

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

H. Robert Cathcart

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H. ROBERT CATHCART

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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American Hospital Association
and
Hospital Research and Educational Trust
Chicago, Illinois

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H. Robert Cathcart

CHRONOLOGY

- 1924 Born, Odebolt, Iowa, March 9
- 1941-1943 Drake University
- 1943-1946 U.S. Army
- 1946-1947 University of Iowa, B.A., Economics
- 1947-1948 University of Toronto, M.H.A.
- 1948-1949 W.K. Kellogg Foundation, Fellow
- 1949-1952 Pennsylvania Hospital, Administrative Assistant,
Department for Sick and Injured
- 1952-1960 Pennsylvania Hospital, Administrator and CEO,
Department of Sick and Injured
- 1958-1960 Philadelphia Hospital Association (Now Delaware Valley
Hospital Association) President; Secretary 1960-1965
- 1960-1970 Pennsylvania Hospital, Vice President and CEO,
Department for Sick and Injured and the Institute
(219 bed psychiatric hospital)
- 1964- Hospital Administrators' Study Society, Member
- 1966-1971 Hospital Association of Pennsylvania
President-elect, 1966-1967
President, 1967-1968
Committee on Nominations, Chairman, 1968-1969
Committee on Program and Structure, Member, 1969-1971
- 1967-1968 American Hospital Association, Committee on Nursing, Chairman
- 1967-1970 Middle Atlantic Hospital Assembly, Member of Board
- 1968-1970 American Hospital Association, Committee on Health Care
for the Disadvantaged, Chairman
- 1968-1969 American Hospital Association, Committee on Organization
of Type VIII Members (nursing education), Chairman

CHRONOLOGY (continued)

- 1969- Hospital Research and Development Institute, Member 1969-.
Chairman, 1983-
- 1970-1971 American Hospital Association
Council on Manpower and Education, Chairman
- 1970- Pennsylvania Hospital, President of Department for the Sick
and Injured, and the Institute
- 1970-1976 South Philadelphia Health Action, Inc., Vice Chairman
- 1971-1972 Group Health Planning of Greater Philadelphia, Inc., Chairman
- 1972-1974 American Hospital Association, Trustee at Large
- 1973- Sunday Breakfast Club
- 1975 American Hospital Association, Chairman-elect of Board of
Trustees
- 1976 American Hospital Association, Chairman of Board of Trustees
- 1976-1977 Coordinating Council on Medical Education,
Vice Chairman, 1976; Chairman, 1977
- 1977 American Hospital Association, Speaker of the House
of Delegates
- 1977- Greater Philadelphia Partnership, Member
- 1978 American Hospital Association, Joint Committee with the
Federation of American Hospitals, Member
- 1978- American Sterilizer Company, Member of Board
- 1978-1983 Children's Aid Society of Philadelphia, Member of
Board
- 1978-1983 Joint Commission on Accreditation of Hospitals,
Member of Board of Commissioners

CHRONOLOGY (Continued)

1978 National Executives Service Corps, Member, Board of
Technical Advisers

1978- Philadelphia Area Committee on Health Care Costs, Member
1978-1979 University of Pennsylvania Postgraduate Residency
Subcommittee, Member

1979 Leonard Davis Institute Advisory Council, Member

1979- Magee Rehabilitation Hospital, Member of Board

1979 National Health Care Management Center, Advisory Committee,
Member

1980-1983 American Hospital Association, National Commission on
Nursing, Chairman

1981 American Hospital Association, Committee on Medical
Education, Chairman

1981-1983 University of Pennsylvania, Adjunct Professor of Health
Care Systems, in the Associated Faculty

1982-1984 Mayor's Commission on Health in the Eighties, Chairman

1982 Old Philadelphia Development Corporation, Member of Board

1983 American College of Hospital Administrators, Committee
on Nominations, Member

1983 American Hospital Association, Center for Urban Hospitals,
Chairman

1983- Voluntary Hospitals of America, Member of Board

1984- Dorothy Rider Pool Health Care Trust, Trustee

1985 American Hospital Association, Search Committee for
AHA President, Chairman

1986 Comprehensive Care Corporation, Consultant

1986 Fred S. James & Company, Consultant

CHRONOLOGY (Continued)

1986 Health Learning System, Consultant
1986-1990 National Library of Medicine, Board of Regents, Member
1986 Whitaker Saudi Arabia, Consultant
1987 American Medico-Legal Foundation, Member of Board
1987 National Committee for Quality Health Care, Chairman

AWARDS & HONORS

Northlands Open University, Whitehorse, Yukon, Canada

Doctor of Administration, Honorary

Villanova University

Doctor of Social Sciences, Honorary

American Hospital Association

Distinguished Service Award, 1983

American College of Healthcare Executives

Gold Medal Award, 1986

American College of Hospital Administrators

Dean Conley Award, 1971

Hospital Association of Pennsylvania

First Distinguished Service Award, 1977

WEEKS:

Mr. Cathcart, in this interview we hope to review your professional life and the people you have worked with and events you have been part of. Maybe we should start off with your birth. That's always a good beginning.

You were born in Iowa in 1924. I don't know how you pronounce the name of the town you were born in.

CATHCART:

Odebolt, Iowa. The popcorn center of the world, where more popcorn is grown than in any other county in America. I'm not sure that's true.

WEEKS:

That's the local claim to fame.

You grew up in Des Moines, didn't you?

CATHCART:

Yes. My father was a country banker. One of the first casualties of the 1927 farm depression where his bank went down the tubes. It was a family catastrophe. He then sought a job which eventually would locate him in Des Moines.

WEEKS:

You attended Drake University there.

CATHCART:

Yes. I went to elementary and high school and the first two years at Drake until I was drafted into the Air Force.

WEEKS:

You were there until 1946?

CATHCART:

I guess it was 1943 to '46.

WEEKS:

Then you entered the state university at Iowa City?

CATHCART:

Yes. Like most of the members of the Armed Forces at that time, we were in a great hurry to go some place. I was discharged in the late spring, early summer, and went from the discharge to the University of Iowa. I was enrolled in the liberal arts college, in economics, I believe. Anyway, I ended up with a degree with an economics title -- whether it's commerce or liberal arts, I am not sure. It was so many years ago.

WEEKS:

How did you decide on hospital administration.

CATHCART:

Well, as a student I noticed in the student newspaper a report on a new program that was going to be offered at the state university under a charismatic, hard-charging man by the name of Gerhard Hartman, who was superintendent of the university hospitals. So I went to visit with him. The dormitories were just two or three blocks from the hospital. He was kind enough to receive me, and he explained that the University of Iowa course was to be launched in a year or two, but that the courses in several other universities sponsored by the Kellogg Foundation were up and ready to go and I wouldn't have to wait. He suggested that I apply at several other schools. One of those schools was Toronto. It was the only school that did accept me.

WEEKS:

Was this the first class?

CATHCART:

The first class at the University of Toronto. That was under Dr. Harvey

Agnew and Dr. Leonard Bradley. The program was very small. There were four students in the first class. Interestingly enough, as far as I know, only three of us entered the health care world. There were two physicians and two non-physicians.

WEEKS:

Would you tell me something about Harvey Agnew. I have heard his name mentioned a great deal, of course, but never knew much about him. I think he had died by the time I got to wonder about him.

CATHCART:

Dr. Agnew was one of the few chief elected officers of the American Hospital Association from Canada. He was what I would call a "golden man" because he had such universal interests. He was first of all a physician, but he was very much interested in the organization of medical care long before that became stylish or the "in" thing. He was interested in the financing and the organization and the structure of health care. He was also a fine artist. he would paint his own Christmas cards each year. Many of his paintings were displayed in his home and office. Apparently they were of good quality. I am not enough of an art critic to know. I certainly liked them. He was interested in music, various cultural pursuits. Growing up working in Canada in the late '20s, '30s, early 40s, was a comfortable environment for a person to be a "golden man," a man of all seasons. He was a very dapper dresser, a very precise person, had a snowy white mustache and a ruddy red complexion, and was truly a gentleman. He would be comfortable in a fine club in London as well as in Toronto.

WEEKS:

Somewhere the name Mary Johnson has come into it. Was she his wife?

CATHCART:

She was his wife later after I had left the university. The wife that he was married to when I knew him died, and Mary Johnson married him later. I believe she is still living.

WEEKS:

I think she is too. Someone suggested that I might talk with her.

CATHCART:

Yes, she would be very articulate and very precise, I think.

WEEKS:

Another name that comes to mind -- I don't know whether he was at Toronto when you were there -- Burns Roth.

CATHCART:

Yes. He came after I did. I may have met him, but I wouldn't know anything about him. Is he still living? I am not sure.

WEEKS:

I'm not sure either.

CATHCART:

Dr. Agnew apparently was known by the Kellogg people, and the Kellogg people were interested in having a presence in Canada. He was also the chief executive officer of the Canadian Hospital Association at the time. He was the editor of a journal, which seems today an overpowering responsibility, but he managed it some way or another. He was present at the course at the University of Toronto but his first associate was Leonard Bradley who had a medical degree, I think, from one of the prairie provinces and had then become interested in health care administration after some service in the Canadian Armed Forces and went to the University of Chicago program in health care

administration. He had just come from that course when Harvey Agnew employed him for this work at the University of Toronto. Dr. Bradley was a very important opinion-maker and opinion-former as far as I'm concerned. He was very much involved in the course. Dr. Agnew would come in on various occasions to run seminars and that sort of thing.

WEEKS:

Another Canadian we hear a great deal about from those days was Basil MacLean. Was he in any way connected with the university?

CATHCART:

Not at that time, but a very good friend of Harvey Agnew's. I believe he had already gone to Rochester.

WEEKS:

Of course he was gone about the time I came into the picture so I never had the opportunity of meeting him. Of course he is one of Al Snoke's heroes, and he talked about him a great deal.

CATHCART:

We had MacEachern, MacLean and Agnew. In some respects they were all quite similar, I suspect. Again, sort of Renaissance men. Much more so than would be apparent today.

WEEKS:

Their names come up in any historical view that you have of the field.

What about the residency? I know that you received a Kellogg fellowship, but what was the policy of the university? Was this a one year course and a one year residence?

CATHCART:

At that time it certainly was. One year of residency in Toronto as a

part of the School of Hygiene. I was one of their youngest students, and I suspect it was a bit of a problem of what to do with me. I had very little hospital experience. Although it should be noted that Mr. Hartman, back in Iowa City, had said that if I was to be interested in health care administration that I should have some hospital experience for which I was very grateful to him. He had me employed as an orderly at the University of Iowa Hospital. That gave me some knowledge of what a complex organization a hospital was. While I was at the University of Iowa casting about for what I should do or couldn't do and that seemed to be an interesting opportunity. By becoming an orderly I could get a little bit of an understanding of the cast system and the culture of a hospital. It certainly gave much more relevance to what I would be reading and talking about in Toronto.

Since two of the four of us in that program in Toronto were physicians, it was very, very important that I have some sort of basis of reality in the hospital world to talk and work with those people.

WEEKS:

Hartman is a very unusual man too. Until I talked with him -- I had known him before, of course -- until I talked with him I didn't know that he was fluent in Russian, that he played the violin in the Buffalo Symphony.

CATHCART:

I am very surprised to hear that.

WEEKS:

He is a very unusual person.

We were going to say the policy of the university was one year in residence in Toronto and then another year working?

CATHCART:

Yes. That is the so-called residency experience. It is my recollection that that was modified shortly after I left so that they had two years in school and one summer of work experience.

WEEKS:

In between the two years.

CATHCART:

Right. At the time I was there, that first class, we were to have one year of some sort of supervised experience. Again, because I was as young as I was and because the Kellogg people had given me a bursary to go to Toronto, they were able to fit me in with the Kellogg fellowship here in Battle Creek for one year.

WEEKS:

I think that many of the schools started out the way that Toronto started with one year in classes and one year in supervised residency, but I think most of them have gone the way Toronto did with two years and the summer in between the two years of hospital experience.

The Toronto university course was subsidized under a grant from Kellogg, wasn't it?

CATHCART:

Correct. I think, looking back on it and reading some of the subtleties of it, perhaps it was viewed with some suspicion by the university as being a trade and not a professional endeavor. It was a matter of concern to the students who followed me, apparently, that it was viewed too much in the trade and not as a professional endeavor. There was a great deal of work among the students and the alumni of the program to convert it from a diploma program to

a master's program. Apparently that has happened, although I haven't kept in close enough touch to it. But I get the alumni newsletters and there were for years constant references about how to manipulate it or how to develop it so that it would become a master's program. That certainly didn't bother me whether it was a diploma or a master's degree. I think as the other peer programs developed into master's degree programs there was concern that the Toronto program would be viewed as less of a program if they didn't have the master's degree. I suspect having it in the School of Hygiene, which was associated with the School of Medicine, that there was a good deal of resistance from the medical people.

WEEKS:

I'm sure. Quite often they feel threatened if someone is moving up close to them.

CATHCART:

I was too naive to worry about that. I had such a wholesome, rewarding experience at Toronto working with Dr. Bradley, and knowing Dr. Agnew was important. There was a course in epidemiology taught by a crusty Scotsman who was very articulate, very, very helpful. I remember him saying that the national disease of Canada was obesity. When you think of that -- that was in 1948 -- you recognize what a problem that was. I think all the time as he was speaking about that he was smoking. Completely overlooking the perils.

The most important part of that Toronto experience was the very important course in the social services, the survey course of western social services that started from the English Poor Law. This was a five-hour course for a total year. It was conducted by the School of Social Work for their students. The hospital administration students were permitted to sit in on this course.

It was directed by a faculty headed by Mr. Cassidy and Mr. Morgan. Mr. Morgan had just arrived from London in the past eighteen months. Dr. Cassidy was from the United States and had been in Saskatchewan helping to establish some health care programs there. He had worked with the very early pioneers in the establishment of the social security program in the 1930s in the United States. He knew the inside development of the Social Security Program of the United States and had then gone to Saskatchewan, then ended up in Toronto. He and Morgan created this program which was a survey course of the social services through England, Canada and the United States. They kept drawing parallels and used practicum. Although at that time, it was quite avant garde to be without a text book. They used a text by DeSwinets who was a professor at the University of Pennsylvania for this survey of the social services of the English speaking world. That was the most helpful course I ever had at any school.

WEEKS:

When you went to Battle Creek, Andy Pattullo was there, of course. He was one of the early fellows, I think. I don't know if he was the first.

CATHCART:

Certainly one of the early ones.

WEEKS:

Because he came out of one of the early classes at Chicago.

What was involved in this work?

CATHCART:

The fellowship was designed for the students to have experience in a "urban and rural" area. At that time Grand Rapids, I presume, was identified as an urban area. I was to have six months in an urban center and six months

in a rural center. As I remember there were six or eight Kellogg fellows distributed throughout southern and southwestern Michigan in urban and rural institutions. We came together once every three weeks in Battle Creek for a day. It was obviously very much of a high point, certainly for me, to take the bus from Grand Rapids to Battle Creek, have a delicious dinner, and then go back on the bus late at night to Grand Rapids. I was assigned to Grand Rapids' Blodgett Hospital. It was there that Ronald Yaw was chief executive officer. He is a man of great charisma.

WEEKS:

Tell me something about him. I just met him casually, but everyone speaks highly of him.

CATHCART:

Mr. Yaw was a very competent executive who thoroughly enjoyed his job and his life. Today, if you were to speak to him, he would be as lucid and sharp on his experiences in Grand Rapids as I think he might have been thirty years ago. He was very much in control of the situation. The medical staff had great respect for him and the board of the hospital did. He had enough humor and enough balance that he didn't take himself so seriously that he would worry himself to death like some of his contemporaries did. One of the people who viewed hospital administration as very much of a profession, and a person who had to be involved in all aspects of the institution. He was a supporter of educational programs, service programs. He was, for his day, a good evaluator of quality and of effectiveness of service.

WEEKS:

At that time Kellogg was building some hospitals too, or had built some. Didn't they build one in Coldwater?

CATHCART:

Yes. At least the two that I knew about were the Coldwater and Hillsdale hospitals. I believe both Hillsdale and Coldwater are county seats. I think their concept was to merge the public health function with the hospital function. Where it was possible to recruit a physician as health commissioner of a county, he would also serve as the director of the hospital. Their feeling was that there should be a blending of the public health and hospital function. They thought one way to accomplish that was to support physicians who had a public health background and who could also manage hospitals and that would bridge the gap between the public health sector and the private sector.

WEEKS:

Was Vergil Slee operating about this time? He was in Hastings.

CATHCART:

He may have been, but I did not come across him. I did not remember him at that time. There was a more charismatic individual at Coldwater, but he must not have made a great impression because I can't remember his name.

I was assigned, after my six months in Grand Rapids, to go to Hillsdale. One of those pioneer, pilot type hospitals. Hillsdale was not exactly the model that Kellogg perceived because their superintendent or administrator of the hospital was a non-physician who did not have a direct linkage to the public health services of the county. He was a very competent person who managed this institution which must have been one of the finest of its type at that time.

WEEKS:

I guess Kellogg went out of the hospital building business when Hill-

Burton came in, didn't they? Maybe even before.

CATHCART:

Probably before. In 1948, when I arrived in Michigan, one of the most memorable tools that I had was the hospital survey of Michigan -- I'm not sure whether it was the entire state of Michigan or just the southern part of the state -- which had been sponsored by Kellogg. It was the model used by the people who set up the Hill-Burton Act.

WEEKS:

I remember George Bugbee telling me about the special study done in Michigan, I think through the Southwest Michigan Hospital Council which Kellogg was supporting. About this same time Vergil Slee was coming up with his data collection which later became the CPHA. Did you come across Wes Eisele?

CATHCART:

I remember the name. This survey by the Southwest Michigan Hospital Council was just a phenomenal piece of research that must have been the model or pilot for the national, as a result of the Kellogg investment. They probably built the hospitals first and then decided to do the studies and then to duplicate that type of concept throughout the nation. I suppose these Coldwater and Hillsdale hospitals were sort of pilots for a thousand or more hospitals throughout the United States. Because for the next ten years there was a very major building program for hospitals.

WEEKS:

Were you conscious of the Battle Creek Sanitarium when you were in southwestern Michigan?

CATHCART:

Only because of its overwhelming dominance of the Battle Creek business district. It was so huge. That was such a large business. I don't know whether it was functioning as a sanitarium then. The Army took it over during World War II.

WEEKS:

In 1948 I think they had possibly one building running, the one they called the Annex during the twenties when there were so many people coming they were putting people up in houses and homes. Then the people -- I'm not calling them patients because they weren't patients in the ordinary sense. I lived in Battle Creek back in the twenties, so I can remember a little about it. They don't call it the Battle Creek Sanitarium any more. They call it something like the Adventist Health Center.

The reason I was asking you this is two weeks ago I interviewed Donald Welch. Do you know him? The head of the Seventh Day Adventist hospital system. I was amazed to learn that they have about seventy-five hospitals and that some of them are quite large. I think you mentioned that they are very well run, and I agree with you. It seems to be a well-run system.

Then we were going to talk about your degree that you have from White Horse, Yukon, the Northlands Open University. That peaked my interest.

CATHCART:

That developed many years later, after being in Toronto. It was something that Gary Filerman involved me in. I am not quite sure why or how I got involved in this, but apparently because of my work at the University of Toronto and this Northlands University running correspondence courses and they are based in Toronto although they have their charter from the Yukon.

WEEKS:

White Horse, Yukon.

CATHCART:

The program is all correspondence. Apparently contacting a hundred or more individuals throughout the Dominion. Gary Filerman was trying to support them to give them some prestige. It was perceived that each year as they were concluding their academic activities it would help if they would bring in someone from the outside to participate in a convocation for the students who had been pursuing this correspondence course and who would come together in Toronto. Therefore they devised this issue of giving the degrees, as I said, to create a ceremony for an outside person to attend. Because I had some experience in Toronto, Gary Filerman thought I might be a good person for one of those years. That's what came out of that.

WEEKS:

Just in passing I also note that later on you received a Doctor of Science from Villanova too.

CATHCART:

Yes. That was recognition for the work with nurses. The dean of the School of Nursing at Villanova has a special interest in nursing history. That relates to the history of Pennsylvania Hospital.

WEEKS:

This might be a good point to look at the history of Pennsylvania Hospital where you have spent most of your professional life. Would you like to begin at the beginning and tell me all about Pennsylvania Hospital?

CATHCART:

You should note that I left the Hillside Health Center after only two

months rather than six months. That was an arrangement developed by Mr. Graham Davis, who was then Andy Pattullo's boss at the Kellogg Foundation, and John Hatfield. John Hatfield and Graham Davis were elected officers of the American Hospital Association and knew each other because of their work at the hospital association. Apparently, John Hatfield had indicated an interest in having someone join the Pennsylvania Hospital staff because he was going to be doing a good deal of traveling the year that he was a chief elected officer in the association. Graham Davis was either his immediate predecessor or follower in that office. So he apparently suggested that I be a candidate for the Pennsylvania Hospital position although Kellogg was at that time preparing its fellows to work in rural health activities. Philadelphia, at that time, was the third largest metropolitan area in the country. So ironically, although I had been prepared to work in rural health affairs, I ended up in the third largest metropolitan area.

I was also somewhat younger than my colleagues in that program, and I suspect they were concerned about what they were going to do with me at the end of the fellowship year. So they agreed to cut short the fellowship to permit me to go to Philadelphia. I began on March 1, 1949, in contrast to the regular date which would have been July. That was presumably because Mr. Hatfield was going to be doing so much traveling. That was the reason why I was invited.

Pennsylvania Hospital was founded in 1751, as a result of a physician by the name of Thomas Bond who had not been able to get the project started. He was advised by the townspeople to seek the help of Benjamin Franklin. Benjamin Franklin, in his autobiography, describes this bonding relationship with Thomas Bond in rather careful detail, and takes great pleasure in

describing his role. He pointed out that he and Dr. Bond complemented each other. It is a very fascinating bit of history because you have the professional person, Thomas Bond, who had the concept but didn't have the community contacts or the organization skill for building. So it was the unique blending of a physician with a non-physician, coming together to establish something as a community service. It was established to get the sick-poor off the streets and the lunatics under roof. The charter is from King George II and says it is founded to care for the sick-poor and lunatics.

Franklin, in his autobiography points out that he went to the general assembly of the province and said that they could get the joy and reputation of being generous without it costing the province anything by saying that they would provide two thousand pounds if the citizens would match it. They could say that they would make that appropriation only if they were matched, then get approbation of doing generous things without it costing them anything.

Then Franklin went to the citizenry of the city and said look, if you give a contribution we'll double it. That was an attractive approach to the community. He pointed out in his autobiography that the people in the rural areas were not in favor of what was going on in the city and that members of the general assembly from the country were opposed to the project because it was a city project. It was an interesting thing that we were fighting rural and city issues at that time. This may have been the first grant made by a government agency. It was devised by Franklin. Franklin concludes his summary of this founding of the hospital by saying that there were very few things that he used his cleverness for that he had had greater pleasure about. So it is a very interesting three or four page description of founding the hospital.

Four or five years later Franklin published a history of the hospital which is a good historical document now. That history was done as a fund-raising device. He did that to sell copies to raise money to support the hospital. Franklin was the first secretary of the hospital. There is a minute book which is probably two and half, three inches thick of that first year, all in Franklin's handwriting. He became the second president of the hospital.

Again the history is interesting in that the hospital had a physician on its board in 1751 to 1752, but having tried that has never had a physician since. It had given it a trial anyway. For some reason that did not work out well.

WEEKS:

I wonder if that physician was Dr. Bond.

CATHCART:

It was. There is no good record of why that was dropped.

WEEKS:

I looked in the autobiography and I looked in VanDoren, but I can't find much about Dr. Bond aside from the fact that he studied medicine in Paris before he came to Philadelphia. I don't know whether he was an Englishman or whether he was an American.

CATHCART:

I can't tell you either. I should know, but I don't. He copied the concept from England, the concept of the hospital was based upon his experience in England. So he must have been in England at some time.

WEEKS:

I was struck by the fact of this grant in aid -- maybe the concept of

matching funds started at this time.

CATHCART:

I would think so. When I think I am not going to be challenged, I always tell people that. Being here on record I have to be more careful. But I think it may very well be the beginning of that concept.

WEEKS:

So many things began with Benjamin Franklin. He seemed to be so original in all of his thinking. Every now and then you will run across an article which will tell all the things that Franklin invented or suggested, all the way from bifocals to a new kind of stove and many other things, of course.

CATHCART:

His social inventions are really the best. This concept of the hospital, the concept of grants in aid, how to provide leadership for elected bodies, political bodies. It's just phenomenal.

WEEKS:

Schools and fire departments.

CATHCART:

Insurance companies.

WEEKS:

It's just amazing.

Do you know anything about how the hospital was staffed in the beginning? Were all the doctors of the city given privileges?

CATHCART:

Again there are remarkable parallels with today. The hospital is successful because of a strong board. The board was very strong right from the beginning. They were very careful about which physicians were to practice

at the hospital. The board was all consuming in its control of the hospital. Patients could not be admitted without board approval. There had to be some sort of guarantee about who would finance the patients. The physicians served -- it was very much a privilege to be serving at the hospital. Not because it was so financially rewarding for the physician because the physician did not need the hospital. Patients were cared for in their homes, and probably better quality care. They were considered only as associates or helpers by the board, carrying on this community responsibility.

WEEKS:

At that time, as you say, most patients were cared for at home. When were they taken to the hospital? Was it in the extremes?

CATHCART:

No. They were taken to the hospital because they had no homes to go to. The charter calls for care of the sick-poor and the lunatics. Sick-poor, medically and surgically ill patients, were taken to the hospital to get them off the streets because they were not desirable and were perceived to be a danger to the rest of the population. If they had a home or any family structure they were much better outside the hospital in the home. Physicians attended to them. So these must have been hopeless and very unfortunate individuals who were patients of the hospital.

That was not true with the lunatics. Philadelphians, as they do today, would pay to have their mentally ill relatives cared for or hidden from the public. There has been a tradition of paying for psychiatric services right from the very beginning through to today.

WEEKS:

Did they use the hospital during epidemics?

CATHCART:

Yes.

WEEKS:

Like for cases of yellow fever?

CATHCART:

Yes. Benjamin Rush was a member of the staff and he was one of the few physicians who stayed in the city with the patients despite the epidemics. The epidemics were so lethal that the doctors would often walk away from the patients, but he did not. He was the person who was so compulsive about bleeding patients that he probably did more harm than good, but he stayed with them. He was also the person who was very much involved in the humane treatment of the insane. One of the few people who had the concept that psychiatric illness was really an illness problem not just a character disorder.

WEEKS:

He was a close friend of Franklin's too, wasn't he?

CATHCART:

I believe he was. Much younger.

WEEKS:

The history of the Pennsylvania Hospital which you spoke about that Franklin wrote for fund raising purposes. Is this the correct title? Some Account of the Pennsylvania Hospital. In 1754?

CATHCART:

Correct.

WEEKS:

Do you want to start talking about your professional career when you went

to Pennsylvania Hospital in 1949? You were quite young then.

CATHCART:

I was twenty-five. I became twenty-five the first month I was there.

WEEKS:

What did you do as administrative assistant? That's the title I have down here.

CATHCART:

I suspect it was somewhat of a gofer's job for Mr. Hatfield and his associate Edward James. Mr. James was a very energetic young man who interestingly enough did not interview me and did not participate in the employment interview. But I was assigned to him when I arrived at the hospital. Therefore I worked pretty much as his executive assistant. One of the major tasks that I had was concern about fire safety. There had been a fire catastrophe in Illinois in 1948, early 1949, in which many people had been killed. It was apparent that that could happen at the Pennsylvania Hospital at that time. The board became very concerned about this and wanted to know what could be done.

At that time a significant portion of the patients of Pennsylvania Hospital were housed in buildings that were built before 1900, anywhere from 1755, which is our original building and is still standing and still in use, to a building that was completed in 1898. Most of the buildings were of that period. There were no fire alarms and very few fire escapes, no exit signs. The hospital was immaculately clean. You could walk down corridors and you would find buckets of sand and buckets of water that were standing there for fire defense, but no fire extinguishers or fire alarms. No outdoor exit sign or anything of that sort.

They were sturdy granite buildings but they were also fire hazards. Because of the dangers of a fire I was assigned to develop some sort of a fire safety program. I worked with a consultant about developing ways of enhancing the safety of the patients.

WEEKS:

One question that I forgot to ask you back when we were talking about the board. How is the board appointed now? In the beginning it was appointed by the legislature, was it?

CATHCART:

I doubt that. I think it was a self-perpetuating group.

WEEKS:

It still is?

CATHCART:

Yes. It is governed by -- the corporate name is the Contributors to the Pennsylvania Hospital. A contributor is anyone who contributes \$30 or more one time. If you can make a one-time contribution of \$30 or more, you become a lifetime member of the corporation. They meet once a year to elect the board.

WEEKS:

This is elected by corporate members then?

CATHCART:

Yes, but it is pro forma. It is well controlled by the bylaws today. Only the present board can nominate individuals.

WEEKS:

I was wondering how the control came about because I know of a small hospital where you can be a member for a dollar or more and it's nominations

from the floor and it begins to be a favoritism sort of thing. There is a lot of jockeying around, paying dollars to get votes.

CATHCART:

At one time that was a possibility at Pennsylvania Hospital, but in the past ten years that has been modified so that there cannot be any takeover. It is completely in the hands of the present board.

WEEKS:

I am amazed that you became administrator of the hospital and chief executive officer after two or three years there.

CATHCART:

Yes. Mr. Hatfield left in May of 1952. I was appointed administrator at that time. I served as administrator of the downtown hospital. There are two departments of the hospital downtown, a department for sick and injured and then a psychiatric hospital which is four miles west of the center city. That is a 225 bed psychiatric hospital.

WEEKS:

Is that the one that is called the Institute?

CATHCART:

Correct. Then in 1960 I was asked to be the chief executive officer of both institutions. Up until that time each hospital had had its own chief executive officer reporting to the board. The board also had reporting to it a controller for the corporation, a treasurer, and a public relations person. In 1960 they decided to bring all of that together and report to one chief executive officer. They asked me to do that, then become involved in the entire corporate affairs of the hospital.

WEEKS:

The board is apparently very active.

CATHCART:

Very much so.

WEEKS:

And they set the policies.

CATHCART:

Yes.

WEEKS:

And you carry them out.

How have your ideas of medical staff changed from the early days? One, are all of your medical staff M.D.s or do you take in osteopaths?

CATHCART:

There are a small number of osteopaths.

WEEKS:

Do dentists have privileges for dental surgery?

CATHCART:

Yes. The staff for the department for sick and injured is called the professional staff. It is not called the medical staff. The staff of the psychiatric hospital is called the medical staff. The psychiatrists are much more threatened by other health practitioners than the physicians at the downtown hospital, so therefore they have not broadened their name. They are concerned about psychologists and social workers and so on, while the staff downtown is much broader. So there are Ph.D. psychologists, and there certainly could be biochemists. In fact there are some basic scientists who are members of that professional staff, as well as dentists.

In the late 1940s the president of the staff was a dentist, in fact. At that time oral surgery was one of the most significant surgical services at the hospital. Had it not been for a strong oral surgical service in the early 1950s, there might not have been a surgical service of the hospital. oral surgery and gynecology were the principal surgical services. A very, very strong person was chairman of oral surgery. That was the time when patients were brought into the hospital for a two-night stay for oral surgical work. Today all of that would be done on an ambulatory basis. But at that time he was very key, very significant.

WEEKS:

What was the reason that there wasn't more surgery of the usual type?

CATHCART:

The hospital weathered World War II. It was very severely handicapped. Its physical plant was old and did not accommodate to the creature needs of patients. It was also a hospital set up to care for the sick-poor. It was also a hospital that failed to recognize that it was in the midst of a revolution as to how health care was to be financed. There was an organization in town called Blue Cross that gave out little pieces of cardboard. Then when you gave those pieces of cardboard to patients they thought they would bring them to the hospital and they would find that they would get something special if they had that piece of cardboard.

One week they were charity patients, the next week their employers had given them something new, this piece of cardboard, and when they would come to the hospital and get the same level of service they didn't think they had gained anything. The hospital was not responsive to those changes.

So it offered to these newly entitled people the same accommodations that

they had been offering for two hundred years, forty-bed wards, twenty-two bed wards. Huge, beautiful rooms. Clean, nice service, but they were in wards. So we had a major ward population and then a tiny private patient population. At that time there were, I think, eight rooms with full baths. That was about it. The rest of the patients were in huge wards. There were maybe forty single bed rooms that were much smaller than the room in which we are sitting. It was just large enough for a bed...

WEEKS:

We were talking about the replacement of some of the buildings of the eighteenth century and nineteenth century. Doesn't Blue Cross call for semi-private or two-bed rooms?

CATHCART:

There was a definition, I think, at that time that you could have as many as six people to a room and still call it semi-private. We barely scraped by by having some ugly rooms in a huge ward building. You had the option of being a semi-private patient with a Blue Cross card and going into an ugly six bed room on the north side of the building or going to the south side of the building with very lovely sun and being in a twenty-two bed room that had lots of air and light and color and excitement. But you used the same toilets and shower facilities as the ward patients did. This wasn't very attractive to the individual who had just gotten his Blue Cross card and felt that he was taking a step up in the world. He soon found out he hadn't as far as the hospital was concerned and therefore wanted to know where he could go to get a step up in the world because he had earned that Blue Cross privilege.

So the hospital was caught without adequate facilities, physical, creature comforts. The operating rooms -- one of the standard fixtures in

each operating room was a little board with four fly swatters on them. The circulating nurses and orderlies were stationed in the operating rooms to use these fly swatters. The rooms were so old and windows had to be opened in the summer time because of the tremendous heat. The x-ray facilities had been upgraded last in 1924. They had not been changed significantly since then. The laboratory was built in 1894. It was the third building in the nation to be designed specifically for clinical laboratory purposes but it hadn't been changed significantly. So there was a great deal of delayed maintenance and obsolescence in the physical plant. The kitchens were again of the late nineteenth century and had not been changed. There were a series of four pavilions for surgical services. Every other one had an elevator. So the patients had to be carried up in elevators and then be taken across open porches, open walkways with canvas on top of them which was picturesque. But it was far from ideal to take the patients out in the wet, cold weather. In fact, the sewing room manufactured what was known as Pennsylvania Hospital hood which you would wrap around the patient's head as you took him between these buildings in the winter in the snow and sleet because there was no elevator. Only half of the buildings had an elevator.

The fire safety features, the lack of plumbing, lack of privacy. The only thing that was available was superior nursing care and superior medical care. Absolutely high quality. Pennsylvania Hospital was the last hospital in the United States to pay house officers because it was so competitive in obtaining house officers.

WEEKS:

Was one of the reasons for this the fact that in a hospital of your type, in the inner city, you've got all kinds of cases? Was it because of the kinds

of patients that these residents might care for?

CATHCART:

It was the variety of patients, very clinically oriented. It was not the university ivory tower hospital. It was a clinically oriented hospital. It had a reputation of superb quality physicians. They were very high quality physicians who were very devoted to the teaching effort. Not only did they get no income from their internship but they had to pay for parking. They did get their meals and room at no charge. But it was a very coveted position, very highly sought after. It was a teaching hospital for the Thomas Jefferson University and the University of Pennsylvania. A red and blue service on each ward depending upon your admission, which service you were admitted to, whether it was the Pennsylvania or Jefferson service. The schools were very competitive in wanting to have their students and faculty at the hospital.

In 1957 it was declared that it was too small a hospital to have both services there, both schools at the same hospital. We decided to maintain the affiliation with the University of Pennsylvania. It was perceived to be the better of the two schools. The first formal, written affiliation, although the teaching had been going on for nearly two hundred years there had never been a written affiliation.

WEEKS:

The big question now in my mind is finance. Where does the money come from to run the hospital and do you have enough money to keep up in technology and buy all of those expensive contraptions that are coming out now?

CATHCART:

Of course in the 1950s the technology was not such a compelling factor. We had some x-ray machines and EKG units and so on. The finances were not

available in the 1950s. You did not know whether you were going to be alive next week and didn't know where your next dollar was coming from. The psychiatric hospital, in the very earliest days, had charged people for psychiatric care and did no free work there. The earnings of the psychiatric hospital were, of course, transferred downtown to keep the sick-poor, the medical/surgical patients. It was felt that anybody who was psychiatrically ill probably could afford to have a surcharge. We weren't the least bit bashful in making that surcharge. That helped.

Then as now, the hospital had this great orientation toward psychiatry. Psychiatry is big business for us. More patient days in psychiatry than in any other service. The hospital had planned to move out into the far western suburbs around 1890. A large block of land had been purchased. The land had been in the hospital name for many years, but before World War II it was operated as a farm. The farm grew vegetables and had milking cows for our cream and milk and butter. These came in from the farm. The two operating hospitals had to make use of all of this produce whether they wanted to or not. They couldn't purchase it any place else. Then during World War II they couldn't operate it as a farm because of labor shortages. The cows got tuberculosis. That put us out of the farming business. But we had that land. Then the rush to the suburbs after World War II created a high value for that land. That land was developed by the hospital. The hospital itself developed it into residential building lots. That was managed as a business of the hospital. The proceeds for those sales were used to care for the sick-poor. That held us together until Medicaid legislation in 1966.

In 1966 we began to generate cash and for the first time we had some understanding of our revenue potentials. Since 1966 it has all been a much

better, happier situation. The hospital is a money machine right now because its stays are short and the acuity of care is high. It has a very respected professional staff.

That came about as a result of a conscious decision in the late 1960s, early 1970s, to appeal to a narrow number of physicians. It was thought that many of the physicians were being compelled to join the faculty practice plans at one of the six Philadelphia medical schools. When they joined faculty practice plans there was control over their income. They perceived that they were not getting all they were earning. We reasoned that maybe three, four, five percent of those doctors would want to be teachers and also millionaires. If they wanted to be straight millionaires they would go to the suburbs where they had excellent hospitals. If they wanted to go into pure teaching they would stay at the ivory tower, the university. But three to six percent of those doctors who wanted to do both would come to our place where they didn't have to join the faculty practice plans. We would permit them to practice as fee-for-service practitioners and they would also be teaching. They were anxious to do teaching because they wanted to teach, because they got a challenge out of that, but they would also do teaching because it would enhance their professional reputation which in turn would enhance their referrals, which in turn would enhance their pocketbook. We felt that if they became successful the hospital would become successful. So the hospital became successful because of these entrepreneurs, real gangbusters. That was our competitive strategy against the six medical schools who owned hospitals plus the one across the river in New Jersey. There are seven medical school owned or controlled hospitals in the metropolitan area.

The staff physicians have continued to recruit superior house officers

for the clinical teaching program. The creature comfort for patients is well known throughout the community. All patient facilities are very, very attractive, some of the most attractive facilities in the Philadelphia area. Not ostentatious, but very clean, very well maintained. We do have a considerable charity load in maternal and child health care. We are the largest maternity hospital in the metropolitan area. We offer a large charitable commitment in psychiatry in a psychiatric unit in our downtown hospital. They care for the charity or Medicaid psychiatric patients.

So the hospital has been successful.

Another element in that change, rather dramatic change, is that we are very close to Independence Hall, four blocks away. That area has become a high income place where individual homes are valued anywhere from a quarter to a half million dollars. It has become restored and a very stylish place to live. So the immediate neighborhood has changed remarkably. In the middle 1960s our family went away for a three week vacation. There was a row of houses about a block away from the hospital that probably housed three hundred people, many of them single women or single individuals with four or five children, mostly black. Three weeks later we came back and none of them were there. It was just rejuvenation that took place at that time, but that changed tremendously the type of patients we served because that neighborhood changed.

Today, as I mentioned earlier, we are staffing two health districts, plus we have some relationships with medical groups that will bring us some sick-poor people. One of the major concerns of the board today is that we may have neglected our public service. Our board is very, very seriously asking those questions -- what can we do to prove that we are living up to the purpose of

the hospital?

WEEKS:

Does welfare money come in to help support these sick-poor?

CATHCART:

Sure, through the state Medicaid program.

WEEKS:

In other words, most all of your people who are sick and poor are eligible for Medicaid.

CATHCART:

Yes. There are a few who fall between the cracks, patients who come from New Jersey. We are interested in the patients from New Jersey because our physicians are interested in them. The hospital is treating a lot of acute care patients. It takes a large population base to keep a neurosurgeon or a heart surgeon or a head and neck surgeon or a neurologist busy. So he has to have a big referral area. He cannot take only the paying patients from those referring doctors. Since we want to work with our staff we take the free patients as well as the paying patients from those referring physicians. If we ever give off the indications that we are not willing to take all kinds of referrals, we are afraid we will lose the paying ones.

WEEKS:

With all of these university hospitals clustered more or less in that general area, is there any cooperation among them for -- I am thinking in terms of high priced technology equipment and so forth.

CATHCART:

It is very competitive. There is no discussion there. There are scowls, and innuendoes, fierce advertising campaigns demonstrating who is better.

WEEKS:

We are getting that same thing in this area too. In Detroit, even in Ann Arbor where we have only two hospitals, we are getting a lot of pressure, hospitals trying to have a good image.

CATHCART:

Pennsylvania Hospital's present policy is to be the last hospital in Philadelphia to advertise. We are regarded as a stable, trust company-type hospital that has a background and a heritage and I think we are only enhancing that when we keep reminding people that we are the first hospital in the nation. We still have our eighteenth century buildings. They have been converted for ambulatory purposes.

WEEKS:

You are in a historical district too.

CATHCART:

So it all fits together. If we just had more parking.

WEEKS:

Have you been affected by HMOs? Do you have a contract with any HMOs?

CATHCART:

Yes, we do. In February of this year by the stroke of a pen an HMO walked away from us and took seven percent of our patients because we were not competitive enough price-wise to maintain their population. So, yes, we know what HMOs are.

WEEKS:

I've been wondering many times about what is going to happen in these days of low utilization where HMOs and other similar groups are putting pressure on hospitals for better rates. Where is the end of all of this

coming? Does it mean that some hospitals are going out of business?

CATHCART:

I wish I knew. As I said, we had with one stroke of the pen seven percent of our patients taken away. We are still running about 80% occupancy.

WEEKS:

That's very unusual, isn't it?

CATHCART:

The hospital staff has been very, very cooperative. They have been very supportive, the professional staff. Our fiscal year begins July 1 and we are about six or seven percent ahead of admissions from last year.

WEEKS:

That's very unusual.

CATHCART:

It is a very supportive staff.

WEEKS:

You must be doing something right.

CATHCART:

I wish I knew what.

WEEKS:

Because utilization as high as 60% is unusual and many times 50% or even 40%.

Are you doing anything for the aged?

CATHCART:

The aged are very important to us. We are planning ahead for the period from 1995 to the year 2000. We feel that the adult patient must be a large part of our year 2000 market. In the Philadelphia area the management and

planning for the aged is balanced between the social forces and the medical forces. The social approach is not very supportive of the medical approach because they think the medical approach is too scientific and too procedure oriented. So we are trying to bridge the gap so that people working with older people respect us as a health care facility, a facility that has respect for the older patient. We feel that if we can gain standing in the geriatric community, as it were, we will be a resource for those patients. The patient over sixty-five consumes three times as many resources as any other. When he becomes seventy-five he consumes six times as much. So we think that is a very important part of our future. To prepare for that future we have devised a program for adults, a comprehensive package of adult care programs. Last year we opened an adult day care center where we go and pick up patients and bring them in five days a week. They have a meal and an organized program, with a large health element in it. We have our own home care unit, we have a hospice unit which is a very major thrust. We have a very major thrust in geriatric psychiatry because we have on the campus of the downtown hospital, a community mental health center with some eighty-five or ninety professionals providing ambulatory mental health services. We will by this time next year have a thirty-six bed skilled nursing facility. So we will have a complete package of services for the older patient.

WEEKS:

This skilled nursing facility is a little higher level of care than say a nursing home?

CATHCART:

Yes, it is transitional.

WEEKS:

Have you thought about going into the nursing home business?

CATHCART: .

We have thought about it, but we have concluded we don't know enough about how to do that.

WEEKS:

There is no question that there is a different skill necessary to run a nursing home. We have here in Ann Arbor a man who has three nursing homes of his own and he is on the board of the National Health Enterprise. They are the number three for-profit type of chain. They have quite a number of nursing homes now. They are selling their regular hospitals, many of them. They are going into psychiatric hospitals, they are going into rehab hospitals, specialized hospitals where they can get some income apparently. Then they are going into nursing homes. I was wondering since you are strong on psychiatric that maybe you might be thinking of going into nursing homes also.

CATHCART:

I'm afraid we don't know the business well, and think that mission can be accomplished by affiliation at this point. The hospital has one for-profit corporation which operates its parking decks and physicians' offices. And one or two joint ventures with physicians with sophisticated technological pieces of equipment. As I said before, we have not been reorganized. We are still a hospital, we are not restructured. We have not gone into these other areas as strongly as many hospitals.

WEEKS:

Congregate living is another thing that is coming in now. This man that

I was telling you about also operates apartments for the retired in Florida. Apparently the day is coming when this will be much, much bigger with this change in population, aging in population. People want a secure place, they want the comforts.

CATHCART:

It's very, very important. But its a field we don't understand.

WEEKS:

When you stop to think about it, when you think of all the HMOs there are, the question that comes to my mind is where did they get the executives who knew enough about the business to run them?

CATHCART:

They don't. That's the reason many of them are in trouble. We tried that too and we found out we didn't know much about that. We got our hands burned on that.

WEEKS:

Is there anything more you want to say about your hospital?

CATHCART:

No. Oh, we could talk for hours and days.

WEEKS:

I was going to turn to the hospital association, if you don't mind. You started out with the Hospital Association of Pennsylvania, didn't you? You were president-elect, then president. I wanted to ask you about some of the things that were going on in HAP. I interviewed Jim Neely and he was telling me something about the experience with the insurance company.

CATHCART:

Where we got our hands burned.

WEEKS:

Would you like to talk about that a little bit?

CATHCART:

Sure.

WEEKS:

Was that while you were president?

CATHCART:

Was he talking about the insurance company that the association formed?

When did you talk with him?

WEEKS:

Just before he went with Equitable. The insurance company had more or less -- did they give up business?

CATHCART:

Pennsylvania Hospital had the concept that it would be good to have an HMO or an alternative delivery system which was called Care Card. We went to visit with Jim Neeley and asked him if he would like to lead that effort. We said that we would get together with three other hospitals in the state and we did. The group was made up of hospitals in Harrisburg, York and Pittsburgh. We put in some capital and started the effort. Jim Neely gave up his very good job at the Hospital Association of Pennsylvania. The effort was a colossal flop. We didn't know enough about the business.

WEEKS:

You were talking about the hospital insurance venture.

CATHCART:

After Jim had left his very secure job at the hospital association he joined and established the Care Card Corporation. Because the hospitals

didn't have deep enough pockets or enough knowledge I feel as though we led Jim Neely down the primrose path, took him from a very secure and interesting job and left him without any income or any position.

WEEKS:

I think he felt badly about the fact that it didn't go well. As I remember his saying something about they were under-capitalized. That was one reason they couldn't make it go.

CATHCART:

That's exactly what I say. Our pockets weren't deep enough.

WEEKS:

Was there also insurance such as malpractice or liability insurance?

CATHCART:

Jim Neely developed an insurance company when he was with the hospital association called the Hospital Insurance Company of Pennsylvania. It was one of the most successful captive insurance companies in the United States. It was a source of great, great financial return to the association. It was a hundred percent business success. It's now falling upon hard times, but during Jim Neely's tenure with the association it was very successful.

WEEKS:

This covered malpractice and liability for hospitals and physicians or just for hospitals?

CATHCART:

Yes, for both.

WEEKS:

I was wondering when you were talking about your maternity unit at Pennsylvania Hospital if you had trouble with large malpractice insurance

costs.

CATHCART:

Yes, we certainly are aware of those. We had a problem of finding insurance. Pennsylvania Hospital never became a policy holder of the state hospital association program. Our board felt that the new association insurance company was not mature enough and did not have good business management. That may or may not have been a correct decision. Nevertheless we never became involved as a policy holder. We tried to manage our own insurance activities. Part of the hospital's marketing and competitive position has been to buy or insure malpractice insurance coverage for a full-time group of obstetricians. We have a group of obstetricians, about twenty in the group, that is a full-time part of the organization. Then we have ten or twelve obstetricians outside in private offices. The outside people do not benefit by the insurance, but the inside people do. I think that is one reason why we have been able to build and maintain the largest maternity service. Because the doctors know that they are covered. The hospital takes all the risk.

WEEKS:

Are these inside people on salary?

CATHCART:

Essentially they have their own mini practice plan at the hospital.

WEEKS:

A Permanente of their own.

WEEKS:

Yes.

WEEKS:

It's a partnership deal, I suppose.

CATHCART:

The hospital has an arrangement where we recover a certain percentage of their revenues. In return we provide them malpractice insurance and the physical facilities.

WEEKS:

I see. This is unusual. So many hospitals are getting rid of their maternity departments. It seems strange and good to hear that somebody is putting an effort into building it.

CATHCART:

That is particularly unique in a center city hospital. You would think that might be true in a suburban area. We will have about 4,000 births each year now. We hope to push that up to 5,000 in two or three years. Again, the strategic plan there is to have a full menu of services for obstetrical patients. At one end of the spectrum is the midwife service. We will have 300 to 350 midwife deliveries a year in a discreet birthing center. It is controlled by the midwives. The physicians may use this center if they follow the protocols established by the midwives. Not very many of them want to do that.

The next listing on the menu is a normal obstetrical delivery by a physician who might want to use a birthing room that is on the labor and delivery floor, but not in any way related to the birthing center that the midwives run.

The next item on the menu would be a full obstetrician delivery labor room, delivery room and a scientific process.

The next listing on the menu is the high risk obstetrical service which is very technologically oriented. Patients may come in four or five weeks ahead of time because they are in such great risk.

Then sort of rounding out that menu is a very sophisticated high-risk nursery service. Since so many of these high-risk patients deliver a defective product. Defective products need to be housed and cared for.

That is our strategy in obstetrics.

WEEKS:

Two or three questions come to my mind right away. One, if the midwife section is taking care of patients they can call upon physicians for help if they need it, can't they?

CATHCART:

Yes.

WEEKS:

Is there any protocol for when they have to call?

CATHCART:

They develop their own protocols. They serve under the department of obstetrics and gynecology. The director of the department has to approve their protocols. They define when they have complications and when they need help. It happens to be in a building across the street from the labor and delivery area, on the eighth floor. You would have to drop down eight floors, go through a tunnel, up three floors in an adjoining building for help with patients. But that is better than having a completely free-standing activity without any ties.

WEEKS:

Did I understand that your malpractice insurance is self-insurance?

CATHCART:

Somewhat self. It is a combination.

WEEKS:

There aren't many insurance companies that write malpractice any more, are there?

CATHCART:

It is a very small field.

WEEKS:

St. Paul and somebody else.

CATHCART:

Ours is done through Lloyd's at great expense.

WEEKS:

Are there any other experiences while you were active in the management of HAP?

CATHCART:

None of the things that we have talked about was developed while I was an officer in the Hospital Association of Pennsylvania. Jim Neely was not even in the state at the time. He came after I was finished with my work at the hospital association. He came and he was very helpful in getting me nominated as chairman of the American Hospital Association. So he was instrumental in that.

WEEKS:

He served two periods at AHA and then he was also in South Carolina, wasn't he?

CATHCART:

Yes. I believe he went from the American Hospital Association to South

Carolina, then he came back to the American Hospital Association (AHA). Then he came to Pennsylvania. Ed Crosby was the chief executive officer of AHA. Crosby was known for his hostility to anyone who would think of leaving the Association. Everyone had to be very careful that if they were looking outside not to let the boss know that. Jim set up a breakfast meeting with me one day in Chicago and we sort of snuck over in the corner and whispered that he might want to move into the Pennsylvania job. I acted as his courier back to Pennsylvania and told them to keep it very confidential so as to protect him. Because he did not want to incur the wrath of Dr. Crosby.

WEEKS:

Yes, I think Dr. Crosby was probably strong on loyalty. Maybe this goes back to his Salvation Army upbringing or something.

You did receive the first Distinguished Service Award from HAP, didn't you? That must have made you feel very good.

CATHCART:

Yes. It was very flattering.

WEEKS:

While we are on awards, you have the Dean Conley Award from the American College.

CATHCART:

I see yours up here.

WEEKS:

That isn't actually mine. I was editor of Inquiry when the award was made to Anne Somers and the magazine got a duplicate of the plaque that she got. I felt good about it because we did talk with Anne about the type of paper that she had and felt very good when her paper was selected.

You also have the AHA Distinguished Service Award, don't you?

CATHCART:

Yes. And the top award from the American College of Healthcare Executives.

WEEKS:

Yes. The Gold Medal Award. That must make you feel very good.

CATHCART:

Yes, I am very pleased.

WEEKS:

There was also another association, the Philadelphia Hospital Association, which later became the Delaware Valley Hospital Council.

CATHCART:

The background there was that the Philadelphia Hospital Association was a constituent of the state hospital association. It was the older of the two organizations. Right after World War II it was decided that there should be a local organization in Philadelphia known as the Philadelphia Hospital Council. That acted as a trade association and also a planning group for health facilities for Philadelphia. It was to be sponsored jointly by Community Chest and a dues collection, so we would have two sources of income. It was to also be a trade association. The Council selected C. Rufus Rorem as its first chief executive officer. Rufus Rorem, if you have not interviewed him, should certainly be interviewed.

WEEKS:

Yes, I have. He is a delightful person.

CATHCART:

Dr. Rorem came there -- not as a trade association person -- he didn't

want to be a trade association lacky. He wanted to be a planner and a global figure. He was also brought to Philadelphia because of his esteem for van Steenwyk. So we had at one time van Steenwyk and Rufus Rorem in the same town working together. The Philadelphia Hospital Association and the Philadelphia Hospital Council were competing organizations. It seemed apparent that there was no reason to have two competing local hospital organizations. So, one of the tradeoffs was that the Philadelphia Hospital Council would change its name to the Delaware Valley Hospital Council and merge with the Philadelphia Hospital Association. Another of the tradeoffs was that because of the community base of the Philadelphia Hospital Council, the board was controlled by trustees. I think at that time all of the board of that organization were trustees. The full-time technical administrators, such as myself, were resentful of that and thought that there should be administrators on that board. As a tradeoff, again, it was agreed that there would be some hired help on the board of the council. At that time it was also agreed that the chairman of the council would always be a trustee. That's all been changed now. I think, to its detriment, that the Hospital Council has professionals like myself as chairman and they control the board. I wish the trustees still had control of the Council.

WEEKS:

Was this the group that Carol McCarthy was with originally before she went to Massachusetts, before she went to Chicago?

CATHCART:

Yes.

WEEKS:

Then you were also a member of the board, weren't you, of the Middle

Atlantic Hospital Assembly?

CATHCART:

Yes.

WEEKS:

I have often wondered how these small organizations make their need felt.

CATHCART:

That's really just one gigantic trade show once a year. That's all.

WEEKS:

We used to have a tri-state out here. I think it has now gone by the board. I haven't heard of it recently.

I have quite a list of things you did at the American Hospital Association. Shall I start at this chronologically and ask you?

One, your position as the chairman of the Council on Nursing. This opens up the whole nursing question. Were you considering nursing education and the nursing role?

CATHCART:

Certainly at that time there was a great deal of defensiveness on the part of the association about the hospital schools of nursing. The hospital schools of nursing were then producing a high percent of the total nurses in the United States. This gave that constituency a voice in the management and policy making of the Association, and to a lesser degree in the organization of the nursing services as such in the hospital.

WEEKS:

What do you think is going to happen to nursing education? Are we going to have all baccalaureates some day?

CATHCART:

We are a long ways from it. We have a community college or a junior college movement which is very strong producing associate degree nurses. Just by need of numbers, bodies, it would be almost impossible to discount that group. I think the movement away from hospital schools will continue.

WEEKS:

There are so many attractive roles that women can go in to today. They can go into almost any profession today. We know that in hospital administration half the students are women. In medicine the proportion is quite large. I'm not sure the exact percentage. And law. There was a television advertisement the other day showing a person on a utility pole with a big wrench doing something and when that person came down and walked over to get her glass of iced tea, took off her hat, it was a woman. This sort of thing. Women can do anything. We know they can. So the question comes up of what to do with the nurses. What about the nurse practitioner? Does the nurse practitioner have a role in your hospital?

CATHCART:

Oh, yes. In various specialties they are very key.

WEEKS:

You have clinical specialists of one kind or another then?

CATHCART:

We certainly do.

WEEKS:

I have you listed as chairman of the Committee on Health Care for the Disadvantaged. Any particular outcome of that?

CATHCART:

That was a period when -- the AHA was trying to dovetail with the Great New Society of the Johnson administration. It was trying to help the hospitals coordinate that thrust and to make them good team players and help them find ways to fit into caring for the disadvantaged. Building bridges with that constituency.

WEEKS:

This Council on Manpower and Education. Was this education in hospital administration or education in general?

CATHCART:

More related to preparing for the personnel needs of the hospital whether it be laboratory technicians, x-ray technicians or nurses or hospital administrators.

WEEKS:

What do you think is going to happen with all of the graduates in hospital administration. I don't know the exact figure; I haven't seen one recently. I haven't talked to Gary Filerman, but I'm sure he has ideas. There must be at least a couple of thousand graduates every year, aren't there?

CATHCART:

It would seem to me from the number of letters of application that we get. It is an almost terrifying number. The ironic part of that is, as you mentioned a few minutes ago, drawing nurses into general administrative positions when nursing itself needs excellent administrators and there is a great shortage. But the nurses themselves seem to be leaving nursing and nursing administration to go into hospital administration. It seems

unfortunate to me.

WEEKS:

Do you think it is because an administrator may have more prestige than a nursing administrator?

CATHCART:

Prestige and probably more dollars.

WEEKS:

More dollars too, yes.

CATHCART:

And it is not quite probably as demanding on a day-to-day basis as being a nursing administrator. A nursing administrator has to face the fact of whether they are going to have the staff there at midnight tonight and what do they do if they don't. It's a very tough job.

WEEKS:

And the fact that a high percentage of the employees in a hospital are women too. Nursing is the biggest department, I would assume.

CATHCART:

Absolutely.

WEEKS:

What about your trustee at large? What does that mean?

CATHCART:

A trustee at large indicated that I served no regional constituency. I wasn't from a region. The Association at that time had a certain number of trustees from a geographic region and some just at large.

The hospital association activity dovetails with my tenure, my thirty-eight year tenure at the hospital. I think that one of the reasons that you

don't have lots of people with this kind of tenure is that they get restless and impatient because they see the same problems time after time after time. Pennsylvania Hospital has encouraged me to do things outside the hospital. As a result, I don't build up the frustration and dissatisfaction that many of my colleagues do with their jobs because there is always something I can do outside the hospital. Certainly the American Hospital Association, and the Hospital Association of Pennsylvania, are good examples of that. They got me away from the hospital and gave me another viewpoint. It may have even helped other hospitals or it may have helped Pennsylvania Hospital. But it didn't hurt the hospital.

Then as I worked my way through the political jobs, the state and national association, Joint Commission, and so on, as I went through those then I have been able to take on other extracurricular responsibilities that relate to vendors. That results in extra income, and so in a way that has also acted as an incentive payment to me. Although the hospital does not reward people in an incentive payment system, I have my own private incentive system by being able to do outside things that get me outside of the hospital and keep me from being too much of a pest at the hospital and also give me an incentive to do some extra things. That's all a part of it.

WEEKS:

You get a broader picture. It seems that your position at Pennsylvania Hospital is much better than some of the hospitals where they frown upon the chief executive officer being away so much. When you are working your way up in the American Hospital Association there are several years, at least three years when you are very busy. You must have to be away a great deal. You must have to travel. This means that you have to leave some of your decisions

back home to subordinates.

CATHCART:

Sure.

WEEKS:

Some hospitals don't like that. I have heard of presidents of the AHA losing their jobs when they get through, maybe before they get through.

When you were serving on the Joint Commission, which you mentioned a minute ago, was that with Babcock or Affeldt?

CATHCART:

Affeldt.

WEEKS:

I interviewed him. I enjoyed it very much. He is a Seventh Day Adventist too, by the way.

CATHCART:

Is he? I didn't know that.

WEEKS:

He is a graduate of Andrews University over here. Our only Seventh Day Adventist's college in Michigan.

CATHCART:

Is that right?

WEEKS:

Then he went to Loma Linda.

CATHCART:

I knew that, but I didn't connect it.

WEEKS:

I don't think he makes a great point of it, but I did ask him when I saw

Andrews University and Loma Linda on his resume. I thought he must be.

Do you want to talk about your time as president, president-elect or past-president of the American Hospital Association?

CATHCART:

I think by that time it had been called chairman.

WEEKS:

Yes, I'm sorry. I can't quite get used to it.

CATHCART:

It was a fascinating experience because I had watched Dr. Crosby work while I was assigned various tasks for the American Hospital Association. Then I was involved in the search committee for Alex McMahon who followed Dr. Crosby. I knew many of the twists and turns that brought about his appointment. I remember the long board meeting at the Palmer House in Chicago of the American Hospital Association when votes were being taken on Crosby's successor. That was practically a marathon session.

WEEKS:

Didn't the search committee recommend Walt McNerney?

CATHCART:

Yes. That was the first committee. I was on the second committee that recommended McMahon. McNerney did not get enough votes so there was another committee appointed. I think Sister Marybelle headed that committee. I remember trying to recruit various people for that job. The man at Henry Ford, Stanley Nelson. We tried to recruit him. We tried to recruit some other people who were not interested in it or did not want to take it on. Then we came across the name of Alex McMahon who was unknown to most of us. The original plan was that McNerney would become president of the AHA and

McMahon would move in as president of Blue Cross. It reversed itself. It was a very bitter and highly contested meeting.

WEEKS:

Didn't the man from New Mexico or Arizona -- wasn't he a fiery leader?

CATHCART:

Arizona. Stephen Morris.

WEEKS:

We were talking about Stephen Morris and John Kauffman.

CATHCART:

Yes. They were very adamantly opposed to McNerney. They then established another search committee who they hoped would do what they wanted them to do. The search committee came up with someone that no one knew. In that effect they didn't do exactly what Morris and Kauffman wanted, but it was close enough that they could accept McMahon.

I imagine for the sake of continuity here, I think you knew that I was chairman of the search committee that identified Dr. McCarthy.

WEEKS:

Yes. That is one point that I wanted to ask you. In the 1972 search committee, after Crosby died, the committee was charged with bringing one candidate up, one favorite person. In 1985 with Dr. McCarthy, weren't there three?

CATHCART:

There were to be three. The board asked for three. The committee selected three names. One of the three people was Donald Wegmiller who was also the chairman-elect. There were some negotiations. As a result of those negotiations he dropped out. I think I conducted those negotiations. So the

committee then ended up with two candidates. Charlie Sanders, was it? And Dr. McCarthy.

WEEKS:

I don't know him.

CATHCART:

He was general director of Massachusetts General Hospital and went from there to Squibb. He was restless at Squibb and would have been pleased to accept the job at AHA. The committee, therefore, brought those two names to the board.

WEEKS:

She seems to be very active since she was appointed.

CATHCART:

She is the first woman, probably, in any major trade association that is not a feminist organization.

WEEKS:

I have noticed quite a few changes since she has been in office.

CATHCART:

I have no idea what is going on.

WEEKS:

Things like the publications look different. Hospitals magazine. Maybe this was taking place before she came. I don't know.

Were there any events that happened while you were chairman that you would like to talk about?

CATHCART:

Well, Alex McMahon was such a strong person, brilliant person, I would say, who had pretty much his own agenda. My job was to be supportive of him

and help interpret to his constituency what he was trying to accomplish. And to make it as easy as possible for him to fulfill his role. He is a dynamic man.

WEEKS:

Yes, he is.

CATHCART:

That may have been my major contribution.

WEEKS:

I talked to Alex. He seemed to lay more stress on the Washington scene than Crosby had done, or Bugbee. Didn't the Association make arrangements for an apartment in Washington for him because he was spending about a third of his time in Washington?

CATHCART:

Yes. He came to Chicago with his first wife, Betty I think. After their divorce he really had no base in Chicago. He worked out of Washington, preferred Washington, felt that's where the action was. He enjoyed the rough and tumble of Washington and did it very well. After he married his second wife he spent more time in the Duke University area. He went from the Carolinas to Washington and Chicago. He sensed the need for representation. Not only did he sense it, but he enjoyed it, relished it.

Crosby was very reticent and felt very uncomfortable in Washington. He believed it was unclean to be there. He didn't want to get his hands dirty. I think he felt very intimidated by the Washington scene. Crosby had a very effective Washington office person by the name of Ken Williamson, and I think Williamson probably told him to stay out of Washington which probably did not make Crosby feel welcome in Washington. Williamson bit the dust in between

Crosby and McMahon because he got into a problem with Morris and Kauffman.

WEEKS:

He was saying snide things about Nixon, wasn't he? That's the story I heard. He offended Morris and Kauffman, possibly, because they must have been strong Republicans.

CATHCART:

Another chain of that thread, if we were ever writing a novel about all of this, would be that Kauffman at Princeton had his administrative resident, Jim Cavanaugh. Jim Cavanaugh went from Princeton down to Washington to work in the administration of Nixon in the domestic policy office. I'm sure that Cavanaugh was a very committed Republican and probably fed back to his former boss, Kauffman, that the AHA was getting in his way. I imagine that that had something to do with it.

WEEKS:

Apparently Williamson was making public remarks about Nixon which didn't reflect on the AHA very well as far as other Republicans were concerned.

CATHCART:

Anyway, McMahon recognized that's where the action was. He was ever so much more energetic, brighter, cleverer than Crosby. When I was chairman I tried to stay out of the way and be helpful.

WEEKS:

Did you ever have to testify?

CATHCART:

No.

WEEKS:

He took care of all of that?

CATHCART:

All of that.

WEEKS:

How did Jack Owen fit in?

CATHCART:

Apparently very well. But you see Owen was brought in by McMahon, as you remember. There was an interim appointment, Dr. Gehrig. Then when he decided to change and bring in somebody else, McMahon went out and recruited Jack Owen.

WEEKS:

He had been in New Jersey, hadn't he? Another Princeton man.

CATHCART:

Yes. Jack Owen did well with McMahon. And he must be very satisfying to McCarthy.

WEEKS:

I notice they are featuring in their new AHA News -- each issue has a column by Jack Owen and one by Carol McCarthy too. She must feel that he is occupying a good place.

CATHCART:

I think also the hospitals as a group have many more meaningful relationships with the federal government because of the public policy making in Washington which was not as true with Crosby and Bugbee.

WEEKS:

When Bugbee got the Hill-Burton through he was satisfied.

CATHCART:

Washed his hands and walked away.

WEEKS:

He has told me that he hated being a lobbyist. He was a registered lobbyist, and he hated it. He hated waiting in the hall outside a senator's door, and that kind of thing.

CATHCART:

But McMahon took to it like a duck to water.

WEEKS:

He had had that history in the Carolinas.

CATHCART:

Oh, rough and tumble. Real politics.

WEEKS:

I'm sure he loved it.

CATHCART:

I think McMahon secretly wanted to run for governor or senator from some state too. He became chairman of the board of Duke when Terry Sanford was president. Terry Sanford went on to political ambitions and sort of took that away from Alex. Alex probably needed the money he was getting out of the AHA and couldn't get as much of a political base as Terry Sanford did.

WEEKS:

I hope he is happy at Duke now. He's still at Duke, isn't he?

CATHCART:

Yes, he is.

WEEKS:

I was interested in the Committee on Medical Education. I was wondering how AHA entered into the question of medical education except the AHA has representation on some of the liaison committees, don't they?

CATHCART:

That, plus the fact that AHA members spend so much money on medical education. The residency programs are financed by the hospitals. In our place that is probably five or six million dollars a year. You repeat that enough times in enough hospitals and you add up an incredible amount of money. Also the hospitals are not interested in lengthening the training and preparation programs because that makes those residents so much more expensive. The issues of licensure, the issues of malpractice, the issues of what is the appropriate curriculum for those people, are all of interest to the American Hospital Association.

WEEKS:

How does the federal government at the present time support residency training, or any training of medical education in the hospital? Is there much support?

CATHCART:

The federal government is a big player in the field.

WEEKS:

Is there any effort on the part of the government to encourage the limiting of the number of new medical students?

CATHCART:

I think you had better talk to a medical educator, but my impression is that they have withdrawn the capitation grants for new students and I think they are subtly cutting back on medical education funding. Many of the public policy makers and the members of Congress have postured that they are going to cut residency programs. Thus far their bark has been worse than their bite, but we are standing around first on one foot and then on the other

worrying that the ax will fall. It has not fallen, but it could any day.

WEEKS:

We are going to have to find something for these fifteen thousand graduates every year to do.

Have you worked with George Bugbee at all?

CATHCART:

No. I have met him on several occasions.

WEEKS:

He just wrote his autobiography.

CATHCART:

Did he? Has it been published?

WEEKS:

I think the AHA is supporting it.

Let's take a little break here and talk about people.

CATHCART:

Good.

WEEKS:

Somebody told me that you said that I should see Perloff while he was still with us. I did. He died before he had a chance to read the transcript. It was very close timing. I hadn't met you, of course, but somebody who knew you and knew me said that you had mentioned that if anyone wanted to interview Earl Perloff they had better do it right away. He was very bad. I didn't have a long interview with him but he did talk about the Perloff Committee and the Health Care Corporation and so forth. Did you have any experience with him? He was quite prominent in Philadelphia hospital affairs, wasn't he?

CATHCART:

Yes, he was. I had great respect for him. He was bright and articulate. He was a leader in the Philadelphia community. Our hospital did not relate, at that time, to the Jewish community in any way. I was a bridge, and I welcomed the opportunity to be with any Jewish leader I could.

WEEKS:

He was very much a gentleman. That's one thing that impressed me about him. He was so courteous and so attentive. He took me to a place for lunch...

CATHCART:

The Locust Club.

WEEKS:

Yes.

Another Philadelphian is Dr. Koop. He was at Children's Hospital, wasn't he?

CATHCART:

Yes, he was.

WEEKS:

I got the impression that Children's Hospital was for the elite. Or was it just an elite hospital?

CATHCART:

Its governance mechanism is for the elite. Its patient load is the community at large. Its board is a very old Philadelphia WASP group. It is an elite hospital.

WEEKS:

I haven't met Dr. Koop yet.

CATHCART:

Dr. Koop was an intern at our hospital. He comes to Pennsylvania Hospital for his own medical care. I am a Regent of the National Library of Medicine. He is also. He comes to some of the Regent meetings. At our next meeting I am going to take a photocopy of his intern records and give them to him. His missionary zeal was evident then. He was going to missions on Sundays to provide health care to the mission people.

WEEKS:

Have you any way of knowing how he was chosen to be Surgeon General?

CATHCART:

None.

WEEKS:

I don't know how that process comes about.

CATHCART:

He is a born again Christian type. He has very fundamentalist religious beliefs. The sanctity of life and all of those sorts of things. He has lost some of that now, you might say. The way he has come out on this AIDS thing has been so frank and so realistic that it seems as if he has modified a number of his beliefs.

WEEKS:

It's hard to think of him recommending the use of condoms if he is that type of person.

CATHCART:

He is also bright and he knows when he is wrong, I guess.

WEEKS:

Could we digress just a minute and ask you what you do at the hospital

for AIDS victims? Do you care for them?

CATHCART:

Yes, we do. We have the highest percent of AIDS patients of any hospital in this area. We take care of about 22% of all AIDS patients in the Philadelphia area at the Pennsylvania Hospital. We are in a neighborhood that is attractive to the homosexual, and we have many homosexual patients. We have a strong infectious disease department that has been very much at the forefront in caring for AIDS patients. These patients have a great respect for the hospital. We have had absolutely no problems in the management of it.

WEEKS:

When you see these people, are they in their terminal stage usually?

CATHCART:

Not necessarily.

WEEKS:

I was wondering about the length of stay and this kind of thing.

CATHCART:

We have many, many re-admissions.

WEEKS:

Re-admissions? You treat them for their secondary symptoms and hope.

CATHCART:

Yes. Our hospice is very much involved with their care, and the home care program.

WEEKS:

Your hospice -- do you have a statement for what you consider the length of a terminal period? Do you think of anybody at say six months from death or three months? I have noticed a difference...

CATHCART:

It is entirely personal. There is no set pattern. Each patient is evaluated. We reject any federal support. We do not take any third-party's money. It is completely hospital financed. We generate no revenues because we feel the federal and state support programs would cause us to sacrifice the philosophy of the program. Therefore, we decided very early on not to take any support from them. Therefore we are completely free to do as we will.

WEEKS:

And you are doing a good work it seems.

CATHCART:

I hope so.

WEEKS:

How about home care? Do you have your own staff or do you contract?

CATHCART:

Yes, we own a joint company with two other hospitals.

WEEKS:

And the nurses work for the joint company?

CATHCART:

Yes.

WEEKS:

I am very much sold on home care. When I came to the university I worked on a study of progressive patient care. It was a small rural hospital, 120 beds or something like that. They had their own hospital-based home care, so they hired their own nurses. They started out with a nurse with a master's degree in public health nursing directing the program. They got off to a fine start. They covered a whole county. It was very fascinating. If you would

be interested, I will give you a little booklet.

CATHCART:

Sure. I would like to see it very much.

WEEKS:

We can't talk about Philadelphia without talking about Bob Sigmond. Have you worked with him?

CATHCART:

Oh, yes. I've known him for thirty-eight years.

WEEKS:

One thing that endears Sigmond to me is his attitude toward Rufus Rorem.

CATHCART:

Yes.

WEEKS:

It is almost like a father/son relationship.

CATHCART:

Absolutely.

WEEKS:

I call Rufus maybe once every two or three months. Bob says he tries to call him every week. Since they have gone into that Quaker home down in New Jersey, I guess Rufus just doesn't know what to do with himself -- intellectually. So I try to send him an article or send him something once in a while, and try to keep in touch with him.

CATHCART:

You knew Bob had had his hip replaced.

WEEKS:

Oh, did he? The crippled one. How is he holding up?

CATHCART:

He was very uncomfortable with his hip and finally decided to have surgery. I think he is very pleased.

WEEKS:

I hope so. I'll drop him a note.

CATHCART:

He is to make his first airplane journey next week to Chicago.

WEEKS:

Is that right? Is he still working for BCA?

CATHCART:

Yes.

WEEKS:

Which brings me to Barney Tresnowski. Was Barney in Philadelphia for a while?

CATHCART:

Yes, he was. He was at the northern division of Albert Einstein.

WEEKS:

Who was it he was with, Lucchesi?

CATHCART:

Lucchesi, Pascal F., M.D.

WEEKS:

You have had some experience with Lucchesi then. Can you tell me something about him?

CATHCART:

Pat Lucchesi was a second generation Italian who I first met when he was the head of the Philadelphia General Hospital. He was dynamic, relatively

small stature, but full of ideas and vigorous. Tremendous drive. He presided over Philadelphia General Hospital when it was one of the great hospitals in the nation. He, much to the surprise of everyone, was selected by the Jewish community to head up their new organization known as Albert Einstein Center which was the consolidation of three hospitals. He took over. The predecessor up there had been a fellow by the name of William Doane, M.D., who was a non-Jew also.

So Lucchesi went to Albert Einstein Center and he was the one, I think, who recruited Bob Sigmond out of one of Rufus Rorem's offices. Pat Lucchesi and I apparently got into some sort of a disagreement. I think I got Pat Lucchesi pretty angry with me. I was so much younger than Pat Lucchesi that we had to have E.A. van Steenwyk mediate. van Steenwyk was from Iowa, as was I. van Steenwyk grew up in a small community very close to Odebolt. So we had van Steenwyk, Rufus Rorem, who was from Iowa and grew up in the same part of Iowa that I did. We had Rufus Rorem, van Steenwyk and myself, and Lucchesi. I was very much younger than the other three. They were very, very supportive of me in my early days in Philadelphia. Lucchesi had a flamboyant style. He had a hospital car, which was unheard of at that time. The city had a hospital car which was not unusual, for city officials, with a chauffeur. But when he went to Albert Einstein he required that he have a chauffeur driven automobile. That was the talk of the town at that time. But it was a part of his character. It was pure Pat Lucchesi. Pat had a lovely family, devoted. He had a very dramatic death at the dinner table during a Delaware Valley Hospital Council meeting at the Bellevue-Stratford Hotel. Just as he was getting ready to speak he collapsed and died. Right in front of 250 people.

WEEKS:

I didn't know that. I had heard of van Steenwyk having a tragic death. Was that while he was in Pennsylvania?

CATHCART:

Oh, yes. He was still president of Blue Cross.

WEEKS:

I had always just associated him with Minnesota. I thought maybe he grew up among the Swedes and Norwegians there. But he was from Iowa?

CATHCART:

He was a Dutchman from Iowa, Orange City, Iowa. Then he became visible when he was in Minneapolis. Northwestern Iowa is not very far from Minneapolis.

WEEKS:

That's right. Then he was in Chicago for a while building houses.

CATHCART:

Somewhere along the line. He went directly from Minneapolis to Philadelphia.

WEEKS:

Yes. This was before he got into Blue Cross in Minnesota.

Did you want to say anything more about Rufus?

CATHCART:

Obviously he was very supportive of me. Very fine. It was a great opportunity. He was heartbroken when he was fired from the Philadelphia hospital council, but he was trying to be a statesman and not a rabble-rousing lobbyist. He probably felt the same way as Bugbee did about lobbying. It felt almost unclean.

WEEKS:

Then he went to Pittsburgh, didn't he?

CATHCART:

Yes.

WEEKS:

Bob Sigmond was there also at that time.

CATHCART:

Yes.

WEEKS:

Then Rufus went to New York when he retired.

CATHCART:

Yes.

WEEKS:

That's the way I remembered it.

Did you know Kenny Williamson?

CATHCART:

Yes, I did.

WEEKS:

He could be quite an abrasive character, too, couldn't he?

CATHCART:

Yes, he could. Not so abrasive as so cock-sure of himself, such a strong ego. He would come on and he would make other people feel inferior because he was so strong-willed and so sure of himself. He had pretty firm opinions. If you didn't happen to agree with him he would let you know that he didn't agree with you. I think he would respect you, but he wouldn't change his opinion because you wanted him to.

WEEKS:

I got this impression interviewing him.

How about Mr. Denenberg?

CATHCART:

Dr. Denenberg. He was a lawyer from Nebraska, got caught up in Philadelphia. He is a person who has a flair for the dramatic. In public hearings of Blue Cross rates he said to the Blue Cross president at that time, Bruce Taylor, "I want you to decrease your rates by ten percent." The Blue Cross president said, "Mr. Commissioner, I'll do that when you give me the order in writing." The commissioner turned to his secretary and took a yellow pad similar to yours, tore out a page, and wrote I order you to decrease your rates ten percent.⁴ He knew he was playing before television lights and radio and a huge audience and he loved it. He is brilliant. He shook up the system. He was more right than most of us, right more times than I am. His goals were appropriate, his means of achieving them were not.

WEEKS:

How did he exit from the picture?

CATHCART:

I think he was so abrasive that people just got tired of him, as I remember.

WEEKS:

Was his appointment withdrawn?

CATHCART:

He may have been fired. I wish I could tell you, but I cannot remember that detail. It's an important detail. Either that or perhaps the administration that he had served was going out. Probably the latter. Then

he tried to run for an elected political office.

WEEKS:

I think he did.

CATHCART:

He failed in that because he wasn't a good enough politician. He is too much of a firebrand to be a good politician.

WEEKS:

When you said doctor, is he an M.D. or a Ph.D.?

CATHCART:

I think he is a Ph.D., or a doctor of law.

WEEKS:

It could be that.

CATHCART:

He likes to be called doctor -- in a facetious manner. You know he is now a local television personality. They just call him Herb Denenberg. He does good TV, has a spot on the evening news.

WEEKS:

As a commentator?

CATHCART:

On consumer issues. He dresses up in fancy costumes, and he has the Herb Denenberg trash barrel or garbage can and he puts all the things that he doesn't like in that. He does exposés on consumer fraud. We have, in Philadelphia, a street called Jewelers' Row where there are a hundred or two hundred jewelry stores. He caught a man selling and misrepresenting diamonds there. He brought that to the public attention, and the prosecutors convicted the man. So he is very busy doing this consumer watchdog business.

WEEKS:

Sort of a Ralph Nader to Philadelphia.

CATHCART:

Yes, but it is small time. A man who had as much background as he could have joined a Philadelphia law firm and done very well. He is a ham actor, and he loves it.

WEEKS:

Well, if he is happy.

CATHCART:

I suspect he may be. I'm not sure.

WEEKS:

You mentioned that Stanley Nelson was one of the candidates -- was this the 1972 search?

CATHCART:

Yes. He wasn't a candidate. The committee hoped he would be. I called him and asked him if he would let his hat be put in the ring and he did not want to do so.

WEEKS:

He was at Ford's by this time, wasn't he?

CATHCART:

Yes, he was.

WEEKS:

He has really carved out quite a career for himself there.

CATHCART:

Absolutely.

WEEKS:

In your work you have been on the committee about governing board evaluation of the quality of medical care?

CATHCART:

The National Committee for Quality Health Care? This is an effort launched five or six years ago by investment bankers, who were concerned that there would be some restrictive legislation on the use of tax-free funds for hospital capital programs. They then enlisted pharmaceutical companies and other hospital suppliers, anyone who has a vested interest in the capital expenditures that hospitals make. They have also enlisted investor-owned and voluntary hospitals. It's a small group that does bring together the non-profit and the for-profit hospitals and the suppliers at one table.

WEEKS:

In a small way sort of a political action committee.

CATHCART:

Yes.

WEEKS:

I have a number of things here. They may even be alphabetic, but they are not chronological. You can dismiss some.

Comprehensive Care Corporation as a consultant.

CATHCART:

I am still active with them on a retainer basis. This is a company that brings in a health care provider, mostly hospitals, and introduces them to a mental health service. It might be a drug or alcohol abuse program or a psychiatric unit. They move in and take over an entire nursing unit. By vigorously marketing that specialty service they hope to attract inpatients to

the hospital and thus fill beds that might not be occupied. They own a few hospitals of their own, but most of them are on the basis of a contract with a local community provider. They provide a very structured therapeutic program and a medical direction for a program.

WEEKS:

That brings to mind a question. In your hospital, drug abuse and alcoholism cases, do you handle those in your regular hospital or in your psychiatric?

CATHCART:

To a minimum degree in the medical/surgical hospital. It is an important diagnostic category at the psychiatric hospital. The psychiatric hospital is very Freudian oriented. It believes that substance abuse, alcoholism are merely symptoms of the psychiatric illness. The attempt there is to treat the disease and not the symptoms.

WEEKS:

I see.

I have a note here on the American Medical/Legal Foundation. You are a member of the board of that.

CATHCART:

Yes. This is an effort established by Richard Wilbur of the Council on Medical Specialty Societies, CMSS. John Affeldt...

WEEKS:

Is Wilbur of the famous Wilbur family?

CATHCART:

Yes. This is a small effort to provide credibility, factual information about medical/legal issues. It is based in Philadelphia.

WEEKS:

You were consultant to the American Sterilizer Corporation? Are they still independent?

CATHCART:

Yes, they are still independent. At least they will be until August 31. They are changing ownership form, but they will be maintained as an autonomous corporation even after August 31. I am not now a member of the board. It was a New York Stock Exchange company, and then because of the threats of takeovers of various nature converted to an employee-owned company. In the process of becoming an employee-owned company, the employees who were the executive officers of the corporation had to borrow large sums of money from the banks to buy the company. The earnings did not hold up. The new owners were not successful in meeting the covenants of the loans. So, the company had to be refinanced again. That small group of employees that owned the company after it became private will lose control of the company on August 31st when a special shareholders/stockholders meeting will be held. It will be owned by some financial interest in New York, but it will still operate as the American Sterilizer Company probably with some of the same management.

WEEKS:

That makes you think of the American Hospital Supply Corporation and what happened to it.

CATHCART:

Absolutely. Great famous names. Coming out here last night from New York I sat next to the former chief financial officer of Allegis Corporation that owns United, Hertz, Westin Hotels and Hilton International. I say former because he had been fired two weeks ago because of the changeover there in

that company. That company is being sold off in pieces. He was a victim of that reorganization.

WEEKS:

So many of these hostile takeovers have ended in somebody making a lot of money, but usually the company faulting or going under or being sold piecemeal.

CATHCART:

It was his opinion that United Airlines will probably end up so highly leveraged that they will probably fail.

WEEKS:

How do they spell this new corporate name?

CATHCART:

Allegis, I think it was.

WEEKS:

I have seen it, but it slipped my mind.

You made a trip to China?

CATHCART:

Yes, in 1977. Visited hospitals.

WEEKS:

Did you come away with any impressions on Chinese medicine or hospital operations?

CATHCART:

That was before China was really open to visitors, in 1977. We were very privileged to have royal treatment throughout our journey. We visited many hospitals, saw acupuncture being performed as an anesthesia as well as a treatment modality. Recognized that there is very much to be done to bring

them up to a level that is consistent with our practices.

WEEKS:

Their medical schools, are they turning out most of their physicians or are the students going to foreign schools?

CATHCART:

Almost all home production.

WEEKS:

The stories you hear about the barefoot doctors and so forth...

CATHCART:

Are pretty true. At that time. Whether that is true now or not -- that was over ten years ago.

WEEKS:

It would take quite a while to make a dramatic change.

The Children's Aid Society of Philadelphia. Is this like our Michigan Children's Aid?

CATHCART:

I would imagine.

WEEKS:

A place for taking care of children, foster homes.

CATHCART:

Foster homes, that sort of thing.

WEEKS:

And you are on the board of that?

CATHCART:

I was. Not now. I've been off about ten years, I think.

WEEKS:

Dorothy Rider Pool Health Care Trust. I am not familiar with that.

CATHCART:

This is based in Allentown, Pennsylvania. Mr. Pool was chairman of the board of Air Products Company. During World War II Air Products Company moved from the Midwest to Allentown to be near the Bethlehem Steel Company, which is in Bethlehem, and produced oxygen for their furnaces. Then it developed into a very major chemical company. Mr. Pool became very wealthy as the chairman of this company. He had also been wise enough to marry a very wealthy lady. So they combined their resources and created a fund that, I think, is about \$40 million by now to improve the health care for the people of the Lehigh Valley. He died seven or eight years ago and established this trust. There are trustees, and I am the trustee from out of town. The only one out of the Lehigh Valley. I'm about sixty or seventy miles away. So I help with the management and the distribution of those funds, in accordance with his will.

WEEKS:

What do they do to improve the health?

CATHCART:

They foster educational programs for physicians, continuing education for nurses, they sponsor colon/rectal cancer screening programs, they helped establish the premier trauma center in Pennsylvania, the best trauma center in the Commonwealth. They are helping with the care of the older people in the Lehigh Valley.

WEEKS:

Kind of a broad program.

CATHCART:

Anything that is related to health care. The Poole Trust fostered a medical school affiliation with Hahnemann University.

WEEKS:

The Health Learning System. This isn't the outfit in Chicago, is it?

CATHCART:

No. The Health Learning System is a privately owned company which is going to go public in December I think. Rothschild is going to manage that issue. This is a company that sets up a health learning system with companies, mostly pharmaceutical companies. Smith, Kline, Beckman have Tagamet. Their concept to sell Tagamet is to employ Health Learning System to come in and set up a learning system to convert physicians to using Tagamet. Health Learning System then recruits the top people in the field of gastrointestinal diseases. Then they work with family practitioners. They have a very good rapport with the Family Practitioners Association. They set up educational programs for family practitioners or any practitioner that deals with GI diseases. They then educate the physicians to the advantages of this type of drug. They don't use the word Tagamet, they use the generic name. Since Tagamet at that time was the only thing in town, the physician became convinced that that was the way to manage the ulcers, then he would order Tagamet. These contracts would be \$10-\$12 million dollars. Very elaborate educational programs, printed, television, conferences, refereed medical journal articles, all of the above.

WEEKS:

This is interesting because I used to be familiar with the system of detail men, they called them, and who tried to inform physicians about uses

and reactions of drugs, and all that sort of thing. But this is much more sophisticated and easier to visualize.

CATHCART:

The man who owns this company conceived of this idea ten or twelve years ago and has been highly successful. He has come to the conclusion that financing medical care is changing so rapidly in the United States and moving away from the physician. The physician is no longer the decision maker that he used to be. He has to share that decision making with other people and some of the people he shares with are hospitals. Since I know something about hospitals, he has asked me to work with him on a consulting basis on how you reach hospital decision makers.

WEEKS:

Do the hospitals still allow pharmaceutical companies to send representatives in to make presentations to the medical staff, or members of the medical staff, to meet in a room let us say?

CATHCART:

I don't know. Some hospitals may do that, but we have detail men all through our place all of the time. They are doing it on a one-on-one basis. That same detailing.

WEEKS:

Try to buttonhole the doctor in the hall or something.

CATHCART:

Our pharmacists are not too happy with it, but I don't know how you stomp it out. We have plenty of other things to worry about besides that.

WEEKS:

The problem as I see it is getting to the physician physically to present

this. If you have a good presentation that will help, but the big thing is to get to the physician.

CATHCART:

For example, Comp Care gets only five percent of its referrals from physicians.

WEEKS:

Is that right?

CATHCART:

The rest of it is by direct advertising and marketing. They have very powerful TV ads on substance abuse and psychiatry. I think Health Learning Systems can help Comp Care increase the number of referrals. If they can increase the referrals from physicians by three or four percentage points it would be very important to Comp Care. So I am trying to get the two companies together. I don't know whether they will come together, but I would think one could help the other.

WEEKS:

At least you might get them to talk together. I'm not familiar with the Fred S. James & Company either.

CATHCART:

That's an insurance brokerage firm. Marsh McClennan, Johnson and Higgins, Alexander and Alexander, Fred S. James, Frank B. Hall are the main brokerage companies. They are national brokerage companies. Again, the Fred S. James Company New York office -- I had lunch yesterday with the president of Fred S. James of New York, talking and helping him understand some of the health behavior of individuals in New York City. Have you come across David Willis?

WEEKS:

No, I haven't.

CATHCART:

David Willis is the editor of the Milbank Quarterly.

WEEKS:

Oh, yes. I have met him.

CATHCART:

David was our luncheon guest yesterday. I introduced David to Fred S. James Company.

WEEKS:

I have talked with him once or twice at the American Public Health Association meetings.

One thing that intrigued me was -- and I can't identify this listing -- was the Hospital Research and Development Institute.

CATHCART:

Yes. HRDI. That's made up of some thirty hospital people such as myself. I suspect maybe for your records you might want to get a list of the current membership. If I think of it, I will send it. It has people like Wegmiller, Scott Parker, Gordon Springer. People who like to consider themselves as being leaders. It is an effort that was put together by some old-timers. Frank Groner, Pat Groner, Stanley Nelson, Ronald Yaw, Ray Brown were sort of a luncheon table, and they would meet once or twice a year at the American Hospital Association meetings. Ronald Yaw one day said to the group that he had just had an exchange with one of the members of his hospital board in Grand Rapids. This board member was an executive of the American Seating Company. The American Seating Company had just gone into the business of

producing hospital beds and hospital furniture. They had gone ahead and produced the first two thousand or three thousand units. They had sold their first order and went into the hospital and found out that the beds were too wide to go into any of the hospital elevators or through any hospital door. He pointed out that this company was in and out of the hospital furniture business within six months and had dropped a lot of money. So, he said, "Why don't we get together and help these people?"

So the group got together and found a man in Pensacola, Florida who ran a local advertising firm. His name was John Appleyard. They hired him as the chief executive officer of this group. Today there are forty-six or forty-seven clients. We have a limit of fifty. We charge these clients a certain fee for services. Not a big fee, maybe \$18-\$20 thousand a year. For that fee we get together with them twice a year and we present two panels a year -- we call them panels, which involves six of our HRDI members, who sit across the table with the clients such as: Morgan Stanley; Paine Webber; the Mellon Bank; the First National Bank of Chicago; Service Master; American Sterilizer; Eli Lilly; Smith/Kline/Beckman; Johnson and Johnson. All of those are our clients. We critique what is happening in health care. Often we get special assignments from the client. Next month I am going to Cape Cod for a day to be with the Kendall Company because they are new clients and they want to have a meeting. I don't know why they are going to Cape Cod, but I don't mind going to Cape Cod in September. They have these clients and we brainstorm with them. Then if the client has questions during the year, HRDI identifies one of our members to be a liaison with the company. One member can liaison two companies, but not more than that. It is a collegial group of people who want to get together. This sweater came from Hill-Rohm which is a client of

HRDI. Hill-Rohm is a bed company. Two weeks ago they had us down at their farm just outside of Cincinnati for two days in which we had a futurist talk to us and had a comedian come in, and also heard about some of their plans for their future. We played softball, went swimming and so on, in this southern Indiana farm.

WEEKS:

I was thinking, what if the American Seating Company was buying your consulting services and they were about to go into the hospital furniture business. Can they approach you and say, "Can you critique my plans?"

CATHCART:

Yes. Sure.

WEEKS:

Then if they didn't build the beds to fit they would...

CATHCART:

Sue us, I guess. We don't try to get it into that much detail. We probably couldn't have prevented that error. It was a classic example of a company getting into a new area of business in which they knew nothing. They know a lot about schools. One of our customers, Service Master, thinks so highly of the concept that they asked us to help form a similar group of school superintendents, because they deal with schools. They would like to have the same sort of service. That is getting off the ground. Whether that will be successful or not, I don't know.

WEEKS:

But this turns out to be a profit-making organization then?

CATHCART:

Oh, yes. I am the chairman. My job is to keep all the temperaments and

the egos playing together. Some very strong-willed people are members.

WEEKS:

You calm the waters, huh?

CATHCART:

I try to. Not always successfully.

WEEKS:

Is this different from the National Executive Service Corporation?

CATHCART:

Yes. The National Executive Service Corps. Frank Pace, former Secretary of Defense, former president and chairman of the board of General Dynamics, set up this organization to use retired executives for philanthropic corporations. Because these executives presumably have knowledge about management. They contribute their management skills to the local YMCA, or the college. The reason I was involved was to make those services available to hospitals. They just need the hospital viewpoint.

WEEKS:

Just offhand, do you think that management is a science enough so that if you have the proper training to run one company you might be able to run a quite different company?

CATHCART:

I don't know how you would run them, but you might be able to ask some good questions. I don't think I would want to say you could run it.

WEEKS:

The Group Health Planning of Greater Philadelphia. That was quite a while ago, wasn't it?

CATHCART:

I've forgotten what that is all about. That was something out of the OEO experiences in the Johnson era. We were up to our ears in all sorts of outreach programs. This was a real do-good thing that blew apart when the funding stopped.

WEEKS:

The Coordinating Council on Medical Education.

CATHCART:

That was quite a while ago too. CCME. That was strictly politics, again. This was a coordinating group of the AMA, the AAMC, the AHA, ABMS (American Board of Medical Specialists), and the Council on Medical Specialties Societies. Each had their own ideas about medical education, both undergraduate, continuing education, and graduate education. This organization -- this was an attempt to keep them from going six ways to Sunday. It lasted for less than ten years. It got so acrimonious, Cooper and Sammons were fighting with each other. So acrimonious that it finally fell apart. No organization would cede any authority to this group. It was a general, sort of United Nations debating society.

WEEKS:

Physicians usually are quite protective of their turf and are afraid somebody is going to move in and change it.

CATHCART:

They were quite comfortable as long as I was chairman because I wasn't a physician. But I was only chairman for, I think, two or three years.

WEEKS:

Were you a consultant in Arabia?

CATHCART:

I still go -- I hope I continue to go to Arabia. If it doesn't blow up. I hope to be there in November. I go to the Whitaker International which is a totally owned Saudi company which is operating hospitals in Saudi Arabia.

WEEKS:

I wanted to ask you about the pharmacists' role in your hospital. Does your pharmacist visit patients or do they instruct patients on the use of medicines, or misuse? How do they enter into the health care picture?

CATHCART:

I am going to have to back away from that because I don't want to mislead you. If I weren't being recorded I would guess it, but I had better not guess it. The last time I visited the pharmacy was about three weeks ago and I was so unhappy with them because it was so filthy that I had to take the vice president down the next morning and show him how dirty it was. I guess I was not worrying about what they were doing, I just wanted to get the place cleaned. I was so angry with them.

WEEKS:

That's too bad to hear.

CATHCART:

Good people, very good people, very industrious, very nice people.

WEEKS:

I was pleased to read that you were on the board of regents of the National Library of Medicine. I have only been there twice. I have been impressed both times. It is quite a place.

CATHCART:

It certainly is.

WEEKS:

When we were there I was editing an abstract journal at the University. They took us through the abstracting department where these people worked behind glass enclosures and couldn't say a word, translating from many languages; quite impressive.

CATHCART:

You wonder who they could attract who would be willing to work under such rigid controls.

WEEKS:

I would hate to be in that position.

How is the for-profit hospital? The New England and Mid Atlantic states are not so much affected by investor-owned hospitals, are they?

CATHCART:

No, we are not. Too hostile an environment.

WEEKS:

So it really hasn't had much effect on your hospital operation.

CATHCART:

No, it has not. Although the practice of psychiatry in the Philadelphia area is influenced by the investor-owned hospitals. Nearly half of the pay hospitals in the Delaware Valley are investor-owned. So they compete with us.

WEEKS:

As I mentioned before, they are moving into it as a source of profit. Their general hospitals seem to be mostly in the south or California, Texas.

CATHCART:

Growth areas.

WEEKS:

That undoubtedly is the reason. I was quite surprised that the Hospital Corporation of America, at least a year or so ago, had two clients in Michigan and they were both small management. They had no hospitals. They did buy an aged retirement home type of thing where they operate on a rental basis rather than requiring investments by guests. If you go in as a patient you can pay so much a month.

Are the PROs working out? Are you satisfied in your hospital?

CATHCART:

Again, I am not really close enough to it to know. I cannot document anything I say. I have to report the feelings of the people who do work with them who are very frustrated and feel that they have been insensitive and feel that it isn't worth the time and effort, that they are spending more resources than they are conserving. I don't know that for sure. People who I respect feel that way, so therefore I have to assume that's true. I think that it's playing a useful role. I suspect those on the firing lines are unduly harsh and perhaps are not as objective about that as they might be. It's a very necessary role.

WEEKS:

As I remember the PROs are developed -- are they developed for a certain geographical area?

CATHCART:

Yes. On a state-by-state basis, generally one per state.

WEEKS:

Maybe the physicians resent other physicians on the PROs coming in.

CATHCART:

Oh, yes. I occasionally see letters from our staff people to the PRO which are very vitriolic. I would never send such letters, but they do. I guess it's good therapy for them to be able to do that. They are not effective letters. They argue for motherhood and virtue instead of being reasonable and arguing the facts of the case.

WEEKS:

Pretty emotional?

CATHCART:

Yes. It destroys their credibility as far as I'm concerned.

WEEKS:

Would you like to talk about the Leonard Davis Institute? I don't have anything in my records about that and I think there should be.

CATHCART:

Leonard Davis may have been the founder, if not the builder, of Colonial Penn Insurance Company which was a major health insurer for senior citizens. For many years they had an exclusive contract with the American Association of Retired People. Colonial Penn was an enormous financial success, and was one of the bright stars in the Philadelphia business scene until they lost that exclusive contract with the AARP.

With these resources and interest in health care, Leonard Davis was instrumental in helping the University of Pennsylvania establish a health care administration program, part of the Wharton School. One of my colleagues, working at the Pennsylvania Hospital as a vice president, Howard Newman, and Bob Eilers, a professor at Wharton, were asked to establish this program. Eilers and Newman did this. We have youngsters from that program coming to

the Pennsylvania Hospital for some practical experience; they do some term papers and some studies, have a residency period. The Leonard Davis Institute has a program of some investigation, research and fosters studies of various types. They need to have the credibility of somebody who at least knows what a hospital is and how it functions on a day to day basis. They are accused of being too policy oriented, too far away from the actual delivery of services. So I am one of their pigeons that they use on their letterhead to document that some hands on hospital people do work with them.

WEEKS:

This is the Howard Newman of HEW and Dartmouth?

CATHCART:

Yes.

WEEKS:

He is now at the Institute?

CATHCART:

No. Howard is a practicing attorney in Washington, hoping for Democratic landslide for the next president because I think he would like to go back into the government business. Howard used to work for the Pennsylvania Hospital. He was a vice president. Then he decided he wanted to know more about Washington, so he was the White House fellow, the first hospital administrator to be a White House fellow. Under Lyndon Johnson. Then he came back and was bored at the hospital so he helped form this program in health care administration at Wharton. After he did that he went to Temple law school.

WEEKS:

Yes. I have met him only once or twice but I was impressed with him. I'm glad to know that he had a part in that.

AARP must have been a big money maker.

I am confused about the hospital administrators' study societies. You know we had one of these that was started in Iowa, I think, by the University Medical Center Executives or some such. There are about eight different hospitals in it. Then Al Snoke said he started one.

CATHCART:

For physicians.

WEEKS:

Was his for physicians?

CATHCART:

Yes. This is the counter one -- counter to physicians. This doesn't have any physicians on it. Al Snoke's, I think, was the Association of Medical Administrators or something like that. This was the counter force to that. This thing developed at the time when there was a great deal of controversy between the physicians and non-physicians being in charge of hospitals. This also dates back to the period when the American Hospital Association would elect a physician one year and the next year a non-physician as the chief elected officer. Do you remember that? Rotating back and forth.

WEEKS:

Do you have any program at all?

CATHCART:

Oh, my yes. I am the president next year or this. Yes, we have a program. We work half day for four days. Some very good papers, very good people.

WEEKS:

Where is Pat Ludwig?

CATHCART:

He's at Kalamazoo.

WEEKS:

Did he take the Methodist hospital?

CATHCART:

I don't know which one it is. It is a combination, maybe Bronson.

WEEKS:

He's an industrial engineer by training, isn't he?

CATHCART:

I don't know.

WEEKS:

He was with the Michigan Hospital Association and before that he was in New York somewhere -- Buffalo.

CATHCART:

State hospital association there. This Hospital Administrators' Study Society, or Health Care Administrators' Study Society, is David Kinzer, Alex McMahon, Don Wegmiller, Scott Parker, Don Schrapshauer. It's an incestuous group. This Hospital Administrators' Study Society, HRDI, and VHA are all very interwoven. You see one person in one organization and again and again. A Department of Justice anti-trust lawyer would be set on fire, this incestuousness.

WEEKS:

Does this same thing apply to Voluntary Hospitals of America?

CATHCART:

Yes.

WEEKS:

I guess it was Stan Nelson who was telling me that it started out originally with about thirty hospitals. Then from new members paying entrance fees, kind of keeps the thing running.

CATHCART:

It's beyond that now. There are ninety-nine shareholders, compared to thirty. Then there are many other affiliates. So there are 700 hospitals under the same umbrella. The big source of income today is the commission on purchasing -- the kickback on purchasing. They shovel a lot of money through their supply company each day. Then there are modest assessments against the hospital itself.

WEEKS:

Is basically shared purchasing their big thing?

CATHCART:

They would deny it, but it is one of the biggest. They hope that they are more centered than that. They want to be sure that they have more service. They want to improve the competitiveness of the institution. They want to help bring the institution and the physician together. I think the jury is still out on that organization.

WEEKS:

How about representation before legislatures?

CATHCART:

To some degree they do that. It helps fragment the industry.

WEEKS:

This is one of the problems that I see for AHA, the fact that there are too many of these subsidiary groups that feel they have to operate on their

own, specialized interests and so forth.

CATHCART:

Absolutely true. Today we have talked about the National Committee for Quality Health Care and Voluntary Hospitals of America, American Hospital Association, CCME (Coordinating Council on Medical Education), all wanting to have a public voice.

WEEKS:

Someone like McMahon was very effective in Washington, probably.

CATHCART:

Yes.

WEEKS:

I can't remember any critical events that he might have had to face, but I'm sure that he was an effective spokesman. This is one thing that Kenny Williamson said after he was terminated from the Washington office. He opened his own consulting firm. He had people like the Voluntary Hospitals -- I don't know that he had the Voluntary Hospital Association, but groups like that. Maybe the Protestant Hospital Association.

CATHCART:

Yes. And individual hospitals themselves.

WEEKS:

Because these people thought that they couldn't be effectively represented by AHA.

CATHCART:

That's right.

WEEKS:

And when you stop to think about it, AHA is an umbrella and has very

diversified membership.

CATHCART:

Absolutely.

WEEKS:

With many interests.

The Mayor's Commission on Health Care in the 1980s.

CATHCART:

That was a project financed mostly by the Commonwealth Fund and the Robert Wood Johnson Foundation. The study permitted the city to plan what it was going to do about health care and develop a plan to attack all the problems.

WEEKS:

Did you publish a report on this?

CATHCART:

Oh, yes. Lots of papers.

WEEKS:

One question that always comes to my mind is how do you put these things into effect once you agree, you have consensus on certain needs, then what is the next step?

CATHCART:

You hope that the people who are part of the study process will stay around long enough to borrow and do some of the things they said that should be done. The problem is that they leave their jobs or they die or they run off to some place else and they don't stay around and implement what they said should be done. So many studies are collecting dust on shelves.

WEEKS:

Especially reports to the government, I am sure. You are probably an exception to the general rule because not many administrators stay in one position.

CATHCART:

Yes. I have to live with my words, so I am careful what I say.

WEEKS:

Maybe that is why you are a consultant and a member of so many groups.

We talked a little about the HMOs and I think you made one suggestion that maybe there would be so much competition among them that some of them would fall by the wayside. Maybe that's not paraphrasing you properly.

CATHCART:

I think that's true. There will be a good deal of dropout. Very much so.

WEEKS:

There have been many mergers in the last year that I know of, several at least.

The next thing looking to the future would be what do you think of the possibility of national HMO networks? We know that Blue Cross is attempting it. I don't know how many they've got signed up now. Probably half of the Blue Cross Plans are agreeing to some kind of a network. I don't know if they have the network itself worked out. Have you heard anything?

CATHCART:

I have not. I would spend my time on regional programs. I think health is a regional issue, not a national. I think if you could get a good alternative delivery system done on a regional basis you should count your

successes and go off and celebrate. I think it is going to be very, very difficult to do it nationally. You might get some networking of independent regional plans such as the old Blue Cross Association.

WEEKS:

Blue Cross, I think, has gotten into the idea of networks because of national accounts. They are looking at the accounts rather than the service. As you know, Michigan Blue Cross is dominated by the automobile companies, and they have to satisfy them. Kaiser-Permanente is another possible. I don't know whether the day will ever come when they will have regional plans all over the country or not, but they are spreading out somewhat in the past five years.

What do you think the role of the commercial insurance is in this deal? Do you deal much with commercial insurance companies?

CATHCART:

Not very much. We are a strong Blue Cross area, an increasing amount of HMOs. If the insurance company happens to own the HMO, we deal with them. Obviously any payor is someone to be concerned with and to study because providers are going to do what the payor says. He who controls the dollar controls the system. So it behooves us to know what the financier wants and how it wants it delivered. He will modify the system to fit in the way he wants.

WEEKS:

We talked a bit about specialized hospitals, for instance your psychiatric hospital. It seems to me that it used to be, a generation back, that there were more specialized hospitals than there are today. We came to the position of thinking in terms of the community hospital giving all the

services necessary except a few referrals to the big tertiary hospitals. Have you any thoughts about specialized hospitals?

CATHCART:

I think it is very risky to be in the specialized hospital business because somebody might discover a drug that will wipe you out. Or again a policy maker in Washington can sign a regulation that can wipe you out, such as the eye hospitals which are now anachronisms. We have an eye hospital within a block of ours that is less than ten years old and it is just barely hanging on. If it has an occupancy of 40%, it's lucky. But they do a booming business in their parking lot because they do a lot of ambulatory surgery. If they were designing that hospital today they would take away all of the beds and convert the beds to parking and be successful.

WEEKS:

This is understandable. Don't put all your eggs in one basket then.

CATHCART:

I have a lot of confidence that we are not going to figure out how to cure psychiatric problems. So, I think you are safe if you are in that specialty business because I don't have very much confidence that we are going to figure out how to master the mental health problems in the country. For another ten years anyway.

WEEKS:

A couple of words that I have come across in the last two or three weeks have been the idea of clusters and the idea of campuses. I think you used the word campus, didn't you?

CATHCART:

Yes.

WEEKS:

I noticed that Stanley Nelson talked about the campus. In fact, when I was trying to reach him by phone the umbrella organization is now Henry Ford Health Care Corporation. They have an office out in Troy, which is in the north part of Detroit. I called out there to his office and they said, "Well, he is at the main campus."

I got to thinking about this and I questioned him about it. At the same time I was talking to the Seventh Day Adventist and he used the term clusters, which means the same thing I think. It's to organize your campus, in other words cluster your services so you can arrange them and even take in satellites. You have a whole system worked out. How do you see that as a wave of the future?

CATHCART:

I don't think that's very new. We've been doing that for years and years and years. You look at New York Hospital and Columbia Presbyterian or the state university hospitals which have a burn hospital which may be run by the Shriners or orthopedic hospital run by some lady bountiful, or a cancer hospital, and a pediatric hospital, and a psychiatric hospital. Certainly the big megacenters in Texas have that pattern. They all know each other, and they all happen to be stationed together. The University of Alabama follows that, but they are not under the same leadership.

WEEKS:

Mr. Welch was saying that in some of their big hospitals, including the one they have in Orlando, the Florida Hospital, they have some of their high technology in a separate building and they transfer people by ambulance, if necessary, or wheelchair to this center where some of their outlying hospitals

might want to have it independently if they didn't have this service. I guess we are just going to have to move and try to meet the situations as they arise because you can't plan too far in the future apparently.

Have you had any experience with another term, regionalization, where you have had not ownership but an informal or formal contract or relation with outlying hospitals that you would furnish them services? They are not exactly satellites but they are members of a group of cooperating hospitals.

CATHCART:

The Pennsylvania Hospital is a shareholder hospital for Voluntary Hospitals of America in the Philadelphia area. We, in effect, have the franchise. We joined with a hospital in Allentown known as Health East, which is a shareholder, and formed a regional health care system using the VHA terminology. That regional health care system has eight or ten hospitals in it in a relatively small geographic southeastern Pennsylvania area. We hope it will make sense to do things jointly and work together.

WEEKS:

Is this mostly on purchasing or do you get referrals?

CATHCART:

Anything. Purchasing, establishing an alternative delivery system.

WEEKS:

Administrative advice?

CATHCART:

Yes. Anything that you think you might be able to do jointly better than you do it separately. I've often thought, could that be a good source of training? For example, one of those hospitals has a school of nursing. Should we all help that school maintain itself? One of the hospitals is a

burn center. Should we be sure that all of our burn patients go to that institution? We like to think of ourselves as a high-risk obstetrical hospital. Can we get all of those patients? A lot of that is rhetoric. We have not seen this happen yet. There may be possibilities. It is an idea that is attractive enough to study and try to make work, and not to become paranoid if we don't succeed.

WEEKS:

Kellogg supported a study of regionalization in Michigan back twenty or twenty-five years ago, but it didn't work out because there wasn't any two-way referral. The doctors became...

CATHCART:

Hospitals don't refer patients, doctors do. We can't control the doctors.

WEEKS:

Apparently this was the trouble.

CATHCART:

We do not hold this out as a means of obtaining new patients. If it hangs together for twenty or fifty years, it might. But that's a long treatment.

WEEKS:

Have you any feeling about the many suggestions floating around now about increasing Medicare benefits and Medicare premiums? Also do you think Social Security withholding should come from higher limits than whatever the high limit is now?

CATHCART:

Well, I think the basic issue here is this catastrophic health plan that

is proposed. I think it has cleared both houses of Congress. It has a provision in there that will be basing the beneficiary's contribution to the fund based upon the income of that person. The higher the income, the greater the percentage of contribution. That's in some way a means test in reverse. It's a means test for the first time for any Social Security program. Up until now the multi-millionaire got the same thing as the person who has earned a basic minimum wage. Now this breaks with that precedent. President Reagan hasn't signed this, but if he does I think it can have enormous consequences. Because it provides new revenues for the system that can be adjusted at the will of Congress by adjusting that from 3.2 percent up to 3.8 percent and then next year up to 4.2 and so on. And it can be done without too much public scrutiny and it opens up a huge new pool of resources for health care. Therefore, I have told many of the people I work with and health care vendors that they can plan to have great new sources of income because we as a society, if this bill passes, have made the decision that we want to put more and more money into the health care sector and we have devised a means to do it and a means that will take the American public twenty or thirty years to wake up to what they have done. In the meantime the health providers and vendors can grow bigger and bigger and bigger and figure out more expensive things to do.

WEEKS:

I think it was last year or the year before they started charging income tax to people receiving Social Security if their income was over \$30 or \$35,000 a year. Then a certain percentage of that was subject to income tax, which is entirely a new thing.

CATHCART:

But this is even more phenomenal. This is going to turn on the faucet that will shoot health care expenditures up to the ceiling. If you are a vendor to the industry, you ought to sit back and count your gains as you run to the bank with all that new money.

WEEKS:

It's going to be a shock when some people find that out.

I'm getting down near the end of my questions, but I was wondering what you feel about the rumors, or at least the statements that are being made here and there every now and then, about we are going to have national health insurance or a national health service. That the time has come. One, can we afford it if the time has come? Two, what do you think?

CATHCART:

Well I have no great new knowledge on this. I just have to pass on, I suppose, what other people have said that sounds sensible to me and that is that we have huge fiscal problems nationally as it is, why would any policy maker want to jump into making that even more difficult, that fiscal dilemma. We as a nation love to pick social problems apart little pieces at a time, slowly correct one piece at a time. Eighty percent of the people are pretty well cared for. They control most of the votes and it will be minor reforms that they will support. One thing that could upset this is -- and it is a very major concern of mine -- that the voluntary sector fails to act as an agent of the public. We are spending public monies and we are not as responsible to the public for those funds as we should be. I think the Pennsylvania Hospital has done so much better than most hospitals and that is because it has had a board that takes its responsibilities very seriously.

They are in charge of the hospital. I'm a hired gun from out of town. The medical staff are technicians, and they are privileged to practice in this environment which the board controls, sets priorities for. I'm afraid that system isn't strong in many other places in the nation. As those boards lose control, or don't follow up on their responsibilities, then the public policy makers who are frequently politicians will exploit that and feel that they have to move in to give the public protection and to give the public value for their tax exemptions that they grant to non-profit hospitals. When we do that we will have a far different health care system than we've had up to now. We will have lost the privilege and lost an opportunity to keep it in private hands, in the hands of people who are socially motivated who want to do good for their community, want to conserve resources, and will demand a business-like, cost-effective operation. It would be a backward step to transfer this privately controlled hospital to a public agency.

So I think that is the risk that we are facing.

WEEKS:

One last thing. Does your hospital do much in the way of health education, reaching the general public? I know many hospitals advertise, but I don't call that the right kind of education. For instance, getting people to take certain tests or getting people to watch their blood pressure or their cholesterol or whatever may be a topic of importance.

CATHCART:

We are not a role model for the rest of the world by any means in that way, but we do have child birth classes. We do have a yearly diabetes detection program. We do have colon cancer programs. We do have diabetes education programs. We do have a teratology hotline.

WEEKS:

Teratology?

CATHCART:

That's a high risk obstetrical hotline. We do have a telmed program. We are doing lots of those things, but as I said, I wouldn't hold ourselves out as a model.

WEEKS:

Is there anything you would like to add to this documentary?

CATHCART:

I want to thank you for the opportunity of being here. I have certainly enjoyed it. It's very stimulating talking with you.

WEEKS:

I have enjoyed having you here. I think this is going to be a good contribution.

Interview in Ann Arbor

August 26, 1987

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