HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

T. Stewart Hamilton

T. STEWART HAMILTON

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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T. Stewart Hamilton, M.D.

CHRONOLOGY

1911	born in Detroit, June 19, Son of J.T. Stewart Hamilton and Lucy Safford Hamilton
1930	Philips Exeter Academy, graduation
1934	Williams College, A.B.
1934-1936	Harvard Medical School
1938-1939	Wayne State University, College of Medicine, M.B., M.D.
1938-1940	Harper Hospital, Detroit, Intern and Assistant Resident
1940-1941	Truro, Cape Cod, Massachusetts, general medical practice
1941-1942	Massachusetts General Hospital, Boston, Assistant Director
1942-1945	U.S. Army, Captain to Lieutenant Colonel, Executive officer of the 6th General Hospital (M.G.H. Unit)
1945-1946	Massachusetts General Hospital, Boston, Assistant Director (in charge of Baker Memorial Hospital)
1946-1954	Newton-Wellesley Hospital, Newton Lower Falls, MA, Director
1954-1976	Hartford Hospital, Hartford, CT, President and General Director
1960-1966	Joint Commission on Accreditation of Hospitals, Commissioner
1964-1970	USPHS Cancer Control Committee, Member
1969-1975	Liaison Committee on Medical Education, Member
1978-	University of Connecticut School of Medicine, Professor

MEMBERSHIPS AND AFFILIATIONS

American College of Hospital Administrators

Fellow; Regent for New England, 1953-1957

American Hospital Association

Life Member; President, 1963

American Hospital Association

Medicare Advisory Committee, Member, 1966

American Medical Association

Intern and Resident Committee, 1955-1968

American Public Health Association

Member

Association of American Medical Colleges

Member; Secretary-Treasurer, 1968-1970

Connecticut Hospital Association

President, 1966

Connecticut Medical Association

Member

Council of Teaching Hospitals, Association of American Medical Colleges

Chairman, 1978

Hartford County Medical Association

Member

McLean Fund

Trustee, 1968-

Massachusetts Hospital Association

President, 1951

Massachusetts Medical Association

Member

Medical Administrators Conference

Member

Phoenix Mutual Life Insurance Company

Director, 1962-1982

Rotary International, Newton, MA

Member, 1946-1954

Society for Savings

Trustee, 1961-1970

Society of Medical Administrators

President, 1968-1970

University of Hartford

Regent, 1962-1968

AWARDS AND HONORS

American College of Hospital Administrators

Gold Medal Award, 1971

American Hospital Association

Distinguished Service Award, 1969

Connecticut Bar Association

Distinguished Public Service Award, 1975

Connecticut Hospital Association

Distinguished Service Award, 1970

University of Hartford

Doctor of Science (honorary), 1975

New England Hospital Assembly

Gold Medal Award, 1975

Trinity College, Hartford

Doctor of Science (honorary), 1975

Wayne State University, School of Medicine

Distinguished Alumnus Award, 1970

Williams College

Doctor of Science (honorary), 1969

WEEKS:

Dr. Hamilton, this is an autobiography of your professional life, and I hope you will talk quite freely about your experiences.

I have a note here that you were born in Detroit in 1911, and that your father was a hospital administrator at Harper Hospital in Detroit. In fact, your father-in-law was an administrator too, wasn't he?

HAMILTON:

He was Director at Massachusetts General Hospital, retiring in 1934.

WEEKS:

In one of the articles that I read about your life -- I don't know whether it was in connection with your becoming president of AHA in 1963, or whether it was when you received the Distinguished Service Award from AHA in 1969 -- the writer said that you had become an Easterner in mannerisms and appearance with your background of going to school in the east at Philips Exeter and Williams College and Harvard. He said that you had become an Easterner, but I noted that you came back to Detroit to go to Wayne State University Medical School. I was wondering when I was thinking about that, isn't that the outgrowth of the old Detroit College of Medicine?

HAMILTON:

Yes.

WEEKS:

That was a famous old college. I can remember in Detroit when they founded Wayne University.

HAMILTON:

They used the date of the College of Medicine as the founding date of the University. It was a proprietary school at one time. Then it was taken over.

It got into dire straits and Bert Shirley bought it and gave it to the city of Detroit.

WEEKS:

Dr. Shirley who used to be down on Adams Street?

HAMILTON:

Yes, sir. He had a hospital down there, Shirley Hospital. He gave it to Detroit, and it was part of the Detroit City College system. Then Wayne University took it over. It had taken it over and it was part of the state system by the time I came as a student.

WEEKS:

I remember meeting Dr. Shirley back in the 1930s or early 1940s. I had a job detailing physicians, and I can remember calling on him out there in his Adams Street office by Grand Circus Park.

HAMILTON:

Not far from the Fife Shoe Store.

WEEKS:

Yes, I can remember Fife's Shoe Store. And, of course, the David Whitney Building where most of the leading doctors were if they weren't in the Professional Building. Those were great days.

You served your residency at Harper Hospital?

HAMILTON:

My internship and residency, yes. Then I went into family practice out on Cape Cod because Mrs. Hamilton had gone there summers for years and we both loved it. We lived in the town of Truro, which had a population of 300 in the winter. My office was in Wellfleet which had a population of 900 in the winter and about 6,000 or 7,000 in the summer. Truro, of course, got up to

two or three thousand in the summer. It was a resort area even in those days, and, of course, it is so much more so now. With the National Seashore there you can hardly get on or off or around it for the people.

WEEKS:

The last time I was out on Cape Cod, which was several years ago, I can remember the traffic that was there was so different from what it had been a few years before that.

HAMILTON:

The development is much greater from the bridge to Orleans. But it is getting pretty bad out there. I had a dear friend who lived right on Route 6. One of his main complaints was that he couldn't get across the road with his car to take his trash to the dump in the summer. Traffic was so heavy that you just couldn't make a left turn.

WEEKS:

How did you happen to leave?

HAMILTON:

At that time World War II was coming on and I had a commission in the medical department of the Sixth General Hospital, which was an affiliated general hospital out of Mass General. The plan, which had been developed in World War I, was that institutions like that -- Harper was another -- would develop a cadre of the officers and the nurses for a general hospital so that when there was a mobilization and the country needed them, they would get the equipment and get the enlisted personnel and on activation a full unit would go on active duty who had been trained, to some degree, together.

I was in that unit and I expected to be called to active duty at any time. The war was developing. Dr. Faxon, who was head of Mass General then,

was a friend of my father and knew that I had been interested in administration. He contacted me and said, "I know that you are in the unit, but we have an opening in the administrative side here at Mass General, and I would like to have you come up and be one of my assistants."

We debated it in a long walk on the beach, and decided that at least at MGH, when we came back we would be coming back to something we knew. Here we didn't know what would happen. I was just beginning to build my practice. So we went up to the Mass General. I was there just a year when our unit was activated. We were mobilized one day and the next morning we took the train for Camp Blanding, Florida. Fifty-four officers and 155 nurses. We went from there to North Africa and to Italy. I was overseas for just under three years.

WEEKS:

You were in charge of a hospital?

HAMILTON:

I was the adjutant, and then the executive officer of the Mass General unit which was a 2,500 bed general hospital. I came back as an assistant director there. Then I went, six months later, to Newton-Wellesley Hospital. I was there for seven years.

WEEKS:

Did you succeed Gary Hartman?

HAMILTON:

Yes. Gary had been gone for several months. I never knew him at that time. I got to know him later. A fascinating, very able fellow. I could never understand why he took that position. It was a nice community hospital, staffed, in large part, by physicians who had their primary appointments in

the medical schools in the city. So it had a very high caliber of medicine. It was an excellent place. It was 150 beds, I guess. He got them cranked up on a campaign and then was off.

WEEKS:

I think he went back to the University of Chicago to get his Ph.D., didn't he?

HAMILTON:

He may have had his Ph.D. then, but I think he went from there to Iowa.

WEEKS:

That's right.

HAMILTON:

He went from the College of Hospital Administrators to Newton-Wellesley, and then from there to Iowa. He spent the rest of his career in a very important contribution to the University of Iowa.

WEEKS:

I have known him over the past fifteen or twenty years through his association with Iowa. So he has been there for a long time. As you say, he is a fascinating character. I didn't know until I interviewed him -- I had known him before, but I never knew that he was fluent in Russian, that he played a violin in symphony orchestras.

HAMILTON:

I didn't know that side of him.

WEEKS:

He is a fascinating man.

HAMILTON:

A man of many parts.

WEEKS:

Yes, he is. I've enjoyed knowing him.

If we could go back a minute, one of the persons I have never been able to get much direct information on is Dr. Nathanial Faxon. Was he at Mass General twice? And at Strong Memorial in Rochester, New York at one time?

HAMILTON:

Nat was in general practice with his father in Stoughton, Massachusetts. His father continued to practice until he was over ninety. Nat was in World War I. As a result of that experience, he came back and Amy's father, Fred Washburn, recruited him as an assistant director of the Mass General. When Strong Memorial was being developed, since Dr. Washburn was one of the leaders in the country, he was consulted about it, recommended Nat, and they took Nat to Rochester and he started, built, organized, and ran that hospital for a number of years. When Dr. Washburn retired in 1934, the trustees felt that Nat hadn't had quite enough seasoning and they passed him over for a man who was the Commissioner of Health for the State of Massachusetts, who had had no seasoning at all. It was a disaster for the man and for the hospital. Within a year he was overwhelmed enough that he took his own life. Then they called Nat down and asked him to come, and he did.

The thing was, Nat was old enough, but he hadn't been in the field very long. By this time he had another year, and, I thought, ran that hospital extremely well for a number of years. His agreement, because of his age, was that he could stay on for a year or two after sixty-five. I think he remained there until sixty-seven and then retired. He lived to be in his nineties, as his father had before him.

WEEKS:

He was president of AHA too, wasn't he?

HAMILTON:

Yes.

WEEKS:

In the 1930s sometime?

HAMILTON:

Yes. And Fred Washburn was president in 1913, I think. Very early on. He was born in 1869.

WEEKS:

You were talking about military medicine. On Wednesday I have Al Gavazzi -- do you know him? He's from the Veterans Administration.

HAMILTON:

I know the name, and have heard of him, but I don't think I've ever met him.

WEEKS:

He's coming here on Wednesday to talk about the Veterans Administration. I haven't touched that topic yet.

HAMILTON:

That should be fascinating.

WEEKS:

I hope it turns out well because, as you say, it's a fascinating subject.

One of the things I learned about military medicine, which you probably can comment on, is the fact that in World War I the survival rate of the wounded was at one point, and at each successive war we have been able to raise the percentage of recovery dramatically. I've been wondering how this

has affected domestic medicine, for want of a better term. The soldiers who come back from the war -- the surgeons and the other physicians who come back from the war — have they learned something?

HAMILTON:

It has caused quantum leaps in what went on because of the new things that were tried. Plastic surgery was one of the professions, specialties, that grew out of World War I. And the tremendous advances in orthopedic and reconstructive surgery out of World War II. Neurosurgery out of World War II, anesthesiology, out of World War II. Blood transfusions and that sort of thing were just really beginning.

WEEKS:

How did this come about? Was it that here was a population that needed help and they could take new measures, they could experiment?

HAMILTON:

Yes. Money wasn't a problem, and you had masses of people. You had tremendous problems thrust upon you and you had to solve them. I think the other aspect of World War II -- I'm not old enough to know about World War I but I don't think it occurred -- was the GI Bill. There were a tremendous number of doctors who had had a very basic training, had come from general practice, young docs, went into the army. Then they came out anxious to do more, to do better, and went back and took residencies. They were the hardest working bunch of people I ever saw. The same was true in the colleges, as you probably remember, when the soldiers and sailors who got out, and were spending twice as much time trying to get the extra two or three percent of anything they tried.

We had one member of our outfit, as an example, a boy from Texas, who

came to us fresh from OCS. The last time he had seen a doctor was when he was delivered, I think. By the time the war was over, he took his GI Bill and went to Boston University and got his M.D. degree and had a very successful career in family practice up in Amherst, New Hampshire.

Another one who was a young medical officer with us, Steve Worthy, from Carrolton, Georgia, came back to Boston and took the residency in OB/GYN and went back down to Carrolton and revolutionized medical practice in that town. He really brought in top-grade medicine, and organized things. He got an excellent little hospital built there. The last time I was there, which was ten or fifteen years ago, they had some fine physicians and surgeons in that town. Very good ones.

So this was the sort of impetus that it created.

WEEKS:

Generally, did you call them medics in World War II?

HAMILTON:

Yes.

WEEKS:

Was that developed as much as it has been since?

HAMILTON:

You're thinking of the Korean War and MASH and whatnot?

WEEKS:

Yes, Vietnam and so on.

HAMILTON:

I think it was really just beginning. It began in World War II, and really was very rapidly developed later on.

WEEKS:

We often read about the wealth of experience some of these medics had. Were some of those the men who went back to school?

HAMILTON:

A lot of them, I imagine.

WEEKS:

I'm surprised at the percentage of the veterans who took advantage of the GI Education Bill. It was a very high percentage.

HAMILTON:

It was one of the most fortuitous accidents this country ever stumbled into, I think.

WEEKS:

I went back to school in 1955, graduate school, at Michigan State. Then I came to the University of Michigan. I was amazed at the number of young men that were around in these suntan pants.

HAMILTON:

Chinos?

WEEKS:

Yes. You could almost spot a veteran because they all wore them. I can remember sitting in class and looking around and thinking, gee, there are a lot of GIs that are able to take advantage of this.

HAMILTON:

Indeed there were. It was very exciting.

WEEKS:

This is a point that I am glad that you have commented on because I have often wondered about this effect. I have had people say that physicians came

back from the army or the military and they expected different things from the hospitals back home.

HAMILTON:

That, of course, was the origin of the Hill-Burton Act. The people who came back expected much more. In order to attract doctors to the rural, less populated, areas, the government decided that they had to build hospitals, so the Hill-Burton program was set up -- mostly to build small hospitals.

WEEKS:

I had an interview with George Bugbee on Hill-Burton and of course that was marvelous.

HAMILTON:

What a mind he has!

WEEKS:

Yes. One person I regret not being able to interview is Dr. Parran. I wish he had lived because he had a great deal to do with Hill-Burton in that he saw that money was there for the Commission on Hospital Care to really investigate.

After the war you went back to Mass General.

HAMILTON:

Yes.

WEEKS:

Would you like to tell me what kind of a hospital it was in those days?

HAMILTON:

About like it is now, only less of it. The White building was there, the big outpatient department, the Baker Memorial, which was the hospital for people of "moderate means." That was where I was in charge after the war.

And the Phillips House which was built in the early 1920s. The Baker, probably around 1930, and the White Building a little later than that. That's the big tower. That was built, by the way, as the result of bequest from George White -- Cuticura Soap. That's why Cuticura soap was, in those days, used at the hospital.

The outpatient department, when I was there before the war, was seeing a thousand to thirteen hundred people a day. After the war, it dropped down to seven or eight hundred. I think it's back up now. There have been many new buildings built since then. The place is just absolutely jammed. And more are going up.

WEEKS:

Do you know Rufus Rorem?

HAMILTON:

Oh, yes.

WEEKS:

Rufus was telling me that back when he started, when Blue Cross was just beginning and he was active in its founding, he was working for the Rosenwald Foundation. One of the first things he did was to go out and try to understand the financing of hospitals. He started looking at hospitals to see what kind of bookkeeping they did, what kind of funds they had, how they budgeted. He was amazed at how little they did.

HAMILTON:

I remember when I came back from the war, my dad sent me a little book from Detroit. He said, "This came out while you were away, and I think you ought to go over it. It's the best thing I have seen in my career." It was Rufus Rorem's basic primer on hospital financing. Of course he has a son,

Ned, who is more famous than he ever was, as a composer.

WEEKS:

I had a nice note from his son. In the oral histories, I wrote sort of a short version of Rufus'. We published it in Health Services Research, the journal of AHA. His son wrote me a letter thanking me for doing this for his father.

What I was going to tell you was that Rufus Rorem, and this has connection with Mass General, Rufus was out going to hospitals and trying to learn about their methods of bookkeeping and funding and so forth. He said he was in some little hospital up in New Hampshire that had twenty-eight beds. He found nothing there. A few days later he was at Mass General which had 28 operating rooms.

HAMILTON:

He found the same thing?

WEEKS:

That is the only allusion I have had to the size of the operating theater there.

HAMILTON:

It's the biggest hospital in New England in matter of beds. Hartford Hospital is the biggest in the number of patients admitted because the General had a lot of longer-stay people.

When I was there, the financing was as Byzantine as one could imagine. I was in charge of the Baker, but I don't think I ever saw a financial statement for the Baker, or hardly ever. We knew in general what we ought to do, and we tried to do the best we could with the least expenditure. If we did something wrong, somebody told us to change. Otherwise, the trustees went out and found

the money to make up the difference. Their philosophy was that you ought to try to get somewhere near breakeven, but you really shouldn't be turning a black figure.

WEEKS:

Those were great old days, weren't they?

HAMILTON:

Long gone.

WEEKS:

That was quite common, I think. You always had a few wealthy angels who would help you balance the budget.

HAMILTON:

My dad used to tell at Harper where, at the end of the year -- of course in those days the hospitals were all on a cash basis, not on an accrual basis -- at the end of the year he would bring in the report to the trustees. There were five or seven of them. They would sit around the table and say, "Well, gentlemen, how shall we divide this?" They would bring their checkbooks and make up the difference to bring the books into balance.

WEEKS:

Were the boards in those days mostly benefactors?

HAMILTON:

They were almost all wealthy people. The leaders. The man who was head of it for many years at Harper was Dick Webber, who headed the J.L. Hudson Company. Then the head of Burroughs Adding Machine Company was another one.

WEEKS:

When I started working in drugstores, I worked for Schettler Drug Company. I worked out in Grosse Pointe. A lot of those people, the Webbers

and all, were our customers. What they didn't buy at Hudson's. I guess for a long time Hudson's didn't have a drug department.

HAMILTON:

That's right.

WEEKS:

Edsel Ford and his side of the family all lived out there.

We mentioned Jim Hamilton a moment ago. Did you interact with him? I'm using that term advisedly.

HAMILTON:

Not a great deal. Of course Jim was just about a generation older than I. He was a little younger than my father. He got more pleasure out of putting down doctors who were administrators than almost anybody I've ever known -- or trying to. So we were never close. I knew him and respected him. He had left Yale-New Haven before I came to Hartford. Al Snoke was there then. I guess you haven't interviewed Al yet.

WEEKS:

I don't have him yet.

HAMILTON:

He's in the midst of writing a book himself. Yale-New Haven, when I was down there, was known as the Snoke Pit.

WEEKS:

I interviewed Ig Falk before he died.

HAMILTON:

An interesting man.

WEEKS:

Then I was traveling more. I haven't been traveling so much lately.

Jim was always in New England, I think, even when he was in Minnesota.

HAMILTON:

He did some amazing things. He had a tremendous amount of drive, a magnificent mind. He was meticulous about keeping things in files and so on. I guess you must have run into that when you visited.

WEEKS:

When I went to see him on the Cape, he took me down to the basement and showed me at least six or seven four-drawer files in which he had information on every graduate in the Minnesota program, plus other things. He kept in touch with every graduate. I think he ran roughshod sometimes over things, but he had good objectives. He was the one, of course, who brought Bugbee into the AHA, I think. That was certainly a plus factor.

Do you want to talk about Hartford Hospital as it was when you came there and again when you left?

HAMILTON:

I used this anecdote a while ago talking about a friend of mine. It's interesting that of the four people who interviewed me and who invited me to come from Newton-Wellesley to Hartford, three of them are still living. One is in his nineties, one in his eighties, and one...

Jim Taylor, who was president of the hospital, I remember very well saying to me in the first interview, "This institution has been around for a long time, and it has a great momentum. We are not looking for anybody who will ride on that momentum, or slow it down. We are looking for someone who will accelerate it. Do you think you could do it?"

It is a fascinating institution in that it's -- Hartford is interesting in that for a city of its size, you would expect a number of small hospitals,

and it has three big ones, of which Hartford is the oldest and the largest. It was very well known as a place for graduate medical education when you and I were young. When I was a house officer, and in medical school, that was considered a cracker-jack place to go, especially if you were going into family medicine. It was still very good. A few years before I came they had done an unusual thing. They had hired a man as the director of medical education, a physician, Jack Leonard. He really put the medical education program on the map.

They had a very well known, and justly so, school of nursing. But the two in combination made the institution really quite unique for an institution not intimately connected with a medical school. With Jack's support and push, and staff's interest and the board's interest, we expanded the Division of Medical Education a great deal during the years that I was there. The advantage of something like that is that you have a crew of bright, young people coming through your place, and it makes a marvelous cadre from which to select the brightest and urge them to stay on and come on the staff.

We had a program, and I guess they still do, of partial support for a graduating resident in his or her first year of practice there. They can do some work in research or teaching or something within the hospital, at the hospital's invitation, and get a supplement to what they would be earning in the days when, with people going into private practice, earnings were pretty slim.

I imagine that will be changing now as more and more people are going into groups. It may become less necessary. We became interested early on in medical school affiliation. We talked with Yale, and they felt it was too far away. We considered at one point seeking to establish a freestanding medical

school. But that only got into the early talking stages and was discouraged by medical educators whose opinion we respected. All this time we were also encouraging the University of Connecticut to start a medical school. Their then president, Dr. Jorgensen, was also very interested in doing this. Finally he succeeded in doing it. It created what has turned out to be a very good school, but not without some very difficult problems because it brought to the surface the competition between the three hospitals in the city and the medical practitioners primarily. It really became destructive. I'm sorry to say that it's like a volcano that is not quite extinct. Every once in a while it rumbles and gives off some gas.

WEEKS:

Do all three hospitals have....

HAMILTON:

All three hospitals have affiliations. And, of course, the Institute of Living which is right next door to Hartford Hospitals does. They are the psychiatric hospital. Newington Children's does. They are nearby, but they are a specialty hospital. Mount Sinai, St. Francis and Hartford are the three in the city. The university -- the site selection was chosen, first, to be sure it wasn't anywhere near Hartford Hospital. Then, because of that, not near others. It's out in Farmington, Connecticut, which was a lovely suburban town. It's by far and all the biggest operation in the town, but it has attracted all sorts of things. Mostly good. Marriott Hotel; Stauffer Chemical has built one of its major research branches right across the road and work with the school. They have about a two hundred bed hospital. It was supposed to be one-half of a 400 bed hospital. The other half has never been built, and probably, in our lifetime, certainly won't. Particularly with the

declining census.

As a matter of fact, I ran that hospital for a year after I retired, while they were looking for a new director. I got to know it pretty well.

Shall we talk about any connections with AHA, or are you going to get into that?

WEEKS:

Yes, a little later.

I noticed that in something I read about you, the establishment of a cardiac ICU. Then I began wondering what services you had when you came there and what you developed.

HAMILTON:

It was an excellent hospital when I came there, with probably as good an anesthesia department as there was in the world. As a matter of fact, the American Board of Anesthesiology is still located in Hartford, Connecticut, because Ralph Tovell -- he was the anesthesiologist for the European theater in World War II with D.E.D. Churchill as the head surgeon -- came from Hartford Hospital. After the war he came back and developed the department. Really developed anesthesia as a specialty in medicine. There were a few hundred around, but his was <u>the</u> residency in the country for many years. In addition to that, curiously enough, we had a remarkably active neurosurgical department, which was, and I guess still is, one of the busiest in the country.

But the key to any first-rate hospital, I believe, is a strong department of pathology, and here we are blessed. Beginning with Wilmar Allen -- who later became my predecessor as director -- we had a department led and staffed by a remarkably able group of people. Their leaders, in my time, were Drs.

Ralph E. "Wally" Kendall, Robert Tennant, and Ronald Beckett. They set the quality tone for the department and the hospital. As a matter of interest to our discussion, Bill Allen served as president of ACHA in the later 1940s or early 1950s.

Because of this, and a very good but not spectacular surgical and medical department, very strong, but we didn't have any world leaders, the hospital enjoyed a fine reputation. Things began to grow and it was felt that we had to get some space for intensive care. One of the first intensive care units was built there; we took a wing from the hospital, which had been built under my predecessor, Dr. Wilmar Allen, and converted that. Then we had an OB one which wasn't that much needed because the crises are not much, compared to what they used to be. And a pediatrics one which resulted in the hospital becoming a major pediatrics center in the area.

Out of these things, we felt that moving from just having a chief of medical education, we were demanding so much time of our clinical chiefs that it was a real sacrifice for a good many of them to give up that much time from their private practice. We talked about trying to work a half-and-half arrangement, or give them a stipend. It moved from there to feeling that the time had come to start looking for someone to be a salaried chief and handle that side of it.

We decided to let the departments move when they were ready. Medicine moved first. Pediatrics moved next, but they went half-time. The pediatric service was not all that big. Then surgery, and last, to no surprise, was OB/GYN.

The thing that happened in pediatrics where they had gone half-time was that the half-time chief felt that he really needed some help. He began to

look around and others began to look around. They found a fellow named Leon Chameides who was just finishing a residency in pediatric cardiology up at Strong Memorial. They invited him to come down, and we hired him. Shortly thereafter our chief decided he wanted to go to Newington Children's, so this youngster became our chief of pediatrics. He really developed pediatric cardiology for the institution and for the city. He did a magnificent job. The thing that just staggers me about this man was that his family — he's a Polish Jew -- his family were utterly overrun by the Nazis in World War II and scattered to the winds. A good many of them he has never been able to locate. His parents, he's sure, were killed. He was picked up at age about twelve as a waif on the battlefields by a British soldier and taken back to England. He got his first schooling beginning at age ten or twelve over in England. He came to us with his boards in pediatric cardiology at about twenty-six. He's an absolutely wonderful person. He is not chief now, but he still has an office there. He subsequently located one of his brothers as a professor in a university in Australia. How he got there, I don't know. It was one of those happy endings to a war tragedy. Delightful person.

In many cases these things just happen. We had one young man named Henry Low, who had his early education in China, his medical education in China and in this country, and his residency with us in surgery. He went on down into New York in heart surgery. At the annual meeting of the hospital last year, he had back at the meeting, eleven of the twelve patients on whom he had done heart transplants. And the twelfth couldn't get time off from work. So he, at last report, had been doing heart transplants now for about two years without a fatality.

WEEKS:

That is so much better than the average, isn't it?

HAMILTON:

Well, he is a remarkable man. From another country -- Chinese. It was fortuitous that he happened to land at our place as a resident. He must have applied, known it was good. He was a resident there when I first came.

The place has changed. There are many more physicians now on the full-time side of the hospital than there were when I came.

WEEKS:

How large is the staff?

HAMILTON:

Must be 900, with most on the active staff and the rest with courtesy privileges. A busy place. Mostly surgical.

WEEKS:

You must have high occupancy then.

HAMILTON:

Yes. With the shortened patient stay -- patient days have gone down a little, but very little -- the number of patients admitted has gone up. Of course it's going down now because they are doing so much day surgery. Mrs. Hamilton had a lens transplant last fall. She was in at 8 o'clock and out at noon.

WEEKS:

Is that right?

HAMILTON:

They are doing -- I would guess they are doing about five or six thousand operative procedures a year, on a day basis. It is a primary teaching

hospital of the medical school. They staff it for teaching. It has the largest number of beds in the state. St. Francis has a lot in the family medicine side, but our hospital has become more and more specialized over the last thirty years.

WEEKS:

Do you do a wide range of transplants?

HAMILTON:

Yes.

WEEKS:

So you must have some highly specialized teams.

HAMILTON:

Starting with kidney.

WEEKS:

Kidney is probably one of the safest of the procedures, isn't it?

HAMILTON:

Yes. There are some problems afterwards.

That was another case of a man who was brought aboard, one of our surgical residents, who got interested in this. He was brought aboard as a research fellow and was carried by the hospital for eight or ten years while he developed the technique. He went all over the world and came back.

Orthopedics was good, but not outstanding when I came. I think it's very good now.

WEEKS:

Thinking of this man that I am going to talk to about veterans. In your hospital, did you have many veterans that you were taking care of who might otherwise have gone to a VA hospital?

HAMILTON:

I would expect so. I can't say. But until the medical school was established, our staff were the "dean's committee" for the VA hospital over in Newington. So there was a lot of connection. Our people were over there too, doing the surgery. I don't know how it's running now.

WEEKS:

Another question I would like to ask, which is probably silly, but I was wondering if certain surgeons and backup people do more than one kind of transplant surgery?

HAMILTON:

No.

WEEKS:

It's usually highly specialized?

HAMILTON:

The people who do the coronary bypass surgery and heart valve surgery -- there is only one, at the moment, doing heart transplant and that is Henry Low. He also does other heart surgery. He started doing other heart surgery, and he still will occasionally do a bypass or a valve replacement. The kidney people stay in that area. I don't know if they have done any livers or not. Certainly not while I was active.

WEEKS:

It would seem to me that that would be one of the trickiest. It's so vitally important.

I noticed that after this nuclear disaster in Russia that an American was over there doing bone marrow transplants. I don't know how common that is here.

HAMILTON:

Fairly, I think.

WEEKS:

So you finally were pleased with the fact that you supported the cardiac care unit.

HAMILTON:

Our problem, and I guess it's true in every one, is to try to keep these things in balance. The operating theaters can produce far more patients for the intensive care unit than the intensive care unit can handle. Every now and then you get into a jam where patients have to stay in the recovery room overnight until things loosen up. Also, as a result of it, we did what the MGH had also done even before. We took pretty much the whole floor for things like cardiac surgery, and have the areas just off the intensive care unit to be sort of a step-down unit. People could be forty-eight hours in the ICU and then moved over where they would still be under close surveillance but not with all the gadgets and noises.

WEEKS:

When I started at the university in 1962, the first job I had was working on a progressive patient care study which started out in Manchester.

HAMILTON:

Which is one of our neighbor hospitals.

WEEKS:

We went up to Manchester to look at that hospital.

HAMILTON:

It is staffed by a great many of our alumni, a very high quality of medicine out there.

WEEKS:

It isn't a simple process that could be widely accepted probably, but some do it partially...

HAMILTON:

The step-down units?

WEEKS:

Yes.

HAMILTON:

This is one of the things that we did at Hartford in 1964, or thereabouts. We built a six story continuing care unit as a step-down unit for patients from the hospital. It has worked remarkably well, particularly for people with hip replacements, say. They will spend forty-eight hours in the hospital and then they can just be moved along the corridor and into the continuing care unit. It's quieter. The rooms are bigger and more commodious and pleasant. The whole atmosphere is different. They need, and get, less care.

WEEKS:

One thing I noticed somewhere, maybe in the AHA Guide Issue, there was a listing of nursing home beds in your hospital.

HAMILTON:

We have a nursing home called Jefferson House, which got its name because it was once on Jefferson Street. In the late 1970s the "house" was moved out on to the Newington Hospital grounds. It started off as a home for the aged in 1878. In its first one hundred years of existence it took care of about six hundred people. People would move in and stay there until they died. They would admit a few people a year and that was all. It became, to some

extent, the retirement site for the servants of some of the wealthy people. It was very well endowed. When we built our continuing care unit, we decided that the government was moving in on caring for the elderly, and there wasn't the need for that type of facility. We closed it and built our continuing care unit. Then the need began to rise again. Plus the fact that we wondered what to do with this remaining endowment. We got a very indepth legal opinion which concluded that the hospital, having accepted this at one time, was unable to divest itself of the responsibility, and we either had to do something about it or give the money back to the descendants of the donors. They also concluded that if we were to try to do that, because of the expense of doing it, what would trickle down to the descendants of the donors was so little that it probably should not be regarded seriously.

And so, the need rising again, we went ahead and rebuilt Jefferson House, with a new building out on Newington Children's Hospital property. They had a lot of land out in Newington, which is only a few miles away. That's the nursing home unit. Patients can go out there for up to a month for rehabilitation.

WEEKS:

Here again it's a step.

HAMILTON:

It's part of a step-down.

WEEKS:

In other words, it's not just a custodial place?

HAMILTON:

No. Anything but.

WEEKS:

It is a rehab?

HAMILTON:

Rehab. They are beginning to reach out now, and have set up day care units, one in Manchester and there may be another one.

WEEKS:

They have a therapy program?

HAMILTON:

A therapy program in a site quite a way from Jefferson House itself. They also have a therapy program in Jefferson House for ambulatory patients who come in. People who are living at home.

WEEKS:

You spoke of the endowment on Jefferson House. Does the hospital itself have quite a good endowment?

HAMILTON:

It's a remarkable institution in that way. I would guess its endowment has a book value in the $60 million range. Market value is probably twice that.

WEEKS:

The reason I asked the question was because I have heard of Rhode Island Hospital having a good endowment. Then I begin to associate that with the older, longer established hospitals in the east.

HAMILTON:

The other side of that institution which is unique is that it is out of debt. Occasionally it has been in debt, but only briefly. We had $2 million when I came and we are old-fashioned enough that we fought to get it paid off.

The bank was glad to have it paid off too, because they loaned it to us at two percent. That was paid off a few years after I came. Since then, I don't think they have been in debt. They are planning a new $100 million expansion, without borrowing. This is under my successor, John Springer.

They are starting out on a campaign for $30 million in contributions, and the rest is going to be from hospital surplus and from unused endowment income and things like that.

WEEKS:

Isn't that marvelous!

HAMILTON:

Well, it's unusual. The Mass General has got a whopper of a debt right now. And a lot of others do.

WEEKS:

Yes, I know. I sometimes wonder about our own University Hospital here which has just opened about a $300 million edifice without increasing their beds or anything else. I wonder how they are ever going to pay it off, aside from getting state funds.

HAMILTON:

One of our major problems -- or one of John Springer's because he succeeded me -- but it was mine while I was there was the main building which was built under Bill Allen's aegis was designed before World War II. World War II came along and they had to put everything in the freezer. Nine days after VJ day the shovels came in and they started building, but the plans were still six years old. So it is mainly four-bed rooms with the bathroom down the hall. Not much room for other equipment. What they are doing, floor by floor, is reducing them to two-bed rooms. They are putting two stories on the

Bliss wing, which was built while I was there. We built it to take two more floors. We had two floors in shell and built it to take two more. They'll be filling the two floors in shell and putting two more on in order to make up the difference, so that the bed numbers will be only a little bit less when they get done.

WEEKS:

That's probably sufficient under present conditions.

HAMILTON:

Under present conditions it seems to be working out.

WEEKS:

I just wanted to ask you one short question about the nursing school. That's a three year school?

HAMILTON:

It was. It was closed a year or so before I retired. It was a famous one. We felt that it was important, seeing the trend, to do something about it before it gradually went downhill as more and more move to the collegiate side. The Mass General, of course, has a degree-granting authority. We figured we couldn't get it, and probably didn't want it. So we set up a plan with the Hartford Community College for the first two years. Our director of nursing went over as the dean of that program. Then, in an arrangement with the University of Hartford for the last two years for the nurses who wanted to go for a baccalaureate. So they could take their first two at the state community college right in town, with their clinical training at Hartford Hospital, then...

Like so many things that we plan so well, it didn't work out quite as well as we hoped. But it is finally getting squared away and I think it's

doing pretty well. The University of Connecticut School of Nursing has a baccalaureate program and their students are there and a number of their graduates come there as professional nurses after graduation.

WEEKS:

There is a big question right now among nurses as to what their role is and what their education should be.

HAMILTON:

They don't want to be the handmaiden of the doctor any more. I imagine that's a lot of the Women's Lib movement. The two things came along together which has accentuated it, speeded it.

WEEKS:

I think there is still another thing too. Women are getting into every profession. Look at the women in medicine.

HAMILTON:

When we were young, nursing was about the only thing a girl could do. Certainly the only thing a poor girl could do. You could get a profession without putting out any money. You earned while you learned. Now, as you say, the opportunities are legion.

WEEKS:

There is a great deal of competition. I have talked, as you have, about nurses who want to be nurse practitioners. The other day I read there are 130 odd licensed nurse midwives in Michigan.

HAMILTON:

We have them in Connecticut. We ran a nurse practitioner program at Hartford Hospital, after I retired, for a number of years. Now, by the state law, it has to have collegiate connections. So, I don't know what they are

going to do.

WEEKS:

You have hospital licensing in your state, don't you?

HAMILTON:

In spades. We also have a Commission on Hospitals and Health Care which is dedicated to cutting costs. Hospitals have to go through unbelievable...

WEEKS:

Certificate of need, do you go through them?

HAMILTON:

Yes, it goes through them. The HSA is still alive under perhaps another guise supported by the business coalition. We go through them. But that isn't as high a hurdle as the cost commission.

WEEKS:

I was talking with my friend, Sy Gottlieb, who is with the Greater Detroit Area Council.

HAMILTON:

Sure. I know Sy.

WEEKS:

This apparently is the way it has got to be today. You get the leaders together and they decide whether something should be approved or not. Indirectly, some way, that influences the decision of the state board.

HAMILTON:

The worrisome thing in Connecticut, to me, is that the people on this commission -- and that's, of course, a political appointment -- are getting so worried about what competition is doing to place the small institutions around the state at a disadvantage that they are, I'm afraid, moving to stifle the

growth and development of the big institutions. My philosophy has always been that you are better off putting your money on the winners. I'm afraid that this is going to redound to the disadvantage to the state in the future. Because it will make it discouraging for the ablest of practitioners to want to come there. Although, Connecticut has many other attractive aspects to draw people. It's a lovely place to live -- even for a Michigander.

WEEKS:

I guess I'm sort of -- I must have a little touch of New England blood in me. I read Yankee magazine.

HAMILTON:

Wonderful magazine. I love it.

WEEKS:

I, somewhere, have gotten the idea that you have great concern over the care for the aged. I know that this goes back to the beginning of your time. I'm wondering if you could talk to this point, your experience on the Medicare committee back in 1963. I know that you are concerned about the care that aged need.

HAMILTON:

I'm still involved in that, as a matter of fact, in two institutions in the area.

The first thing that came up, and I was active at the AHA on it at the time, was the federal push for Medicare. Philosophically, we were in complete agreement with what Mr. Rubicoff who was head of HEW, and Wilbur Cohen and others felt at that time. But we had a curious problem that came up in understanding the importance of this in that, as we looked at our books -- I know you have interviewed Phil Bonnet because he talked about this. As we

looked at our books and as our friend institutions looked at their books, we recognized that the elderly -- in those days we were talking about people over sixty-five, might have to push it up a bit now — come into the hospital twice as often and stay twice as long, which means that on an average annual basis they are having four times as much hospital expense as people of a younger age. Yet when we turned around and looked at our bad debts, our bad debts were almost zero in the old folks. Our bad debts were all in the young hospital population. This led us to worry and led us into the support, without speaking pretty personally here of my own philosophy, to support the idea that it might well be that we were forcing old people to divest themselves of assets that were irreplaceable in order to get hospital care, because they weren't working and so on. We had no way of proving that, but we wondered if it wasn't true.

Certainly, the AHA ended up, as I remember, taking a relatively neutral position on this. We finally had a vote -- you had to either fish or cut bait -- a vote, and the numbers will show, I think the numbers were quite strongly in favor of supporting it. It did not do much to win friends over on Dearborn Street, the AMA headquarters.

I was president-elect when AHA had its momentous special meeting of the House of Delegates to consider this issue. Frank Groner was, as the past president, the presiding officer of the House of Delegates. For reasons that I don't remember, if I ever knew, Frank asked to be relieved of the responsibility of chairing that particular meeting. I think it may have had to do with his Baptist relations. Baptists believed strongly that they didn't want to take money from anybody. I think that's where that came from. So the chairmanship for that meeting would have then evolved on Jack Masur, who was a

government employee. Of course he couldn't do it. So there I was the sitting duck. I was so new at the job that I didn't know enough to be frightened. I remember chairing that meeting very, very well, because it went on, and on, and on. Debate, some eloquent, and some not, on both sides. Finally, George Hay, who headed Wills Eye Hospital in Philadelphia, got up and said he had listened to the debate, and he had been interested in it, and followed it with a great deal of passion. The one thing it reminded him of was the man who was on his deathbed and his minister came to him and said, "John, you know and I know that you are dying, and the time has come to renounce the devil and all of his works." John looked at him and said, "Pastor, do you think I'm in a position to make any more enemies?"

It brought down the house, and then they had the vote. I don't know whether that anecdote influenced it or not, but it certainly broke the tension very well.

Then I was on the committee of the AHA putting together the specifics of Medicare. There was one issue that we kept pushing and pushing, the feds never really paid any attention to it. This was our conviction that this plan was grossly underfinanced, that it was going to lead to expenses beyond anything that they were planning. They pooh-poohed it. However, our sense was that on balance they planned very well for Medicare. But that Medicaid was an afterthought that came in without much of any hard thinking at all. It just sort of flowed in.

WEEKS:

As part of Wilbur Mills' three-layered cake.

HAMILTON:

Yes. And in the first few years, as you know, there were only two states

in the country that used it, California and New York.

The other thing that worried us was the establishment of Part A and Part B and setting aside the medical specialists because we felt that this was going to cause a very rapid increase in costs. It was part of our concern, cost, of course. We fought for their being included in the hospital side, and lost. I remember we had been happily, and sometimes unhappily, fighting with our anesthesiologists and our radiologists at home about this. I came back from that meeting and said, "Well, fellows, Uncle Sam is giving you the ball game. Don't need to worry about any threats from me any more."

The pathologists, curiously enough, at Hartford Hospital, were, and still are, on salary. A superb department.

WEEKS:

Would you say that the other specialists who are billing direct now -- would you say the total expense for radiology, say, or for anesthesiology now that they are billing direct, plus what the hospital has to bill...

HAMILTON:

I think it has gone up faster than the other aspects. To some degree it has dragged the other aspects up with it. Because if their personnel, because they are earning more money, are earning a lot more money, and they are eating at the same dining room table with hospital people, you've got to keep pace. But the thing that it did really was, from the doctor's standpoint, it eliminated with Medicare a great deal of the charity work that they had been doing. When you and I were starting, doctors were doing well if they collected much over fifty percent of their billings. All of a sudden it went up to ninety percent.

The other side of it was that for the hospital employees, the attitude of

the institutions, like the ones with which I was associated, was that a hospital in many ways is like church. It's not like a business. If you come here to work, you have got to expect a pay scale more like that of someone in the church field than when you are in the business field. If it's money you want as a secretary, go on over to Aetna. Because, sure they'll pay you more. But we think we've got some other rewards here that make up the difference.

Once Medicare came in, and Medicaid, so that, in theory the bad debts, the free care of hospitals was cut way back, there was no excuse not to bring the hospital employees up to the going level of the community. As always happens when this happens, you tend to override. Then it'll, in time, as it is doing now, it will fall back. But it takes time.

WEEKS:

Have you had much in the way of union trouble in your hospitals?

HAMILTON:

Let me talk about the city first. Mt. Sinai, which is across town, was organized half a dozen years before I retired, and they still are.

WEEKS:

Is that 1199?

HAMILTON:

Yes. St. Francis, no. 1199 got into the Institute just across the street from us two years ago. This has us worried. There had been a number of beginning attempts to unionize in various parts of Hartford Hospital, but I think it's farther from it now than it was when I retired even. Before I retired we had a very capable, very union oriented, young man who was the president of our employees' council. During his tenure, which was three years from president-elect to past president, he tried his darnest to get the union

organized. It has really never gotten anywhere. There were a few scares. We've had an employee policy which, so far, has done a remarkable job.

Another anecdote. This was after I retired. Because of the change in nursing education, nurses in their education, rather than their training, are passed through the operating theater. It is so foreign to anything they get used to, and the people they are seeing are all asleep, and they are talking about interpersonal relations, that the number of nurses going in to work in operating rooms declined so dramatically that some years ago they started at Hartford Hospital to develop a program of OR technicians, taking people and training them in a narrow field, indepth. This worked very well. A federal inspector came around one time and our numbers didn't agree with what were on his books, so he started to holler about it. John Springer, my successor... was just told that he had to fire a third of our operating room technician force. Rather than doing it, although the word got out and they were all terribly nervous, and they were going to organize and so on, but rather than doing it and saying it's the government's fault, John took a team of four or five or six people, including three OR technicians, down to Washington. They visited our representatives and senators and a few other people. They became part of the act to try to do something about the problem. A - they were successful, and B - it was a marvelous employee relations step for John to have made. If it is like most of them that I made, he didn't realize he was doing it, but he did it. But he's smarter than I am, so he probably did. It worked very well.

The last I heard, there really were no rumors or rumblings of union.

WEEKS:

There may be a growth of unionization in coming years, I don't know.

HAMILTON:

That's the only field that's growing. Certainly in industry, it's falling back. But in the health field it seems to be gaining.

WEEKS:

This is it, because they can't organize more auto workers and the union membership is dropping off, they have got to look where they can find people.

HAMILTON:

One of our big hospitals in Connecticut had a walkout, closed down for a month when we left, in Waterbury.

WEEKS:

This is the unfortunate thing about walkouts. I have talked to Leon Davis who founded 1199. I admire him very much.

HAMILTON:

A fascinating guy. I don't know him at all, but I have heard a lot about him.

WEEKS:

I talked to the woman who used to be the head of the state nursing association here who has been behind seventy-some contracts in Michigan. That's about a third, or a fourth at least, of the hospitals in Michigan. I think that Hartford Hospital by having the right kind of employee relations probably can avoid unionization. If you can avoid it, I think it's better for everybody.

HAMILTON:

Our university hospital, John Dempsey Hospital, is unionized. But this was done really through the legislature. I was there when it happened, and we weren't, as management, allowed even to say to the employees, "Look, most

coins have two sides and you want to look at both sides."

But we did, at the legislature's insistence, we did leave all of our buildings open for them to call meetings and use the facilities and whatnot. It was really just a question of which union was going to win.

WEEKS:

You were talking about discontinuing your nursing school. I assume before that period most of your supply of nurses came through the school.

HAMILTON:

Correct. We took classes of about a hundred.

WEEKS:

Now you have to go out into the market and get your nurses. Are you finding what many other hospitals find that nurses are not trained alike and are not all capable of doing certain procedures, or the hospital says a nurse can do this but can't do this? Do you find that you have to have an inservice education?

HAMILTON:

This is, of course, a bit from hearsay because much of it is after I retired. But the answer is, yes. In the old days when the nurses went through the school at the institution, they were educated or trained in that institution's mold. They could go right from graduating to being a nurse, or maybe even an assistant head nurse on the floor. Now, their education is quite different. Many of them don't know the institution itself. Like a medical student graduating, they need an internship of some kind to acquaint them with the institution and its techniques, where the facilities are, what buttons to punch to get what you want. Most institutions, and Hartford is no exception, have a training period for these people to orient them to that

place.

WEEKS:

I think we should talk about your AHA -- we have spoken about the Medicare committee. Your committee assignments came mostly before you became president, I assume.

HAMILTON:

Yes. I think the first one I had was to help write a manual for admitting officers. I was at Newton-Wellesley -- right after World War II. Then I served on a number of committees. I also served on an internship and other review committees for the American Medical Association. I was on the nursing committee, was put on the Council on Professional Practice and became vice chairman during the time Russ Nelson was chairman. Then he went through the presidential chairs. I was made president-elect a year or so after he completed his term. I went from being chairman of the Council on Professional Practice.

Afterwards I was involved on a committee to follow up on the Knowles Committee Report to help in the reorganization of the AHA, which really was the one that built the structure for which his report stated the philosophy. The AHA structure of regents and regional delegates has grown out of the work of that committee. It has done a lot in some ways for the AHA, but it has made their annual meetings very boring.

WEEKS:

I got that impression from what others say.

HAMILTON:

It was exciting when I was there. You never knew what was going to happen.

WEEKS:

The thing that has impressed me about AHA, our new head is going to have some trouble before she gets through, I think, is one, even from the very beginning the AHA was trying to represent many disparate kinds of...

HAMILTON:

Be all things to all men.

WEEKS:

That's right. So you end up being equivocal. You very often can take stand....

HAMILTON:

Come out with an "unequivocal maybe," as one of my friends would say.

WEEKS:

Yes. So that I see as a problem. Do you see a problem coming up for the AHA as far as the multihospital systems?

HAMILTON:

I see a good many. One of them is the bigs versus the smalls. The small hospitals are the first ones to be getting into deep trouble with all of the changes that are taking place in this watershed period. The other one, which you touched on, which is at least as great, is the for-profit, not-for-profit. Coupled with that, the not-for-profit reaction to the increasing power of the for-profits setting up the Voluntary Hospitals of America and a number of these other big groups. We are, I think, moving to where in a decade we are going to see seven, maybe ten, maybe fewer, conglomerations of institutions instead of the seven thousand that we had when I was president.

It worries me, having had most of my experience in big hospitals, to see the AHA turning, as they have done twice in the last few years, to

administrators of very small hospitals, for several reasons. Newton-Wellesley was not a small hospital, but it was not a great big one, but you get a hospital of 100 beds or less and the administrator has to carry all the keys, he has to know where all the valves are, he has to know the home numbers of most of the key people so that if anybody has any trouble, he's the one they call. If he's gone, as is necessary while on AHA business, unless they can put somebody in to run his place while he is gone, he or she is going to be just torn apart by this, I would think.

The other part of it is that in dealing more and more in the world of business, I think it is of great help to have someone who is used to running a big business himself or herself. If you are running a $50, $100 or $200 million a year operation, these people who are running big companies will listen to you. The senators will listen to you. But if you are running something like a $100 thousand a year budget, it's hard to get their attention.

It also, I am afraid, may alienate the big hospitals. This is just my old man's observation, as I sat and listened to the House of Delegates last time.

WEEKS:

The position comes up that they don't need the AHA any more.

HAMILTON:

The ones whom the AHA needs most, need it less and less. Or will, I'm afraid.

WEEKS:

I talked with Jim Sammons of AMA. When you stop and look at it, only half of the physicians in the country belong to the AMA.

HAMILTON:

If that.

WEEKS:

I think a little less than half. If they are going to fulfill the requirements of an association, which is basically to represent, to educate -- two of the big things — possibly do research, if they are going to represent all of these doctors out there, or all these hospitals, they have got to find some way to make themselves necessary to them. The association has got to become necessary for these people so that they'll want to join.

HAMILTON:

I would guess that among the members of medical academe who are members of the AMA, a good many of them are members because it's the thing to do to maintain the relationships between the medical school and the practicing community in the minds of the deans and others. As a matter of fact, one of our associate deans at the University of Connecticut is the president of our county medical association. I'm sure he's doing it as sort of a pro bono publico.

WEEKS:

Since in very few states are physicians required to belong to a county or state or AMA in order to have staff privileges -- that's no longer true. I think legally that was settled, wasn't it?

Let's skip back to Hartford just a moment. I was thinking when we were talking about staff privileges. Did you have a strong credentials committee overseeing applications for staff privileges?

HAMILTON:

By department. Indeed, we did. The active staff, which were the key

people were only by invitation. You applied, and were accorded courtesy privileges. Then they had, if there was someone they thought they wanted to consider, they had a courtesy with assignment appointment which was sort of an in-between, sort of a limbo thing. If you were approved, as most of them were, then you were invited to become a member of the active staff.

WEEKS:

While acting on the courtesy staff, they had a chance to observe their professional ability. I was wondering about some of the horror stories we read sometimes about someone, say in California, who...

HAMILTON:

It's always in another state.

WEEKS:

Right. This may be the reason for it. But it suddenly appears in Connecticut or Michigan and is admitted to the staff of a hospital, and begins doing all of the bad things he did back in California. It must be very difficult to run these people down.

HAMILTON:

It's getting more so because people don't dare be honest in their assessment when you write them or even when you telephone them. We did most of ours, if we have any questions, by telephone.

WEEKS:

I can understand the wisdom of that. A man will say something over the phone he won't put down in writing, if he has a criticism.

HAMILTON:

Sure. Because if it's in writing, it's there when it's called into court.

WEEKS:

Have you had any trouble with anyone legally questioning your decision?

HAMILTON:

Oh, yes. But we've never, to my knowledge, gone to court. Mostly, in the past, we handled these things on a personal basis, very quietly. I was involved in one or two of them where we would go to the doctor and say, "Doctor, we just feel that your way of practicing is far enough from ours that we would like to have you either resign from the staff or agree not to admit any more patients. If you seek to admit a patient, we will have to move to drop you from the staff."

Then we had a few years ago, a surgeon -- and this happens to everybody, but surgeons more, I guess -- who was very able, and got into trouble with narcotics. Somehow or other they were able — this was after I retired — to talk with this person, get him to go for treatment, get him to contact the board of registration and ask to have his license put in limbo until these people felt he was ready to come back if they did. It never got into the newspapers. He was out for two or three years and came back and is doing beautifully.

WEEKS:

Isn't that wonderful!

HAMILTON:

Then we had one that came very close to trial. Someone who is in a surgical specialty. It had nothing to do with his technique, but it had to do with his extracurricular activities with regard to patients. He, at one point, resigned, and then decided he wanted to get back on and reapplied. We refused him and threatened suit. It got close enough so that finally our

lawyer went to see his lawyer, who was a distinguished person in town, and said, "This may be unethical of me, but I don't know how much your client has told you but I want to tell you these are the witnesses we are going to bring to court which will result in assault charges against this man. If you want to open it up in court."

That was eight years ago. It hasn't come to court yet. I don't think it will.

WEEKS:

What is the malpractice situation in your state?

HAMILTON:

It's bad enough so that John Springer has worked out an arrangement with, I think it's Aetna, a very special sort of a thing between the hospital and the physicians. The physicians who insure through this hospital plan can get their insurance for a premium of about half of what the going market rate is, maybe a little more than that.

WEEKS:

Does Aetna feel that your presence in this will remove risks?

HAMILTON:

They are getting a preferred treatment, really.

WEEKS:

Being an insurance city....

HAMILTON:

It's ironic. There is a lot of insurance in this area that you can't buy, even in the insurance city.

WEEKS:

Yes, I know.

HAMILTON:

Especially in the insurance city.

WEEKS:

The insurance company, is it St. Paul Casualty?

HAMILTON:

St. Paul was one of the big ones. They pulled out, I think.

WEEKS:

They pulled out at least partially. But their argument was pretty good in that since the malpractice insurance was becoming a greater percentage of their total underwriting and was showing great losses, that they couldn't afford to keep doing it any more. I guess nearly every state must be working on legislature.

HAMILTON:

They are. I think they've come up with one in the last session, but I don't know whether it has really been put to test yet.

WEEKS:

Limiting claims.

HAMILTON:

Or paying them over a long period of time.

WEEKS:

It's a bad situation.

One point I wanted to ask you was about the physicians role in the hospital, particularly in the management. One, board membership. Two, sitting on committees of management, or working with administration. Paul Ellwood has come up with -- what is it MESH that he calls it? I don't quite understand it, but it's moving physicians into management.

HAMILTON:

We have done this increasingly. In the beginning, I was opposed to it. I have come, if not 360 degrees, 270 degrees. We now have three or four physicians on our board of directors of thirty. We have one or two on our executive committee of eight or ten, which is the committee that really does the work of the hospital. They are involved in a great many of our decisions, and we are in theirs -- some of the quality control committees and whatnot. There are administrative people, have been for a long time, but also board and trustee people, board of directors people. On our research committee we have a director who complained, when I asked him to go on, that he didn't know anything about it. I said, "That's why I want you to go on it." He's off now, but that was fifteen years ago. He made a tremendous contribution because he would be able to say, "From somebody not in the field, why are you doing it this way? Explain it to me in layman's language." It was very helpful.

When I came there, the medical staff and the hospital ran almost parallel. The administrative people -- as executive director, I never attended any staff meetings. After a meeting of the executive committee of the medical staff, the chairman would come down and tell me what they had talked about. The medical staff never attended the board meetings. Then we began to pull them together, through the joint conference committee. On balance, it has worked very well.

I think the most fortuitous thing that we came into there in an effort to do something about this was, half a dozen years before I retired, we set up a conference which was known then as the Williamstown Conference, because our first several meetings were up in Williamstown. We got a group of about one

quarter administrative, one quarter board -- maybe a little more, and the rest medical staff, to talk about broad issues and about an agenda. We started on Thursday night, went all through Friday, knocked it off at Saturday noon. First we talked about issues. But the important thing over time was that people got to know each other. The horns began to disappear; people discovered that others really didn't have horns. I think it has done a great deal to improve the relationship between the three groups.

WEEKS:

That's marvelous.

HAMILTON:

We had our troubles too.

WEEKS:

Oh, yes. I'm sure you do. The M.D. members of the board, are they selected by the medical staff? Are they appointed by the board?

HAMILTON:

The ex-officio ones are selected by the medical staff. There are two of those. The others get their appointments through the nominating committee of the hospital. They win in a competition with presidents of companies, professors in the universities.

WEEKS:

The members of the corporation...

HAMILTON:

Six hundred people. The idea behind it at the beginning was that you had a broadly representative group in the community who met once a year at an annual meeting, who got various reports. If the hospital began to go sour, they had the authority to throw the rascals out. They elected the directors.

If things got bad enough, which I don't think they have, they could do it.

The directors are elected for five year terms, renewable up to age seventy. They are nominated by a nominating committee which includes directors and corporators, sometimes people from the outside.

WEEKS:

Can anyone be nominated from the floor? The reason I'm asking these silly questions, I'm thinking of the little hospital where we did the study of progressive patient care, which had a corporate membership which cost $1 a year.

HAMILTON:

That happened at Princeton, too. Damned near blew the place apart.

WEEKS:

Some people who wanted a vote would pay the dollar and say, "John, you are now a member, come and vote for me."

HAMILTON:

That is possible, but we have never seen any of it. I would think that if there were any sniff of it that someone would make plans to correct that.

WEEKS:

Your members pay an annual fee?

HAMILTON:

No.

WEEKS:

Anybody can join who wants to?

HAMILTON:

No. They have to be invited. The nominating committee nominates corporators every year. They nominate directors. They recommend the

committees. The staff are appointed by the executive committee of the board, on recommendation of the staff.

WEEKS:

I talked to George Crile, Jr., of the Cleveland Clinic. I asked him how they control their medical staff. Since they were salaried people, did they have a quality control committee or somebody. "Well," he said, "We have committees, but we don't need to worry because these men are working together and they police each other. If somebody doesn't do well, or do his share, we soon learn about it and we can get rid of them."

HAMILTON:

I think the future is going to see that much more formalized. I think we have got to develop some methods of measuring the quality of care. It's going to be easier in surgery than it is in medicine. Ted Howell, I don't know whether he is on this list but probably should be. He was head of Henry Ford Hospital and then was with Peat, Marwick, Mitchell. He, early on, developed a system that never really flew at Henry Ford. He computerized the way doctors took care of patients to find out the most efficient way. The radiologists will tell you you can't do an upper GI series before you do a barium enema, or vice versa. You have to be very careful because one will knock out the other and slow you down three or four days. He was brilliant enough that he devised, largely on the medical side, a method for measuring these things. How long it takes to arrive at a diagnosis and so on. It is going to be very complicated, but I think with computers and the bright people we have got, in ten years we are going to see more of it.

WEEKS:

Do you think this will come through PROs? Will it be individual

hospitals?

HAMILTON:

I think individual institutions, or groups of hospitals. By struggling with malpractice insurance premiums or something.

WEEKS:

It would seem something should be done.

HAMILTON:

I think we have come a long way from the days when Dr. Sample, of St. Albans, Vermont, was a specialist in brain surgery, orthopedic surgery, and heart surgery all at once. In a town of five thousand people. I never knew him, but I heard a lot about him.

WEEKS:

There are some amazing people who just come out of the hinterland sometimes. It is surprising what ability they have, and how much influence.

HAMILTON:

I'm sure he was able, but he wasn't that able.

WEEKS:

No. For his day, maybe he was.

HAMILTON:

What is it? Seldom in error, never in doubt.

WEEKS:

It takes that kind of person to be that way.

Would you like to talk about your experience on the Joint Commission? Was Dr. Babcock there then? Of course you knew him from Detroit.

HAMILTON:

Yes. He was also a member of the Society of Medical Administrators to

which I belonged. He and I were the only two who had fathers who had also belonged.

WEEKS:

Madison Brown is very much interested in medical administrators, isn't he?

HAMILTON:

Yes. He has done some good histories on it.

WEEKS:

Didn't he just finish one, or his wife just finish one?

HAMILTON:

Yes.

WEEKS:

I guess the point that I have been looking at as far as the Joint Commission is concerned, one, is the origin. The fact that the College of Surgeons gave it up.

HAMILTON:

They couldn't afford it.

WEEKS:

George Bugbee was quite willing to take it over.

HAMILTON:

He and Charlie Wilinsky were going to take it over, but the AMA and a few others...

WEEKS:

Said this is our territory.

HAMILTON:

Yes. The organization of it, when I was in, had a very delicate balance

between the American Hospital Association and the American Medical Association and the Canadian Hospital Association and the Canadian Medical Association. I don't know how good that balance is now.

WEEKS:

I think the Canadians have dropped out.

HAMILTON:

They have their own. That's what happened.

WEEKS:

And there is a public member now. And the dentists have a member. Then I think AMA and AHA each have seven, don't they?

HAMILTON:

In those days, the AHA and the AMA were on opposite sides much more often than they seem to be now.

WEEKS:

Wasn't there also a complication in there that the American College of Surgeons sometimes didn't get along with the AMA?

HAMILTON:

The College of Surgeons, the College of Physicians, each had three votes, or maybe it was one. They often disagreed with the AMA.

WEEKS:

Another point that came to my attention was that you were an AHA commissioner, representing AHA. There were members from AMA and they were usually from their board of trustees, weren't they?

HAMILTON:

More or less.

WEEKS:

I think they came to the meetings often instructed as to how they should vote on any particular issue that was on the agenda.

HAMILTON:

That's just what we felt. That they came there as Charlie McCarthys, kind of.

WEEKS:

But, you, as an AHA representative...

HAMILTON:

We were responsible later for what we did. Nobody told us what to do.

WEEKS:

This is the difference that I saw in the two organizations represented here.

HAMILTON:

I think in many of the tough issues that the freedom of action that we had redounded to our advantage rather than the AMA's. Because of the way that they were instructing their people, they tended not always to pick the best and the brightest. At least this was the impression some people conveyed to me.

WEEKS:

The commissioners were policy setters?

HAMILTON:

Yes.

WEEKS:

You had no direct authority about accrediting a certain hospital?

HAMILTON:

We didn't ever see those.

WEEKS:

So you were policy makers and the staff would take care of the other side of it.

HAMILTON:

We would occasionally hear about it.

WEEKS:

Did you enter into what kinds of things should be done in making inspections? Now they have widened out, of course.

HAMILTON:

Yes, we did. We discussed that, as I remember, mostly on things that where members of the commission had received comments from the field or areas where we felt that the emphasis ought to be placed. Of course it was a good deal simpler then than now. We talked also about things like the joint conference committees, setting up programs like that to improve relations between the staff and the institution. We talked about expanding services. I remember we tried to get long-term care facilities included. The AMA blocked it. The scuttlebutt was that the reason they blocked it was because of the position that the AHA had taken on Medicare. Now that was third-hand hearsay to me.

WEEKS:

Oh. Well, by that time there was a lot of hard feeling about the AMA's tactics in fighting Medicare and fighting national health insurance.

HAMILTON:

We had a board meeting of the AHA, this is going back a bit, and Al Snoke

is writing about this. It was in Chicago. It was during the time that the debates were going on, but before the House of Delegates meeting that I was telling you about earlier. "Bing" Blasingame had been invited to come as the luncheon speaker. Instead of talking about anything else, he chose to really lash out at the American Hospital Association. It was a very threatening speech about the terrible things that would happen if we didn't abandon our present position of seriously considering this and stand in opposition, shoulder-to-shoulder with the American Medical Association. And, as those things so often do, it had a reverse result of what he anticipated.

WEEKS:

I don't know a great deal about him, but I got the impression that he was a little unguarded in the way he spoke sometimes.

HAMILTON:

I guess so. He had a fellow named Howard who made most of his snowballs for him, I gather.

WEEKS:

Did he? Howard preceded Sammons, didn't he?

HAMILTON:

I guess he did fill in for a while -- Burt Howard.

WEEKS:

I haven't met him.

HAMILTON:

I hardly know the man, so, again, this is pure hearsay.

WEEKS:

I am skipping around here a little bit. I think we have talked around this too. Twenty years ago, we were talking about the hospital being the

center of all health care. Today we are talking about establishing satellites and walk-in clinics and surgicenters.

HAMILTON:

HMOs.

WEEKS:

How is this effecting Hartford? Are they going in for satellites and clinics?

HAMILTON:

Yes. They have set up a corporation beyond the hospital itself. They have made an affiliation with a hospital in Meriden -- Meriden-Wellingford Hospital. In another area as a temporary measure, they lent one of their senior associates to run a life-care community that I happen to be involved in, which has a 60 bed nursing home in connection with it. The man who was appointed director before we opened decided to go back to Baltimore to head a facility where he had been assistant previously. So they are looking for a director. While they are searching for a permanent director, Hartford Hospital's associate director is over there running the 300 bed unit, plus the 60 bed nursing home unit.

WEEKS:

Has Hartford been affected by the desire of HMOs or PPOs to contract for beds at lower rates?

HAMILTON:

Yes. I don't know to what degree. I have been retired ten years. I do know that they have an agreement with the Kaiser-Permanente HMO in the city. They do practically all of their hospitalization coverage. They have a very active and successful IPA-HMO that's run out of the hospital itself.

WEEKS:

Do you see merging of HMOs and so forth as a part of the future? As an example, one of the girls who used to work at the university -- a research person -- has been in Nashville working for Health America.

HAMILTON:

Hospital Corporation of America?

WEEKS:

No. This is an HMO corporation, but it happens to be in Nashville where HCA is. They were absorbed just recently by Maxicare from California, which is one of the big HMO chains. It seems to me that eventually we are going to end up with just a few of these HMO chains. Blue Cross is trying to become national.

HAMILTON:

I can't speak to that, really. I haven't followed it that closely. If it came to pass, it might alleviate what to my mind is one of the main disadvantages of an HMO, and that's coverage when you are away from your home base.

WEEKS:

This is the principle behind the Blue Cross - HMO-USA or something like that. They will be able to go to a national employer and say, "We can protect you in any state in the union." They have sixty-some now. So it's possible that they could have one in every part of the country. I suppose in another ten years we will be looking back and saying, "My, given what's gone on in the last ten years, what's ahead."

Have you gone into office buildings for physicians?

HAMILTON:

We had one of the first in the country. There was one there when I came. It was built in 1946. We put an addition on it after I got there. It's now being turned over to the hospital, and there is a huge new office building and parking garage being built across the street with a tube connection to the hospital. It's shelled in now.

WEEKS:

Connecticut General?

HAMILTON:

Connecticut Mutual.... They weren't used to dealing with the clients in a building. They would build a building and lease it, but not have 100 clients. The hospital bought the building from the insurance company, set up a separate board so that the doctors wouldn't get nervous about my getting my mitts into the day-to-day operations. It ran very well, and it still does. They are now, as I say, going to more than double the size of it.

WEEKS:

You seem to have spread out just about like any other big hospital of your size would.

I wanted to talk with you about foreign medical graduates. That, and your experience on the liaison committee on medical education.

HAMILTON:

I was one of the founding trustees of that.

WEEKS:

Is that right? The liaison between AMA and AAMC, isn't it? Are they the two parties?

HAMILTON:

The Liaison Committee on Medical Education? Yes. There are public members in that too. But it is the AMA and the AAMC. They accredit medical schools.

WEEKS:

This Liaison Committee on Medical Education does not include graduate medical education, does it?

HAMILTON:

No. There is now a LCGME, which is on graduate studies.

WEEKS:

You have served on the Council for Foreign Medical Graduates?

HAMILTON:

Yes.

WEEKS:

Would you like to talk about this educational situation?

HAMILTON:

The foreign medical graduates council I got on through the AHA, and I think was asked to go on the board at the very beginning organization of it when there was really no control over foreign graduates coming in. It was recommended that, like the LCME, that we accredit and decide which medical schools were training physicians so that they could come in here and practice on a level with people trained here. It was absolutely impossible. There were so many medical schools all over the world. So it was decided, just about the time I came aboard, that an examination should be developed to examine the product rather than trying to visit the school. They took, as their base list, the World Health Organization's list of medical schools. If

any school on that list had a graduate, they could qualify for the exam. We debated about whether to give the exam around the world. They tried it once or twice, but it didn't work, I think. So then they have been giving it in this country.

In setting up the exam, they took questions from the national board exams which were simple enough so that if taken by an American graduate, less than two percent would fail. They administered this exam, and were getting about a sixty percent fail rate. People were allowed to take it, I think, up to three times without getting further education. On balance, it worked remarkably well as a screen.

Two anecdotes. I remember we had a man with us in the early days at Hartford Hospital who had come in through some government program with our neurosurgeons and they wanted him to get a license. To get through this foreign medical graduate exam because he was the best neurosurgical resident they had had in a long time. So the chief of neurosurgery came storming into my office one day and said that they had refused to let the man take the exam. I said that I happened to know Dr. Smiley and I would give him a call and find out what was the matter. So I gave him a call and gave him this fellow's name. He called me back later in the day and said that he was embarrassed to tell me that this man was not a graduate of any medical school that is listed by the World Health Organization. There was that sort of screening.

The other side of it was that there was a tremendous pressure that developed -- I was not involved in this directly -- particularly in New Jersey and New York, saying that the exam was too tough, that these people that they had were wonderful, and that we ought to lower the passing grade from 60 to 55. Unbeknownst to me, this Jack Leonard that I mentioned earlier

-- he was deeply involved in this — conned the cooperation of the people of LCFMG, got a copy of the exam and gave it to the seniors in our school of nursing. I went to a meeting with this in my pocket. When the argument got very hot, I remember getting up and saying, "Well, gentlemen, (there were all gentlemen there) we've just completed a study of Hartford Hospital, and if it's a case of lowering the grade from 60 to 55, there is no need going overseas because our nurses could pass the exam very well and you can give them your residency appointments. That stopped the argument.

WEEKS:

Pretty potent argument.

HAMILTON:

My friend, Jack Leonard, saved my life.

WEEKS:

Are the numbers of spots for residents being filled mostly by Americans?

HAMILTON:

More and more, because the numbers are not increasing and the number of graduates is increasing rapidly from medical schools. Foreign medical graduates are having a harder and harder time to find a spot anywhere. I expect that that's going to make a big change in the years to come.

Medical schools themselves... I was appointed to that committee because of my association with the council of teaching hospitals. I was an AAMC appointee. We went through a period of rapid development of new medical schools. Tremendous pressure from the federal government to double the size of medical schools. The very thing that they are decrying today.

WEEKS:

Was this in the 1960s?

HAMILTON:

Yes. Late 60s. A lot of them were very experimental ones. One of our worries was that they used to be enough alike so that you could hardly tell them apart. These were getting so different that we didn't know whether it would be possible for students to transfer from one to the other. Michigan State was an example of one, an interesting experiment. Then there were others where they took kids out of high school and put them through in six years, with a college degree and an M.D., where they started them in groups and they stayed in the same group all the way through, with the same preceptor.

WEEKS:

I did attend a meeting of deans of schools started since the beginning of the 1960s. It was an interesting three-day session. I could see that there was a great difference in the various schools and their goals, and their student body and so forth. What are there, something like 17,000 medical school graduates a year now?

I don't know that you are quite old enough to be a founding member of the ACHA.

HAMILTON:

My father could have been.

WEEKS:

But you are a Fellow, and you were a Regent too, weren't you?

HAMILTON:

Yes. I joined immediately after -- I had applied while I was still in service -- joined, and became a Fellow while I was at Newton-Wellesley Hospital. I was elected Regent for New England. In those days there was one

regent for each region — there were nine, I guess, regents in the country. I was regent for New England for a term or two. It was a very interesting experience for me. I learned a good bit of what was going on then in the field of education because I had not had a formal education in hospital administration. I benefited a great deal from the courses that they were putting on, and benefited a great deal from helping to prepare some of these programs that were started. This congress that they hold in Chicago every winter was started while I was active there, although I can't say I was instrumental in it. I had a part in it.

WEEKS:

Do you think that the College has really established hospital administration as a profession?

HAMILTON:

I just can't be sure of that. I don't know. I don't know whether hospital administration has been established as a profession, and if it had, I don't know whether the College would get the credit or whether some of the university programs such as Gary Hartmann's and Jim Hamilton's would deserve it. One thing it has caused is that it has helped train people for the field, which has been an advantage. The other side of that is that it has acted, perhaps inadvertently, to make the field comprised more and more of laymen than physicians. My hunch is that we are going to see a change in the field as more and more physicians graduate from medical school, and there aren't as many physicians in practice. I think a lot of them are going to be moving into this. That's why I am a little reluctant to say that the College has established it as a profession. I don't know what the future holds on that one.

WEEKS:

There is quite a movement in the programs in hospital administration too. They have proliferated. Not only that, but undergraduate programs have too. Many of those graduates expect to run hospitals where maybe they are capable of only running a department.

HAMILTON:

There are fewer and fewer hospitals to run.

WEEKS:

Of course, many of the graduates are going into the insurance field, or Blue Cross, or all of these tangential fields of the health business.

HAMILTON:

I think the College has done a great service for many people in hospital administration in giving them a focus and giving them some pride in what they are doing. As Mr. Reagan has said, "Making them stand tall on the job." You can do a better job if you feel that it's important.

WEEKS:

I agree with you. It's the same idea as waving the flag and having a patriotic feeling. You take pride in what you are, and it builds your identity.

We touched a little bit on planning activities. In your state do you have coalitions? What is the planning process? For instance, if you wanted to put an addition on your hospital.

HAMILTON:

The hospital decides what it wants to do. In our situation, at present they probably first off go to the Capital Area Health Consortium, which is the one that John Danielson headed, and let the other institutions know what they

have in mind and get their concurrence to go ahead. Then they go ahead developing a plan. The next step is to present it to the HSA where it is debated, sometimes for a long time, sometimes for a short time. Then they go before the cost commission which is there to save the state and the people money. I am a little from Missouri on that one because, having been through this a few times, particularly with our McLean Home and with our nursing home at Duncaster where I was actively involved, the added time and the added cost of preparing for this and answering the questions that they ask delays construction by six months to a year to two to three years in which time costs are continually rising. Hiring experts and others adds a great deal to the institution's cost of preparing the plan. The jury is still out on whether it saves money in the long run. It looks good at the beginning.

Hartford Hospital's plan was by far the biggest that had ever been presented to the cost commission and they ended up knocking off four or five million dollars, I guess, or maybe seven or eight million on a hundred million dollar project. But whether that was penny-wise and pound-foolish remains to be seen.

WEEKS:

And whether they were competent to judge. Are they competent to judge whether this is necessary or whether this is good?

HAMILTON:

Whether they are or not, you can't do it without their vote. There are some of us who would wonder whether or not they have a right to an opinion, but that is really rather an arrogant question to be asking since they have the authority. Actually, in Connecticut now, the commission is three people. One of them is an ex-legislator. One of them is a nurse whose father was a

physician, and one of them is a dentist. So there are at least two people with some direct experience in the field.

WEEKS:

I was wondering if you would like to talk about what you see for the future. Sometimes people look at me -- take a double-take, as they say -- when I say what's coming after capitation or what's coming after DRGs, or how are we going to take care of the underinsured or the uninsured. Would you like to talk about what you see is the future of Medicare and Medicaid?

HAMILTON:

First, DRGs. The idea was developed for an entirely different purpose than that for which it is being used. The government is finding that it is paying out more money than it was before, but it now has a method of ratcheting down, and it is going to use it -- pretty indiscriminately. And it is going to cause some great problems.

Two, the aged and the underserved. The increasing cost of medical care and the government's now backing away from what it is paying, as you and I both know, is resulting in the old folks now paying probably as much as they were paying before Medicare ever got started, for the same service. Coupled with that, this present administration's attitude toward the -- and the general public too, because they reflect the general public, I'm afraid -- toward the people who can't afford anything, is resulting in a great many people not getting anywhere near adequate care. I think that that is a crime in a society as well-to-do as ours. That we can't take care of our poor. I think we have got to see a turnaround.

In the matter of another thing that concerns me a great deal is the swing away from service to profit, caused by the proprietaries in the first place,

caused by Medicare to a good degree, and Medicaid, and other programs. Frank Braceland, Psychiatric Chief of Staff at the Institute of Living, said long ago, "When money comes in the door, research flies out the window." Research isn't the only thing. There is something to be said for the old philosophy of a not-for-profit hospital not making a profit.

But pendulums swing, and I can't help but believe that this pendulum toward making profits and the for-profit side is going to swing back. The disadvantages of it are going to become obvious enough to the general public so we will begin to see it swing back again toward something closer to a neutral ground. I fret a great deal about the loss of the philosophy that -- I guess again because I am old -- the philosophy of the days when I started and we were told that very few people enter medicine with the idea of making a fortune, and those who do are disappointed. That's not true any more. It has always been a sure way to earn a living, but it has become a sure way to become wealthy if you pick your specialty properly. I don't think it well behooves a healing art to be making a fortune in the process.

WEEKS:

I notice that when you went to Mass General the first time you went at a salary of $2,500. Is that correct?

HAMILTON:

Yes, sir. We had an apartment with food, too. We lived very comfortably. But even in that day that was very modest. I came back from the war as a Lieutenant Colonel and the executive officer of the hospital and Dr. Faxon said, "Well, Hamilton, we think that you've had a good bit of experience over there. You've been gone four years. We want to raise your salary accordingly. So we'll start you at $7,500.

WEEKS:

That's quite a raise from the other one.

HAMILTON:

Of course I was earning that as a Lieutenant Colonel in the army. So it wasn't that much.

WEEKS:

He couldn't very well offer you less, could he?

HAMILTON:

Of course part of that was really the Mass General philosophy. After I was at Newton-Wellesley for a year or so when Dean Clark came in to succeed Nat Faxon, he talked with me about coming as his associate. Then I was sent to one of the trustees to talk about my salary. He said that money really wasn't the important thing that they would be willing to go as high as -- a figure that was less than what I was earning where I was. I figured I didn't want to come back to that.

WEEKS:

They were probably operating under the idea working for Mass General was...

HAMILTON:

The greatest hospital in the world.

WEEKS:

And you were getting paid for absorbing all of this prestige that came along with it.

HAMILTON:

Oh, yes. And they still do it. Then I used the same technique. I'm no better than they are. I remember one of my associates one time said that his

assistant had gone over to Mount Sinai for a third again as much as he was earning. I said, "Gee, if you would want to go to Mt. Sinai, I'm sure they would rather have you than him."

WEEKS:

What do you think is the future, or the possibility of having national health insurance in our lifetime?

HAMILTON:

I think it's much better than it was ten years ago.

WEEKS:

I am beginning to hear rumblings about that.

HAMILTON:

I have written two or three papers on national health insurance and I think the last one I concluded that it was an idea whose time had past. I think it's coming again. Something has got to be done to solve the problem of the people who can't afford it. It may be through a national health insurance.

WEEKS:

I was talking with Miles Hardie, the Englishman, as I said before. One question that I asked him was, how about the brain-drain from England. We used to hear of the British training their physicians and then they would leave for the colonies or the U.S.A. He said that has almost stopped in Britain, that physicians seem to be satisfied with the system.

HAMILTON:

I think it's true in Canada too.

WEEKS:

I don't know whether our physicians will be able to accept that idea of a

national health insurance. I got the impression when interviewing Dr. Sammons that the AMA is just as adamant as it has ever been.

HAMILTON:

When they get the 17,000 a year graduates in a few years, they will never get to the point where they are in Mexico where the doctors are driving taxicabs, but these people are going to have a hard enough time finding a job.

WEEKS:

I think they are beginning to be worried about it.

HAMILTON:

There are many fewer doctors going into solo practice. They are joining groups -- some help, some security.

WEEKS:

When I talked to Dr. Garfield about the Kaiser Permanente...

HAMILTON:

Wonderful person, isn't he? I guess he died.

WEEKS:

Yes. I saw him two or three months before he died. He was saying that their physicians are so apparently content to work under a salary plus partnership arrangement. They are able to cut down their hospital admission, they are able to do more outpatient work.

HAMILTON:

And give good care.

WEEKS:

Yes. Dr. Garfield impressed me very much.

HAMILTON:

A bright, bright man. I never knew him. I knew who he was and heard him

speak a few times.

WEEKS:

I have really enjoyed this conversation we've had.

Interview in Ann Arbor

August 11, 1986

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