of it, but would you have thought it? Such things as the curriculum committees AUPHA had later, the staff, and accreditation--the whole series?

When I took over the Chicago program, I previously had been on the Foundation's Advisory Committee for eleven years. The Chicago program had had a grant from the Foundation for years. I was anxious that it continue. I was in a position where I would be glad to hear any advice.

Charles Goulet was Ray's successor as superintendent of the hospital (University of Chicago Hospitals and Clinics), and he was Secretary and Treasurer of AUPHA. One night Chuck and I had dinner with Andy Pattullo of the W. K. Kellogg Foundation in Chicago. In the course of the dinner Andy was more belligerent than is his normal practice, and very critical of AUPHA. We, Chuck and I, were visualizing the program that AUPHA could have, but Andy was indicating that nothing would ever come of it. He mentioned that in the Foundation they called it "Ah-poo-ha."

Chuck had driven us up from the university campus to meet Andy. It was about ten miles. On the way back I said, "Chuck, you know what we were being told? For goodness sake, to do something. Stop talking and do something. I

think if we submitted a project that made some sense to Andy, the Foundation might approve it." Well, that startled Chuck considerably. I didn't feel so smart at that, because I was older and had dealt with foundations a great deal more than he had.

Chuck had a dictating machine at home. He went home and that night dictated a draft of an application. We put money figures in for five years, as I recall, and with that "Ah-poo-ha" changed to AUPHA. We got the grant and looked for an executive secretary.

As I recall, Fred Gibbs was President of AUPHA at that time. Fred--my, what an interesting character everybody is, but we know so few people well enough to evaluate them. Fred was one of the nonmedical colonels in the medical service of the army--I can't think of the proper name. He retired as a colonel--you had to if you didn't go any farther than that. Colonel was tops for a non-M.D. in that unit. Fred hadn't completed high school. I'd known him at AHA because he knew more about management literature in general as well as in the health field than anybody else in the field. He had been Chairman of our American Hospital Association's Methods Improvement Committee.

After the armed service, he went up to Minnesota and got his high school, college, and everything else. He took Jim Hamilton's course, and afterwards, as he had intended, went to George Washington University in Washington, D.C. and organized a program. Startled all of us by having tremendous enrollment, but a pretty good program. As you look at it accreditationwise, it stood up a great deal better than some other programs.

Well, who were we going to hire for executive secretary for AUPHA? It was a hard thing to know. The grant was there, but it wasn't that much money either, you know. We couldn't hire the most expensive fellow in the field.

Chuck Goulet was secretary and he sat in the Executive Committee, which was small. I just had been on it too. Maybe I was President-elect. There were one or two others also.

Finally, Chuck said, "I had a resident at Johns Hopkins Hospital when I was administrator who did his Ph.D. work with Jim Hamilton. He's smart." That was Gary Filerman. We hired him.

Incidentally, Jim, who was strong-minded, had done what Gerry Hartman did at Iowa, had established a Ph.D. in hospital administration. That's contrary to what I think should be done. I know it's contrary to what Walt McNerney once gave a talk on. Our Ph.D.s at Chicago are in the business school with focus on the health field, or could be in sociology with the same thing--but it's a Ph.D. in business administration or in sociology.

Hiring Filerman set the state for the resurgence of AUPHA largely through his hard work and talents, and for establishing an accreditation program. I was used a lot. I suppose I enjoyed it. Had the time in Chicago. Took the time to be on the accreditation commission or committee--I don't know what they called it. It gave me a chance to visit nearly all the programs in the country which I thought was very helpful in evaluating Chicago and brought some very ticklish issues to the fore.

WEEKS:

You finally retired from the University of Chicago, but you have been busy since then, haven't you?

BUGBEE:

Retirement age at Chicago is 65. I think I stretched that a little, but I did retire in 1970 after eight years there. Joel May and the faculty invited me to continue to carry the practicum which was part of a two course sequence

in the second year. Just two out of the twenty that a student takes in a two year period in the business school. I have done so. I have found it pretty fascinating, because I thought it was intertwined with my career.

Maybe this is reminiscing, but I have often repeated it and thought about it: When I was the administrator of City Hospital in Cleveland, I kept in touch with department heads although I had four assistant administrators and tried not to jump over them. I nonetheless felt free to talk with department heads and did on a regular basis. It was usually with the assistant administrator unless the department head wanted to talk in confidence, which I think is right. I found there was sort of a checklist of management. I could almost repeat it. The laundry has only a few things an administrator has to check, medical records room--I could give you what they are, if I had to. Well, when I came to the American Hospital Association, I was thinking of items that would be useful to administrators. It seemed to me, if there were a checklist, and, if it were fully developed, it would be useful. I talked to Ray Brown about it. He may have been Chairman of the Council on Administrative Practice at that time. He said, "Why don't you hire a young alumnus and let him work at it?" Richard Johnson had just finished at the Chicago program. I hired Richard and he worked for a year. I thought he made quite a lot of progress, but it was not a finished checklist. Ray hired him back as an assistant.

Eventually the American College of Hospital Administrators published something they called "Hospitals Visualized" by Brown and Johnson which was a checklist. However, it was a limited checklist, because it did not go into medical staff at all, or board, or administration. It was a departmental checklist. Not bad.

The next chapter in that development was after I'd gone to New York. Ed Crosby got in touch with me. He wondered if he could assemble a few people in the apartment I lived in to talk over a policy matter that he would like advice on. Of course, I was pleased. It was this: The Ford Foundation, which was new, had to divest itself of large blocks of income. They were going to give it to universities and colleges. They wanted to give 200 million, as I recall, to hospitals. They did to voluntary hospitals on a patient day basis. The reason Ed came was to talk over whatever strings they might recommend be attached. Also he wanted the foundation to give the American Hospital Association a grant to improve the administration of hospitals, if they were giving away all that money. It ended up Ford Foundation did give $750,000.

I don't know whether that meeting was helpful, but Ed hired Dick Johnson for that and out of it came a survey outline. I think it was quite a good one. Dick assembled quite a staff and they tested it with hospitals. I think it is now considered a self-survey instrument. I often wonder now as I read the hospital surveys written by students--they are in effect doing a management audit.

In any event, Ray, when he was Director of the Program in Hospital Administration at the University of Chicago, had assigned two students to a hospital for their second year. They wrote a survey report jointly. Then there was a class session where they reported with the administrator of the hospital present. There were a number of problems. Among other things, Ray often coupled a smart with a poorer student, so you couldn't tell who wrote what--but the smart one wrote it. Worse than that, during the class report, the minute the students mentioned criticisms they thought of...One of the

questions was: What are the strengths and weaknesses of the hospital? Still is one of the questions, and the students certainly outlined it. When they mentioned the weaknesses, the administrator usually started talking, justifying the situation. You never got anything else but talk from him. This may have been useful, but I don't think it was good use of the short time available.

When the students moved from four quarters, which was true when I took over, to six quarters, we then made it a single student to a survey. We assigned the second year for the survey and adapted -- the students had been using "Hospital Visualized" under Ray -- and adapted the Dick Johnson AHA survey outline for the students' guidance. We have added to it considerably because it has a little different function in class. Students are not administrators evaluating their own performance. It proved to be a very useful device.

As I said, I have been doing the practicum at Chicago after retiring. Then one of the very able former students, William Richardson of the University of Washington, who has a Ph.D. from Chicago, called me. He invited me to do the same survey course at Seattle, which I have done for the last five or six years -- a pleasant interlude in life.

I am now old enough so I can't even have a faculty appointment. I was called "Consultant" out there. At the University of Chicago my title has been "Professor Emeritus." For a long while it was "Professorial Lecturer" which they told me was an elegant title. I thought it sounded terrible. With the rearrangement of the faculty at Chicago I shortly will not be doing the practicum there and I am finished at Seattle. It's about time I stopped. They have kept me busy. I am to be 74 September second, so the time comes

when you had better give up -- at least not assume responsibility. My definition of senility is: "You won't know."

WEEKS:

After you left the University in 1970 you spent some time with HEW, didn't you?

BUGBEE:

When I resigned in 1970 Dr. Paul Sanazaro, who was Director of the National Center for Health Services Research at HEW invited me to come to Washington and talk. He had a Ph.D from Iowa as his deputy, Thomas McCarthy. Tom, I think, was the architect of the National Center. He gathered in different H.E.W. research money. There was a lot of reshuffling and new legislation. He worked while others were asleep. It ended up that Paul, who had been chairman of the research advisory committees, became director of the center.

They knew of my HIF experience and my other experience in the field. They were trying to mount research in hospital management so they invited me to have some sort of connection with them. I said I didn't want more than half time, I think I said up to half time, and not all of it in Washington, that at my discretion. If I were to travel back and forth there were a few items that would make it possible for me to do it. They said fine, so I had a contract.

Then the question of the contract. I could have the contract through the University of Chicago, but I know there would be some overhead with it, so I said: "Why not AUPHA?" That was fine. I thought that I was going to have an office out in Rockville where the NCHSRD headquarters was, but it turned out that wasn't their plan. So, though I had an apartment out near their building, I had an office with AUPHA in Dupont Circle for two years. It

involved me in their affairs more than perhaps it should have. I enjoyed the contacts as a matter of fact.

My contract provided that one of the focuses should be the dissemination of research findings. I did a report on that.

In fact, I did a variety of reports though the primary focus was an effort to generate research to improve the internal operation of hospitals. This is a very difficult area. Years ago, Anthony J.J. Rourke, when chairman of the committee of the Federal Hospital Council which reviewed research grants for the Council called for a meeting of foundation executives in New York. These were the foundations which had made grants in the health field. The purpose of the meeting was to try to find out why there were not more applications for research in hospital operation. Rourke, while at the Stanford teaching hospital in San Francisco, had carried on research on sterilization of infant formulas which was quite useful. He did not see why there were not more such ventures. A related question was how active individual foundations were in stimulating research applications in the hospital and health field.

About Paul Sanazaro: I am very fond of him as a teacher and a gentleman. I like him on every count. (I've had him on this VA forum. I've had him until they have all heard him.) Paul was criticized by his personnel. I understood it because he was so inarticulate at times. For instance, he called me in one time and said I should write something about cost containment. Well, heavens -- hospital cost containment! I wrote 30 or 40 pages, clarified my own thinking, possibly his. That's all I ever heard of it, except he said it was wonderful. I don't know that it was that good. I can still remember my conclusion, that was: If you want to contain costs, you have got to contain them. If you contain them too much, the public will raise

hell. And that's about where we are, isn't it? It took a long time to get there.

I also looked into their publication system, which was terrible. You know, everybody on the staff of the center changed so often. It was a mare's nest. No checkup on whether a person finished a grant or turned in anything. All the underpinnings were gone, or there were people who didn't know what they were doing, or didn't give a damn anyway, because nobody would give them help if they needed help, or know what they were doing. That part was frustrating, but it was a good two years and I enjoyed it.

When assembling a faculty at the University of Chicago I thought it important to have someone adept in operations research. I was still concerned with the lack of intramural research. The faculty of the business school recommended a mathamatician with some practical experience in business. His mathmatical talents were substantial and had been proven. I persuaded Charles Goulet at the University Hospital, to hire Arthur Martin half time. We paid the balance. From this experience I came to the conclusion that the methodology of the operations researcher had only limited application to major problems within the hospital. Indeed, after approximately a year and a half of study in the hospital Arthur Martin gave a talk at one of the annual symposiums on hospital care at the University of Chicago where, summarizing his experience, he concluded that the major problems within the hospital or organization of resources and staffing were largely settled by administrative decision with the philosophy of a given administrator.

Later, at the University of Chicago, we had a small conference of consultants, management engineers and operations research people. I make it sound pretentious. It was a relatively small gathering where we discussed

their contribution to improve hospital operation. My own conclusion from that conference was that in employing such individuals, the hospital employs someone who has seen operations in multiple hospitals and who may occasionally have methodology that is helpful, but largely is useful as a "wise man." This to me was finally an answer to why there are so few research ventures with demonstrated use of sound methodology with payoff for the hospital field as a whole which are related to internal operation. Indeed, the National Center for Health Research & Development did not turn up much. For example, one of their major ventures was inclusive rates for hospital care, hardly a significant or large problem.

By the way, at the Rourke meeting of foundation executives the consensus was that the best applications for grants came through stimulation by foundation staff members.

WEEKS:

Weren't you active in something at George Washington University?

BUGBEE:

Just as I was finishing at HEW, Matt McNulty, Vice President for Operations at Georgetown University asked me to look into whether they should have a School of Allied Health. Well, I didn't know much about allied health. I knew more than I wanted to about it when I was finished. It sort of horrifies me. Right across the street from here, Northwestern set up a school. I see all those smart young kids going in to learn to be an inhalation therapist or something and I think: What the hell will they do after they have inhaled a little while? Inhalation therapy is one of the good ones compared to some of them.

Anyway, I had an office at Georgetown, met with his faculty and key

people, and investigated what they were doing now, what they could do. I finally wrote a report and essentially said it would be just as difficult to finance as their medical or dental school, that they probably ought to have one if they can figure out how to do it. Perhaps he thought I might help get the money. Matt, again, is an operator. I don't think they have an allied health school now, nor was I a help, though I tried.

WEEKS:

Since then you have been busy with a VA project haven't you?

BUGBEE:

As I was finishing the contract with Georgetown, I had a call from Mr. L. H. Gunter, an old-timer with the Veterans Administration. I'd known him for years off and on. He was running the VA hospital in Cincinnati. He and Ray Brown wanted to see me. They did and I visited with them. They were talking about some kind of continuing education for VA hospital directors. They wanted something that was especially focused on the hospital administrator -- that would raise his sights administratively. We had a meeting with two or three others and talked. Out of it -- again I am not sure how much of it was my ideas and how much theirs -- came an offer of a contract to run three forums a year, later four.

It was titled the Veterans Administration Health Care Administrators' Forum. Not my name, it sounded pretentious. I call it the VA Forum. Anyway, only fifteen do attend, five days in length, ten speakers a half day each, none of it how to do it, how to run a hospital, all of it forces for change in the health field impinging on the hospital. There were all sorts of suggestions, some of which I followed, some of which I didn't including speakers. I remember one of the suggestions was to take a picture so the

picture gallery (points to pictures on his office wall), and I have two more for this year.

The need for it was reinforced by the Bureau of the Budget making a rule a few years ago that anybody in government, I suppose above a certain rank or grade, must have a week of inservice education every two years. So, the VA has had to scuffle around pretty hard to find enough inservice education programs to meet the need. They think of this as the top of the class. Those who attend it give it very high grades -- as well they might.

VA puts a lot of money in it. They asked me to prepare a budget and I did. I put in an honorarium for speakers which I thought was enough. The entrepreneur from the VA said, "Double that." Thank goodness I did, because, while the quality of people I have had, by and large, would not be attracted by the honorarium alone, it sure breaks their fall.

From my standpoint, I write them all that my assignment is to coordinate, to discuss, to interject questions when I think the group attending don't know what they are talking about. So I am very busy.

VA gives me an administrative assistant who is always what they call "Assistant Hospital Director Trainee." This is a one year assignment as a rule. I know how to organize a meeting, goodness knows I should, so people have a chance to listen to what's being said. The assistant is of great help.

I have Gus Swanson, who is head of medical education for AAMC (Association of American Medical Colleges)as a speaker, and Sir George Godber, who is retired from the British National Health Service, is invited over. I've lately asked Dr. Lowell E. Bellin of New York who was health commissioner. I have Victor Gotbaum. He used to be head of a union in Chicago, but now has 30,000 members, some in the municipal hospitals in New York. He has a

master's in political science from Syracuse--awfully smart fellow. He comes and talks about what's happening to labor nationally and in unions in hospitals and in New York City. I have someone who talks about Canada, and so on. The forum always ends up on prospects for and effects of national health insurance. When I am in Ann Arbor, I invite Wilbur Cohen, but have had other people. I think I have had all those who have served as Assistant Secretary for Health--everybody has been except the current one. So, I think those from VA learn a lot at the forums. You would think I would have been bored, but problems change. When I started this six years ago--I am in the seventh year -- the whole drive was for more medical schools and more doctors. I'll tell you it's not the drive now. Anybody that knows anything is scared to death that we are training too many, and have too damn many schools. It has been an interesting activity.

Mrs. Bugbee died in 1970. She had had a heart problem for years. Finally our internist, who has carried the family through everything, said the time had come for surgery--which she didn't survive. So, I rattle around. I spend about a third of the time in Genesee, a third traveling, and a third here. Incidentally, my contract with Veterans Administration gives me office space in Chicago, and secretarial services. I am still awfully hard to find by phone or letter, because I move around. The house I live in in Genesee, if I am not there, nobody's there. I've thought of putting in an answering service, but I have thought it's better to let the thing ring. At least they know I am not there. Otherwise they would be paying charge for a call and still find out I am not there. So, I haven't done anything about it. Activities in retirement have kept me pleasantly busy.

WEEKS:

Out of your long experience in the health field what opinions have developed about the future of health care delivery in this country?

BUGBEE:

With seventeen years in two hospitals, eleven in the AHA, it gave me really an intimate contact with, I think, the best minds in the operation of a hospital, and, in some degree, of the field. Then in HIF, where really my assignment was to set research policy and administration.

Odin and I worked hand in glove, so it's hard to tell which is which. I thought it was our job to find projects worthy of research, and researchable. The researchable part Odin was very resourceful about and did much of it. We made many grants around the country, as you well know, not necessarily large ones, but we made them.

Then ending up at the University of Chicago with some need of knowing the field and with AHA, NCHSRD, and the VA contract. I have been terribly privileged to have opportunity to see the field as a whole.

From the standpoint of the current government health field conflict, I have been pleased I wasn't the executive of the American Hospital Association. I think it is a very touchy time for those who are working in the health field, nor do I see the future clearly outlined. Years ago we would have thought we would have national health insurance. I don't see much likelihood of it with the memorandum, I mentioned earlier, to President Carter. Incidentally, it spoke of a tax on payroll as if it were something different than Social Security where our tax on payroll is now inadequate to finance that system. So, I don't know whether national health insurance will come. Furthermore, I think there is much more appreciation of the difficulties that come with national health insurance. It isn't all apple pie

by a long shot.

On the other hand, I don't see how we can continue the sharp increase in prices. Our economy has gone up and down, but I don't think it can ever go down as far as 1929. I don't see how it can--that it would be tolerable. But we can have a sharp recession, such as we haven't had. That might end the rate of increase in medical care costs. It might touch off health insurance--national health insurance. Barring that, it seems as if we'll simply keep jousting and wait for the right answer to come along.

It is a time of great ferment for those concerned with the future organization of medical care. It is a dangerous time. Crackpot schemes can be sold on the basis of the need for action rather than proof that they will be successful. My long time associate and friend Odin Anderson has said recently of medical care, "There is perhaps no enterprise in modern society on which we spend so much and about which we know so little." Probably Odin is right, but certainly we are a little better off than that. Much more has been written analyzing our situation and available to students of the field. Who Shall Die? by economist Victor Fuchs is an example, but there are many others. I would like to think that some new ideas have clarified our thinking and will help develop solutions.

Many people now agree that our health problems are by no means all susceptible to improvement through more medical care. Rather, what is needed is a change in life style. Less smoking and drinking and more running. We owe credit to Lalonde of Canada for making that point so well. McKeown's conclusion based on his earlier studies of mortality in England over a period of many years that factors other than medical care have been at work in improving the control of disease are significant. He suggests improved living

conditions since the trend began long before there was much effective medical care. In any event, these are two who lead us to question how much more spent for medical care is the answer.

Then too, attention being given health maintenance organizations following Kaiser's success on the West Coast and the revitalization of the HMO enrollment increases countrywide. At the same time and coincident there is evidence that more and more attention is being given quality of medical and hospital care. Cochrane, in England, has questioned initiating new medical procedures without adequate clinical trials. We can all think of treatments given on a widespread basis and now discredited. Impetus also comes from demonstration by Brook and others that current medical care results are far from optimal, or of the quality that providers have thought true.

My friends Anderson and Andersen, through their research, have given us much better understanding of the medical care delivery field. Particularly interesting has been their documentation that most countries in the western world have had essentially the same increase in medical care expenditures as has been true in this country. More significant has been their national surveys showing that voluntary health insurance has left large segments of the population with little or no protection.

I have cited only a few of many contributions to better understanding of the medical care field. These seem more than straws in the wind. On the contrary, I believe that important new knowledge will inevitably come together to bring rational solutions to our present quandary, but then I am an optimist by nature.

A final note: Modesty is hard to come by. I am pleased that these words seem worth recording. I have been carried away by enthusiasm generated by a good questioner. Rereading, I am embarrassed it is so egocentric. I even like rereading it. I, who have preached humility to students! Perhaps this brash inconsistency supports my worry that judgment does not necessarily improve with age.

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