HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Edward J. Connors

EDWARD J. CONNORS

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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American Hospital Association
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Hospital Research and Educational Trust
Chicago, Illinois

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CHRONOLOGY

1929 Born in Sioux City, Iowa, February 23

1951 University of South Dakota, B.S., Mathematics

1951-1953 U.S. Army

1954-1955 Rhode Island Hospital, Administrative Resident, Administrative Assistant

1955 University of Minnesota, M.H.A.

1956-1960 University of Michigan, Program in Hospital Administration, Assistant Director

- 1956-1960 University of Michigan, Bureau of Hospital Administration, Community Surveys, Study Director
- 1956-1960 University of Michigan, Bureau of Hospital Administration, Study of Hospital and Medical Economics, Research Staff Member
- 1957-1960 University of Michigan, Bureau of Hospital Administration, Study of Progressive Patient Care under a Kellogg Foundation grant, Project Director

1960-1969 University of Wisconsin Hospital, Superintendent

- 1961,1963 University of Michigan, Graduate School of Business
- 1966, 1967 Administration, Clinical Preceptor, Supervisor of Graduate Students

1962,1964 University of Chicago, Graduate School of Business Administration, Clinical Preceptor of Graduate Students

1963-1969 University of Wisconsin Medical Center, Assistant Director

1963 American Hospital Association, Committee on Personnel Management, Member

1963-1969 Wisconsin Hospital Association, Member; Board of Trustees, V.P., 1963-1966; Legislative Committee, Chairman, 1963-1966

1964 Madison (Wisconsin) Hospital Council, President

1964-1966 University of Minnesota, School of Public Health, Policies Advisory Committee, Chairman

1964-1967 W. K. Kellogg Foundation Advisory Council to the Division of Hospitals, Member

1964-1967 American College of Hospital Administrators, Book Award Committee, Member

1964-1967 American Hospital Association, Advisory Council of the Hospital Research and Educational Trust, Chairman

1964-1969 University of Minnesota, School of Public Health, Education Advisory Committee, Member

1964-1967 Abstracts of Hospital Management Studies, Advisory Board, Member

1964-1967 W. K. Kellogg Foundation Study of Wisconsin Nursing Homes, Project Director

1965-1969 Dane County Health Planning Council, Member

1965-1969 Madison United Hospital Laundry, Member Board of Directors

1966-1969 U.S. Public Health Service, Health Services Research Study Section, Member

1966-1969 Wisconsin Regional Medical Program, Member Board of Directors

1967-1969 University of Minnesota, Alumni Association, Program in Hospital Administration, President

1967 Commission on Accreditation of Programs in Hospital Administration, Member

1968-1969 U.S. Department HEW, Health Services and Mental Health Administration, Consultant (on contract basis from the University of Wisconsin

1968- Northwestern University, Health Services Research Center, Executive Committee, Member

1968-1970 American Association of Medical Colleges, Charter Member of General Assembly representing Council of Teaching Hospitals

1968-1971 W. K. Kellogg Foundation Study of Long-Term Care Facilities in Wisconsin, Principal Investigator

1969-1974 University of Michigan Hospital, Director

1969-1974 University of Michigan, Program in Hospital Administration, Professor

1969- Teaching Hospitals Information Center, Advisory Committee, Member

1969-1970 American Hospital Association Special Committee of the Board of Trustees on the Provision of Health Services, Member

1969 Blue Cross Association and Council of Teaching Hospitals Liaison Committee, Member

1969 Michigan Blue Cross Committee on Hospital Utilization, Member

1969 American Public Health Association, Program Area Committee on Medical Care Administration, Member

1969 Presbyterian Hospital, Advisory Committee to the Health Services Department, Member

1969-1973 National Center for Health Services Research and Development, Consultant

1969-1970 American College of Hospital Administrators, Ad Hoc Committee on Colloquium, Member

1969-1972 Council of Teaching Hospitals, Executive Committee, Member

1970-1974 Commission on Accreditation of Programs in Hospital Administration, Chairman

1970 National Committee on Vital and Health Statistics, Uniform Hospital Abstract Form Subcommittee, Member

1970-1972 American College of Hospital Administrators, Committee on Education, Member

1970-1974 Greater Detroit Area Hospital Council, Planning Committee,

Member

1970-1973 Comprehensive Health Planning Council of Southeastern Michigan, Member

1970-1974 Commission on Physician and Hospital Activities, Member at Large

1970-1973 Michigan Hospital Association, Board of Trustees, Member

1971-1974 Michigan Hospital Service, Trustee

1971-1974 Greater Detroit Area Hospital Council, Board of Trustees; Executive Committee, Member

1971-1972 President's Science Advisory Committee, Member

1971-1974 American Hospital Association, Council on Manpower and Education, Member; Chairman, 1972

1972 Family Planning Medical Service, Inc., Director

1972-1973 U.S. Department HEW, Research and Advisory Committee on Long-Term Care for the Elderly, Member

1972-1974 American Hospital Association, General Council, Member

1973-1974 Catholic Hospital Association, Board of Trustees, Member; Special Committee, Member

1973-1974 Medical Alert Communication Editorial Board

1973-1975 American Hospital Association, House of Delegates, Alternate Delegate

1974-1976 Sisters of Mercy Health Corporation, Consultant

1975 American Hospital Association, General Council, Member

1976-	Sisters of Mercy Health Corporation, President
1976-1978	Sisters of Mercy National Office, Generalate Committee on Health Affairs, Member
1977	Catholic Hospital Association, Special Study Committee, Member
1977-1978	Catholic Hospital Association, Long Range Planning and Development Committee, Member
1977-1980	American Hospital Association, Advisory Panel on Multi-hospital Systems and Shared Services Organizations, Chairman, 1978-1980
1978	American Hospital Association, Book Publishing Consulting Group, Member
1978-	National Committee for Quality Health Care, Member
1978-	Henry Ford Hospital, Advisory Board for Applied Research in Health Care, Member
1980-	Mercy Health Conference, Member Board of Directors
1980-1982	American Hospital Association, Council on Management, Chairman
1980-1982	American Hospital Association, General Council, Member
1981-1982	Associated Hospital System, Chairman
1981-	American Hospital Association, HRET Planning, Budgeting, Control Systems Project, Steering Committee, Chairman
1982-	Blue Cross & Blue Shield of Michigan and Participating

Hospitals, The Reimbursement Committee, Member

1982- American Hospital Association, Special Committee on Equity of Payment for Not-For-Profit and Investor-Owned Hospitals, Member

1983- American Hospital Association, Board of Trustees, Member

MEMBERSHIPS

American College of Hospital Administrators

American Hospital Association

Wisconsin Hospital Association

BOOK PUBLICATIONS

Hospital Income Flow, with James B. Bower, John E. Mosher, and Clyde S. Rowley. Madison: Mimir Publishers, Inc., 1970

I'd like to start with a little bit about my own roots and heritage. I came from an Irish family that immigrated from Ireland because of the potato famine after the difficulties in the mid-1850s-1860s. They are a very rural people, a very proud people, a very poor people. They came to America through Canada and they homesteaded in the state of South Dakota. One of the things I'm particularly proud of is that the original land is still in my family and is being farmed by my family. The land was homesteaded in, I think it was the late 1860s or early 1870s. It is hard for us to remember now, or think of it now, but the Irish were a minority in an all Catholic community because for some reason that little community in South Dakota was settled by the French and everyone was Catholic. In fact, up until 1950 there was not a public grade school in the community because no one went to it, all went to the Catholic school. But there were about five Irish families in this farming community--my own family being one of them--and all the rest were French Catholic. So the Irish Catholics, in my view and as I would understand it as an adult, were really discriminated against because the were Irish. I think those early roots had quite a lot to do with how I found myself into the health field.

I think I learned in those early years the concern about the people, about

what we were trying to do in communities to make life perhaps a bit better, the understanding of service.

I was in high school during the war years--went to a Catholic high school, prep school--in Sioux City, Iowa, and I think that that, along with my Irish roots, and those rural traditions, have had a profound impact on, I suppose, the way I think and my values and what I'd like in life and the way I'd like things to be. There was an order of Brothers called the Marianists out of Dayton, Ohio. They were very, very tough; fair, but very tough. It was sort of a "no nonsense" high school and no frill high school. The basics, as we would understand it today, were not only insisted on, they were grilled into us. This approach was influential in trying to get us as individuals to think about what we wanted to do in life, what we felt was important. Why did we want to do that? The teachers were not directive as I would recall it now, and they were not manipulative, but they were challenging. They caused us, as young teenage high school boys during the war, to give some pretty serious thought to who we were, why we thought the way we did and what we wanted to do in life.

I became persuaded during those years that I really wanted to become a teacher. So I went to the University of South Dakota right after World War II directly out of high school and started on a path of wanting to teach, and probably combine a teaching career with coaching. I was drawn also to working with people. So after I got into college I had some feeling that I really wanted to get into school administration.

The years at South Dakota, I think, were excellent and formative. That's when I became interested in, and knowledgeable about, the field of hospital or health administration. There were two people that really brought to my

attention the oppotunities that they thought existed and their view that perhaps I had some of the skills and abilities and interest that might fit in health field. One was a fellow named Jim Harvey, and Jim is currently president of the Hillcrest Medical Center in Tulsa, Oklahoma. Jim and I were classmates at South Dakota. I correct that, he was a year ahead of me, but we were roommates and we played on the football team together and we were very close friends. Jim was searching around for a career choice and thought about medicine. He was bright enough and smart enough to go to medical school, but decided he really didn't want to do that. But his interest in health was long standing. I never really knew how Jim found out about this emerging field of hospital administration but he did. He went on to graduate school immediately out of college and was so excited about it and so interested and so convinced it held a good opportunity that he was influential in my choice of what I wanted to do. I then decided that this was the way to pursue a career, a little bit with some regret because I was really attracted to the field of teaching and I guess the way it turned out later is that I've done some teaching anyway.

I want to record there were two other persons that were influential in that decision. Because I really knew nothing about the field, I thought it was important to talk with some active administrators and so I sought out two. One was Mr. Harold Wright, who was the administrator of the Methodist Hospital in Sioux City, Iowa and the father of a close friend of mine. Harold Wright subsequently went on to be the director of the Methodist Board of Hospitals & Homes on the national basis. He was a hard-working, and I suppose, effective administrator in a community that has some typical health problems, and a lot of competition and so forth. He gave me a realistic view

and said it's hard work, it's tough and you don't get much affirmation from very many people. Being an administrator means you're pretty alone and with many decisions you never know quite where you stand with your board and physicians. There are different points of view. It's darn hard work but very satisfying, if you think and believe, as he did, and as I do, that hospitals are instruments of society, instruments of a community, and they're there to serve people and therefore, they're very important instruments created by society to serve people.

The other person I sought out was Mother Carmelita Manning. Those were the days in which the top religious leaders were called "Mother" and "Father" and that sort of thing. Carmelita Manning was related through my wife--that was before we were married--and she was the head of the Sisters of Mercy order in Detroit, Michigan. She cautioned me that I would probably be discriminated against because I was Catholic, and I ought probably not go into this field because it wasn't really a place for a Catholic layman because the religious hospitals were organized and staffed and administered by nuns. Also many of the nonreligious hospitals, as she had seen it, would never hire a Catholic as chief executive officer. I did not accept that point of view but it was interesting to me that a woman of her persuasion and intelligence and tremendous ability had this deep-seated conviction--and this was in 1950--that Catholics were actively discriminated against in various walks of life. There may have been a bit of truth to it, but I fortunately still believe that such a conviction is basically wrong. Her additional advice was, "It's darn hard work, and you may not make it 'cause you're a Catholic." Everything else was positive. Everything else said, "Look, its a field that desperately, badly needs youngsters able and willing to try to come in and do something

about hospital leadership, hospital management, etc. So, with very, very little knowledge I decided I was going to pursue this as a graduate student.

One thing intervened. I had signed up for ROTC and frankly, it was after World War II and none of us felt that there would be any likelihood for us to be used or needed or drafted and it was $30 a month, and $30 a month was darn important in those days. The Korean War broke out and I found myself as an infantry officer in Korea because that was the branch of service that the commission was in. I did have thirteen months of combat in the Korean War. I suppose in retrospect that experience also had a very profound impact on me. I was thrown into a situation that I was obviously almost totally unprepared for. I found that I had to reach pretty deep into my own set of innate abilities and courage and all the rest to just sort of make it each day. As an officer, of course, I quickly discovered that although I was young and inexperienced, I had quite a lot more going for me than most of the people I was responsible for and they, in fact, were looking to me as a person who was supposed to know all the answers. I never really had a chance to share with them the terrible feeling of inadequacy and fear and all the other emotions that go with such an experience. I suppose my ability to cope was aided by two influences: my belief in God; and the experience of athletics. I was a fair athlete in college and in high school and some of the discipline that came from such experience stood me in good stead, for example: the feeling of team spirit; the necessity to be concerned about one another; and the necessity to hang in there together. Some of these basic attributes I found were needed when it came to the forty young men that I was initially responsible for in combat. Later I commanded a company, 200 men in very difficult situations in combat. I suppose I changed more in those two years

than most persons change two years out of college. I surely learned the futility of war, the insaneness of killing, and the pervasive influence of survival. So I came out of the army ready to go to graduate school quite a different person than I would have, I think, if I had gone directly from undergraduate work.

Through Jim Harvey, really, then I went to University of Minnesota and I found it to be a fascinating field with a first class and inspiring leader in Jim Hamilton. I was smart enough to know that I didn't know anything about the field and, therefore, didn't carry around the burden of trying to know any answers. Thus I found the academic experience under Jim Hamilton's leadership to be, perhaps not very technically helpful, but enormously helpful in terms of attitude, point of view, concern, understanding, and values about the importance of management in the health field. I kind of chuckle occasionally when current persons in academic hospital administration sort of disdain or look down on or criticize or say, "Well, we used to teach a lot about the laundry and so on." Well, that opinion is just nonsense and not accurate. I don't think such persons know what Jim Hamilton was like in the classroom. Sure there were some approaches that perhaps in a current understanding we'd do a little differently, but Jim Hamilton was a man of tremendous capacity and ability and had the day-to-day ability to really challenge students, to stretch them, to make them think. He did it with a lot of tough techniques of teaching. He was and is a first class actor. I told him later after I got to know him a bit better, that he really belonged in the theater. He was a dramatic teacher, but he had a way of making us very, very excited about the career that we had chosen. Realistic but excited. Just sort of made us feel we couldn't wait 'til we got our hands on an opportunity. Jim Hamilton, I

think, made us think very deeply about what is the purpose and role of the hospital. Why does the hospital exist in the first place? What is it's basic mission? Why is it there? I think that was so important in the formulation of attitudes and opinions that I am everlastingly grateful to him because it isn't the question of what's the latest technique in accounting or organizational theory or whatever. The essence, it seems to me, in management is to understand what it is that you're trying to do and what the organization is all about. Jim Hamilton and Jim Stephan and that faculty at the University of Minnesota did that for us as students. They did one other thing for us who had no knowledge of the field--they opened up some doors, and so I went to the Rhode Island Hospital in my administrative residency. I found out that the transition from the classroom to the practical world was difficult and that the real problems were tough. The power struggles, the competing points of view, were real. Mr. Oliver G. Pratt was administrator at that time and was very influential in my life and my development. He prided himself and his organization in the fact that he took young men from the University of Minnesota -- he and Mr. Hamilton were close friends--and there were a number of successful people that preceded me as students. I was fortunate enough to be asked to go to Rhode Island Hospital as an administrative assistant. I have really two recollections of the Rhode Island Hospital experience. The first was the reality of very poor people. I came from a very modest setting myself, but I had never really seen in America the poverty to the extent that it was extant in Providence, Rhode Island including the poor and near poor and marginally unemployed first generation, primarily Portuguese people. I became conscious of the fact that the way those people were treated, even by an institution of the prestige and quality of the Rhode Island Hospital, was less

than satisfactory, less than desirable. The long, hard benches in the outpatient department, for example. No continuity of physician contact and the endless waits because scheduling was for the convenience of the doctor and not the patient, etc., made me painfully aware that there were classes of medicine and classes of citizens, and the economical classification of people, citizens and patients did make a difference as to how they were treated.

I guess I made up my mind those years that such treatment was unfair and unjust, and to the extent that I would have anything to contribute I would try to do something about eliminating or reducing the inequities. In other words, I would try to change the fact that some people didn't have a very good shake when it came to decent medical care.

The Rhode Island Hospital also, I think, helped me understand what management was all about in a practical sense. Oliver Pratt had an excellent administrative staff. He had functional and technical experts, particularly in the area pf nursing and planning and in finance. So I became conscious of and aware of the absolute necessity for team management. He was very much a team player, a team builder--open communications with his staff, proud of the fact that the institution was moving in a purposeful direction. Very dedicated person. He came out of public administration--city administration--small New England town. Very New Englandish. Very conscious that he was not personally a member of the social and economic set in Providence. Probably didn't have many close friends other than the hospital field because he didn't quite fit in the society of the Providence, Rhode Island that was dominated by a few families with a great amount of money. He had a way of not only helping us young people like myself while doing his job but also of trying to steer the hospital in that community in directions that were obviously the right

ones. One of the early hospitals to understand they had to get into the ambulatory care and try to change the habits of the physicians. He was a man of enormous capacity, ability, and dedication, a man who really cared about people. A real humane person, never too busy, always able and willing to answer and respond to the dumbest question that would come from a youngster like me, and aware of the power struggles that went on in that community. It was and is a hospital that is committed to high quality education because there really was no medical school in the state of Rhode Island in those days. That hospital, along with two or three others on the East Coast, attracted students from Boston and New York medical schools and so the quality of graduate medical education was very high. Good students came to Rhode Island to a setting where education was stressed and the faculty was primarily in private practice, a model some people wouldn't think was a very good idea today, I guess. The students got supervision and they got good solid clinical training. All the marks and measures of success were there. So the RIH was my first formal introduction to that form of medical education. It was a setting in which one could absorb as much as he wanted. There were no boundaries or barriers to what you were able to do if you were motivated.

I suppose that experience helped me understand a need for creating environments that are modeled intentionally as educational and academic settings. In other words, the need to provide an environment in which young people can really formulate their own understanding of what the hospital is all about, what management is about, etc. The Rhode Island Hospital was a place where that took place. I had every intention of staying at Rhode Island Hospital until one day, unannounced and unanticipated, came a fellow named Walter McNerney, and we sat around Jim Hamilton's living room in South

Duxbury, MA, one Saturday afternoon and at the end of the day Walter said, "I'm going to Ann Arbor, Michigan, and I want you to come with me."

It took me about ten seconds to say "Yes." That was literally the way it happened.

So I left the Rhode Island Hospital a few months after my administrative residency to join Walt McNerney at the University of Michigan in Ann Arbor where Walter had been recently appointed as the director, and first professor of the Program in Hospital Administration. I was with Walter for nearly five years. I guess I couldn't adequately record the stimulation of those five years and the unusual opportunity I had as a person to work that closely with Walt McNerney at a point in his career when he was developing himself and formulating some of his own ideas, and to be, really in the truest sense of the word, a colleague of his. There were only the two of us at first and the University of Michigan took us under its wing and helped us enormously. In those days we were in the business school plus we were a part of a very excellent university that was committed to quality education. The business school, the medical school, the university hospital and the school of public health made good their commitment that they would do what it took to develop quality graduate education in this applied field of hospital administration.

There was quite a debate before the University of Michigan decided to get into this field. After the war when some of the programs in hospital administration sprung up, Michigan stayed out of the field of graduate study in hospital administration at first. I learned during those years that there were two reasons they stayed out of it until the mid-fifties. One reason was that, as I understand it, there was the understandable rivalry between the school of public health, the graduate school of business, and the medical

school as to who should own the turf that health administration represented. There was an impasse for several years. I suppose like most things, given that kind of infighting, university officials decided it wasn't worth a faculty fight as to whether the medical school, public health school, business school, or university hospital would win.

The decision at Michigan was helped through by the Olsen report. The Olsen Report was from a study financed by the Kellogg Foundation in the early fifties as to the content of and the responsibility for graduate education in health administration. One of the conclusions of the report, at least the way the report was interpreted, included the idea that it really didn't make any difference whether a program of hospital administration was in the medical school, business school or graduate school or whatever. It did make a difference though that all the relevant disciplines were brought to bear upon this emerging field. I think Michigan picked up that cue and developed a multidisciplinary approach to the field in the mid-1950s.

The University of Michigan therefore got into education for hospital administration partly because they saw that there was a need. They did it after systematic study and they ended up placing the administrative responsibility for the program in the graduate school of business administration. It was a wise choice in my opinion, because that faculty took seriously that responsibility, and really embraced two young people, Walter McNerney and myself, in making sure we had whatever we needed. By whatever we needed I don't mean money. I mean the opportunity to reach into other faculty disciplines for teaching and for understanding and opening doors within the university. Thus the graduate school of business under Dean Russell Stevenson took on this program in hospital administration. From the very first day

there was an advisory mechanism--almost like an executive committee--that consisted of four key power figures: Dean Furstenberg in the School of Medicine; Dean Vaughan, School of Public Health; Dr. Kerlikowske, the director of University Hospital; and Dean Stevenson. Those four people said, "We want this to go. We want it to be of high quality and whatever it takes we're willing to try." Walter McNerney, of course, was bright and clever enough to see that as an enormous benefit. So he effectively utilized the committee and the resources represented. He did it through considerable personal charm and charisma and led the program in a direction that I think surprised some of the committee. He took a view of hospitals and health administration that was, in those days, far-reaching and forward-looking. The two of us had an enormously exciting time for nearly five years, starting from scratch a program in health administration--hospital administration--in an excellent university.

Among the things that I learned there was that one of the most difficult things is to be in a classroom with bright students. You'd better know what you're talking about. So, it opened up a whole series of contacts and insights in an academic, multidisciplinary setting that I just had no contact with before that time.

I hope that history will recall too that the graduate school of business had a lot to do with the success that the University of Michigan's program in health administration now enjoys. Herbert Taggert, who was associate dean, spent endless personal hours in making sure that we had quality students and that when we needed and wanted administrative support we got it. Professor Taggert monitored, in the best sense of that word, what was going on with these two young, unknown health administrators, McNerney and Connors. All the divisions of the graduate school, people in finance, in personnel

administration--that's what it was called then--and accounting were committed and helpful. Even though I think they were intellectually and philosophically opposed to specialization they believed that there was something about this health field that was sufficiently different to warrant discreteness. So when it came to the basic disciplinary fields of management the Program in Hospital Administration benefited from the talent of the school. So from the very first the Michigan program was built much less on practitioner and internal operators--the how-to approach--and much more on the root disciplinary activities that need to be brought to bear in health management. The opportunity to draw from public health, business administration, medical school, university hospital was conceptually, I think, very sound. I suppose that neither Walter McNerney nor I would change very much in the approach, in the location, and the opportunity to draw together relevant disciplines.

The work at Michigan in those years quickly got us into research study and inquiry. I became aware during those years that we knew really very little about the field of hospital administration. I didn't find that disappointing, it was just the state of the art at that time. In '57, '58 there was a tremendous economic crisis in the state of Michigan. The crisis seemed to be very cyclical, predictable. The crisis brought much concern about hospital and physician costs. Through a lot of interesting negotiations it ended up that Walter McNerney was asked to direct a study of hospital and medical economics in the state of Michigan. He was asked to do this because he was acceptable as well as capable--acceptable to the medical community in the state of Michigan in contrast to the faculty of the School of Public Health who were not acceptable, even though such faculty had the background and experience needed. The study was funded by the Kellogg Foundation primarily,

augumented by some state money and some university hard money. That decision had some problems to it and strained our relationships with the school of public health, who felt that unless they could do the study it shouldn't have been done at all. The study projected Walter very quickly into a whole new and different realm of activity as compared to the academic part of classroom teaching and gave our program needed resources and visibility. Walter was able quickly to recruit a team of people that subsequently had quite a lot of influence and a lot to do with the future developments of the program. That's the time when Bill Foyle, Whitney Spalding, Tom Fitzpatrick, and Don Riedel came to Michigan plus Ashley Weeks and Bev Payne. Most students took for granted that such talent was part of the faculty. The basic reason such people were there was this study of hospital and medical economics. It also got Walter very quickly into some very difficult political relationships in the state and university and nationally. In many ways, I think, the study demonstrated to a lot of people that Walter had the capability of dealing effectively with political activity--and always landing on his feet. Such experience probably later was a determinant when the Blue Cross Association board hired this young professor out of the state of Michigan. His ability and the respect he earned from the study were, in my opinion, the start of his national career. The leaders of the auto industry, the labor movement, the physicians, and so forth, realized they had a person that wasn't just the average college professor.

I think there was an excellent foundation laid for the graduate education in hospital administration at the University of Michigan in those years. Walter and I together had a lot to do with that foundation. It's one of the things I'm really very proud of in my work in this field.

It should be recorded that in those years we had great opportunity to try to develop effective relationships with the practitioners of the field. So, again, because we felt that we needed help and such help was important, we were able to go to such people as Robin Buerki of Henry Ford Hospital and Ronald Yaw of Blodgett Hospital in Grand Rapids, George Cartmill of Harper Hospital and others and say, "Hey, we're in this business, we're in the state of Michigan, and we need help."

Without fail, those people responded and helped. They produced what they were best at, which was to agree to accept our students; to agree to be available for practicum, for administrative residency, for problem solving--real live issues and questions facing the practitioner. There were six or eight administrators from the state of Michigan, maybe ten, who really emerged as being able, willing, and capable of promoting and contributing to the success of the graduate program. I don't think that Walter and I could have developed quality as quickly as I think we did without that continuing help from very prestigious people--mostly in the state of Michigan but a few selected national persons also. In a sense I feel that graduate education as it's now understood has suffered from the lack of those sound ties to the operating setting. I don't mean to imply there isn't a danger of parochialism and the latest war stories of the how-to practitioner, but that isn't what the practitioners were all about in those days either. Rather our approach was a conscious attempt to make realistic and meaningful and contemporary what we were trying to do in the classroom. So the program in hospital administration was shaped by some very able practitioners as well as by the two full-time faculty and the resources of the university.

We also found ourselves into another activity called community service.

Building on the traditions of the University of Michigan, we became committed to education and research service. Our way of service was not the rendering of direct care because the University Hospital unit of the university had service as its base mission. Thus we did not really get involved very much with the operation of, or the problems of, the administration of the University Hospital.

Through the support of Andy Pattullo of the Kellogg Foundation, we got into the fabric of the work of the hospitals throughout the state of Michigan. You'll recall that those years, second half of the fifties, were years of tremendous growth and building of hospitals. The Hill-Burton program was at its high point. Every community in the state of Michigan was trying to build a hospital or remodel or expand. The Kellogg Foundation was often looked upon as a source of funding and support for hospitals' capital needs. Communities were scrambling around to come up with their one-third "obligation" and they would often turn to the Kellogg Foundation for help. Partly, I think, as a defense mechanism, but more seriously, I think, as an attempt to really find out what was appropriate, the Kellogg Foundation referred many requests for help to this new program in health administration at the University of Michigan for study. A lot of questions and issues regarding need, demand and use were raised in the process of such study. The Kellogg Foundation would say to a community, "Why don't you study what you need and then maybe we c n talk." It was not a delaying tactic, rather it was honest conviction on the part of Andy Pattullo and Emory Morris that communities need definitive study about what was appropriate to provide in that community: the number of beds, the number of specialists in relationships to other hospitals, and so forth. So I suppose at the rate of

about three or four a year with very limited resources and I suppose in some people's opinion, limited ability, Walter and I took on community studies. I was fortunate in that I was the person who ended up often carrying through on many of the studies and writing the rough draft. This allowed me to interact directly with the physicians and the hospital administrators and the local boards. I found such studies fascinating in being able to have hands-on experience in places like Benton Harbor, Midland, and Sault St. Marie. I had the opportunity for hands-on experience in what a fifty bed hospital is like with five physicians, with a typical community board and so on. Thus many of the things we were trying to understand in the classroom became much more meaningful. There was a direct interaction between that community service work and the approach used in the academic setting. The experience had the other benefit to me personally of being rewarding and enlarging and enriching, but I do fundamentally believe that it also had the spinoff benefit to our students. There was no economic motive.

So, I think during those five years, we got into education mostly because of the reputation and resources of the University of Michigan; we got into research because of timing in the state; and we got into community service in the state of Michigan through the Kellogg Foundation. In a sense these five years really rounded out my experience and included what I suppose most people would take ten or fifteen years to experience in other settings. McNerney is and was a person with a way of developing the values, abilities, and resources in others. He is so bright and so articulate that he sometimes frightens some people. They don't know how to interact with him because they're a bit scared of him--a little afraid of him intellectually. Some people find themselves not trusting their own instincts in dealing with Walter. I had some of those

emotions when I first met him, but I quickly learned that if you're just yourself and if you really kept coming from a logical and inquisitive, very basic point of view and didn't try to pretend what you didn't know, you could interact with Walter. I also learned that he had a set of insecurities and instincts and strengths and weaknesses as anyone else. But he also had the capacity of stretching a person, of really challenging, on a constructive colleague basis, what was thought about things and why. I suppose no one else in his career has ever had the opportunity that I had to really literally everyday put feet up on the desk and have a go-at-it with Walter McNerney. I'm sure that both of us later were into situations where we didn't have that luxury and opportunity. I suppose I learned more about the health field from Walter McNerney than any other experience. The opportunity came about when we would be driving back to Ann Arbor from Sault St. Marie at 12 o'clock at night because we had an 8 o'clock class the next morning. We would often start debating about what we saw or heard, and did it really make any difference, and why, etc. I really would recommend the value of those community studies for anyone who wants to understand the differences in pluralism because the state of Michigan is a microcosm in the United States in many ways--urban, intercity problems, rural problems. McNerney was an excellent teacher. The students who were intellectually able got more than those who were overpowered by him. He's a warm, generous, genuine person, who works hard, lives hard, plays hard, and who really cares about values. He cares about people and he doesn't have much tolerence for mediocrity. He's energized by people who have different points of view who are willing and able to challenge him. He has an intellectual capacity that I would suppose is very, very high on any rating or ranking scale. He has a sense of where health and hospitals fit and he had a

sense far before his time in recognizing the complexity of reimbursement, of regulation, of control, and of private initiative and private responsibility. He was able to verbalize and articulate points of view, I think better than any single person I have ever come across. I don't know why or how but I just feel it was probably the most single determining factor in my own development and career and understanding to have that opportunity. I am eternally grateful to Walter for my tutelege.

I want to comment briefly on the important role played by John Zugich of University Hospital. John is a quiet, very constructive, very effective person. John, in his own way and style, had an enormously influential hand in the development of the graduate program at Michigan. From his base as associate administrator of University Hospital he was able to give guidance and steering to McNerney and myself in the politics of the university. He would seek out the faculty members of the medical school who were able and willing to contribute substantively, for example. He also was a very good teacher and he gave much without very much recognition, and surely no reward. He gave of himself very much during the last part of the fifties and I don't think the graduate program would have moved as quickly and as fast in the university setting without the guiding hand of John Zugich. I think that fact deserves to be recorded.

I entered then in 1960 to a fascinating and different phase of my career. I got a call one day from Andy Pattullo of the Kellogg Foundation. He said, "You're going to get a call from Dean John Bowers of the University of Wisconsin. He's looking for someone to administer their hospital and he wants to talk to you."

I said, "Andy, you've got to be out of your mind. I don't know what a

university hospital is let alone be able to administer one." I was 29 years old. I don't think they had any idea of how young I was. They never asked me. But it turned out that John Bowers, an internist, who had gone to the University of Wisconsin two or three years before that time, was trying to implement some changes at the University of Wisconsin and needed someone to run their University Hospital. I went out to Wisconsin and met with John Bowers and the president of the University and the leaders of the medical school. The experience reminded me of the earlier warning of discrimination. When it got down to the final interview--the decision was pretty well reached--the president of the University was pretty nervous and fidgety. The president was a man by the name of Conrad Elvehjem, Scandinavian by birth and extraction, I guess. He said, "I have to ask you this. I want you to know it doesn't make any difference, but are you a Catholic?"

I said, "Yes. Why did you need to ask me?"

He said, "Because I'm going to be asked. We've never had a Catholic before in this level of administrative position at the University of Wisconsin."

So, maybe Mother Carmelita wasn't all that wrong. I don't mean to imply in any way, you know, that there was, in fact, any discrimination at the University of Wisconsin, because it's a very open, liberal and accommodating university in every aspect. It is a comment on how far we have advanced since that time to reduce bias and discrimination. So as a young and very unprepared person, I agreed to be the director of the University of Wisconsin Hospital. I was hired in '59 and got there in '60 and was there for nearly a decade--nine years. The 1960s was an era dominated by scientific medicine. The National Institutes of Health was in its heyday. There was more money

around for research than could be reasonably spent and the driving force of the academic health centers in those days was research. Teaching and patient care were, I guess the kindest way I can put it, of secondary interest. Every professor in every position had to have his research laboratory.

So there was for me a lasting impact and understanding that there were new ways to think about hospitals and health care that I hadn't thought about before. I had been intrigued with such issues during the years that McNerney and I were together but neither of us was really a researcher. Further, the state of the art at that time was not as developed as to include other disciplines. Another impact was that I really became very critical, in a sense almost cynical, about some of the things that we as hospital and health administrators and physicians do, because in many ways there's not much evidence for some of the decisions that we make about the relationship between hospital and medical care and health of people. So, the whole question of the high technology of medicine and to what extent is it a good idea that technology is diffused so widely became issues for me. I had just assumed during those years that one of the jobs of hospitals and health administrators was to bridge the gap between scientific medicine--what was known and what was available--and it was, in fact, our job to have the latest equipment, to get the latest specialized services and so on.

Thus I began to develop some very fundamental and, in many ways, disquieting i fluences on my own thinking. I became aware of a major problem in terms of utilization and quality, and the recognition that we don't know very much about the health status of people and why people get sick and why they stay healthy. We don't know much about the outcome from the intervention by the physician. Previously I had thought, isn't it wonderful--all these

scientific advances and modern drugs? What I'm sharing is that I became much more aware of the limitations and the concerns and the conflicts that modern medicine and high technology produce with respect to the health of people. This experience caused me to re-examine what really is the hospital all about. Is it part of the problem, or is it part of the solution to health care? I began to see the hospital from the point of view of intelligent, committed, outside people--economists, sociologists, anthropologists, behaviorists--who didn't have an axe to grind about this hospital or this doctor or had nothing at stake in terms of their own situation. They were really raising fundamental questions, and the debates and the discussions that we used to have around those study sections were enlightening. The discussions were not so much about should this one get the grant or should that one get the grant but what the grant intended. This would spark the kind of discussion that would carry us far into the night. Those experiences were fascinating; the context continues for this day. I continue to try to read, at least some of the things that are being done. The experience had a positive impact on my willingness to be more critical about the very fabric I was part of--the hospital and medical care scene. It brought with it, I think, the conviction that organizations and hospitals had to be more of change agents than they were. That brought a whole new set of frustrations; it's damn hard to be a change agent. It's easier to go along.

The experience stimulated me personally. I was able to get together some money from the Kellogg Foundation, and a couple of federal grants in order to study important topics. Two things that I recall. One is we studied the question of how is long-term care and institutional care in the state of Wisconsin being organized, financed, delivered. I was struck with the reality

that about a third of the hospitals in the state had long-term care units as an integral part of their mission and had a facility in place. The organizational unit was the hospital. That was quite a different pattern from most states where it was primarily private, for-profit entrepreneurship that got into the nursing home and extended care services. I was trying to figure out what it was and why it was. We did, I think, reasonably good work in "what it was" and did some basic descriptive, definitive work about the patient characteristics--at least their medical needs--from a diagnostic point of view, who paid--all those sorts of things. The "why" was more difficult to get at and we concluded it was because the state of Wisconsin had a very far-thinking director of the Hill-Burton program during the years that there was a lot of money around for construction. And he diverted, as much as he could, to long-term care by convincing hospitals' boards and doctors that they really didn't need more acute beds but what that community needed was long-term beds. I think he did that often when the local community itself maybe didn't agree with him, but after all money was money. So, you see to this day in the state of Wisconsin a whole different pattern of the delivery of long-term care. I happen to think it's a more attractive mechanism of thinking about the institutional phases of long-term care and good to try to integrate it into the fabric of medical care and the organizational framework of the boards of trustees who have community concerns and interest rather than the proprietaryship for-profit motive--but that's a bias.

So, I think what we were trying to do was to demonstrate and establish the fact that it is important to contiue to ask some inquisitive questions, in that it is possible for a practitioner to do some modest work in research. So I systematically tried to do that.

Another tremendous influence was the opportunity through the study section to look at the health care systems of other countries, and three or four of us later published in the Milbank Quarterly. We did a definitive study of Britain from the point of view of health services research. Another team did a similar thing from the point of view of Scandinavia--particularly Denmark. There just is no substitute for face-to-face discussions with people who are involved in health care delivery systems quite different from your own. I learned that there is no way that you can adequately get an understanding just through reading. The reading becomes much more meaningful when you can have some hands-on activity and discussions. So I was able, during those years, to do the definitive work as part of the team and got enormous insights into the British system particularly.

I became convinced that the access to medical care and the distribution of health manpower are two of the issues that we cannot solve in this country and we're not going to be able, in my lifetime, to solve them. I've come to that conclusion. I have not given up, I am not cynical about it, but we have never had primary health care organized in this country, and we probably never will. It isn't the nationalization of the health service in Britain that is the fundamental difference. In my opinion, it is the fact that they always have the front-line family or general practitioner and that family or general practitioner, with few exceptions, is the gatekeeper. This GP is the person who, at least intellectually and theoretically, is knowledgeable of and concerned with the holistic concerns of a person in his or her family. The GP is the point of reference for health care and is the point of knowledge about the socio-economic personal aspects as well as the disease aspects of health. We never have had it in this country. I don't see it happening even with the

rebirth of family practice as a legitimate specialty. We're not organized this way and I think we will continue to be very pragmatic and very disorganized when it comes to the assurance that there are defined points of access to care--if we have a system to primary care. We aren't going to have one.

I think one of the major advantages of the British system over ours is that fine point of entering. Yes, you're going to argue about the adequacy of the care of the family through the practitioner and whether or not citizens have adequate choice and some other things. For my value point of view, for whatever reasons, way back, long before the nationalization, they hit upon a delivery scheme. I think they were enlightened. I wish that was one of the traditions from Britain that got into America. But it wasn't, of course.

The Wisconsin work ended in the late sixties when I took a leave of absence for a year. My work with the National Institutes of Health and the old Public Health Service work in research grants led me to be contacted by Bob Marston, who is now the president of the University of Florida. He was, I think, the first director of the first regional medical program and then he moved in to be the director of the branch of HEW that was concerned with mental health, the old Hill-Burton program, the then regional medical program, the comprehensive mental health center development, etc. Bob Marston, who is a physician and was a dean at Alabama, went to Washington under the Johnson administration and took over that part of HEW that dealt with all of those things. He was one of the first people who insisted on infusing from the outside people who were not career public servants, but people who would be able to bring their experience.

So, he said, "Would you want to come to Washington with me?"

I said, "Not permanently."

He said, "Is there any basis on which you could come?"

I said, "I'd love to go for a year or so but I've got a job here."

So he said, "Let me talk to the university."

So he talked to the university and the university said, "Yes, it's in the best traditions of academic life, sabbaticals and the rest. We could make some arrangements for that."

It turned out that arrangements were made and I did spend a year in Washington at the federal government in sort of a free-lance but inhouse full-time consultant. They just paid my salary through the state of Wisconsin. There was no personal incentive. I was free from operating responsibility; I didn't have charge of any of the bureaus or divisions but I had Bob Marston's ear and support, and Paul Sanazaro's. I was able to look into any kind of issues or problems that they wanted looking into.

It was a year in which I worked closely with Paul Sanazaro, a clinician, a very fine internist out of the University of California, who was also on the study section of the Public Health Service. He decided, although he was going to keep his hand in clinical medicine, which he does still teach a day a week, there was a field called health services research that was far more fascinating and was a greater need than the practice of internal medicine. He made that deliberate decision. He's such a thorough person that once having made that decision, he would not want to be a second-rate person. He was a fine internist and was up to the minute in the latest advances in his specialty. He wanted to do the same thing in health services research so he systematically went about learning the field and disciplines. He's a storehouse of knowledge and information and insight, and, I think, knows more

than any single person in the country about the state of the art of research in health services and can cite you the studies, the ones that were good and the ones that weren't so good, in his opinion.

Paul was then the first director of the National Center for Health Services Research & Development. His deputy was a fellow by the name of Tom McCarthy. Tom McCarthy is a graduate of the Iowa program, one of the first Ph.D.s, and one of those people that probably will never be remembered or recognized for what he did because he's been a civil servant all those years and not prominent himself. He's not written very much and he hasn't done much research himself, but he had been a broker between hospitals and the academic communities in health services--in federal government as far as health services. I think he has made it possible for more people to get funds and to get stimulated and to get involved with health delivery from a research point of view by making sure that the opportunity for federal money came to the attention of good people.

So Tom McCarthy and Paul Sanazaro, as director, were setting up the National Center for Health Services Research & Development. They had about $50 million per year to distribute. I heard the other day that that figure is now $22 million, so, you know what's happening.

HEW is unmanageable, absolutely unmanageable. There is no institutional memory, people come and go, reorganization is the way of life. It's always being reorganized, either by the latest secretary or undersecretary or whatever. I always had a feeling of some disdain for any bureaucrat in Washington, but I changed my mind about them. The people who hung in there--a lot of them have left--but the people who hung in are very high quality and they've worked under very difficult circumstances of change, political

environment and so on. There are some very knowledgeable people, but you have to find those few people because as an institution there's no institutional memory. Reorganization, and suddenly it's as if there was no organization before. So, you can't, as in most organizations, go back in time and say, "Well, we decided this, and the purpose of that whole effort was this, and here's what we've accomplished, and here's what's working, and here's what isn't."

There really is no organization called "Health" of HEW. It's a series of departments and bureaus or programs none of which is being managed or led or steered. Some have direct pipelines to Congress so to be sure that their part of HEW is funded, giving them enormous freedom then to work with the grant money or the operating budget, or to work with the states, or work with the private sector, or whatever. There really is no accountability in that system. I don't mean this negatively about any single person, I just think it's a fact that there really is no accountability. There's technical accountability about appropriateness of the way the funds are spent, all that. I don't mean that. I mean the accountability for programs. Accountability to say, why are we doing this? What do we think we are trying to accomplish? To what extent are we beginning to accomplish that? Are we willing to say that isn't a very good idea, let's try something else? I think it's a perception that many of the people in the private sector have that somehow there's a place called "the Health" of HEW and if you just get to the people who know, you can get some straight answers and talk some sense, but that it just isn't the way it is.

Another thing I discovered, and I should have known that, is that the federal government is very pluralistic and one department or division doesn't

know what the other department is doing, and will be coming at perhaps the same problem from an opposite set of policies and point of view. Let's see if I can cite some examples. We were trying to make sense out of capital financing. People were discrediting the Hill-Burton program: Built too many small hospitals. Should go out of existence, etc. I kept trying to defend the point of view that it had been stimulation to a lot of communities that otherwise wouldn't have a hospital. Hill-Burton offered an opportunity for a federal grant, helped raise private giving, got the community proud of the fact that they'd have a hospital. OK, maybe we have a few too many beds here and there, but isn't it better that we have those hospitals than if we didn't have them? I was arguing, it turns out unsuccessfully, for the federal government to stay in there with some sort of grant program or stimulation for those hospitals that needed to be replaced, where the population was really growing and so on. So, here the "health" part of HEW was working on a whole other point of view, putting money into loans through HUD that was directly opposite to what "health" was trying to do. HEW was trying to tie those loans to some evidence of need. Planning. So, I learned the obvious, first hand, which was that the federal government is very pluralistic, that one department probably doesn't know what the other one is doing. If they know and don't agree, they'll still go on disagreeing anyway because there's not the point of accountability, management, coordination, etc. that you assume in most organizations.

That's why I also concluded that with political and operating bias we ought to be very wary of centralization of responsibility for the delivery system to the federal government and particularly to HEW. It is so removed from the realities of many communities in America that there is no way it can

be responsive to the realities, even though there would be good people trying to be responsible and dedicated and committed. It is because they're caught on the horns of standardization and uniformity and a rule is a rule is a rule whether or not it fits in rural Iowa or inner city of Washington. So there is a built-in lack of capacity to respond to pluralism and variation.

The experience in Washington plus what I saw in England led me to conclude to be opposed to centralization of the dollar through tax base, but not because I think that people should not have an assured way to get health care paid for. Not that at all. But as soon as we centralize that dollar it becomes a federal responsibility and we lose the tremendous opportunity for initiative, for response, for variation, for private response and initiative of people served.

In the system in England, it has become so rigid and calcified that it cannot respond. It just cannot respond. It responds politically in the short-run to crises, but it cannot respond to fundamental changes in the delivery system.

We have problems in this country in the political system and must have some changes, but I don't think we can do it if we put all our eggs in the government basket because it'll then be impossible to change. We might have a better chance in bringing about change in the access to care, in controlling the cost, and having reasonable quality if responsible private organizations, private initiatives, hospitals, physicians and so on, believe that's a problem and try to do something about it, than if we go the other way.

So the government experience was a very sobering one for me. I really saw the potential by harmful outcome of believing that we can solve some of these fundamental problems through centralization of the health dollar and through

federal control of planning and the resource allocation processes. I really became terribly afraid of too much concentration of the power and authority in the single agency or the single place or a single level of government. I feel it has problems, and we would be much better off in the next couple of decades to maintain pluralism and to try to rekindle and reawake the spirit of hospitals and physicians to do something about health care than to go the regulatory centralization.

So I think the federal government experience was very helpful to me. I have a great respect for the people who work there. They're much better as persons than the private sector would ordinarily believe. It's not managed. It's incapable of being managed, because of its size and complexity and diversity of interests and the ties to the Congress and political processes. It's just not the place to put our hopes with regard to how a community is going to provide itself with medical and hospital care.

WEEKS:

Do you want to talk a bit more about academic health center?

CONNORS:

We were clearly into an era in academic health care centers where the driving force was research and research money and there was fierce competition for faculty members. There was constant hiring Wisconsin from Michigan, Michigan hiring from Harvard, etc. Each academic star had his dowry and his price. I remember as a young hospital administrator spending a lot of my time, probably most of my time, trying to scramble to fulfill the commitments that there made to faculty people, because there is never enough money, never enough space, and so forth. In retrospect I would say it was an inappropriate lack of balance in the award system, in the way in which people approached

their jobs, etc., between and among patient care, teaching and research responsibilities.

Wisconsin is a fascinating place. The home of the Progressive Party and of LaFollette. I think it still has the only major city in the country that has a socialist as a mayor. The motto of the University of Wisconsin, and I'm paraphrasing a bit, was that the boundaries of the state were the gates of the university or the fences of the university. Enormous pride in their state university. One of the few protected places that didn't get scarred in the McCarthy era. The university was a place where it was OK to be liberal or different or whatever. Very high quality place, in my opinion, in the health field, particularly strong in the basic sciences, biological chemistry, and genetics. That came out of the tradition of the agricultural school not the medical school. Very strong agricultural basic sciences in their commitment to rural Wisconsin, so the excellence in the university setting continues to this day.

We got into a situation in which the town and gown phenomenon that we all have heard about and believe about was in fact there. It was more a state situation than a local situation in the city of Madison. The University Hospital in Wisconsin really was developed during the Depression years and there was great concern and resentment on the part of practicing physicians in that state that somehow their livelihood and their practice were threatened by this university setting. So the question of ownership of patients and control of the referral system was very deeply ingrained in practicing doctors in the state of Wisconsin.

Even in the late fifties there was still technically in the legislation a quota system for welfare patients that not more that "x" number could be

referred to the University Hospital. As I think back on that, it had nothing to do with the needs of people or patients or the appropriateness of the tertiary care center. The need to keep people at home for some reasons but send them for others was purely and crassly based on, probably, a perceived economic problem.

The doctors knew how wrong that was, and yet, you know, this was a very liberal setting. It made great tension and comtinues to this day, but not on the same basis. It has pretty well been demonstrated that nobody's economic welfare is at stake--physician's economic welfare--is not at stake now.

There was tremendous tension between the town and gown. So, on one hand we had this striving force for research, and the other hand we had the dependence upon the practicing physician for referrals, a very tense set of historical relationships and concerns. The faculty of Wisconsin, as most places in the sixties didn't do very much constructively about the tense situation. They did not put as first priority the needs of that practicing physician when the patient returned home, or understanding the need for good communication with the referring doctor.

We spent a good bit of time trying to patch up a set of very shaky relationships. My staff and my team, and somewhat myself, ended up going out to county medical societies and just asking about what kind of problems were they having with us and were there any things we were doing well. We sure heard about things we weren't doing very well. We tried to bridge what I perceived to be an enormous gap between hospital needs of the citizens of Wisconsin on one hand and what we were, in fact, doing on the other.

It was a situation with a worn-out hospital, technically obsolete. Space had such a premium because of a lot of factors: conditions of patient care

that were less than satisfactory in terms of just basic human dignity; open wards; lack of bathrooms; lack of privacy. We faced a difficult task of trying to develop reasonable and better facilities. I was able to start in motion what has subsequently been a complete replacement of the hospital. I started to learn about the world of capital finance and the difficulties of publicly-owned facilities and the difficulty of the capital financing of those operations.

I became very active those years at both the state hospital association level and the American Hospital Association level. I think probably through friends like Walter McNerney and others I was asked as a relatively young person in the field to be on councils and committees, particularly in the American Hospital Association, and found that work personally rewarding, stimulating. I perhaps contributed a bit too. I surely felt, and continue to feel, that I got more out of those activities technically than I was ever able to give or to share.

Some things occurred during the years at Wisconsin that are, I guess, still more than just passing interest. We were the scene of really the first major confrontation between police and the students who were concerned about Viet Nam war. It broke out within half a block of the hospital. I can't remember the triggering mechanism: Was it ROTC, or some guest lecturer, or something that triggered this? It turned out it was a planned event. We treated in our emergency room, I think, 150 students and police within an hour --and you know what emergency rooms in university hospitals are like--it's usually the most junior intern on duty. We fortunately had a pretty bright, young junior intern that day. When he saw what was happening he called the chairman of medicine and the chairman of surgery and he said, "We've got a

problem that's just not the care of students and you'd better get down here."

He could see that it was highly politically charged. Fortunately the injuries were relatively minor, although at the time we weren't sure of that. The hostility between the police and the students was right in our emergency room. We ended up having to separate the patients. It was something I'll never forget as a young administrator trying to deal with the press, the regents, the faculty, the state legislature, as well as providing medical care for the students and police. Of course, I became aware that we were really in very early days of some very difficult times, that subsequently almost every university in the country experienced one way or another. The student activist days in the last half of the sixties had an enormous impact on management because suddenly everything was openly challenged, often not constructively, and often with much hostility. The ordinary way of doing business behind closed doors of the executive committee was suddenly challenged.

All of us went through periods of being defensive about being challenged. After all it was our job, our responsibility. It had always been this way, so what was this all about? On the other hand, there was an important message there, and so collectively we tried to modify the way we governed and managed University Hospital. It became a much more open place where the chairman of the department was not "the end all, and be all, and the answer to everything." There was such a thing as the rights of the younger faculty and there was such a thing as the concerns about the students having a say about their life and their environment. We became aware, really for the first time, of the whole notion of the fundamental right of patients to have a say about how they were treated, why they were treated, whether they were going to be

treated. To me, that was an awakening--something that I now take for granted, but surely it was not a part of the social, economic, or management fabric of the hospitals I was running those days. It was very painful, yet very constructive. I think it made our places more responsive, more concerned about "Why are we doing these things?" than saying, "Well, that's the way it's done."

We were more able, I think, to deal with constructive criticism, more willing to accept different points of view, more cautious, in some ways, in terms of coming to far-reaching decisions without making sure that people had a say or that the bases were touched, etc. It was an awakening to me of the fact that management style is tremendously important in terms of outcome and productivity. Where I innately did some of those things--that is, active communication, openness, team-building--I think it was in many ways the rude awakening of the establishment by the students in the sixties that caused that to be real, caused it to be understood, caused it to part of the fabric of management and administration.

Wisconsin went through a bitter fight within the faculty while I was there. Open, hostile, not constructive. Still recovering in many ways, still an out-and-out power struggle between the Dean and the Chairman of Surgery. John Bowers ended up leaving over it. John was convinced that he had a mandate from the regents to redirect the clinical side of the medical school. He felt, and rightly so, that new blood was needed. Vigorous leadership was required, and it came to a head over the appointment of a chairman of surgery. When the incumbent retired, John felt they had to go to the outside for a replacement. The surgery department and about half of the faculty, I guess, felt that there was an inside candidate. To see in motion, to see in

fact, the power plays that were put in was very distressing to me. It also was distressing to see how power, and the need for power, and the desire for authority would cause otherwise reasonable people and nice people to do what they did to each other and themselves and their families. Nobody wins in those kinds of things. It was enormously harmful to what was otherwise a very good, if not excellent, faculty of medicine. It just tore them right down the middle. You're either for or against the Dean or the Chairman of Surgery. There was no in between. The people's careers and lives were disrupted, hurt. It caused a lot of relocation of people who would not have preferred to do it that way. A lot of uprooting. And of course, it's fair game then for the press, and for the public, and everyone else.

During that crucial time the strength on one hand but the enormous weakness on the other of the academic setting in the sense of the decision-making process became understood. I learned through that episode that it's really very difficult in an academic setting for a firm and final decision to be made. Who really runs the University of Wisconsin? The people of Wisconsin, through their elected representatives in the legislature? Is it the regents? Is it the faculty? Is it the administration? You get to an issue like this, that was clearly devisive, everybody thinks they do. The issue got far broader than the Dean of Medicine and the Chairman of Surgery and got into very fundamental questions of who makes these decisions and why. It spilled over into a realm of consideration that probably in the long run was constructive, but at the time was very stressful and very difficult. It caused me to reexamine some fundamental concerns about governments and management and power relationships. In that sense, I think, it was a learning, developing exercise but very, very painful.

Madison, as you may know, is a very delightful community. I think in my heart and in my own mind it remains as the single most attractive place I've ever been. It is a society and a community that is quite a lot different from the society and community of Michigan. My own impression of the difference is that it was, in those years particularly, and I think continues to be, influenced primarily by the rural agricultural interest as compared to heavy industry. That relative difference and influence brought a difference of values, a different set of concerns about the quality of life as compared to, perhaps, the quality of economy. So, I don't want to in any way leave a negative impression about Wisconsin. It is and was a beautiful place to live and to work and to try. I cite the incident only as an illustration that the sixties was a time of tremendous turmoil and we happened to be in the middle of the basic influences that were going on in academic health centers in those days.

Going back a bit to the question of universities and the John Bowers' incident, as it came to be known. I think the decision was sort of a deal between one faction of the board of regents and the governor's office. It turned out the governor was a close personal friend of the Chairman of Surgery and about half the legislature. A very powerful person, Dr. Curry, went political with the issue, so there was no normal way it could have been contained at the university. The university administration--at that time Harrington was president, President Elvehjem died suddenly in the middle of this--President Harrington really in the end appealed to the governor and the leadership of the Republican Party, saying that we can't win this, we're so dividing ourselves. It ended with John Bowers leaving--that was the price that Curry exacted--with a new Chairman of Surgery from the outside brought

in, and the creation of a new department of clinical oncology so that Dr. Curry could be a department head. The new Chairman of Surgery didn't make it--it was predictable. There was no way he could have survived in that. It took about two other changes--I think now they have a real department of surgery in a sense of not having a divided house--so it was a compromise. John Bowers did not want to stay anyway, but I don't think he had a choice over the incident, because he burned a lot of bridges and a lot of poker chips were expended in the power struggle. I think the decision was actually made by the then president of the university, the governor of the state, and a very powerful outside Republican senator who said he could handle the legislature, and did. I don't know if the decision could have been made any other way, but it was clearly not made by the faculty or the regents or by the established organization that was supposed to make decisions--because they were unable to make it. They were unable to resolve satisfactorily what got to be an issue far out of it's importance, far out of proportion.

I got involved in research while I was at Wisconsin. I guess one can't be around a university without getting intrigued in trying to find out the answers to some important questions. I got involved in two ways. One was, I was asked to serve on a study section of the then U.S. Public Health Service in the emerging field of health services research. During those years the amount of money spent for scientific research in medicine--biological research and so on--was enormous but practically nothing was being spent in research in the health delivery system, the economic side, the quality side, etc. A few thoughtful people in Washington kept insisting that there needed to be set aside money so that people other than the practicing physician or the practicing scientist could have the stimulus to do fundamental research about

health care, to make it possible for economists and sociologists, behavioral scientists and others to really identify the crucial problems of health delivery systems, and to systematically study them.

I was asked then to be a hospital administrative representative in the study section which reviewed and took action and made recommendations on these applications. I never quite figured out why I was asked. I suppose being from an academic background in a very respectable university was probably the fundamental reason. In most new situations you get into you discover how much you don't know and you either walk away from it and say, "I'm not going to know," or you try to learn something about it. I chose the latter course. I spent tremendous personal energy and time in trying to really understand what the issues were in these applications for research money. What was the fundamental rationale of why the economists wanted the study of this aspect of health care or that aspect of health care? What were the fundamental disciplinary tools that brought to bear on research. I think I did a reasonably good job in going in from a very uninformed practitioner to somebody who at least understood not only the strengths but also the limitations of research. I recall those experiences had probably three lasting impacts on me. One was, I was again very fortunate in working closely with and rubbing shoulders with the people who were and many who still are, the health research leaders of the U.S. I don't think there are any of the health economists that are now active that we didn't either work with directly or support their work as junior people. There were people like Bob Haggerty, the pediatrician who was then in Rochester, who was ahead of his time. He was writing about the nurse practitioner and about productivity of the doctor and he was writing about these issues and the problems from a pragmatic point of

view. He was able to get at them also from a discipline point of view.

That opportunity over about a four year period, even though it was on top of a taxing job in Wisconsin and maybe at the expense of it ... I don't think at the expense of it, because I would just end up working longer and harder. It was really very stimulating, probably the most stimulating professional experience that I had at that time.

I would like to talk a minute and discuss the development of the Ameriplan of the American Hospital Association that I found to be significant to me and probably had some impact on the field.

In the late sixties Dr. Ed Crosby, who was the head of the American Hospital Association, believed that the American Hospital Association needed to have a more positive stance with Congress and with the Executive Branch with respect to how health services were to be provided in the future, recognizing that in the late sixties the Medicare and Medicaid programs were then three or five years old. Even in the beginning fiscal problems were apparent. That is, the cost of Medicaid in some states far outstripped the projections, particularly states like New York. The Medicare utilization and costs were running significantly higher than the projections when the legislation was passed. The American Hospital Association at that time had issued a statement called "The Financial Requirements of Health Care Institutions." In this AHA attempted, and I think quite well, to define what was reasonable for hospitals to expect in the way of payment. Remembering that the Medicare law was passed on the premise of reasonable cost, the financial statement attempted to cover such things as capital formulation, bad debts, charity care, depreciation, operating costs, etc. That statement of financial requirements was viewed very positively by the hospital field

because it enunciated what good financial managers knew for a long time, that is, that for a hospital to be able to respond to technology changes, to expand the services needed locally, it needed capital and it needed a solid financial base. The statement was viewed negatively by those who were expected to pay the bills that would be related to financial requirements, particularly the federal government, which was in the position of paying directly for care. The government was learning of the financial consequence of the entitlement commitment to the aged.

In Medicaid, those states that had no reasonable programs for welfare prior to Medicaid were also learning the financial consequence of beginning to pay for service that before had either been subsidized by other patients or paid through voluntary donations and contributions of one kind or another. Thus, as I recall it, the statement of financial requirements was viewed as self-seeking by hospitals.

The statement did not offer any positive, constructive recommendations as to how health services ought to be provided. To make such recommendations Crosby appointed a multidisciplinary committee called the Perloff Committee, under the chairmanship of Earl Perloff who is a delightful person still living in Philadelphia. He is a businessman on the governing board of a couple of hospitals in Philadelphia. On the committee were some hospital administrators like myself, and some persons who were generally knowledgeable about health and economics but not direct providers. The Perloff Committee struggled for about a year without any real constrictions or restrictions or directions by the AHA and its board. We were given a free hand to say how health services ought to be provided in the coming decades, what the organizational bases should be, what the structure should be, what the financing should be. The

result of that work ended up in a statement called "The Provision of Health Services," commonly called Ameriplan.

That statement was issued, as I recall, in 1970. It had several major recommendations. One, it called for the formation of health care corporations. The central idea behind that terminology was an attempt to respond to what the committee felt to be the major deficiency in the organization for the provision of health services. A deficiency, I think, which continues to this day, incidently. That deficiency being that there was no defined point of responsibility for the health people. Everyone was responsible, and no one was responsible. Of course, the individual and his or her family properly has, and should have, some responsibility. There also should be responsibility from the provider of health services side, hospitals, primarily acute inpatient facilities, physicians directly responsible on a one-to-one basis for patients that they happen to see or that they happen to have referred to them for a specific illness or diagnosis, other professionals taking a segment of the provision of services to individuals. But, there was no single place where someone could say, "Yes, we are responsible for the provision of health servies to people."

Perhaps health departments have a potential mandate to do that, but are incapable in terms of financial structure and know-how, and probably unacceptable to most physicians. So the idea of the health care corporation in the Perloff Committee was to try to promote the formation of organizations, new organizations, we called Health Care Corporations, that would somehow blend together the legitimate interest of physicians, other health providers like dentists, pharmacists, and hospital nursing homes, into an organization that would say, "Yes, we are capable of coordinating the delivery of, and

taking the responsibility for, the delivery of services to x population."

The Perloff Committee did not prescribe how those health care corporations would actually look in terms of corporate structure, because we were trying to get a concept over. The fact that none of them existed, nearly as we knew at the time, made it hard to be prescriptive and inappropriate to be prescriptive. The second idea was that there should be a choice, wherever possible, for consumers. That is to say, that wherever the population base in concentration was large enough, that an individual, or an individual and his or her family, could make a choice to be related to health care corporation x, or health care corporation y, or whatever. The basic feeling was that it was healthy to preserve choice, that some reasonable competition with respect to responsiveness and quality and cost and access to care was a good feature to be preserved and promoted. In most places in the United States-- given future developments in communication, technology, transportation--that there weren't many citizens any more who would be so remote that they wouldn't have a chance of choice.

The third central idea of the report had to do with financing. That report called for a form of national health insurance that was built on pluralistic financing, that is a continuation of the Blue Cross/Blue Shield, and private voluntary insurance, with government stepping in for all those that were not otherwise covered by employer/employee negotiated health insurance. It called for a minimum set of uniform benefits. It called for the provision of a new set of benefits that were largely not available in the late sixties to the population, for example, ambulatory benefits like: physician office visits of x number per year, drug care for outpatient prescriptions at defined amounts, psychiatric care on an ambulatory basis,

etc. The idea was that the incentive for the population to link up with one of these health care corporations would be these benefits that would be provided to them through the general tax revenues of the government, if they signed up.

So our scheme on financing, later judged by most to be too complicated to be practical, was built on the idea that government funds ought not to be used as a substitute for the existing rather adequate provision for the working population and their families for acute inpatient care. Rather, the government ought to pay for those who were not covered and they ought to provide a new set of benefits that would be the incentive for the population to link up with these health care corporations and would move in the direction of uncovered service, ambulatory care, psychiatric care, and the like.

The fourth major idea of that report dealt with the question of regulation. After much debate, the committee described a preferred model of state regulation of services to be provided in that state or in that geographic area. The idea was that a health corporation as it formed would need to have a defined location of control that would assure the public that the minimum set of benefits was available under conditions that were acceptable. The notion of franchising of geographic areas of service, and the notion of determination of what we would now know as certificate of need for facilities, and what we would now know as rate review and control were parts of the concept. The idea was for a high quality, a relatively polit cal commission set up in the state with a talented staff anf reputable citizens in that state exercising that form of public accountability. You will recall, that those sets of ideas were really before we had any substantive experience with what we now know as the state commissions. The New York controls were

just starting, but it was too early in the late sixties to have any sense of what the impact would be. I would say in hindsight that I would not now subscribe to that feature. The experience in New York, Massachusetts, and Connecticut would lead me to argue now in favor of a pluralistic approach to controls, that is to say, that all major purchasers, and licensure and manpower standards ought to continue to have sets of influences on providers rather than a single authoritarian state agency. I fully acknowledge that the experience in some of the states like Maryland and Washington are more promising than the New York experience, which I think is disastrous. With highly political, financial consequence we won't even be able to understand for another decade. I'm only indicating that given hindsight ten years later I would not now argue favorably for that form of control that I did subscribe to in 1970. Although I believe that controls and influences are essential, I would just argue that they should be pluralistic and maybe even competing rather than in a single authoritarian state agency.

Anyway, the Perloff Committee ideas received mixed reaction within the hospital field. Some, not understanding, said: "What's the health care corporation? It doesn't make any sense. Financing idea's too complicated. Not realistic."

Defensively, I guess, those of us on the committee felt that our ideas simply weren't understood, that we had the benefit of knowing what was coming and, therefore, let's wait and see. What I described sounds a lot like the health maintenance organization. An interesting thing--I think history needs to remember this and record it very carefully--the term "health maintenance organization" as far as I know, was not coined when the Perloff Committee report saw the light of day. In a parallel way and kind of unknown to the

committee, the HMO idea was being worked on and was based on the experience of the Kaiser-Permanente programs. The HMO legislation really came into being in the very early seventies. Soon after, the Perloff Committee was out. A number of people--I can't recall for the moment the name of the physician/author/sponsor/grandfather of HMO legislation, Minnesota-based ...

WEEKS:

Do you mean Paul Ellwood?

CONNORS:

Yes, Paul Ellwood. Paul Ellwood, after studying what the potential of the Kaiser-type organization was with respect to reduced utilization, incentives and reduced costs because of reduced utilization of the inpatient, became convinced that federal legislation had to support the development of organizations called HMOs. This received a lot of favorable federal support, which continues to this day for the promotion of and the nuturing of health maintenance organizations. The health maintenance organization legislation, I think it also should be remembered was first supported by a conservative Republican administration. It was supported because of the same underlying forces that led back to Crosby being concerned in the first place that we had to get a handle on costs. We had to have some changes in the structure of the delivery of health services. The health maintnenace organization story is a separate one. I'm sure some of your participants in this will cover that, but from my perspective it was fascinating to look back and see those two ideas were being kind of born at the same time under different auspices.

Perloff Committee recommendations--those ideas that I covered early--most of the features found their way into the early Ullman Bill--Al Ullman, congressman from Oregon. Those bills to this day have never gotten, in my

view, much play, and have not really been major on the political scene with respect to options and possibilities. It would be fascinating to think through why and I'm not sure I'm qualified to know why, except to say that they probably never really had a major political force behind them. The American Hospital Association activities in the seventies, I would believe, have been more defensive in preventing features of other political and legislative initiatives than in being able to muster the broad coalition of support for some fundamental changes that the Ullman Bill and the Perloff Committee had in mind. AHA has turned more attention, I think, to such efforts as the Voluntary Effort in recent times in promoting competition and keeping pluralism--all, I'm sure, important and legitimate objectives for an association that is trying to represent such a broad spectrum of American hospitals. I'm not in any way faulting or criticizing those remarks of AHA, simply indicating that it probably never really got behind the central ideas in the theme of the Perloff Committee.

I'd like to move on to the experience of University of Michigan indicated earlier in this discussion of my Wisconsin experience. When I add these two up I guess it's thirteen or fourteen years of my life that went in to administrative posts in medical centers and medical schools, teaching hospitals, academic centers. The impressions that I would like to record would include one, the shift and change that took place in the sixties and early seventies in teaching hospitals and medical schools and in the development of what the popular jargon would now call academic health centers. When you think of those words, there's a considerable difference between medical school or, in early days, medical school teaching hospital than the words academic health centers. The differences, I think, are far

more than a play on words. The differences are one, that health is in the title and not medical or medicine, and the emphasis on academic vis-a-vis a school or a hospital. I think those words, in fact, capture the essence of the shift from, let's say the fifties, sixties to the eighties and nineties in which medical schools and their parent universities, most of them, made a deliberate attempt to shift into an academic health center, to define their governance and management in such a way that it encompassed disciplines beyond medicine, and surely the academic disciplines of nursing and pharmacy, etc. Also, the emphasis on the word academic, I think, indicated the deliberate attempt to respond to the desire to bring relevant disciplines of all kinds that are available in most university settings to the business of health and medicine in the delivery of service. It was an attempt to indicate the fundamental commitment to research as the underpinning of teaching and as the motivator of persons who were attracted to such settings. Also it was an attempt, I think, to distinguish academic health centers from institutions whose primary mission was the delivery of service. That shift was very painful, I believe, for most university teaching hospital medical school centers, because it raised, and I think continues to raise, the fundamental issues and questions with respect to the governance and management of teaching hospitals, to the financing of teaching hospitals, medical staffs, and medical school faculties, and the role that these institutions are expected to play in research, in teaching of all kinds, and in delivery of service. In retrospect I would say, one of the fundamental deficiencies and limitations of academic health centers is the relative lack of governance. What is an advantage--considered to be an advantage--in most university circles turns out to be, I believe, a disadvantage in the lack of a decision-making process and structure

which we would call governance. What I'm trying to indicate is that most universities whether they be private or public--and my own two experiences happen to be public, Wisconsin and Michigan--are governed and organized for governance, primarily as an educational institution. That educational institution approach does not, in my opinion, satisfactorily serve the needs of an organization committed to the delivery of health services, the delivery of service to people on a large scale that is subject to a whole set of different outside constraints, flow of money, controls, regulations, etc. The fact that the governance is so diffuse in academic health centers, I think has been a major deterrent to most centers in their ability to have a defined role and to sustain a defined role in the delivery of the patient care side of the triangle of service, research, and teaching.

Now, what do I mean by governance? I think there are five or so fundamental functions of governance. One is the question of philosophy. What is the essential reason that the institution exists? It seems to me, whether we're talking about school or hospital or business, whoever governs that school or hospital or business has to decide what the fundamental purpose of the institution is and apply that particular function to academic health centers. The role of the teaching hospital is very difficult to discern and is very subject to severe competition for resources and for points of view from the teaching and research sides. The difficulty in the situation is not the competition, the difficulty is who makes the decisions in an academic health center--usually board decisions.

It was clearly true in both the experience in Wisconsin and Michigan that the regents, highly motivated and talented and qualified people, were simply too far removed from the situation of the teaching hospital to be able to

exercise intelligently their governance functions for the teaching hospital. The result was that that particular function of determination of purpose and priorities got diffused and confused between faculty on one side, administrative people like myself on the other, university administrative officials on another, and ended up making it most difficult for highly motivated, highly talented people to come to grips with spelling out specific goals and priorities and fundamental purpose.

The second fundamental function of governance, as I would understand it, rests with the appointment of management, the assurance that management is carrying out the established priorities, the assurance that the strategies that are needed to reach objectives are understood and carried out by management. In the academic health center that becomes, again, a very difficult thing to do because governance is so removed. Therefore, the line of accountability for a management person in an academic health center is not clear. On one hand the person is somehow expected to be accountable to the dean of a medical school for those activities that the medical school is carrying out in the teaching hospital. The management person is expected to be accountable either explicitly or implicitly to the vice president for finance on the campus who in many settings often controls most of the services that the hospital is dependent upon like accounting or purchasing or maintenance. The management person is expected to be accountable to faculties and deans of faculties who are so dependent upon that teaching resource to carry out some of the clinical education like pharmacy and nursing, etc. Therefore, the role of the executive in a university teaching hospital is very complex and very difficult, not because there isn't good will, not because the people aren't highly motivated and able--in fact, they are very able and

highly motivated--but because there is no defined governance organization to relate to where the sorting out can take place when faced with highly different and sometimes adverse and competing forces. The role of the executive of an academic health center is unlike the role that the executive plays in a hospital that has a more single purpose, that is, the delivery of care to people, with a board whose single mission is to govern that institution, at least the decision making that is properly governance. The role of the executive of the single purpose hospital is much more crisp, clear, defined, and capable of function. It's not to say that maybe the decisions are any better or that the freestanding governing board in the hospital doesn't make mistakes, etc., that isn't the point. The point, I think, is that for an executive in an academic health center there is a relative absence of governance. I found, and I think many have found, it to be very difficult and inhibiting feature of the health scene, of health delivery, of the hospital scene.

A third function of governance, I think, supports the same comments I just made and that is governance is expected to establish policies, the rules of the road, the limits that management must operate within carrying out the functions of management. The functions of management are well known and well described by most of the literature--planning, directing, controlling, evaluating--but it's the function of governance to establish the policy and the limits of those. Now, again, when there is basically a governance structure that is far removed from the operation of the institution, as is true in large university settings, the creation and making of policy ends up being often badly divided between and among units of the university structure: vice presidents for public relations and state relations; vice

presidents for finance; vice presidents for academic affairs; faculties and their understandable desire to be involved in policy making; and in the management relationships that exist between deans of schools, like medicine and nursing and so on, and the director of hospitals. Therefore, it was my experience in those settings that it was very difficult, in fact impossible, to get on a sustained basis a clear set of policies that affected the operation and direction of the teaching hospital that was capable of being supported by various constituencies because there was no single place or defined place that one really could trade off on policies. Yes, we've debated for all the options; we understand the pros and cons, and this is our policy. Again, when you think it through in retrospect it was a most difficult, challenging limitation.

The fourth function of governance is to enhance, develop, and protect the financial, physical, and human resources of the organization. That's a fundamental responsibility and function of governance whether it's a school or hospital or whatever; somebody has to do that. That somebody, I think, is a board of trustees interacting with their management counterpart. It is clear, I think, in academic health centers that all three of those resources that need enhancement--namely, facility, financial, and human--are not easily carried out by a single responsible group, because of the very structure of universities and academic health centers.

The last function, I think is issuring the quality of service. Quality of service in a hospital is very dependent on the responsible and collective actions of professional groups. That's why in most hospitals a medical staff structure exists and a nursing staff structure exists. When that principle is applied to a teaching hospital there is built-in conflict between the academic

unit whose primary responsibility is teaching, that is, the medical school, the nursing school and research as compared to patient care. So, a medical school as an organizational unit, again in my opinion, is simply not the appropriate unit to be concerned about the quality of medical care. The medical school structure, and Michigan and Wisconsin are examples of this, is organized to carry out teaching of undergraduates and graduate students, the conduct of research, and postgraduate work. Some of the faculty carry out patient care responsibilities if combined with their teaching responsibility. So the very structure of the medical school has elements that have no responsibility for, no direct interest in, and no background for, the care of patients. All the basic science departments surely provide, maybe nurture, the clinical practice of medicine and they are aware of the need for a clinical setting in which students can be taught, but they themselves are not the providers of care and service nor are they responsible, and, often I've found, not interested. Therefore, what is a medical staff in the teaching hospital? Is it the medical school? Is it only that part of the medical school that are physicians with hands-on responsibility? Where is the authority and responsibility for the quality of medical care? Does it rest in the medical staff? Does it rest in the medical school? Is the medical staff open to all practitioners in the community or is it a closed staff? If so, why? What are the pros and cons of that? If a teaching hospital is part of the fabric of the care in a community, can it limit itself only to medical faculty? Or must it, or should it, open itself up to qualified practitioners in the community and access by local community citizens? Those are very fundamental, tough, deep questions, and I don't purport to know the answers to all of them. I have some opinions. The point I'm getting at is that that is

an example where this governance function of assuring the quality of service had unique, and, I believe, very difficult problems, when one attempts to apply it in academic health centers. I could make the same point about nursing and faculties with relation to nursing, pharmacy and so on.

In the sixties and early seventies many universities, including Michigan, were struggling with the question: What is a workable formulation of governance for our teaching hospital, or academic health center, for the medical school, and so on? Various patterns grew up around the country. Some tried to solve it by having a vice president for health affairs that was sort of the single point of accountability and responsibility for translating the wishes of governance: the regents to the management to the academic side. My observation on that generally is that it was not acceptable to the disciplines other than medicine because the physicians or deans of medicine were the kind of people who tended to be appointed to the such chairs and roles and it was (very openly in the settings that I worked) resented by the other health disciplines like public health, pharmacy, dentistry, and nursing. There was fear of domination of the medical school, the fear of the domination of the medical model, vis-a-vis the health care team model. Whether or not those fears were legitimate and appropriate is not the point. The fact that those fears were there--the perceptions were there--was, in my opinion, a great deterrent against that particular model.

Another model that was talked about, and has begun to emerge, was to create a board for the teaching hospital to delegate either some or all of the functions of governance from the legally constituted body like the regents to a board whose sole function would be to govern the hospital. This was either as a separate entity in parallel with the academic units or sort of grafted on

to the fabric of the academic units. Minnesota and some other schools have moved in that direction. Others, including Michigan, tried such a device but it was with internal people. Minnesota's people were external. In Minnesota's situation there was very little overlap with the regents, that is to say, regents would not serve on that board by and large. In some schools it would be a subcommittee of the regents. At Michigan, the approach was more with an internal group. The feeling was that if you were able to get the vice presidents on the university structure and the deans from the colleges and the director of the hospital sitting around the same table and charged with responsibility, that you could overcome some of these deficiencies that I referred to. I think that device worked reasonably well with respect to communication, information sharing, building of mutual respect and confidence, building of some trust, better understanding of points of view and differences. However, it did not emerge, in my own personal experience, as a decision-making structure that really got a the basic deficiencies or limitations previously numerated. The reason for failure primarily was either the unwillingness or inability, one or both, of the regents and the university structure, that is, vice presidents and academic units, to relinquish authority or perceived authority, and surely power and influence.

Thus, the teaching hospital remains to this day a very complex, very difficult, very challenging, potentially very rewarding place to work, but it is, I think, in more recent times, finding itself torn in even more directions than when I was active in the sixties. This was caused because the outcome of Medicare and Medicaid and comprehensive health planning, and other forms of society's concerns about the delivery of care, cost of care, the access to care, the conditions under which technology will be diffused, etc. have not

made any distinction for the teaching hospital. Thus, the teaching hospitals, the Michigans, the Wisconsins of the world must compete in every full respect --economically, politically and service-wise--with these external agencies. The payment mechanisms for in-hospital care through Blue Cross, Medicare, and Medicaid are basically the same for all hospitals and so, as limitations on inpatient care are put down, the university hospitals being expensive relative to other hospitals, they stand out in terms of the cost side. The ability to get a certificate of need requires the ability to make commitments and, again, because of the features I mentioned earlier, very difficult for that structure to say, "Yes, we will provide the following services in 1985," and make it stick.

I've concluded that the true academic health centers are teaching hospitals, not affiliated hospitals who complement the teaching of medical schools, and nursing schools. The owned and operated teaching hospitals in academic health centers probably ought to be pulled out of the mainstream of control through planning agencies and financing, and treated as national resources that are absolutely necessary and vital and important with respect to the production of health manpower, with respect to the nurturing of basic and applied research and held accountable for the quality of the care that's necessary for those other two functions. But they should be pulled out and treated as national resources with respect to the financial base, both capital and operating, and with respect to the relationship to other providers in the general region to assure the full range of services, and treat those university academic centers as a very precious and necessary resource, but not look to them as a basic element of assuring the delivery of, let's say, emergency care or other things. I'm persuaded that that should be the

direction of the thought with respect to organizing, planning, delivering. Otherwise, I think, they're going to be highly uncompetitive in terms of the eighties and nineties because of cost, access to care, relationships with faculties and all. The only major strategy, as I see it, is to really pull them out of the organizational fabric of the university. That's really the Harvard model--Harvard and Mass General, and it's been very successful over the years--and create a separate corporate structure for the teaching hospital of university x in which they obviously would have a mission to be concerned about the teaching and research mission of the schools but not dominated by them. They clearly would be capable of making independent decisions, clearly capable of making independent contracts with the brother university or sister university. That model is being tried in a few places, North Carolina and, I think, some other places. Only time will tell, but the experiences of those places have led me to have deep respect for them, to understand personally the complexity of the management responsibililty, to believe, without defects in the governance part of the structure.

I believe that something needs to be done about that governance structure and the two models are: one, protect them, isolate them, treat them as a national resource in every way; or, two, pull them out and make them fully competitive with all other hospitals. How that will come out is speculative. My guess is that neither model will systematically be debated and adopted but rather the medical and academic centers will kind of drift with the times and be responsive as best they can to the outside controls, the constraints, the expectations--and not face up, in the best sense of that word, to the fundamental organizational issue and problem.

One other element of consideration of academic health centers, teaching

hospitals, and so on, that is worthy of some comment and note, deals with the question of the payment of physicians who are involved simultaneously in the delivery of care, the teaching of students, and research. The experience that I had in both settings, and I think is fairly typical and representative of the tensions that illustrated the sixties and seventies on this matter, really dealt with the issue of how much physicians in these settings ought to get paid. The approach differs across the country. The University of Michigan system, in late sixties, early seventies, was essentially a system in which most physicians--about 95% of the faculty--were on a full-time salary. A few physicians had the privilege of private practice, either at St. Joseph's Hospital, the community hospital in Ann Arbor, or in the university teaching center hospital. It was a throwback, I would say, to the fifties and to the structure in which the top persons in each department or section, after years of being in salaried position and more junior positions, were able to reap financial reward and incentives by having this private practice element. That private option in one form or another was not atypical of many centers, but obviously had some problems to it with respect to equity and fairness to other physicians.

To me, it was a very disturbing element, not because of the economic side, but the implication that there are some patients who are "private" and, therefore, expecting one level of attention vis-a-vis those patients who had economic means or didn't have economic means, but somehow weren't private with respect to the attention by faculty, the accommodations they were assigned to, etc.

The situation, of course, was made more severe as Medicare and Medicaid became operable because, for example, Medicare has a part "A" for hospital

care and a part "B" for medical care. Under part B the aged citizens could voluntarily choose, with some coinsurance coverage, for medical care, as well as hospital care under part A. That principle carried into Medicaid, which is essentially the state program for needy on the welfare. In reality Medicare and Medicaid opened up a new source of payment for service for medical care--physician's fees--that prior to that time was either largely inadequate or not available at all or blanketed very generally under something called "charity." So it immediately posed, one, a new or an expanded source of revenue in teaching hospitals for physicians' services, and secondly, it put the government through Medicare and Medicaid into the business of trying to decide the conditions under which the teaching physician should be paid. The government and organizations like Michigan Blue Shield had to determine what conditions must prevail before the teaching physician got paid and how much they get paid and if they're a salaried physician at the university on one hand, what happens to the fee for medical care? Should it be paid at all? Does it go to the university? Does it go to the hospital? Does it go to the medical school? Who controls it? Those issues were coupled with the complexity of the way in which medical care is delivered in a teaching setting because much of the direct hands-on physician service is carried out by the team of people who are a combination of students: the very beginning junior medical school clerk, to the very senior medical resident who is five years out of medical school and probably at the peak of his or her clinical understanding expertise, to the junior and senior faculty. It is so unlike the care that is essentially the product of a one-to-one relationship between a physician and his or her patient, that the conditions that apply to the payment to the individual physician of an individual patient simply are not

applicable to the setting in which several people participate. Thus the teaching centers had difficulty responding to the fundamental requirements of Medicare and Medicaid to justify the flow of the fee, that is: Who is a responsible physician? Who really makes the decision about the care and treatment? What are the characteristics of the surgical setting? Who does the surgery? Who supervises?

A great deal of tension grew up between physicians who were in these academic settings and these external agencies, particularly Medicare and Medicaid and Blue Shield, to the point where it got to be debated politically on a national scale between the Association of American Medical Colleges and Congress and so forth. Section 227 of the Medicare Amendments in the early seventies was a result of the Health Care Financing Administration and it's predecessor, the Social Security Administration, trying to deal with this constructively. Powerful political forces were put in place, on one hand, to protect the legitimacy of the stream of money to the medical center for medical care, and on the other hand to meet the requirements that the service was delivered by the physician.

That issue to this day is not resolved, the issue of what are the reasonable expectations of the characteristics of the care being delivered that justifies a fee. At the same time it highlighted, "it" being a stream of money, highlighted the perceived inequities of incomes between academic physicians in practice and incomes within the academic departments.

A number of important and difficult questions were raised in those years that I was involved in in both settings. Should neurosurgeons make twice as much or three times as much as pediatricians in the academic health center? Another way of phrasing that question, should neurosurgeons make about as much

or not as much as neurosurgeons on the outside in private practice? Should the incomes, however derived, for the discipline be related to the incomes of that discipline on the outside or is there something special and unique about physicians drawn to academic health centers that care less about those differences and care more about the adequacy of income for all involved? Are academic health center physicians really a large group practice? Are they a series of individual entrepreneurs? Are they only departmental oriented or are they school oriented?

When money gets involved, it's been my experience, that it has the tendency to be very divisive, highly volatile, and is the source of much discontent in schools. Generally the movement, and the movement in Michigan clearly, was away from the full-time salaried physician to develop plans for faculties in which the faculty or the unit of the faculty itself could control the billing to the patient, the receipt of the funds, the distribution of those funds within a department or within a faculty under general rules of the university rather than having their salaries set by the dean and the departmental chairman. Some have moved those private practices outside the university structure for purposes of, one, having more control over the funds from a physician's point of view, and two, avoiding the spotlight being put on what the amounts of the incomes are, recognizing, particularly in the public university, the salaries would be a matter of public disclosure and public knowledge.

The underlying argument was, what impact, if any, does the way in which a physician gets paid and the amount he gets paid in the academic center influence the contribution, the teaching, and the research. The purists tend to be the low income specialties and people who are deans and committed to the

management side. They believe fundamentally that there would be an undesirable impact on the quality of teaching and the commitment to research if a department or a physician was making decisions that would influence the amount of income that person would get. Equally vigorous on the other side are those who believe in motivation, who feel that there are all kinds of rewards, including economic awards and as long as a department or an individual can show high quality teaching and concern about students and show a record in research, that the way and amount that they get paid shouldn't make that much difference.

Those were, in my view, the fundamental debates that went on; they continue to go on. I think, although I don't have the data for this, that the long-term impact of Medicare/Medicaid and Blue Shield funds have been to move away from salary arrangements and move toward practice plans and supplemental incomes outside or under minimum control of the university structures. I think, it remains for somebody else to debate and decide whether that's good or bad. All I can say, is that it was and continues to be a fundamental and very difficult problem that gets in the way of relationships in the teaching hospitals between and among departments, between and among the individuals, a source of tension between students and faculty. For example, if a senior resident, perfectly qualified, renders, let's say, 90% of the care, and 10% of the care is by the faculty and the senior person, should that resident receive any benefit from that? Should any of those funds go to the support of the salary or stipend or whatever it's called, to the resident? So, it has driven tensions there. It's clearly driven tensions between the management of teaching hospitals or the capital-poor hospital trying very hard to meet the needs of patients and faculty, to see, on one hand, the stream of money, and

on the other hand, the inabilities to utilize those moneys for direct needs of patients or the capital needs for equipment. It clearly drove difficult relationship questions between the deans of medical schools, particularly those who felt that faculties all ought to be treated the same. That although the incomes for surgeons should be more than the incomes for some they all ought to be in the same basic organizational framework, salary-based. That led, of course, to the resentments between scientists whose education was every bit as long and probably in some respects, as deep as the M.D. and with incomes of 300% and 400% difference. This led to a situation that is volatile, explosive, controversial and not constructive.

The last major insight and perceptions that I would like to record and share deals with my current and recent last five years with the Sisters of Mercy Health Corporation, Sisters of the Mercy of the Province of Detroit, specifically. Then I will discuss more generally that being a part of the development of what is now commonly referred to in the United States as a multihospital or multiunit system.

With respect to the Sisters of Mercy, they are one of some 400 Catholic orders in the United States who are in the business of delivering health services through the ownership of hospitals. The Sisters of Mercy of the Province of Detroit came to America in 1850s or 1860s or 1870s. It was an Irish order which was asked to come to try to start hospitals in developing communities where there was no hospital service. To my knowledge it never had the purpose or intention to provide a hospital only for Catholics or only for Catholic doctors or nurses. That was never the motivation or the purpose of Catholic hospitals in this country. It was a response to a broader community need, a community call to provide hospital service for people of all religious

persuasions and people without religious persuasion as a work of the church.

These religious orders are affiliated with the Catholic church, but not an integral part of the structure. These are independent organizations, in this case, of religious women, who voluntarily have decided to band together, lead a certain kind of life that flows from the beliefs of their own Catholic church, but dedicated in this case to the health ministry, that is, the delivery of health services to people. So the orders, and this particular one, the Sisters of Mercy, flourished through the last quarter of the 19th century and up until World War II in a response to community need. Thus, a major portion of the voluntary and not-for-profit system comes out of religious influence. The Catholic church was important but not the sole influence because similarly at the same time other churches--Lutheran, Baptist, Methodist, Presbyterian--were responding in their own way to this call for the voluntary taking care of patients and people by providing hospital facilities and services in the local communities. The Sisters of Mercy of the Province of Detroit, thus, over those years developed into one of the largest hospital organizations in the country. The Province of Detroit is one of nine provinces around the country, and there is a very loose federation of all the provinces, but the province is the unit of organization that's responsible for ownership, governance, management, and finance of their work. Their work is schools, education, community service and health third--the major influences that have been determinant of the development of these Catholic systems and were really determinant as to why the Sisters of Mercy Health Corporation was formed.

In the mid-sixties Pope John in the Vatican Councils caused some fundamental change to take place in the Catholic church. One of those changes

is now referred to as the Ecumenical Movement, that is, to try to break down the barriers and isolation of the Church as it relates to other Christian communities and as it relates to society more broadly. Another change was to loosen the rigidities of the life of the clergy and the life of religious communities, and to move toward much more lay involvement in all works of the church, parishes and councils, as for example, the Protestant denominations have known for years. The Catholic structure had been primarily an authoritarian structure with the clergy being the unit of authoritarianism, if I could call it that. The impact on religious orders was two-fold. One was a significant number of people left religious life. Secondly, fewer people entered the kind of life that commits oneself to a vow of obedience and a vow of poverty and a vow of chastity. The tensions on those three vows, in terms of society, and expectations of youth in the 1960s, 1970s, 1980s, I think, are obvious. The result was that religious orders, like the Sisters of Mercy, found themselves in the late sixties and early seventies faced with a declining number of Sisters that historically they were dependent upon in number sufficient to be able to provide the necessary direction, control and sponsorship and ownership responsibilities. They were uncertain as to whether they would be able to sustain the scope of commitment that they were able to sustain when they had greater numbers. So, in 1972, and 1973 a group of ten or twelve highly committed, highly professional, highly talented Sisters of Mercy of the Province of Detroit said, "It's time that we take a hard look at ourselves, where we've been, and what is our current status and what are the expectations of the future."

I was able to join them in 1974 as a consultant largely part-time, although it turned out to be full-time effort, part-time pay, I guess. I was

fortunate enough to be a part of an exciting study of the then existing systems--proprietary, Catholic, not-for-profit, Protestant, etc.--and to sit down and try to speculate what would be the requirements and expectations of the next decade in health delivery generally, and in Catholic hospitals specifically. Given all of that, what governance and management mechanism should the Sister of Mercy choose in delivering or exercising their responsibilities as owners? They found themselves with a significant commitment that they did not wish to treat lightly or walk away from. That commitment at that time was some seventeen hospitals, 5,500 beds, in three states and very diverse communities from the inner-city of Detroit to rural settings of Iowa, to single hospital communities like Cadillac and Grayling, Michigan, to very competitive hospital communities like Battle Creek.

The options were clearly articulated to allow an informed decision by the religious community. One option was to get out of health and was based on a legitimate set of arguments that said, "If you don't really have the nuns to staff the hospitals, why should it be your responsibility?"

The second option would be to stay in health but recognize that some significant changes had to take place if they stayed.

The decision was to stay because the fundamental purpose and reason for existence was always to serve people, not to serve the Sisters of Mercy. The belief was that the communities would be better off if there was a continuation of the influences of an organization based on religious beliefs and religious values with respect to the care of patients, with respect to concern about the dignity of the person, concern about making sure that the environment was conducive to treat the whole patient, his or her spiritual makeup as well as to treat the physical illness.

So the first decision was to stay in health. Then the second set of questions were "how" and "what" and so on. After a couple of years' study and examining all the models and making all the projections, in 1976 the decision was made to form a single, not-for-profit, Michigan-based health corporation with authority and responsibility to do business in the states of Indiana, Iowa, and Michigan, and others as necessary. It was decided to form a governance and management structure that was responsive on one hand to local needs, initiatives, accountability, and on the other to try to reap the benefits of a systemwide approach and centralization of certain activities and functions. So, this organization now is the largest, not-for-profit hospital system in the country. We have twenty facilities that are governed and managed by sixteen divisions, and three additional management contracts. We have nearly 6,000 beds. Our annual operating budget is in excess of $400 million, with assets of $450 million, with some 18,000 employees. Tremendous scope.

There are some fundamental things about governance that I think are proving to be workable and attractive. Any system, when it comes to governance, faces the question of how do you involve local citizens on one hand and how do the local citizens and the local unit relate to the central organizations. The model that seemed to make most sense and have most appeal was the bank holding company model in which, I think, they've demonstrated for several years that it is possible to have a local bank board that is not totally independent and autonomous yet is not advisory and yet is responsible to a central link. That model is essentially what we are trying to do in the Sisters of Mercy Health Corporation. We have a single corporate board of twelve individuals with broad authority and responsibility for the governance

of all the facilities, but in turn, at each local level with much local participation we have created divisional boards. The divisional boards are not independent, and they're not autonomous, and they're not advisory. Rather they get their authority and responsibility through systemmatic delegations, responsibility and authority through articles of incorporation, bylaws, policies--they are accountable to and responsible to the corporate board.

The principles of organization are that we are attempting to implement rest with three points. One is subsidiary. Now that's kind of a fancy, some-times church word, for decentralization. Fundamentally decisions ought to be made as close to the people and as close to the point at which the decision is going to have an impact as possible. So essentially we believe in decentralizing as much of our goverance and management as we think we can to allow for a lot of local initiative and latitude and responsibility within a very broad set of policies and bylaws and requirements. We are concerned about too much centralization and are not on a fast-track of centralizing the responsibility for functions. We believed that, until and unless it can be demonstrated that a certain function can be best due centrally, it ought to remain the responsibility of the decentralized or divisional unit.

The second organizing principle is one of collegiality, that is, the quality of relationships that should exist between and among people with the general theme being apparent in the word. We like to consider ourselves "colleagues" with one another as compared to words like authority superior, or subordinate, that imply, in fact, power relationships. That is more of a style and an intent but a very powerful idea. If one intends to make it work, it implies a lot about the kinds of people that you attract for management, it implies a lot in the way you exercise central authority and responsibility and

so on. We have written some documents on that, and I think it's an underlying organizing principle.

The third one is accountability. All persons and all segments of the organization need to be accountable to someone else with respect to the way in which they've exercised their authority and responsibility. So we have a series of checks and balances with respect to the basic functions of governance and management. Those principles of governance and organization have been spelled out in some detail, both in internal documents and external documents.

With respect to management then we have very few management functions centralized. They're few in number. We, for example, have a single approach to insurance, particularly malpractice, we're totally self-insured. We, in fact, therefore, run a small insurance company, work very hard in the prevention of malpractice incidents, etc. and have dramatically reduced the malpractice costs for our hospitals. We have a single external audit and we report to the public the full certified audit in our annual reports and that is, each hospital has an audit but it's done by a central firm and it's done externally with all the expectations of what a certified public audit is intended to assure for public credibility. We have a single retirement program for all employees. We have a single insured employee benefits program that's just getting off the ground because it's clear that one can do much better in negotiating health, life, dental and disability insurance by aggregating the experience of 16,000 as compared to trying to negotiate that on a one-on-one basis. We have a quasi-centralized purchasing effort that we manage out of Chicago that serves other Catholic communities, Catholic orders, in which an individual hospital has an option of buying into a national

contract, or staying out, but they then do it on an annual basis and there is, obviously, a significant savings there.

I think that the important finding so far is that we believe that we can demonstrate that one need not lose local involvement, local support, local initiative in a system whose ownership and governance resides elsewhere.

Secondly, we can demonstrate economics of scale in the traditional sense and that's important to the extent that it reduces the cost locally, or allows additional services to be provided.

Thirdly, we have been able to improve the involvement of lay people along with the religious colleagues--lay people, of all religious persuasions--in the work of the Sisters of Mercy: lay people who serve on local boards; lay managers, who are not necessarily Catholic; lay professionals who can identify with the concerns about compassionate care and with the spiritual aspects, not Catholic aspects but spiritual aspects of people, as well as their physical diagnosis. I think we can demonstrate that.

I think the overriding thing that has made us very excited about the success of this organization is that: first, it sustains and broadens--moves away from a parochial interpretation of religious values. We really think we can appeal to all people of good will in terms of this precious service called "health services."

Secondly, it is a reafffirmation of the importance of a community-based, not-for-profit approach, the delivery of health care. While I respect the zeal and the growth of the proprietary for-profit hospitals, I do not believe personally that individuals need make a profit in the operation of a hospital. I am deeply committed to the not-for-profit motive with respect to community enterprises of hospital operation. We think that organizations like

ours and other hospital systems that are emerging from religious and voluntary bases, believe the same thing.

Thirdly, I think, that there is a wide-spread latent, potential interest on the part of a lot of people to be concerned about values, and the more those can be expressed in generic terms as compared to specific religious denominational terms, the more appeal they're going to have. But people do care about the quality of life, the quality of their institutions.

If we and other hospital systems are able to demonstrate that value orientation can be sustained along with the commitment for not-for-profit, applying the latest technology of business and management and governance, then I think that hospital systems have a very exciting future. I think the data of growth speak for themselves, notwithstanding the fact that there are many skeptics to this movement and that there are many potential barriers to it, particularly such things as antitrust. However, I think it is a movement that is fundamental and in the next two decades is going to move in the direction of most hospitals being part of organized systems of care. That in turn will, I think, ultimately move toward easier decisions about the regionalization of the medical and other services, something we've often talked about. We don't have the organizational fabric in this country to be able to do it. I think systems are flexible enough to embrace such concepts as HMOs, flexible enough to continue alternate mechanisms of how physicians get paid, are able to get the necessary balance between community involvement in decisions and professional involvement in decisions. In a strange way, I think systems are moving in a direction that perhaps the Perloff Committee spelled out in the late sixties in terms of health care corporations, that is the ability--ultimately the ability--in organization to say yes we are responsible for

coordinating the delivery of service to people, in fact, we are responsible to join with you, the individual person, to be concerned about your health. We have a long way to go toward that but I think it's an exciting and necessary first step. So, I predict there will be much attention paid to multihospital systems.

The Catholic systems, of which we are part, are having a reawakening. It was, I believe, a very discouraged set of organizations five, six, seven years ago. There are many examples around the country right now where religious orders are forming corporate models as the vehicles to continue their work. The religious orders who are unable because of size and scope to sustain a system are turning to organizations like ours. The fact is that in our three or four years of existence we have acquired three hospitals and made it possible in one instance for the United Church of Christ to join with us in an ecumenical way to continue their work under our auspices. The fact is that we have been able to acquire a struggling rural hospital as a way to continue the availability of a medical service for a rural Iowa town. The fact is that hospitals have turned to us for help and therefore, we have three management contracts. These facts demonstrate to me the salability, workability, attractiveness of the notion that there is merit to getting together. Thus, I predict that large voluntary hospitals will start developing systems. Those who have always been in it for religious motivations will be encouraged and strengthened in their efforts, and I think that the proprietary for-profits will continue on an expansionistic mold. Thus, I think the trend is for more hospitals in systems, not the shared services. As best as we can count numbers and define things about 26% of all hospitals and about 33% of all beds are currently in systems. I don't think it's the end of that trend, I think

it's really the beginning of the first phase.

Interviews in Ann Arbor

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March 1, 1980

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