HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

James H. Sammons

JAMES H. SAMMONS

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298

James H. Sammons, M.D.

CHRONOLOGY

1928	Born Montgomery, Alabama, March 13
1944-1945	U.S. Naval Reserve
1947	Washington and Lee University, B.A.
1951	St. Louis University, M.D.
1951	Alabama City/County Hospital, Mobile, Intern
1952-1974	Baytown, Texas, General Practice
1962-1963	San Jacinto Methodist Hospital, Service Chief in Surgery and Obstetrics
1962-1974	Harris County, Texas, Deputy Medical Examiner
1964	San Jacinto Methodist Hospital, Baytown, President of the Staff
1964-1970	AMPAC, Board of Directors, Member
1969-1970	AMPAC, Chairman
1970-1972	AMA, Committee on Membership, Chairman
1970-1972	AMA, Liaison Committee with the American Bar Association, Chairman
1970-1972	AMA, Review Committee on Legislation and Medical Legal Affairs, Chairman
1970-1974	AMA, Board of Trustees
1972-1973	AMA, Vice Chairman of Board of Trustees
1973-1974	AMA, Chairman of the Board of Trustees
1974-	AMA, Executive Vice President

MEMBERSHIPS AND AFFILIATIONS

American Academy of Family Physicians, Member

American Academy of General Practice, Member

American Association of Medical Society Executives, Member

American Medical Association, Member

American Public Health Association, Member

American Society of Association Executives, Member

Baylor College of Medicine, Houston, Clinical Assistant Professor of Family Medicine in Department of Community Medicine, 1972-1975; Clinical Associate Professor of Family Practice in Family Practice Center, 1973-1976; Visiting Associate Professor of Family Practice Center, 1974-1975; Visiting Associate Professor in Family Practice, 1975-

Chicago Society of Association Executives, Member

Economic Club of Chicago

Ethics Resource Center, Inc., Board of Directors, Member, 1977-

Executives Club of Chicago, Member

Harris County (Texas) Academy of General Practice, Member

Harris County (Texas) Medical Society, Member, Vice President, 1962

Houston Academy of Medicine, President, Chairman of the Board

Institute of Medicine, Member

Kappa Alpha, Member

National Conference on Medical Education Planning, Member

Northwestern University Graduate School of Business, Advisory Council, Member

Omicron Kappa Alpha, Member

Phi Chi, Member

Robert Wood Johnson Foundation, Advisory Committee for Community Programs for Affordable Health Care, Member, 1981-

MEMBERSHIPS AND AFFILIATIONS (continued)

Southern Medical Association, Assistant Councillor, 1968-1971

Texas Academy of Family Physicians, Member

Texas Academy of General Practice, Member

Texas Medical Association, Member, President, 1971-1972

TEXPAC, Founding Member

U.S. Chamber of Commerce, Member; Special Committee on Health Care Needs, Member

Washington and Lee University, Society and the Professions: Studies in Applied Ethics, Member 1981

HONORS AND AWARDS

Texas University Sciences Center

D.H.L. (honorary) 1985

U.S. News and World Report

Decision Maker in American Health Care Field 1983

WEEKS:

Let's start by going over a couple of biographical details, such as, you were born in Montgomery, Alabama.

SAMMONS:

That's right. I was born on the thirteenth of March, 1927, in Montgomery, Alabama, in St. Margaret's Hospital. I was delivered by caesarean section, for whatever value that is, by one of the greatest men that I have ever known, Dr. John Blue who was a general surgeon in Montgomery -- one of the leading surgeons in the South back in the 1920s and 1930s.

I grew up though in a little town called Clayton, Alabama, which is the county seat for Barbour County. It's about seventy miles southeast of Montgomery, twenty-one miles from the Georgia line. My father was the agent for the Central Georgia Railroad in Clayton for some almost fifty years. My mother was born on a little farm outside of Louisville, Alabama. I was an only child. I grew up there, graduated from high school there, attended Washington and Lee University in Lexington, Virginia, and had an interruption of slightly more than a year as a result of World War II. I went back there after the war and got my degree, a bachelor of arts, and went to St. Louis University Medical School.

WEEKS:

May I ask you how you happened to decide on studying medicine?

SAMMONS:

I never wanted to do anything else. I can't ever remember a time in my life when I wanted to be a fireman or policeman or railroad conductor or engineer or any of those things. And of course airplanes -- that was way before the days of airplanes, at least the popularization of airplanes. So I

never really wanted to do that sort of thing. I don't remember ever wanting to do anything except practice medicine.

After graduating from St. Louis University in 1951, I went back to Mobile, Alabama, and did an internship at Mobile City-County Hospital which in those days was contracted out to the Sisters of Charity. They were the same order of nuns that operated Charity in New Orleans and a number of other hospitals across the South and the Midwest. Then I went to a little town of Highlands, Texas, where I joined a first cousin in general practice. He had been there about four years or five years when I got there. He and I practiced together for six years, and then because of physical problems he had to leave the general practice of medicine. I stayed there for several more years and then put together a multi-specialty group that started out as a group of five general practitioners in Baytown, Texas, which was where the hospital was located -- about five miles from Highlands. Then it became a multi-specialty group. I was a managing partner of that group. I had put it together and helped design the building that it was housed in. I had been chief-of-staff of the hospital and we had added a wing and so forth. I was there until I moved to Chicago in 1974.

During that period of time that I was in Texas, I went through essentially all of the chairs in the Harris County Medical Society. I was president of the Houston Academy of Medicine for six years, was a delegate, alternate delegate, delegate to the Texas Medical Association, as a member of the Board of Councilors for some twelve odd years. I was a chairman of the Board of Councilors for two years. Was an alternate delegate and a delegate to the AMA back in the 1960s. And was a member of the Board of Directors of the American Medical Political Action Committee, AMPAC. And in 1969 and 1970,

was the chairman of that board. I was elected to the Board of Trustees of the AMA for the first time in 1970. Reelected in 1973, and had been on almost all of the committees that the then Board of Trustees of the AMA had, many of which we don't have today. But was also chairman of the Board of Trustees of the AMA at the time when my predecessor, Dr. Howard's, replacement was obtained. The search committee submitted three names in the end to the board, mine being one of them. Fifteen ballots were taken because of an agreement that it would take more than a simple majority to elect. In the city of Washington, in the Washington Hilton Hotel, on St. Patrick's Day in 1974, they finally broke the deadlock and I was elected by that board to this job. And I have been here ever since.

It has been a very interesting time. It's been a challenge, it's been a trying time. It's been a time of great change in medicine. It's been a time of great change in the AMA. It's been a financially trying time. Shortly after I took this job -- that same year in fact -- we suddenly found that the AMA had spent itself into a deficit financing mode down to relative illiquidity. Our first problem was to reverse that spending process and to go to our House of Delegates and ask for an assessment to get us over. We went to the House and asked for a dues increase. The House changed it to an assessment. In the following year a very large dues increase, the biggest ever in the history of the AMA, put us back on a financially sound basis. We have moved along since that time to our present annual statement which we will give you a copy of that shows some $125 million in assets in the AMA. Our financial statement reflects that value.

In the meantime, the AMA has undergone a whole series of changes. It was necessary right at the beginning in 1974 and 1975, that we carefully look at

all of the cost centers as well as all of the income centers. Certainly, at that point of time, essentially all of the income of the AMA came from either dues or from advertising revenue in our journals which are not unrelated business income in our view, but rather a part of our mission. That is the disemination of information to physicians about the science of medicine and the armamentarium that is available to physicians in treating their patients. However, today less than half of the total income of the AMA comes from dues. That is something that I am very proud of. I think that all associations like ours and the AHA and other professional associations have essentially arrived at the point in time in this country when if they are to carry out their mission, whatever that mission is, — or missions, whatever the case may be — if they are to continue to expand to meet the needs of their constituency and if they are to meet the needs of the public that their constituency serves in these periods of great change and incredible progress -- the fastest moving scientific changes ever in history -- that they simply are not going to be able to rely on dues alone to do that. We have worked on that theory since the very beginning of my tenure. We still work on that theory that it's perfectly agreeable with us to pay taxes on unrelated business income. We have no problem about that. We have a series of for-profit subsidiaries that we use to generate non-dues revenue for the AMA, and are happy to pay taxes on that part of the income in order to have additional revenue for the AMA to continue to carry out its mission. I think we have been extremely successful in that.

That doesn't mean, however, that we have not had to go to the House of Delegates at periodic intervals and ask for dues increases, because we have. We did not ask for a dues increase in 1985, the first time since 1975. We do

have a dues increase that is in effect for 1986. The House of Delegates has not yet made a decision nor have we made a final recommendation to the House at this time on what we think they ought to do about 1987 and the years beyond. Nevertheless, we continue to believe that it is extremely important that non-dues revenue continue to grow.

We find at the AMA, as I'm sure all other associations find, that there is an almost endless number of very worthwhile activities that associations can engage in. You do have to prioritize those opportunities as well as to prioritize those instructions which you have given them. We are constantly being instructed by the House of Delegates, which meets twice a year, and by the Board of Trustees, which meets six times a year, on how the Association should proceed and what its direction should be and additional activities that we believe, either from the staff's standpoint or the House or the Board believe, the association should be engaged in. And each time that happens, of course, that is an increase in expenditure and therefore there has to be some increase in the generation of revenue to offset that expenditure. So we are very devoted to the idea that one simply cannot, in today's real world, expect that all of those revenues are going to come from dues.

Dues are high in 1986 in all facets of organizational life, not just ours but everybody's. There is, I think, a limit. I'm not sure what that limit is but I think we are rapidly approaching it. Therefore, we put a great deal of emphasis and a great deal of effort into and onto development of non-dues sources of revenue for the AMA.

During this same twelve-year time frame, we have had a reduction in staff. We had a very marked reduction in 1975, very sizable for us. Over the years that has gradually come back up to where we are today just about where

we were staffwise in the end of 1974, beginning of 1975. We have put a moratorium at this point on additional staff acquisitions unless we are replacing something that was already in place or unless we have decided that there is a very acute need that cannot be otherwise met. So we are at this point, as everyone in the country is, we are trying to hold down our costs. We are constantly confronted with great opportunities, however, to expand the scope of activity of the AMA, which after all is really why we're here. The preamble to the constitution says "to promote the art and science of medicine, and the betterment of the public health." In order to do those, clearly we have to change as times change and the circumstances change.

During the last twelve years we have become infinitely more active as an organization in a wide variety of fields than the AMA had historically been in. On the other hand, we have also discontinued some of the activities that the AMA had historically been involved in, feeling that they could better be handled in a different fashion. We have reduced the number of councils and committees of the AMA very substantially from where it was in 1974, and prior years, believing then and now -- I think history of the last eleven, twelve years certainly proves that we were correct in the assumption -- that the activities of those councils could be better done with ad hoc committees and ad hoc groups and an increased staff activity at a much more cost-effective level than we had seen in prior years.

So, we have been in a time frame here in which the AMA has undergone some rather, almost revolutionary, changes in its operation and in its outlook.

During that same twelve years I think there has been a marked change in the attitude of the average physician in this country. We did go through some very traumatic years back in the 1960s with the advent of Medicare and

Medicaid. An increasing degree of hostility since that time over government intervention and regulation promulgated as a result of Medicare and Medicaid and block grants and all of the other sorts of things that the federal government is engaged in. We have seen an increase in the number of non-physicians who want to practice medicine, apparently. That has been a very difficult area because these people by-and-large are in the paramedical groups that we need as technicians. Many of them, apparently now, are coming to believe that they know as much about medicine as doctors and therefore they should be allowed to treat patients without the need for supervision or direction or anything else from a physician. We obviously do not agree with that, but that is a very difficult activity to confront because one is constantly confronted with the possibility of charges of restraint of trade and potential violation of the anti-trust laws. So we have to be very circumspect and very careful that we do not violate those laws and that we not, in fact, even appear to be violating the laws. That makes it a very difficult timeframe.

During that same period of time, of course, we've continued to graduate in this country some 17,000 doctors a year, plus what has come back in from outside the United States either as native-born foreign medical graduates or alien foreign medical graduates. We did that all through the 1950s with an open door policy, the 1960s and well into the 1970s, early 1980s before the door actually began to be closed by Congress who had opened it in the first place. That has produced, in many people's minds, an excess of physicians in this country.

The whole question of competition in medicine that has evolved over the last few years as a result of some of the changes in the public attitude

toward the need for physicians and types of delivery systems that have come into being since the 1930s. You know, people seem to think in this country that all of this business about HMOs and IPAs and all this sort of thing, that that is somehow or another a product of the 1970s and 1980s. It is not true. The company doctor goes all the way back in this country to the early 1900s. It's almost like a company store. There was also a company doctor. There were railroad doctors all over this country that saw railroad employees and their dependents on contract back in the 1920s and 1930s, and in fact still do. That still is the case.

Then when Henry Kaiser created the first Kaiser plan building the Grand Coulee Dam in the 1930s, that simply formalized what had been done sort of on a piecemeal basis. But in the last few years, because of the competition models that some of the members of the Congress, Senator Durenberger and others, have pushed very hard for, the takeoff of the so-called HMO which really has nothing to do with health maintenance. It's a misnomer. The fact of closed panel medicine, the ability to select the type of delivery system that you as a patient want to engage in, all of those things have happened with increasing speed in the last few years.

This has changed the face of medicine rather considerably. It has changed some of the attitudes and official positions of the AMA. We now have much more liberal policies, if you will, as it relates to organized medical groups and the contracting by physicians for services. The Independent Practice Association in itself is a very marked departure from the previous historical role of physicians in the individual practice of medicine. The doctor generated, or hospital generated, or combination generated PPO and HMO -- these are marked departures from what we have historically seen in

medicine. Every time some major activity like that, or like those, either begins to be generated by medicine itself or by some one or more outside influences, the AMA undergoes another change. That change has been markedly present in the Medicare and Medicaid programs.

We fought the Medicare program tooth and nail, believing it would not do what it was said to be capable of doing at the price that was then used in those years. Unfortunately, we were absolutely correct about the cost and what would happen to the cost, and what would be the ultimate intervention of the government into the delivery of the care. Unhappily, every one of those predictions has turned out to be correct.

At the same time, however, once the Medicare law became the law, the AMA has done everything it could to make that work for the benefit of the over-65 population. Clearly the Medicaid problem is an entirely different problem and we have had to confront it differently. We have worked with state associations who in turn have worked with state government, since it is a state/federal combination program, to make that work for the benefit of the poor, of the medically indigent of our country.

We are in a constant metamorphosis in the AMA. More rapid, more extensive, perhaps today, than it was five years ago. Certainly more so than it was ten or fifteen years ago. I suspect that over the next decade or well into the next century that we will see an ever-increasing metamorphosis of, not only the AMA, but all of medicine, the practice of medicine.

The high technology that has occurred in the last few years has certainly changed the face of medicine. It has changed the way that medicine is practiced. It has changed the way that doctors are able to respond to patients' needs. We have all kinds of new specialties that we didn't dream of

fifteen years ago that have come from all of this. We see second and third generation imaging devices that make the first generation look like tinkertoys. I think that sort of thing is going to continue unless the restrictive expenditure policies of the federal government become so severe that research and development funds are simply not available for continued experimentation. We believe that we see that happening already. Some of the biggest research and development units in the country in corporate America clearly are beginning to cut back on their R&D funds because of their concern that having spent that money and having developed new technology, they will not be able to sell it because the federal government is not going to be willing to reimburse or to pay for that technology. That is a very major consideration. And it is one that concerns us a great deal. After all, the name of the game for doctors is to be able to take care of people who need care, whether it be acute care or chronic care or long-term care or preventative care. If we do not have the tools at hand that we are capable of having, then clearly we cannot fulfill that mission. So that is a matter of major concern to us. What happens in the R&D in this country over the next few years is going to be absolutely horrendous if restrictive policies continue.

Clearly the other mission that the AMA has is one of education, the quality of education, the undergraduate, the graduate, the continuing. That has been historical. The AMA was founded in 1847 for the purpose of getting rid of the diploma mills and the mail-order certificates and creating a true academic environment for the teaching of medicine. Certainly the Flexner report in the early 1900s was a culmination of that concept. So that since the very beginning of the AMA, education has been one of our major functions

and roles and it still is today. The AMA, along with the Association of American Medical Colleges, AAMC, and some other members from the public sector and students and so forth, and government, makes up the Liaison Committee on Medical Education which accredits all of the medical schools in the United States and Canada. This has been unique in the world. Albeit there are accrediting bodies in other countries, there has never been one quite like the Liaison Committee on Medical Education. That has maintained the high standard of academic excellence in medical schools in this country. The residency programs in this country, overseen by the Accreditation Council on Graduate Medical Education, is also unique in this country. There really is nothing like that anywhere else in the world. That has added immeasurably to the high quality of health care that is given in this country. The AMA is the only group that is represented on every residency review committee. We started them back many, many years ago. We have been a major force in seeing that they did in fact fulfill that role. And for a number of years, we were the only source of financing for the residency review committees in this country. Well into the early 1970s in fact. That has changed now. The AMA is still part of the financing methodology of residency review committees and the whole ACGME activity, but, at the same time, the residency programs themselves and the specialty societies that are represented and so forth, also share in the financing of these programs.

The point that I'm making, obviously, is that we are in a state of change. And it is a constant change. The AMA is not -- had someone asked me the other day, "Isn't the AMA just a great big old monolith that sits over here on the ground and really hasn't moved in terms of its philosophies and its activities in the last thirty years?" And the answer to that is obviously

no. Of course it isn't. It's a big organization that represents -- whether we like it or not -- all of the doctors in the country. The ones that aren't members as well as the ones that are. And we don't like that. We would prefer that they are all members if we are going to represent them. And we wind up doing it anyhow. But we change constantly. We are in a constant change of metamorphosis.

It has been a very interesting activity. We have just redone, in the last two years, the whole scientific side of the AMA. I brought in three incredibly bright young people -- young, in their late forties, early fifties, and that is young in today's world -- who are academicians with extensive backgrounds in research and teaching. They have redone, markedly and remarkably redone, the scientific side of the AMA. And it continues. It is going to continue as long as I'm here.

Now we have redone the non-scientific side, the practice side if you will, the mechanics of practice. The Council on Medical Service, the Council on Legislation, the Council on Medical Education, all are as active as is the Council on Scientific Activities which is our major scientific council today.

These things will never stop. They haven't stopped since 1846. I don't see them stopping any time in the foreseeable future. People constantly ask the question, "Well, is there really a need for the AMA?" Of course there's a need for the AMA. I think Wilbur Cohen said it, when he was Secretary of Health, Education and Welfare, better than anyone else because Secretary Cohen was asked, "Don't you wish the AMA would just go away?" This was back in the days of the Medicare/Medicaid business.

Wilbur said, "No. Because if there wasn't an AMA somebody would have to start one tomorrow. We cannot do without an AMA."

I think that is very true for a wide variety of reasons. The fact of the matter is that we get headlines when we object to things, we seldom get headlines when we propose and promote activities. It's the old saw that dog bites man doesn't sell newspapers, but man bites dog on the front page sells lots of newspapers. So we are accustomed to that. We don't like that, but we have learned to live with it over the last hundred-odd years. And we don't expect that that's ever going to change very much either. The fact is that the AMA is a vital, integral part of the public policy decision process in this country as it applies to the health care of the American people, both from an education standpoint, the scientific standpoint, and the day-to-day practice of medicine. And that I don't see changing.

That's a long way around the horn to say that the last twelve years have been exciting, trying, constant change. I think with a fair amount of accomplishment. Some things that we didn't do that we would like to have done, but we haven't given up on them. We'll try them again from time to time to see if we can bring them about. I think that that's a thumbnail, really, of the way we are.

WEEKS:

Could I ask you a few questions? **For example, population of Baytown?**

SAMMONS:

By all means.

I don't know what the last census said, but I would guess it's about 56,000. In the trade area, probably close to 80,000.

WEEKS:

Now the hospital you were connected with was the San Jacinto Methodist Hospital?

SAMMONS:

Yes. It started out life as a community hospital that had essentially been built by the Humble Oil Company, which is now Standard. They had substantially financed it, let's say, back in the late 1940s, and had given it to Baytown. It initially was San Jacinto Memorial Hospital. Back in the 1970s, it was felt that it needed a different sort of management skill and activity than they had been able to obtain, the board of trustees of that hospital had been able to obtain, and the negotiation was carried out with the Methodist Conference of Texas that operates a number of hospitals in Texas -- several hospitals. The hospital was given to the Texas Methodist Conference. It changed its name to the San Jacinto Methodist Hospital.

WEEKS:

I noted that presently there is a Humana Hospital in town too, isn't there?

SAMMONS:

Oh, yes. There is an HCA hospital there too. In my day there were those hopsitals there then. One of the other hospitals that I had privileges at and did work in was the Gulf Coast Hospital, which was originally started by a group of physicians in Baytown. They built it. Then sold it to Hospital Affiliates. When Hospital Affiliates was bought by HCA, it became the HCA hospital. Baytown Hospital, which had been in Baytown for many, many, many years and was owned by a small group of physicians, they did some sort of sale to Humana. I'm not conversant with the details of that, but somewhere back in the 1970s, Humana built a new hospital -- a new Baytown Hospital. That is still there. All three of the hospitals are still there and still active.

WEEKS:

What teaching facilities are there at the Methodist Hospital?

SAMMONS:

There is a residency program in family practice. That was started after I left there. One of my former partners is, or was -- I guess he still is, I really haven't checked on it lately -- John Nesselrod was the first director of that residency program. John was one of my original partners in the medical and surgical group of Baytown.

WEEKS:

I noticed you were Deputy Medical Examiner for...

SAMMONS:

Harris County? Yes. Back in the 1950s Harris County went from a coroner system to a medical examiner system. Harris County is -- I don't remember exactly -- is either the second or the third largest land area county in the country. The department didn't have any money and they barely had enough to hire a forensic pathologist and set up a lab. So there were two or three of us who agreed to serve as deputy medical examiners for various of the outlying parts of Harris County. Baytown and Highlands are both a part of Harris County, as is Houston, of course. So we did that. Really, I got involved in it to try and help them get the medical examiner system off the ground. Enjoyed it. So much so that I continued to do it right up to the time that I left, and I think a couple of my former partners are still deputy medical examiners for the outlying areas in Harris County.

WEEKS:

Another one of the community services that you have to do?

SAMMONS:

That's right. I think every doctor has an obligation to do that sort of thing. Now, and even while I was still doing it, they started out paying us twenty-five dollars to carry out our duties -- started doing them really for nothing, then they got to the point where they said they could pay us twenty-five dollars. I have no idea what it is now, but I'm sure it's much more than that because it was more than that when I left.

WEEKS:

Could you expand a bit on your experience in AMPAC?

SAMMONS:

Well, back in the 1950s, right after I left medical school, I got very interested in the political process in this country and what I thought I saw happening or going to happen in medicine as a result of what I thought I saw happening in the political process. So by the time I got to Texas and started practicing, I was truly hooked on the political process and what it meant to the people of this country. Between 1952, when I started practicing, and 1962, when the AMA created AMPAC, not only Texas but Illinois and almost all of the states there were groups of doctors within those states that made contributions to candidates, that worked for candidates, that were in fact involved in the political process. I was one of those people.

When the AMA announced that it was going to create AMPAC on a national level, we in Texas created TEXPAC. And of course you know the story of that. There is not a state in the union that does not have a state PAC in it. I had been very active in Texas in a number of areas, politically. In 1964, the Board of Trustees of the AMA made some changes in the original AMPAC board. I was appointed by the Board of Trustees of the AMA in late 1963, December 1963,

to go on the AMPAC board. In those days we were still having to fight the physician's notion that it was somehow or another beneath his dignity to become involved in politics. That was abhorrent to most physicians.

It was never abhorrent to me nor to the other members of the AMPAC board, and we were probably the most active group of people in America in the 1960s, generating state PACs and whipping up enthusiasm in physicians and in our own involvement as an organization in the political process in support of candidates. Now AMPAC only supports candidates for the Senate and the House. It does not get itself involved in the presidential races. State PACs, although they support their own candidates from that state in House and Senate races at the U.S. level, they also are deeply involved in gubernatorial and legislative races and so on.

That was sort of the division of work, if you will, in the 1960s. AMPAC would concentrate solely on U.S. House and Senate races. That is exactly what it is today. During that eight years that I was there, I worked my way through all of the committees and several hundred thousand miles -- goodness only knows how many -- of travel around this country. In 1969, was elected chairman of the AMPAC board. Those were exciting days. It was incredible. you would go into a state meeting and make your pitch and have ten guys get up and say, "Why that's crazy! That's demeaning for doctors to get involved in politics. All we're interested in doing is practicing medicine."

Of course we said to them -- in different words -- but we said the same thing that President Nixon said when he came to address the AMA House of Delegates in Atlantic City in the early 1970s and that is that if you don't get about the business of politics, you are not going to have any business to get about. That's the message that we were delivering back in the early 1960s

and still are delivering today bacause there's a new generation every other year, you know. You have to continue to remind them that that is the method of expression in this country. We don't have revolutions, we don't have coups, we do it in the voting booth. And they must participate. It was a very exciting time in the 1960s -- all the way through the 1960s.

WEEKS:

Were you doing lobbying as well?

SAMMONS:

No. AMPAC doesn't lobby and never has. The AMA lobbies. Our Washington staff lobbies. AMPAC has never attached itself to any piece of legislation, proposed or otherwise. It does not lobby. AMPAC's theory, and one to which I totally subscribe, is that the political process requires people to do the best they can to elect people who have similar philosophies to theirs. The thing that you have to constantly be alert to is to not expect that people with the same philosophy of government, or similar philosophies of government, are going to agree with you 100% of the time. Because they don't.

The analogy that I use when someone gets all carried away with that is that, look, I've got a young daughter. She's nineteen years old. Nancy has the temerity to disagree with her father constantly. I don't throw her out of the house because she disagrees. And certainly you don't throw away your friendship or your political relationship with people of similar philosophies simply because they do not 100% of the time vote with you. That's pretty hard, incidentally, for a lot of physicians to accept. Because when they see them vote for some major change in federal health programs, or see them support some onerous regulations that come out of the Department of Health and Human Services, it's very difficult for them to keep focused the fact that,

yes, they did take a stand opposite that which we would like for them to take in that instance, but in the last one hundred occasions or in the next twenty-five or whatever, they may very well be supportive. That's hard for doctors to come to grips with because they see the extent to which the onerous piece of legislation or regulation can impact on health care. And frequently legislators in the very best of circumstances and the best meaning of situations, frequently do not understand that. That's tough for doctors. It was very hard in the 196Øs. When the Congress was debating Medicare and Medicaid and we were out trying to create new PACs all over the place, it was very hard for them to recognize that, number one, they had to be involved as physicians, and, number two, even so there would be some people that they would support that would not always vote with them.

Incidently, AMPAC probably was the cause of the creation of all of the non-labor PACs. We were the first major PAC, AMPAC was, outside of the AFL-CIOs COPE. When we started it, and after a couple or three years of seeing it happen, then people like the American Bankers Association and the Life Underwriters, -- now there are some forty-four hundred PACs in this country. And we admit that we used COPE as a model. It was the most successful political arm ever in the history of the country. And we -- imitation is the greatest form of flattery -- fine, we imitated COPE in many of the things it did because it had been so incredibly successful. Then we shared our bylaws and our operating procedures and so on with any of the non-labor group that wanted to create PACs, and probably would have shared with the labor groups if they had asked us. But there was no occasion for them to ask us, they had COPE to go to. But it was an exciting time, a very, very exciting time.

WEEKS:

When you spoke of your Washington office the thought crossed my mind, how much of your time do you have to spend in Washington? How often do you have to appear before committees?

SAMMONS:

Well, in the early days of this job I appeared a lot more frequently than I do today. We have some people today that have come along in our councils and on our board that are very good at that and we use them more. In the early days I used to appear every time there was a hearing that we had an interest in. Today, I appear at periodic intervals when I think that there is some role that I can play that maybe some of our other people can't. But otherwise we use an awful lot of our board members and council people and some other members of the senior staff, Dr. Todd being the other major senior staff person to testify. But I spend a fair amount of my time in Washington. It just depends on what's happening in Washington at the time. Out of the last two weeks, ten working days, I spent seven of those ten working days in Washington. But that's unusual. I'm not there that much ordinarily. I would say I'm there maybe a quarter of the time.

WEEKS:

The reason I ask that is because Alex McMahon...

SAMMONS:

But Alex and I have never operated it the same way. And the difference has always been -- at least my perception of the difference has always been -- Alex prefers to do it himself. "I'd rather do it myself, Mother." Do you remember that ad?

On the other hand, I have relied heavily on my Washington lobbying staff

to do the lobbying. So when I'm in town it is a single issue activity, with specific members of the Congress or of the administration. I work more closely, and have, with the Secretary of HHS than many other people. Alex has too. I think both of us have concentrated a lot of time on the Secretary's activities because HHS is so important to us. Both also on selected members of Congress, committee chairmen and members of committees that deal with health issues. I have a larger Washington staff than AHA does, considerably so. I believe that my lobbyist, with all due respect to Jack Owen whom I love dearly and think he is a great, great member of the AHA activities, but I think my lobbying staff is the best in town. So I let them do that which they know how to do best and I try to do that which I know how to do best, and am perfectly happy with that arrangement.

WEEKS:

It appears to me that you are not overexposing yourself so that when you do appear, it has more meaning.

SAMMONS:

That has been the theory that we have worked on all these years, just exactly that. That the greatest danger was not underexposure, the greatest danger was overexposure. When Jim Sammons as EVP of the AMA went to Washington to lobby on -- and incidentally, I am a registered lobbyist for the AMA, out of necessity. But when I went to the Hill or when I appeared before a committee, clearly the signal was that this is extremely important or Jim would not be here. We have tried to operate on that thesis, and have for the last twelve years. And I think successfully so.

WEEKS:

Did you work with Whittaker and Baxter?

SAMMONS:

No. Whittaker and Baxter did that in the 1950s, and I had just started practicing medicine when they did the Wagner-Murray-Dingell bill. No, that was really before my time.

WEEKS:

As I understand it, they were stressing public relations or working on public opinion rather than doing any lobbying.

SAMMONS:

Oh, yes. They were not involved in lobbying at all.

WEEKS:

I don't know whether they are still alive or not but I would love to...

SAMMONS:

I have no idea, frankly, whether they are or not. I know who they are, I've read their stuff. I have never met either of them.

WEEKS:

I was of the opinion at the time that they were doing AMA more harm than good.

SAMMONS:

I think retrospectively that may be true, as a matter of fact. That whole activity, retrospectively, may have been more harmful than it was useful. But the thing that truly, I think, was harmful to the AMA was the Medicare fight. It was never understood by the public. The PR people that were involved -- I'm not certain that they even understood what the fight was about. Consequently there was an awful lot of misunderstanding. As a result, the AMA got painted with a black hat. We were opposed to the care of the elderly. We didn't want to cooperate. All of this nonsense. And it was

nonsense, because who in the hell did they think cared for the elderly before Medicare? And who do they think has taken care of them since Medicare? It's been the same group, physicians. But I think it was very harmful. Retrospection is always better than foresight. I think if we were going to do that fight all over again today, we would certainly do it in a different context than it was done in the 1960s. I don't think I would argue with you about the 1950s activity. The Wagner-Murray-Dingel bill was a very bad piece of legislation. It truly was. It was just horrendous.

WEEKS:

Well, it took in everything but the kitchen sink too.

SAMMONS:

Oh, absolutely. But I'm not certain that the PR fight was the right fight. It may well have been harmful. I'm convinced that the direction that the 1960s fight took was harmful.

WEEKS:

When were you elected as a delegate to the AMA House?

SAMMONS:

Back in the 1960s. I had been filling in as an alternate in the 1950s, and when one of the vacancies became permanent, I was elected a full delegate in the early 1960s.

WEEKS:

I got the impression that you have been in this from the time that you were a very young man.

SAMMONS:

Absolutely.

WEEKS:

You were in it almost from the beginning of your career.

SAMMONS:

Yes. I started going to AMA House of Delegates meetings in 1954. And I've only missed two. So I've spent essentially all of my life with this. I fell in love with the AMA when I was in medical school. I've never fallen out. We had a dean at St. Louis University, Father Schwitalla who himself was very close to the AMA and had served on many AMA councils and activities. The AMA was meeting in St. Louis and he made the observation that he wanted all of the medical students to go down to the auditorium and take a look at this organization because he wanted every one of them to belong and to be active, because he thought it was the greatest thing in medicine.

I went down, along with all of my classmates, and wandered around there for a day or so, and I fell in love with it. The very concept that here were people who were giving their time and themselves to try and help shape public policy for health care was something that appealed to me greatly. It's been the greatest mistress in the history of the world. The love affair has lasted for over thirty years and it gets better every day.

WEEKS:

That's wonderful.

Father Schwitalla must have been a very interesting person. He was a very forceful character, wasn't he?

SAMMONS:

Oh, yes. Very much so. Unfortunately he was ill. He had just had his first stroke when I got to St. Louis in 1947, and was in his wheelchair. But he still had all his faculties, particularly his mental faculties. My

goodness, he was an incredible human being. And a marvelous man. He had literally taken St. Louis University's medical school from a not very good school and had made it into an exceptionally fine school. The force of his personality is what did it, of course. And then he had picked some fine people. Dr. Doisy, who was a Nobel Prize winner, discovered estrogen and vitamin K. Dr. Kuntz, who had written the definitive textbook on neuro-anatomy. And a whole series of people in microbiology -- almost every field of medicine -- pathology, physiology. During World War II, St. Louis had done an awful lot of research for the Air Force on the effects of high altitude flying, physiological effects. So he had brought to that school some very fine people and had made a very fine university out of it, which it still is. But he was a very forceful guy, he sure was. He ruled by fear. The fear was that you would be expelled. In those days, if you were, there was no possible way for you to get into another medical school.

WEEKS:

Is that right?

SAMMONS:

Oh, absolutely. If you were expelled for any reason from one medical school, it was virtually impossible for you to get into another one. So the fear was very real. Everybody felt it. Today that's probably not quite so true. But in those days it was very true.

WEEKS:

The number of applicants compared to the vacancies in schools -- the number of applicants must have been much greater than the places to put them.

SAMMONS:

Well, but it was not nearly as high as it got in the 1960s and 1970s.

The thought proces went that if, for whatever reason, one school has been unable to tolerate you -- whether it's grades or behavior or whatever -- then there's no reason for us to fool with you because clearly you're not worth it. That rigidity of thought was very prevalent in this country in those days in terms of that. Because there was this insistence on excellence, which still exists. There was the competition for seats, which still exists. You were graded, not only on your gradepoint averages, but on your personal demeanor and on your dedication and so on. So conventional wisdom said if they can't tolerate you then we don't certainly want to go through that exercise. It was a very real fear.

WEEKS:

It was a good thing.

SAMMONS:

Oh, yes. As a matter of fact, I think it was. I wish we could instill a little more of that back into the system today. I think we are a little too permissive today in the system.

WEEKS:

As you said, you have served a number of committees. One committee name raises the question, what do you picture as the need for representation of AMA? You, of course, have government, you have other associations.

SAMMONS:

Representation on the part of the AMA in what way?

WEEKS:

For instance, I have a note that you served on the liaison committee with the American Bar Association.

SAMMONS:

Yes, a number of years ago. We still have that committee incidentally. It still functions, but in a different way. In those days it was a joint committee, which it still is when it functions. In those days we were very concerned about the legal ramifications of such things as testing for parenthood, the whole question of professional liability was already rearing its head in those days. We addressed a variety of issues that were common ground issues. We didn't resolve any of them, I hastily add, but we certainly addressed them. I think what we did do -- maybe the only thing that we ever should or could do in that sort of setting -- was to raise the level of consciousness in both groups that these issues were more complex than originally had been perceived. That there was a common interest and, in some instances, a common ground of interest. One of the things that we did do was publish a paper on bloodtesting for parentage that was extremely well done, and I think had a great deal of impact in subsequent years in some legislation. Some legislation at the state level about that. We certainly didn't get anywhere with professional liability. The whole question of the doctor as a witness, the whole question of the doctor as a client. All sorts of tangential expressions of those questions were areas that we did address. I think that committee served a very useful purpose.

WEEKS:

Did you address malpractice?

SAMMONS:

Yes. We addressed contingency fees and the question of what constitutes malpractice. We could never come to an agreement, of course, on any of that because the ABA representatives were a combination of trial lawyers and

defense attorneys. We were never able to resolve those problems in that committee just as we have not been able to resolve them up to this point.

WEEKS:

Contingency fees are not prevalent in Canada or Britain are they?

SAMMONS:

No. This is the only country in the world that really has a contingency fee program. It's unique to this country. In our view there is a need for contingency fees. The AMA has never supported the concept of the total abolition of contingency fees. We don't now. What we have said over the years, and are saying now, is that there needs to be a change in the structure of contingency fees. There needs to be a sliding scale of contingency fees. It is unconscionable in our view that less than fifty cents, and in most cases about thirty cents, out of every awarded dollar finally winds up going to the patient. The attorney getting the rest. Some court costs involved and so forth. But, that seems to us to be absolutely unconscionable. These are multi-million dollar windfalls that really are unjustified. From our perspective, what is needed in the contingency fee agreement, is not the total abolition of contingency fee, but it is a restructuring of the percentage of the awards above $100,000 that needs to be addressed. That is what we have proposed in our legislation which Senator Hatch...

WEEKS:

American Medical Assurance Company, you said was a re-insurance company.

SAMMONS:

Yes. It's a re-insurance company. We are involved in the re-insurance of a number of the doctor-owned primary insurance companies around the country. We are not the primary insurer ourselves, except in one state and we

are doing that in a time frame to allow that state to take it over. But we are in the re-insurance business.

WEEKS:

How do you enter into law suits?

SAMMONS:

We don't enter into them except when judgments are given and awards are made and then if whatever the original primary carrier's limits are, then the next layer up is what we are involved in. It has to get up to that before we are involved.

WEEKS:

It would seem to me that these self-insurance companies or the group insurance companies, they need somebody with a lot of expertise to handle the court fights.

SAMMONS:

They have fine lawyers. We don't get involved in the lawsuits at all. But you will find universally that the doctor-owned captives have very fine lawyers on retainer to represent their clients, their policyholders. They have very good results in the courtroom.

WEEKS:

What has the experience been? Are the costs lower?

SAMMONS:

I don't think the costs are any lower as a result of the doctor-owned captives. Where we believe we see a stabilization of premiums, not necessarily a lowering of premiums but a stablization of premiums, is in those states that have an active tort reform in recent years. You look at California and their tort reform is ten years old, but it's just now going

into effect because they've been in the courts for ten years to finally get it legitimized, if you will. But during that ten-year time frame, we have seen in California a smaller number of suits, a reduction in size of awards, and some early stabilization of premium. We believe that that's going to be the ultimate solution to this problem, tort reform -- and extensive tort reform.

The doctor-owned captive originated in the late 1970s, or mid-70s. The reason for their being was that we were in another crisis. But the crisis that time was the crisis of insurance companies getting out of the business. There was this tremendous void out there and they came into being. Today, that still is a major reason for their continuation. Because when you get right down to it, there are only two companies in the country that truly are writing -- other than the doctor-owned -- that are truly writing liability coverage, and only one of them, St. Paul, is writing extensive liability coverage. And St. Paul is cutting back because it got to be too big a part of their total casualty business. With the irresponsible awards that juries have been making and the irresponsible number of lawsuits that lawyers have generated because of the contingency fee activity, there is still that crisis of availability, or there would be if the doctor-owned captives got out. And certainly the crisis today is one of price. That's the crisis today as opposed to the crisis in 1974-75, for example. But it's a price crisis.

I don't see that ameliorating unless and until we are able to change the tort laws. Changing the tort laws in this country is not just a professional issue of the physicians, but, as you very well know, it's doctors, lawyers themselves, attorneys of all sorts, dentists, architects, engineers, ministers. There are 40,000 ministers in this country today that do not have liability insurance, have not been able to renew or buy their coverage.

Churches, on the whole, are discouraging their ministers from counseling because they don't have the coverage. School districts, municipalities, playgrounds, day-care centers, directors of large corporations resigning from the boards because the corporation is unable to buy sufficient liability coverage for their director. One of the largest corporations in the world, the chairman of the board told me recently that his company was having trouble getting all of the liability coverage, at any price, that they needed to buy.

This is a major upheaval in this country today. People are beginning -- I think the general public is beginning to understand today for the first time that this is not just a doctor/lawyer problem. This is an everybody problem because the public is paying for it. And the public sees it happen when police departments and fire departments can't send their people out; when day-care centers have to close; when churches can't give counseling; when swimming pools, in the summer, can't open; that's for real. That's not some theoretical doctor-lawyer fight. That's real. And the public can see that, put a hand on that. That's very real to them. And I think we are going to see some changes made as a result of that.

It's my view that if the states do not get on with the business of tort reform and state legislations, and do it very seriously, and do it in 1986, it's my view that the federal Congress will do it in 1987 as a result of massive pressure from the public. And I think the Congress would rather do almost anything than have to do that. But I am absolutely convinced that if the states don't do it that the Congress will.

WEEKS:

There has been so much publicity that I am sure something has to be done.

SAMMONS:

Absolutely.

WEEKS:

AHA puts out a weekly newsletter. In it they quite often have tables which show the rate of inflation and then compare it with the rate of increase in the cost of medical care.

SAMMONS:

Absolutely. We do that same thing.

WEEKS:

The other day I was looking at it and thinking that if an OB/GYN doctor has to pay $100,000 premium, what's that going to cost when you divide it by the number of babies he delivered that year, let alone what other services he performs.

SAMMONS:

I don't know that this is typical. We haven't been able to get all of the numbers that we need to say what the absolute average is, but in the OB/GYN field, for example, one of the people that comes from one of those very high-cost states told me recently that he has had to add $500 to each of his surgical procedures, major surgical procedures -- which includes deliveries -- and that he has had to add $25 to his office visits, just in order to pay his premium. Now, that's a very sizable increase. Admittedly that's a high-cost state and a high-risk specialty, but if you look at the rest of the high-risk specialties -- neonatal intensive care units, neurosurgical units, orthopedics and so forth -- you look around the country and the levels are such that clearly there is a substantial increase in price for those procedures as a result of this extremely expensive professional liability coverage. I don't

think that that's average. It may be average for OB/GYN men in high-cost states, but it's the pattern of add-on that is clearly there, and isn't going to go away.

WEEKS:

No. But the public probably doesn't understand that the rising cost of medical care has that ingredient.

SAMMONS:

Not only the public, but the Congress. We had a hell of an argument with them recently about whether or not hospitals should be reimbursed by Medicare for that portion of the hospital's cost that had to do with professional liability coverage. Fortunately, the hospitals won that. And we were all involved in it. But the absurdity of having to fight over that as a legitimate part of the cost of doing business, clearly indicates that it's not just John Q. Public that doesn't understand, it's also John Q. Legislator that doesn't understand. I think we have made some progress with that. But you are absolutely right. The general public does not understand that.

WEEKS:

I am glad you are putting stress on this because it's certainly going to be needed. This idea of the deep-pocket theory that it's a faceless corporation.

SAMMONS:

The deep-pocket is the guy walking up and down the street and the woman trying to raise her children, or carry out her job, or going into the grocery store to buy groceries or whatever. There are no deep-pockets in the doctor's pocket or the hospital's pocket. Deep-pockets is the American public.

WEEKS:

Is Dr. Wilbur still with the Association?

SAMMONS:

Council of the Medical Specialty Society, CMSS.

WEEKS:

His grandfather was an interesting person apparently, Ray Lyman Wilbur, who was on the Committee on the Cost of Medical Care back in the 1930s.

SAMMONS:

And his uncle, Dick's uncle, Dwight Wilbur is a past-president of the AMA, as was Lyman. Lyman Wilbur was Dwight's father and Dick's father's father. Lyman was Dick's grandfather, but Dwight who came along and was president of the AMA in the 1970s is Dick's uncle. He, too, was a very interesting fellow.

WEEKS:

It's good to see a family continue in a tradition.

SAMMONS:

Absolutely.

WEEKS:

I made a note of some of the things that I thought were basic goals of the AMA. I think they have been stated somewhere that I read. We've already talked about representation, not only to governments but to these other associations and groups. For instance, how did you handle the AMA/AAMC relationship? Weren't they a little strained when you came here?

SAMMONS:

That's probably the understatement of the day. They were very strained in my view in the 1960s and into the 1970s. Alex McMahon had a very large

hand in bringing about a rapprochement between the AMA and the AAMC. Even as late as when I came on board in 1974, the AMA was saying ugly things about AAMC and AAMC was saying ugly things about the AMA. Alex and I had agreed that that was totally non-productive. Apparently he and John Cooper had agreed that that was non-productive. At Alex's initiation, he and I went down to Washington and went over to AAMC's offices and sat down with John one afternoon. With Alex sort of the moderator, if you will, we talked about areas of difference and reached an agreement that we would try and begin to resolve these differences by agreeing that we were going to stop writing and saying unkind things about one another. And we did that. Both of us, AMA and AAMC.

Over the last twelve years the relationship has markedly changed. The two organizations, I think, are closer than perhaps they have ever been today. To John Cooper's credit, John has worked at that as hard as I have, and Alex has worked at it equally as hard as both of us. It serves no one's purpose to have any one of the three major organizations in medicine in this country today going off in different directions and with hostility and confrontation. That serves no one, except those who would divide and conquer. That's the only party that's served in that situation.

So, yes, absolutely the relationship between us and the AAMC is probably the best ever existed.

WEEKS:

Was the big concern over the accreditation process?

SAMMONS:

No. You know, I really think the whole thing got started back in the 195Øs with personalities. And who was trying to take over whose territory.

Once those kinds of arguments get started, personalities take over reason. When that happens, downstream it becomes very hard to identify what it is you are fighting about.

When we started looking very carefully in the 1970s, when John and Alex and I did, at our supposed differences, they really weren't there. They were mythical, they were historical. Many of them were just force of habit. "Know he's a son of a bitch because he has always been a son of a bitch, and he ain't going to change. So let's say it. And make him mad again." That kind of nonsensical behavior that really has no justification in our world today. But I think it probably started with personality differences back in the 1950s.

WEEKS:

I was wondering whether it was the teaching hospital?

SAMMONS:

The town-and-gown syndrome in the 1950s clearly was a by-product of all of that. And to some degree that's the thing that we have tried very hard to guard against in the future. Because as changes are made in the financing of medical care, then teaching institutions begin to feel the pinch just as badly as do non-teaching institutions. The worst thing that could happen to the profession would be to have a recurrence of the town-gown syndrome that we had in the 1950s. That would be absolutely disasterous today. I think in the fifties there was a feeling on the part of the private practitioner that the university physician somehow or another was a different kind of doctor. Was he an outright competitor. Clearly, great suspicion on both sides, which I have always found fascinating. That academics teach physicians for four years, certify that they have learned, supervise them through their residency

program, and then when they go out into a non-academic setting -- at least back in the fifties and sixties -- somehow or another they suddenly became suspect as to the quality of care and their ability to deliver.

On the other hand, it worked in the reverse too. As long as the individual was in training, either undergraduate or graduate, the professor was the idol, that the university was the mecca. Once they got away from that, suddenly those people became his or her outright competitor. A lot of that created the town-gown syndrome of the 1950s. A lot of it has the potential, incidentally, the real potential, for re-creating that situation in the 1980s.

You're right. I think that was a major part of it.

WEEKS:

You have talked extensively about your educational process, I mean your support of education and the liaison committees, the accreditation committees, and so on. What I can't understand is some of your staff positions. Maybe they are Board or House. I don't know the difference between a council and a committee. And whether some councils are appointed by the Board and some by the House.

SAMMONS:

The House of Delegates of the AMA is now composed of not only delegates from state medical societies but also specialty societies, sixty-seven specialty societies. The state delegates are selected on the basis of one delegate per thousand AMA members within that state society, or part thereof. So every state has a minimum of one or two, I guess Guam and Puerto Rico and the Virgin Islands are probably the only state delegations with one these days. They are elected on a pro rata proportional basis.

The delegates from the specialty societies, it's one delegate selected by the specialty society for each of the specialty societies that are seated in the House. Not all specialty societies are seated because there are some overlaps, and some of them don't meet the criteria and so forth.

In addition to that, you have the three surgeon generals, Army, Navy, and Air Force; the Chief Medical Officer from the Veterans' Administration; the Surgeon General of the United States. So that there are those five that are in addition to the specialty societies and the state delegates. Then there are a couple of delegates that represent groups that are so important that they need to be seated, but don't really have a scientific specialty. Such as the Association of Group Practice, or the Association of Medical Directors in the country. The House of Delegates is obviously, as at the AHA, is the final authority.

But below that, or above it, -- we prefer in our table of organization to do it from the top down -- the next level is the board of trustees. The board of trustees has all of the fiduciary responsibility under the Illinois corporate statute. It serves as a policymaking body in between meetings of the House of Delegates. Since there are only two House of Delegates' meetings a year, June and December, the Board of Trustees most of the time is the policy-making body.

Councils are groups of people, with some exceptions, elected by the House of Delegates to address specific issues. The Council on Medical Education is elected by the House. The Council on Medical Service is elected by the House. The Council on Scientific Activities is elected by the House. The Council on Legislation is appointed by the Board, for perfectly obvious reasons. The Judicial and Ethical Council of the AMA is elected by the House, but it is

done by nomination from the incoming president of usually one member of that council per president. Since we have enlarged the size of the council, that isn't going to be true any more. There will be times when the incoming president will have to make more than one nomination. But up to the time when wechanged the size of the council, there were five year terms and there were five of them, so one of them was up every year. Now there are seven of them. That is a nomination by the president.

Committees, on the other hand, are appointed. Committees can be appointed on an ad hoc basis by councils to address specific areas. Let me give you an example. The Council on Scientific Activities has a a panel of 900 doctors that are experts in all of the fields of medicine in this country. And when they want to address a specific issue, they will impanel an ad hoc committee from that 900. It will have a very clearly defined lifespan, its instructions as to what it is to address are very clear. The charge is not broad, but fairly narrow. It will perform its function and report to the council. The council will then take that report and decide if it agrees with it. If it does, it becomes a report from the Council on Scientific Activities to the AMA. The Board of Trustees will review it. At which point they will either forward it on to the House of Delegates, or if they believe there is a serious flaw in it, they will send it back to the council and ask the council to review it again. Or if there are some changes in language that the Board believes would enhance the report, they will ask the council to consider the change in the language.

That's the way the table of organization from that perspective works. The internal table of organization -- the Executive Vice President is the chief executive officer of the AMA. In this configuration today, Dr. James

Todd is my senior deputy. On the pretty little plat, I have put him in the same box with me. Directly beneath that box is Whalen Strobhar who is the Chief Operating Officer of the AMA. To the side of that box is the General Counsel of the AMA who reports directly to me and has a dotted line reporting function to the chief operating officer. The same thing is true with my assistant to the executive vice president, Ms. Robin Menes who reports to me, but she also has a dotted line reporting function to Strobhar and to Todd. She reports directly to Jim too.

It is the typical corporate structure. We use different titles, but it is still the typical corporate structure. There is a great deal of latitude that I have put into that structure in the last few years to try and decentralize some of the decision-making around here -- the implementation decision-making. Policy, however, is made by the Board of Trustees or the House of Delegates. I do not make policy. I implement policy. When you implement policy you clearly make administrative policy. But in terms of base policy, that is made by the House or the Board.

WEEKS:

The House, what is that? About 275?

SAMMONS:

No. It's 392, I think it is. Every time I turn around it has changed. April 30 was the cut-off date for membership in 1986. Everything after April 30 is delinquent. So our people have been running the computers trying to find out what the delegate proportionment was. And I'm not even sure what it is, but it's somewhere around 392.

WEEKS:

This is another question I would like to ask you. One of the

accomplishments that I see in your coming in in 1974, or before you came in in 1974, but probably added after you came in. Before 1974, you were on the membership committee, am I right?

SAMMONS:

Yes.

WEEKS:

There had been a slump in membership, as I look at it historically.

SAMMONS:

That's correct.

WEEKS:

What did you do to gain new members?

SAMMONS:

Well, there had never been a membership committee in the AMA until the early 1970s. That came along, really, as a result of some of the slippage from the Medicare fight in the mid-sixties. And for the first time the AMA had seriously addressed this question of, how does one solicit members? You have to remember that until the Whittaker-Baxter thing, there were no dues in the AMA. Everybody that graduated form medical school got a little card that said, "You are now a member of the AMA. If you want to receive the journal, send us three dollars. If you want to be a fellow of the AMA, send us five bucks. But you are a member." With the Wagner-Murray-Dingell, and Whittaker-Baxter business, there was a twenty-five dollar assessment. And with that assessment, there obviously was a fairly considerable slippage. Then the next year they instituted the dues structure, quite correctly so, foreseeing that that sort of fight, albeit not in that same form, but that that sort of fight would be going on in this country ad infinitum. And with the advent of

the dues, there was still more slippage. Then in the sixties with the Medicare fight, there was still more slippage.

So the Board finally decided that it had to address that in the late sixties, early seventies, and did so with the membership committee. That committee began to look at historically how do other groups get members? What are the sorts of things that we ought to be doing for our members to make this association clearly more valuable to them? More valuable than the dues. The representation is the most important thing we do for them. That and the education and scientific -- but that's very hard to put a handle on. You know, it's what did you do for me yesterday? That's hard to transmit on a continuing basis to people. So we had to look at some tangible benefits of membership. Insurance programs, continuing education seminars, video clinics, increased the stable of scientific publications, all of that sort of thing came along during those years. The membership committee of the Board did function in that regard. Once it was set up and put in place and the thrust was identified, then we eliminated that committee as a board committee and have a very significant activity in the AMA of membership recruitment and retention.

But that was directly the result of the slippage. And, of course that, thank goodness has turned around. We still do not have the percentage of market share that we would like, never have had. Since we instituted the dues. But that number is going up. Slowly, but progressively, steadily. Then, of course, until ten years ago we really didn't have student and resident membership. When we decided that that was not productive and we set up a membership category for students and residents, today we have some fifty-two or three percent -- I have forgotten the exact number, but better than

half -- of all of the residents of the country are members of the AMA. And essentially half of all of the medical students of the country are members of the AMA. Looking downstream, that is a very significant retention group. And some eighty-five percent of all of the resident members are retained after they go into practice. And I think we are making some progress with that fifteen percent.

The average citizen that would hear what I'm about to say would say, well, that's not true. He's trying to cover up. What I'm fixing to tell you is true. In spite of what the popular perception is, physicians' incomes have decreased in the last ten years. And the young physician's income has decreased very substantially in the last five. And with the very high malpractice premiums, the difficulty in starting a practice, the fact that there are marked constraints placed today on return from investment, it is very hard for young physicians, unless they join a group or some other salaried position that picks up those extraneous costs for them. Very hard for the young physician to start a practice. As a result, the financial aspects of joining organized medicine at any level outside that residency program becomes a major consideration. That's particularly true if the brand spanking new, young practitioner finds him or herself married with children, or with a big debt. And what we are seeing today is a very big debt as these people come out of their residency program. So we are trying to find some way to help them overcome that problem, in terms of retaining their membership and generating their membership in the AMA.

WEEKS:

Speaking of residents, what's happening to residents' salaries?

SAMMONS:

I think they are beginning to stabilize. There are some increases that are occurring, but not anything near the increases that we saw in the 197Øs or early eighties. I think we are going to see more stabilization, as Medicare puts more constraints on their payment portion of the direct and indirect costs. And I think we are going to see corporate America tell the Blue Crosses of the world or the Aetnas or whomever, or their own self-insured departments, if they are self-insured, that they are going to cut back on some of that too. I guess I am one of the very few that believes that that's going to happen within a fairly short time frame, and that it's going to be substantial. Now, my friend Alex I don't think agrees with that. And I don't think my friend John Cooper agrees with that, certainly not in the entirety. But I believe that we are just seeing the tip of the iceberg in the constraints that are going to be placed by Medicare, as well as by the other purchasers of care.

WEEKS:

Yes, because the capitation plans are going to be squeezing the doctor's income. They can't help but do it. They are squeezing the hospitals.

SAMMONS:

When they start screwing down the DRGs, then the hospitals are going to begin to feel that, the teaching hospitals are going to begin to feel that right up front.

WEEKS:

Already some of our futurists in the business are saying, "What comes after DRGs? What comes after capitation?" I think that the allusion here is that possibly they are not the answer.

SAMMONS:

Well, I don't think that DRGs are the answer. I will be perfectly willing to admit that DRGs have exacerbated the rate of decline in rates of admission, and to some degree in lengths of stay. But I think it's a terrible mistake to equate all of that simply on the basis of DRGs. First of all, it isn't true. The rates of admission started to decline back with the voluntary effort. They continued. So has length of stay. But I think we are about at the bottom of that slide. You can only reduce the rate of admission so far and still provide the necessary care. You can only reduce the length of stay so far and still provide essential care. There is not in place in this country today an intermediate delivery system for home health care, across the country. There is not an intermediate care sort of institutional system in place across the country. What we are seeing, and I think what everybody is acknowledging today that they are seeing, is that people are being sent home from the hospital earlier. Some of them would be better off if they stayed longer. They don't necessarily have the facilities at home to be taken care of. I think we are going to see some very marked changes in the public attitude about that in the next few years.

DRGs for physicians, I don't see that really as being feasible or even practical. You can do that perhaps for some surgical situations where you don't have to have anybody but the surgeon involved, and the assistant. But when you get a severe medical illness or you have a surgical problem in a patient with multiple medical problems, then trying to determine what the appropriate DRG for that spell of illness is far more difficult than when you look at historical data for hospitals. I don't see that happening. I think there's going to be a try at it. I think it's more likely that we may see voucher systems come into being for federal programs, entire programs being

vouchered, than to see DRGs for physicians. I think we are going to see a return in the civilian, or in the private sector if you will, I think we are going to see a return of more and more insurance programs that have fairly markedly reduced fee schedules. We are going to see patients at greater risk. We are going to see physicians at greater risk in terms of payment. And I think we are going to see that in fairly short order. We're seeing it already. And I think it's going to increase in frequency and in magnitude.

We at the AMA have said that we are perfectly willing to look at other forms of payment besides usual, customary, and reasonable. And indemnity programs, we believe, ought to be carefully reviewed again, as they used to be you know. We had indemnity programs in the thirties, forties, and fifties.

WEEKS:

That's practically all we had.

SAMMONS:

That's all we had up until when we got Medicare and they wrote into the Medicare law usual, customary, and reasonable. But we think that indemnity programs deserve to be looked at again. We think that that is an appropriate way to control the basic expenditure levels in health care. And it still places part of the burden where it ought to be, and that's on the recipient, on the patient. Because the idea of first dollar coverage and one hundred percent coverage that was written into so many policies across the bargaining table has done nothing except add to the problem of increasing costs. And we've got to get away from that. And we've got to have frontend deductibles and co-insurance. We've got to have indemnity programs. Otherwise you have no way to control the demand side. The demand side is a driving force. It's not just supply. It's the demand side.

WEEKS:

Being of the senior citizen age group myself, and being an eavesdropper, and being a frequent diner out with my wife, I listen to all of the conversation that I hear these seniors who are eating out -- whether they are taking a pink pill or a yellow pill or so on. And knowing a person in x-ray who says that people come in now and say, "I only received two x-rays. Last time I had three."

SAMMONS:

Yes. How come you didn't do the third one?

WEEKS:

This rising expectation or whatever...

SAMMONS:

Increasing demand and rising expectation. That's absolutely right.

WEEKS:

It's frightening.

I was going to ask you one other thing about the membership. It seems to me that one of your problems, and I'm sure you've addressed it, is what to do about the relationship between the state, county, metro societies. In some cases, does one of those organizations bill for all dues that apply for societies a member belongs to?

SAMMONS:

Oh, yes. As a matter of fact, we constantly address those issues. We now have some six states that are unified states, that in order to belong to the state association or to belong to the county, you have to belong to the county, state and the AMA. In the other states where that is an option, all of them except six bill for the AMA. The six unified states bill for the AMA,

but there are six other states that the AMA, by contract, bills it for itself. Other than that six and the six unified states, the other thirty-eight states bill for the AMA. Now within the state, depending on the state itself, there are some states in which the counties bill for everybody. That's done in Illinois, for example. Cook County bills for everyone, Chicago Medical. But in some states the state bills for the counties as well as the AMA. It depends on the size of the state, and whether the county societies have staff and have the equipment and that sort of thing. It varies all over the lot. But it just depends on the size of the state. There are six states, however, in which we bill for ourselves. We have done that for some years now because of contracts with the states.

WEEKS:

Is there any case you know of a connection between membership in AMA and staff privileges?

SAMMONS:

No. The court struck that down in the fifties. That used to be one of the criteria to obtain hospital privileges, you had to belong to the county, the state, and the AMA. The liberal courts of the late 1950s struck that. Once they struck that then everybody began to suffer. If you look at it, states and counties have suffered too, as a result of all of these changes. Because there are still some 100,000 doctors out there that don't belong to county or state medical societies. That's a fairly significant number of people. But the court struck that in the fifties.

WEEKS:

It would seem a reasonable thing from a professional standpoint.

SAMMONS:

It was a very reasonable thing. As a matter of fact, it was a great disservice, I think, in terms of the ability of the profession to police itself when the courts took that away. Because back then when they took that away, they eliminated the opportunity for county disciplinary bodies to discipline physicians. And we have never been able to get it back. Then the Federal Trade Commission, in the eighties or late seventies, in our famous law suit with the Federal Trade Commission in which the Commission prevailed, essentially stopped all disciplinary proceedings outside the hospital medical staff except those of the state board of medical examiners. Everything else went down the tubes. And that is still the case. So those two activities, the courts in the fifties and the Federal Trade Commission in the seventies, really has made it practically impossible for organized medicine to discipline its own members. It's a very difficult situation.

WEEKS:

Or to locate fraudulent.

SAMMONS:

Oh, yes. We work very closely with the state boards in finding fraudulent physicians. Once one is found, by whatever mechanism he shows up, we flag the file and have a file of these people. The state boards, and we exchange information with them, because as long as you have one fraudulent physician, you have too many. That's our real dedication, in that regard, is to get rid of them all. One is too many.

There was a thing on CBS this morning, on the CBS morning news, Maria Shriver had Brian Galucia, who is the executive director of the Federation of State Licensing Boards, and this fellow from the Dominican Republic that was selling the fraudulent diplomas on. You should have heard it. That guy from

the Dominican Republic made you physically ill to listen to this fellow profess that he didn't know what he was doing, it wasn't him it was the people, and all of this nonsense. But they were using a number that is totally out of all reason. Maria said this morning 32,000 fraudulent physicians in this country. Well, that's ridiculous. That's just absolute nonsense. We don't really know what the number is, but are sure as hell it isn't that. You can't hide that big a group.

WEEKS:

It would seem that they should have some way of checking numbers like that because they are frightening.

Going back to the time you came in and you found inadequate income. You raised dues and you trimmed expenses. What did you do about publications?

SAMMONS:

We went through a massive review of all of our publications. We even, at one point, considered selling some of them. Did sell one, and gave one away. We sold Today's Health, which was a consumer publication. Then we gave away the Archives of Occupational Medicine to the Society of Occupational Medicine in Washington. It was a very small distribution so we gave it to them. But we seriously considered selling some of the others. We decided not to sell them, and instead reduced their size. Went through a period in which we had changed paper weights and did all those things to keep them alive, and yet at the same time reduce the cost. Fortunately, we are back, and have been for some years now, back to the proper paper weights and have expanded the wealth in most of them substantially over the last ten years. But, yes, we went through a very extensive review of our publications. We eliminated a lot of little monographs and pamphlets and all of that sort of thing that weren't

moving and really weren't needed, but that the AMA had just historically done. We took a hard look in the warehouse and we found some real oddities. We found what amounted to a fifty year supply of pamphlets on the treatment of constipation. We eliminated all that sort of nonsense, and trimmed our cost back immediately and substantially.

WEEKS:

Who makes the decisions on the non-periodical publications and pamphlets?

SAMMONS:

They are made here in the building by group vice presidents and assistant executive vice presidents.

WEEKS:

I noticed that in your waiting room you have some of the foreign editions of JAMA. This has grown to be quite a large total too, hasn't it?

SAMMONS:

Yes, it has. As a matter of fact we have a French edition in France for France. A French edition in Belgium. A French edition in Switzerland. We have a German edition in Austria and in Germany and part of Switzerland. We have a Japanese edition, a Chinese edition, a Southeast Asia English edition. We do specialty journals in Argentina in Spanish. We have some specialty journals that are done in France in French that are ours. The difference is that JAMA in the foreign language editions is not published weekly, it's published monthly, except in China where it is published once every two months. We have editorial boards in all of those countries that look over all of the stuff that we publish and then they select the things that they think are important in their country. We put it in the proper editorial form and publishers in those countries then publish and distribute it. And we are paid

a royalty for the service. We don't actually contract with the printers and all that sort of thing. But we contract with the publishers overseas.

WEEKS:

It's almost impossible unless you are on the spot.

SAMMONS:

Oh, yes.

WEEKS:

This has now become profitable again?

SAMMONS:

Oh, yes. Profitable in the sense that we get royalties from the foreign publications. We still are having a debate with the IRS about the allocation of revenue from the journals. They have taken the position that ad revenue is not a part of the mission of the journal and therefore is unrelated business income. We are in the federal courts suing to recover our money that we have paid under that decision.

WEEKS:

This is a considerable amount of money too.

SAMMONS:

Oh, yes. It runs into the millions.

WEEKS:

AHA faced the same problem when they set up their separate corporation, didn't they? Do you think this is what you are going to have to do?

SAMMONS:

No, I don't think so.

WEEKS:

You think you are going to win?

SAMMONS:

We think we are going to win.

WEEKS:

But in case you don't?

SAMMONS:

Well, if we don't win we will just have to pay taxes based on the formula that the IRS and we have negotiated over a period of years. But I really don't envision that we are going to move all of our publications out of the AMA. I'm sure that the AHA did that for good and sufficient reason. But over here we don't think that's necessary.

WEEKS:

You don't do any book publishing?

SAMMONS:

No. Well, that's not true. We do.

WEEKS:

Do you own this Chicago Review Press?

SAMMONS:

No. The only real book that we publish is the Drug Evaluation Guide. We do publish that. But we have a contract with Random House to publish our consumer books: Back Care, Heart Care, the Family Medical Guide, and all that. The only thing we publish ourselves is the Drug Evaluation Guide.

WEEKS:

That's the old New and Non-official Remedies, isn't it?

SAMMONS:

No. The NNR is something still different.

WEEKS:

Is it still published?

SAMMONS:

Not any more. The Drug Evaluation Guide took the place of the NNR. The content of all of our consumer books, we do obviously. But the publishing is done by Random House. So the only book we really publish is the Guide.

WEEKS:

Get rid of a lot of headaches that way.

SAMMONS:

Oh, yes. We publish all of our scientific publications, of course, and we publish A M News. And you are right, if you could farm all of that out you sure would save a lot of headaches.

WEEKS:

I've had a little experience that way so I speak with authority.

SAMMONS:

You're right.

WEEKS:

I'm a bit interested in your budgeting process. It seemed to me that when you came in this was one of the problems -- about expenditures. How do you budget?

SAMMONS:

Very much so. Up until 1975, budgeting was a very loose thing with an awful lot of the allocation of funds and so on within an area -- a lot of it was being done in sort of an informal manner. The councils and committees had a lot to do with it. That may have worked fine when there was an awful lot of money around, but it didn't work at all when times were tough. And we stopped

all of that. We set up a very formalized budgeting structure. And we have a very formal budgeting structure. We do it with constant review. We start our budget a year in advance. And we review the assumptions about on a ninety day basis during that year to be sure that the budget structure is still in place and that the budget is a reasonable budget. And sometimes change the assumptions right up to the last minute. But we don't ever wait until the last minute. And we do it with a very formal structure.

WEEKS:

You do it, may I say, from...

SAMMONS:

We do a zero base. We started the zero base budgeting in 1975 and don't ever intend to get off of it.

WEEKS:

No. Assuming that nothing has proved itself by what it did last year.

SAMMONS:

That's right. It has to prove itself again. And if it doesn't, then it goes.

WEEKS:

I'm glad to hear that. I think it's a very healthy way to keep trim.

SAMMONS:

Oh, yes. At the same time that we really began to enforce zero base budgeting, -- when you start that the first thing that you are confronted with is what do you do with employees that have been hired to do specific programs. So we adopted a position of flexible staffing. And although people are hired at the AMA and are assigned a program, if that program goes -- or we may reassign them in the middle of a program. Wherever they can best be used

-- with their talents. We call that flexible staffing. That coupled with zero base budgeting has given us a tremendous amount of flexibility. At the same time, it has given us a very formal budgeting structure.

WEEKS:

This is very good because nothing is taken for granted then.

SAMMONS:

Oh, hell no. Absolutely not. We found some interesting people around here when we started the flexible staffing. We found some people that had absolutely remarkable talents that could have stayed here for a hundred years and nobody would have ever known it because they had been cubby-holed into a project or a program. We found some absolutely marvelous combinations of talents.

WEEKS:

They're really happy to have a chance to show their abilities.

SAMMONS:

And some of them have been transferred to bigger and better things as a result of the uncovering of those talents. It has worked beautifully.

WEEKS:

One question that has come to mind. I don't know any of the principals so I can't say, but I have heard rumors that at one time there were, let us say, strained feelings between the AMA and the American College of Surgeons, or any other specialty groups. Have you been able to get a good working relationship established?

SAMMONS:

Those things ebb and flow. They occur over specific issues. They don't occur on a constant on-going basis. It is true. We had some very serious

differences of opinion with not only the College of Surgeons, but the College of Radiology, the College of Physicians on the Pennsylvania chiropractic suit. It was a difference of opinion as to how we should address the suit rather than a difference of opinion about basic fundamental philosophies, because we don't have differences there. But those things ebb and flow. That one is long gone and well buried. We have some differences from time to time over legislative strategies, but that's normal in a family this size. With all the specialty societies and 265,000 members of the AMA, and fifty state societies and 2,000 county societies. Hell, I guess I'd be in the grave if I ever found the day where everybody agreed about everything. I don't think I could stand it.

WEEKS:

You brought up an interesting point though. How about these fringe practitioners? Like the chiropractors and naturopaths, faith healers.

SAMMONS:

We still think that that is adverse to the public good and we think that we have an obligation as well as a right, but certainly an obligation, to inform the public about the value of people like that in terms of the health care of the American people. We have constantly said before legislative bodies around this country that these people ought to be sharply circumscribed -- if allowed to do anything at all -- in what they are allowed to do. The so-called limited license practitioner is a major problem in this country today and we think it is adverse to the public good and we say so. That's what got us started in the fight with the FTC. We still have three lawsuits pending. Here and in Iowa and in Michigan. We are being sued and a lot of other medical groups, collectively, being sued over the chiropractic issues.

WEEKS:

They are trying to get into the hospitals certainly.

SAMMONS:

Oh, yes.

WEEKS:

In Michigan we have a lot of osteopaths. There aren't many states that have as liberal licensure laws as we do, I guess. How do you get along with the osteopaths?

SAMMONS:

We get along with the osteopaths very, very well. The AMA has a lot of osteopaths, compared to their total population, a lot of osteopaths that are members of county and state and of AMA.

WEEKS:

I didn't realize they were eligible.

SAMMONS:

Oh, yes. As far as I know, well, not every state -- Tennessee, for example, does not accept osteopaths. And there may be some others. But in most states they are eligible for membership. Osteopathic education today is essentially the same sort of didactic experience that medical education is today. The M.D.-D.O. relationship... there are a great many osteopathic graduates that are in residency training programs, AMA approved and ACGME approved residency training programs. The osteopathic association doesn't like that. They make it very hard for some of their people that are in our training programs and for joining our societies. They make it very difficult for them. We have not only no objection, we welcome them. And we have a fair number of them.

WEEKS:

They seem to be fitting in quite well in Michigan. I've been in a hospital where they have a mixed staff and it's hard to tell one from the other.

SAMMONS:

Absolutely. And that difference is going -- in my view, that difference is rapidly disappearing. I think in the younger osteopathic age groups, that you can't tell the difference.

WEEKS:

Didn't California absorb them?

SAMMONS:

Yes. They took them all at once back in the early sixties. They just did it. And they gave them all M.D. degrees. That incidentally has since been stricken by the Supreme Court, I guess. What they did at the same time they took them all, the state legislature said we are not going to license any more osteopaths. I think that is that part that is stricken by the Supreme Court.

WEEKS:

I did want to talk about a man I admire very much, John Millis.

SAMMONS:

Oh, yes. The Millis Report?

WEEKS:

He did the Citizens' Commission on Graduate Medical Education.

SAMMONS:

I think that Dr. Millis and his report was a major accomplishment in stabilizing, maybe stabilizing is not the right word, establishing in

everyone's mind the absolute need for -- I'm almost tempted to use the word rigid, and I think I will -- to establish a set of fairly rigid criteria for graduate training. The essentials for graduate training residency -- by residency, that is by specialty, and obviously there are some differences depending on specialties -- but, the basic underlying set of criteria that came as a result of the Millis study I think has been, next to the Flexner report, probably is the second most important study that had ever been done up to that time. I think that that now has been coupled with a study that the AMA Council on Medical Education did and released several years ago called Future Directions in Medical Education. Those three together clearly is the basis on which all medical education in this country today rests: undergraduate, graduate and continuing.

The fact that Millis could get it done and get it accepted in that particular time frame was nothing short of miraculous. The content of the report clearly was just fantastic. It was a magnificent report. I can't find any adjectives that I think overdescribe the significance and the importance and the value of that report. The fact that he was able to do it then is nothing short of miraculous.

WEEKS:

We did a book for him when I was at the University of Michigan on a study he did on pharmacy education. We worked with it very fast. It was amazing. I said, "How do you do this? How do you get your commission to work?"

He said, "I choose my commissioners. And I get people who work."

SAMMONS:

Busy people who will get things done.

WEEKS:

He said, "I don't worry about getting a cross-section of the population, I get twelve or fifteen people who have brains." He's amazing. He's up in his eighties, of course, but he's amazing.

One point you made a short time ago about technicians practicing, or wanting to practice medicine, makes me think from my own observation: technicians come in on a two year training period of some kind and then soon they begin to want to have a national association to raise themselves...

SAMMONS:

And they all do.

WEEKS:

No longer paraprofessionals but professionals. Then I can see them, as you say, moving into treatment areas and this kind of thing.

SAMMONS:

Some of them are making great efforts to move into treatment areas.

WEEKS:

I'm sure they are.

SAMMONS:

You know pharmacy — there are pharmacists in pharmacy organizations in every state in this country today that want to change the pharmacy laws to allow them to prescribe. Without ever having examined the patient or knowing a damned thing about them, they want to prescribe. If they want to practice medicine, they ought to go to medical school. That's not the role of the pharmacist.

Some of the technicians want to be able to have free-standing practices and to individually bill third-party payors for their services. On the other

hand then you have a group of "nurse practitioners" who literally want to prescribe, who want to be physicians, who want to practice medicine in the full context, broad spectrum of practice of medicine. Some of the technical areas clearly want to do it within their area, but they want to do it as free-standing practitioners and bill directly.

WEEKS:

In Florida didn't they just pass a law that allowed pharmacists to give prescription items?

SAMMONS:

Certain, yes. A series of drugs now, in Florida, can be prescribed by the pharmacist without...

WEEKS:

Which is wrong, I am sure.

SAMMONS:

Absolutely, it's terrible. The dangers of that are horrendous.

WEEKS:

Think of what their liability insurance is going to be.

SAMMONS:

But see that's the point. They don't want the liability for that, but they are going to get it whether they want it or not. I don't think they understand that. If they really understood it, I don't think they would be so anxious to have it.

WEEKS:

This committee on allied health education and accreditation, is that an AMA committee?

SAMMONS:

Yes, that is an AMA activity.

WEEKS:

So possibly you will have some power to slow these people down a bit.

SAMMONS:

No. COAHEA is really not involved in that activity. COAHEA's role in life, if you will, is a cooperative effort with the technical groups in establishing essentials for training programs and accreditation of training programs. COAHEA has been around a long time. It has membership on it of all of the technical groups, physical therapists, med-techs, lab techs, and on and on. But it's role is to establish criteria for approval of training programs and accreditation of training programs.

WEEKS:

I might throw in too, how do you get along with the American Public Health Association?

SAMMONS:

Sometimes very well, sometimes with great difficulty. It depends on the individual positions.

WEEKS:

They are likely to be more to the left.

SAMMONS:

Well, they are likely to take different positions than we do.

WEEKS:

I shouldn't have characterized them that way.

Do you hire a publisher?

SAMMONS:

A series of publishers. We have one editor-in-chief. Dr. George Lundberg is the editor-in-chief of all of our scientific publications. He has editorial boards for each of the scientific publications that are voluntary editorial boards, selected by us but voluntary services. Then we have a publisher -- we are the publisher of AM News, we are the publisher of our specialty journals, our scientific publications.

WEEKS:

You were speaking about the public misunderstanding. I think AMA, I hope, will use JAMA in a better public relations so we don't hear on television this report of the new drug written up in the New England Journal of Medicine.

SAMMONS:

We share that with you, of course. With all due respect, the New England Journal of Medicine is a very fine publication. No question of that. It is the darling, or has been for a long time, of the academic world. We believe that that's changing. JAMA is such an outstanding publication in the last few years that more and more academics are beginning to rely on JAMA and to reference JAMA to their students. That takes nothing away from the New England Journal. If you look at all the clippings from the newspapers and magazines and the television, JAMA is getting a substantial share these days in quotes and references. The value of the journal has markedly increased and it still is increasing. Always will, I hope. But, yes, I've had that same frustration from time to time. There are some publications that seem to go always to the New England Journal and there are some that seem to always come to us. I suppose that's a good thing. And that large group of publications

in the middle that picks from both of us. That's a very good thing.

WEEKS:

I wanted to ask you about what you are doing in research. I read about the Institute of Biomedical Research that you had to discontinue.

SAMMONS:

What we are doing as far as research is concerned today is that we're helping fund some of it through the American Medical Education and Research Foundation, AMERF. We do not have any research on site since we discontined the biomedical research unit.

WEEKS:

Your foundation is 503 C3?

SAMMONS:

Yes.

WEEKS:

So you can accept monies.

SAMMONS:

Yes.

WEEKS:

I have heard mentioned the Center for Health Services Research and Development.

SAMMONS:

That's on site. But that's in terms of medical practice and demographics and public policy. The biomedical research unit was an institute. The center for health services research is strictly that -- health services.

WEEKS:

Excuse me for interrupting this, but I would like for the record to show that Flexner was not the only one who was working on that Flexner study and we should say something...

SAMMONS:

The Carnegie Institute financed the study. There is no question about that. It never would have happened had not one of the foundations gotten behind it. But before Flexner made his around the country tour, the secreatry on the Council on Medical Education had made a similar trip. That was what convinced the AMA that there had to be a public policy type study of medical education. We went to the Carnegie Foundation and said these are our findings but we don't think we can change the face of the world. We think you, as a sponsor of such a study, could. Would you agree to do it? And the Carnegie Foundation said yes, they would. They selected Abraham Flexner. Our people and a number of other people, as you point out, were involved in that. But Flexner was the fellow, who like Millis, he was the guy that sat in the chair and he made it move and he made it happen. The Carnegie people financed it and the AMA participated.

WEEKS:

So often AMA's role in this is not apparent.

SAMMONS:

That's right, it really is not. None of it would have happened if the secretary of the Council on Medical Education, Nathan P. Colwell, M.D., at that stage of the game, 1909, when he made his tour around looking at medical schools had not come back with such a horrendous report. It was so bad that the AMA said this simply cannot -- we will not allow this to continue. Let's

find some way to solve it.

WEEKS:

May I throw in one thing more? The Joint Commission on the Accrediation of Hospitals. I know you are one of the sponsors.

SAMMONS:

As you already know, we are sponsors with AHA, the College of Surgeons, the College of Physicians, American Dental Association, and a public member. Our relationship is very good. We work with them extremely well, our people and their people. Of course we have seven commissioners, as does the AHA. Our commissioners take it very seriously. They are all active members of the Board of Trustees. In 1974, that was not true. We had appointed commissioners, none of whom were on the Board of Trustees. It was my view that that was the wrong way to do business, that it is too imporant for the board to be that far removed from it. I finally persuaded the Board in the later 1970s to change that, and to appoint only active, sitting trustees. We have been doing that longer than anyone else. The AHA now has come to that same position, essentially, although they still appoint some of their past chairman. But at least the people they appoint are immediately a part of if not away from the policy making of the organization. Some of the other organizations do not do that. That, I think, is one of the major differences.

WEEKS:

I guess the point that I was wondering about was how -- you are always concerned with raising the quality of care. They at JCAH are too. I was wondering how, if there is any way you work together, do you overlap?

SAMMONS:

There is a lot of overlap, but an awful lot of cooperative effort too.

In terms of drafting the essentials for accreditation. All of that sort of thing that the JCAH does and is deeply involved in. Clearly a part of that is stimulated by us, as part of it is stimulated by AHA and others. But it's a very good working relationship. An awful lot of overlap. We insist on quality and we urge our constituencies to have utilization review committees and to do a lot of the quality assurance things that JCAH does.

WEEKS:

Didn't you really set the pace for PROs or PSROs?

SAMMONS:

Yes. We had it taken away from us. Peer review activity was an activity that had been generated by the AMA. Just as we were getting it in place, Senator Wallace Bennett and the committee staff took it away and changed the name to PSRO and ran with it in spite of the fact that we told them up front that the way they were going it would never be a quality assurance activity. It would always be a cost containment activity. And sure enough that's what it turned out to be. And that's why we subsequently fought so hard to get rid of it.

Now I have the same concern with the present federal PRO mandated activity because there are people in the department connected with that activity that don't think it ought to be an educational activity, think it ought to be a totally punitive, disciplinary activity. That is not what the law says. That is not what Congress intended. It is not what we supported. So I think that we are faced with the potential for that being fairly severe.

WEEKS:

It seems to me that educating people, correcting mistakes that they are making, is the more important thing.

I know this is a sore point. Advertising by physicians. The other day on television in Ann Arbor, I watched a man come on and tout his services as a cosmetic surgeon.

SAMMONS:

Well, we have been under a court order now for some several years that prevents us from making statements about physicians advertising. My own personal view is that I never advertised, and if I were in active practice today I would not advertise. I do not personally believe that physicians, and other professionals -- I think it's equally disturbing when you see other professionals do it. But as far as the AMA taking a position on advertising by physicians, we are under court order that says that we cannot say anything -- except, the court order does say that if we believe that the advertising is fraudulent or misleading, we can say that. But the court order very explicitly says that the AMA can do or say nothing to impede advertising by physicians if they choose to advertise.

WEEKS:

What is the position of women going to be in medicine?

SAMMONS:

Oh, rapidly approaching fifty percent in medical schools. It's over a third now. I think in another five years it will be fifty percent. I just looked at some demographics the other day of the practicing and resident world and women, in total, are rapidly getting to a third of the profession. I think that's going to increase. I think it's going to go to the fifty percent and it may even exceed that.

WEEKS:

Will it go into all branches of medicine?

SAMMONS:

Absolutely. They are there now.

WEEKS:

Surgery as well?

SAMMONS:

Yes. The head of the department of surgery at Cook County in their implant and transplant unit is a female surgeon and an absolutely marvelous one. Every field of medicine. I don't think there is such a thing as a field of medicine that women -- number one, I think they are capable of doing all of that; number two, I don't think there's any field of medicine that is closed to them nor should there be. I think we're going to see the fifty percent arrive in about five years.

WEEKS:

How about your hierarchy? Are there many women?

SAMMONS:

No, there are not enough. And a wide variety of reasons. But the real reason is that there are not enough women yet at the county, state level who are active in the Association in order to move up. It takes time to work up and it takes a lot of dedication to the organization activity to work up. I think that's going to change. I think it's beginning to change. It's a happy thing to have happen, to see women work up, to see women move up. In my organization structure within the AMA, we have an awful lot of women that are in high positions. But in terms of the House of Delegates or councils or committees, not nearly enough. We have a woman who is the chairman of the Judicial and Ethics Council. We have a woman who is chairman of the Council on Constitution and Bylaws. We have another woman who has just finished

serving as the head of an ad hoc committee on women and medicine. We have some women in the House of Delegates. But all of that taken together, it is still not enough.

WEEKS:

Would you like to say a few words about what you see down the road? For your organization or for health care in general.

SAMMONS:

I'll be happy to make some comments about that. First of all, I think the AMA is going to continue to grow and expand and its influence will continue to expand. Some of the vicissitudes that the profession is facing right now are bringing them closer to the AMA than they have felt the need to be during the steak and salad days of the 1950s, '60s, and early '70s. As competition gets tighter and financing gets tighter, their need to have the AMA represent them and function in many capacities I think is clearly -- has penetrated their level of consciousness. The AMA is going to be here. The AMA is going to continue its activities in a variety of circumstances, certainly education, certainly science, certainly legislative arenas, certainly the medical practice system.

I think that we are approaching in this country, however, far more so than the average citizen recognizes or even, for that matter, the average physician, that there is a federalization of medical practice in America today that is very real. It's not socialization, in the sense that we do not have a British National Health Service. But if you look at Medicare and Medicaid and the Armed Forces and CHAMPUS and the Veterans Administration, if you take those five major groups in this country, you have federal programs for essentially over half of the total population.

WEEKS:

You don't usually add them up that way.

SAMMONS:

If you add them up that way and you add in the Aid to Dependent Children program and the block grant programs, put the deaf and the blind and the totally disabled, and you put all those people together, you are talking about something slightly in excess of half of the population that presently have their health care, in some fashion, paid for, supported and dictated by the federal government in some form. To me that is federalization.

My concern is that I don't see that decreasing. Now there are people in Washington who talk about privatization of Medicare. The only way that I believe that that's ever going to occur is if we go to a mandatory voucher system for Medicare recipients. I think that would be a good thing. There are people in Washington that are talking about contracting out of the military significant parts of the CHAMPUS program. I think that's a good thing. But we have to be careful with that because there ia a level below which the uniform medical services cannot maintain their level of proficiency if they are not seeing sufficient numbers of people to keep that level up. So that's a judgment call as to where that level is, but we have to be careful with that.

Every time people in Washington start to seriously talk about farming out part of the Veterans Administration care, it never happens. There are thousands upon thousands of contract physicians who do work for the VA. There is considerable conversation these days about cutting back on VA expenditures and so forth. But in all realism I do not see the privatization of the VA system. Primarily because most of their people today are long-term care

people or chronic illness people and I don't see that being privatized today. But I think that we are going to see a continuing drive to federalize. I think we are going to see a continuing drive by corporate America to reduce their part of health care expenditures. I think we will see a return to some of the cost sharing and risk sharing on the part of patients. I think that that's a very healthy thing to have happen.

I think we will see a reduction in the production of physicians in this country. We are already beginning to see it. The curve is going down very, very slightly, but nevertheless it's going down, in the number of entering students. I think that's going to speed up. I think universities are going to find it more and more difficult to finance the same large number of students that they are financing today. It is our view that those decisions should be made by the universities. They should not be made unilaterally by government. They should not be shoved onto the universities, but I think we are going to see a reduction in the number of entering students. We have already seen a substantial reduction in the number of qualified applicants. That I think foretells the beginning of the reduction in the number of students. Either that or the lowering of the qualifications. And I don't believe that medical education is ever going to stand still for a lowering of the qualifications.

So I think the future is going to be very exciting. Technology is going to continue to change the face of medicine. I think we are going to see an increase in the number of transplants over the next few years. I think we are going to learn a lot more about immunosuppresants than we know today. I doubt seriously that we are ever going to see a whole lot of artificial hearts until somebody develops a technology that reduces the support equipment to that

which can be carried and handled in a reasonable way. But I think we will see an ever increasing number of transplants. I think we will see a greater awareness on the part of the public about the effects of alcohol and tobacco and life styles than we have seen before. I think we are making some progress on drunk driving and the accidents that occur from that. I think we are going to see a lot of changes in the way medicine is practiced in terms of delivery systems. Some of the HMOs and IPAs and PPOs are falling through the cracks because they were not well designed, they were not well financed. They didn't understand the competitive market place. There is a medical market place out there and it is a highly competitive medical market place. I think we are going to see increasing tensions between physicians and hospitals, per se, over who controls the PPO and the IPA and who does the marketing and what the share is that goes in each of the pots and so forth. I don't think that is insurmountable at all, but I think it's going to be there and very real. And I think those things are happening right now and they are going to continue.

Interview with

Dr. James Sammons

Chicago, Illinois

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