HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Richard L. Johnson

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

RICHARD L. JOHNSON

In First Person: An Oral History

Interviewed by Donald R. Newkirk
January 5, 1994

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

Coordinated by
Center for Hospital and Healthcare Administration History
AHA Resource Center
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Richard L. Johnson

CHRONOLOGY

1925	Born May 11, Chicago, Illinois
1943-1944	United States Army Private First Class
1947	Northwestern University, Chicago, Illinois B.S., Zoology
1949-1950	Norwegian American Hospital, Chicago, Illinois Administrative Intern
1950	University of Chicago, Chicago, Illinois M.B.A., Hospital Administration
1951-1955	University of Chicago Hospitals, Chicago, Illinois Assistant Superintendent
1951-1955	University of Chicago, Program in Hospital Administration Associate Director, 1951-1955 Assistant Professor, 1953-1955
1951-1953	University of Chicago, School of Business Instructor
1955-1956	University of Missouri, School of Medicine Associate Professor, Hospital Administration
1955-1956	University of Missouri Teaching Hospital, Columbia, Missouri Director
1956-1963	American Hospital Association, Chicago, Illinois Assistant Director, 1956-1963 Hospital Counseling Program, Director, 1958-1963 Administrative Services, Director, 1959-1963 Hospital Financing and Community Planning, Director, 1961
1963-1972	A. T. Kearney & Co., Chicago, Illinois Vice President, Health Services
1972-1994	TriBrook Group, Inc., Westmont, Illinois President
1994-	TriBrook Group, Inc., Westmont, Illinois Chairman

MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives
- Committee on Research and Development, Chairman
- Subcommittee on Membership Examinations, 1981-
- Fellow

American Hospital Association
- Council on Administrative Practices, Secretary, 1956-1963
- Council on Blue Cross, Financing, and Prepayment, Secretary, 1961
- Council on Research and Education, Secretary
- Member, 1960-

American Public Health Association
- Member

American Association of Healthcare Consultants
- Chairman, 1980-1981

Association of Governing Boards of Universities and Colleges
- Member, Board of Directors, 1960-1962

A. T. Kearney & Co.
- Member, Board of Directors, 1963-1972

Illinois Hospital Association
- Member, Advisory Board, 1968

Union League Club of Chicago
- Member, 1969-

William Rainey Harper College
- Board of Trustees, Chairman, 1969-1970
- Member, 1963-1970

AWARDS AND HONORS

American College of Healthcare Executives
Dean Conley Award, 1980
Silver Medal Award, 1984

American Association of Healthcare Consultants
Award of Merit, 1991

PUBLISHED WORKS
(Books)

Brown, R. E., and Johnson, R. L. Hospitals Visualized: A Text for Use with Field Trips in Teaching Hospital Administration. 2nd ed. Chicago: American College of Hospital Administrators, 1957.

Johnson, E. A., and Johnson, R. L. Contemporary Hospital Trusteeship. Chicago: Teach'em, 1975.

Johnson, E. A., and Johnson, R. L. Hospitals in Transition. Rockville, MD: Aspen Systems, Corp., 1982.

Johnson, E. A., and Johnson, R. L. Contemporary Hospital Trusteeship. 2nd ed. Chicago: Teach'em, 1983.

Johnson, E. A., and Johnson, R. L. Hospitals under Fire: Strategies for Survival. Rockville, MD: Aspen Publishers, 1986.

Johnson, E. A., and Johnson, R. L. New Dynamics for Hospital Boards. Ann Arbor, MI: Health Administration Press, 1994.

Johnson, R. L. Dr. Charles V. Evans (in press).

PUBLISHED WORKS
(Other Materials)

Johnson, R. L. Four methods of adding service value to the hospital laundry. Hospitals. 25(7):77-78, July 1951.

Johnson, R. L. Guide to better practice in the admitting office. Hospitals. 25(10):66-68, Oct. 1951.

Brown, R. E., and Johnson, R. L. Factors Affecting the Optimum Size for a Hospital. Np., 1952.

Brown, R. E., and Johnson, R. L. Hospitals Visualized: A Text for Use with Field Trips in Teaching Hospital Administration. Chicago: American College of Hospital Administrators, 1952.

Wittrup, R. D., and Johnson, R. L. Nursing unit for patients receiving radioactive isotopes. Hospitals. 28(5):65-68, May 1954.

Johnson, R. L. How to think about depreciation: the community is the determining factor. Modern Hospital. 86(5):64-65, May 1956.

Johnson, R. L. Measuring the effectiveness of an inservice training program. Trustee. 11(11):16-18, Nov. 1958.

Johnson, R. L. Johnson and Johnson. Modern Hospital. 92(2):66, Feb. 1959.

Johnson, R. L. How graduate administrators are doing. Modern Hospital. 92(2):63-64,140,142,146, Feb. 1959.

Johnson, R. L. Selection of an administrator—what the board and the administrator should look for in each other. Trustee. 12(3):4-7, Mar. 1959.

Johnson, R. L. Meaningful statistics. Hospital Accounting. 14(5):1,4,26-27, May 1960.

Johnson, R. L. Six 'rules of thumb' for doctors, trustees, and administrators in maintaining an effective hospital organization. Trustee. 14(3):5, Mar. 1961.

Johnson, R. L. Good managers lead—but also teach leadership. Hospitals. 36(1):52-56, Jan. 1, 1962.

Johnson, R. L. Effecting organizational change through a formal budget. Hospitals. 37(19):32-34, Oct. 1, 1963.

Johnson, R. L. What are standards of hospital efficiency? Modern Hospital. 101(5):26, Nov. 1963.

Johnson, R. L., and others. Consultants make planning agency flexible. Modern Hospital. 103(2):103-106, Aug. 1964.

Johnson, R. L. Do hospitals need a chief executive? Modern Hospital. 103(3):96-98,162,164, Sept. 1964.

McKinney, J. R., Johnson, R. L., and others. Reader opinion: who finances and who does area planning? Modern Hospital. 103(5):6, Nov. 1964.

Johnson, R. L. How self-governing is the self-governing medical staff? Modern Hospital. 105(2):116-119,184,186, Aug. 1965.

Johnson, R. L. Are satellites best answer to expansion? Modern Hospital. 105(4):103-106, Oct. 1965.

Johnson, R. L. Money shortage tightens noose around traditional capital financing sources. Modern Hospital. 107(5):126-128,180, Nov. 1966.

Johnson, R. L. Urban hospitals face three choices: move, grow, or change. Modern Hospital. 109(5):92-95,97,160, Nov. 1967.

Johnson, R. L. Courage and administrative strategy. Hospital Administration. 13(4):25-34, Fall 1968.

Johnson, R. L. How to make competition fair: have the same rules for all hospitals. Modern Hospital. 113(6):104-108,175, Dec. 1969.

Johnson, R. L. Over-automation: cost-benefit analysis ought to be used before new equipment and systems are selected. Hospitals. 44(2):80-82, Jan. 16, 1970.

Johnson, R. L. Governance seen as weak link in systems for collaborative delivery of health care. Hospitals. 44(11):47-50, June 1, 1970.

Johnson, R. L. With all its problems, this system may be the best one we could have. Modern Hospital. 115(1):79-82, July 1970.

Johnson, R. L. Solution to hospital costs may be oversimplified. Hospital Progress. 51(8):80-85, Aug. 1970.

Johnson, R. L. Changing role of the hospital's chief executive: should he be a member of the governing board? Hospital Administration. 15(3):21-34, Summer 1970.

Johnson, R. L. Hospital Mergers and Shared Services. Chicago: American College of Hospital Administrators, 1971. Audiocassette.

Johnson, R. L. Data show for-profit hospitals don't provide comparable service: consultant. Modern Hospital. 116(4):116-118, Apr. 1971.

Johnson, R. L. Hospital organization and its problems. Hospital Progress. 52(6):70-74, June 1971.

Johnson, R. L. Statistics make U.S. hospitals look healthy. Modern Hospital. 118(2):102-103,106, Feb. 1972.

Johnson, R. L. Physician shortage threatens national health insurance proposals. Hospitals. 46(13):53-56, July 1, 1972.

Johnson, R. L. The increasing shortage of physicians. Hospital Medical Staff. 1(8):3-8, Aug. 1972.

Johnson, R. L. If the patient can't walk into a hospital, where will he walk? Modern Hospital. 119(4):107-109, Oct. 1972.

Johnson, R. L. Physician shortage: a threat to health proposals. Trustee. 25(10):27-32, Oct. 1972.

Cunningham, R. M., Jr., Horty, J. F., and others. Administrator, Clinician, Trustee Relationships. Chicago: American College of Hospital Administrators, 1973. Sound cassette.

Johnson, R. L., and Witt, J. A. How to Plan Your Professional Future as an Administrator. Chicago: Teach'em, 1973. Sound cassette.

Johnson, R. L. Phase III and the hospitals: the real problem will be how to finance new construction. Modern Hospital. 120(6):69-71, June 1973.

Johnson, R. L. Health care myths. Hospital Progress. 54(10):55-58, Oct. 1973.

Johnson, R. L. Medical Accountability. Chicago: American College of Hospital Administrators, 1974. Sound cassette.

Johnson, R. L., and Johnson, E. A. Where the Health Delivery System is Headed: Two Views. Chicago: American College of Hospital Administrators, 1974. Sound cassette.

Johnson, R. L. Requiem for the nonprofit hospital? Modern Hospital. 122(2):43-44,46, Feb. 1974.

Johnson, R. L. Shape of the future hospital system. Modern Hospital. 122(2):45, Feb. 1974.

Johnson, R. L. Specter of bankruptcy: serious overbuilding of hospital facilities in Dade County, Florida. Hospitals. 48(6):39-42, Mar. 16, 1974.

Johnson, R. L. Governance seen as weak link in systems for collaborative delivery of health care. Hospitals. 48(11):47-50, June 1, 1974.

Johnson, R. L. Developing Performance Appraisal Standards. Chicago: American College of Hospital Administrators, 1975. Sound cassette.

Johnson, R. L. Hospital economics: 19 myths the public holds dear. Hospital Financial Management. 29(1):12-16, Jan. 1975.

Johnson, R. L. Health field today—an iconoclast's delight. Michigan Hospitals. 11(6):206, June 1975.

Johnson, R. L. 'Enemies list' for hospitals. Modern Healthcare (Short-term care). 4(2):27-29, Aug. 1975.

Johnson, R. L. Hospital mergers and shared services. Medical Record News. 46(4):29-33, Aug. 1975.

Johnson, R. L. How to Play the Numbers Game with HSAs. Chicago: American College of Hospital Administrators, 1976. Sound cassette.

Johnson, R. L. Hospital economics: 19 myths the public holds dear. Hospital Financial Management. 30(3):14-17, Mar. 1976.

Johnson, R. L. End of the wobbly three-legged stool. Trustee. 29(5):20-22, May 1976.

Johnson, R. L. Financial future of hospitals, Hospital Financial Management. 30(7):12-15,18,20, July 1976.

Johnson, R. L. Wobbly three-legged stool. Osteopathic Hospitals. 21(6):14-16, June 1977.

Johnson, R. L. Wobbly three-legged stool, part II. Osteopathic Hospitals. 21(7):12-15, July-Aug. 1977.

Johnson, R. L. Effect of separate counsel on the medical staff's legal status. Hospital Medical Staff. 6(8):8-13, Aug. 1977.

Johnson, R. L. Comments on bed ratios/average occupancy rates. Federal Register. Sept. 23, 1977.

Johnson, R. L. Going for broke: the hospital/government game. Hospital Financial Management. 31(8):9,14,16-18, Aug. 1977.

Johnson, R. L. Cutting costs by controlling physicians. Hospital Progress. 58(11):70-74,124, Nov. 1977.

Johnson, R. L. Rural hospitals face change for a bright future. Hospitals. 52(2):47-50, Jan. 1978.

Johnson, R. L. Johnson says future of voluntary nonprofits still looks tenuous. Hospital Progress. 59(2):6-7, Feb. 1978.

Johnson, R. L. Hospitals in wonderland. Hospital Progress. 59(8):44-49, Aug. 1978.

Johnson, R. L. Appraising performance at the top. Hospital & Health Services Administration. 23(4):36-47, Fall 1978.

Johnson, R. L. Power broker—prototype of the hospital chief executive? Health Care Management Review. 3(4):67-73, Fall 1978.

Johnson, R. L. The 1980s: the rise of HMOs and marketplace competition. Hospital Progress. 60(6):38-43,66, June 1979.

Johnson, R. L. Revisiting 'the wobbly three-legged stool.' Health Care Management Review. 4(3):15-22, Summer 1979.

Johnson, R. L. Hospital buildings have few alternative uses. Hospital Progress. 60(10):42-44,70, Oct. 1979.

Johnson, R. L. Legal perspective: how much process is due? Trustee. 32(10):12-4,16,19-20, Oct. 1979.

Johnson, R. L. Caterpillar and the butterfly: despite regulation, the system thrives. Hospital Progress. 61(4):54-61, Apr. 1980.

Johnson, R. L. Boards are remodeled as hospitals merge. Hospitals. 54(9):101-102,104-105, May 1980.

Johnson, R. L. Boards are remodeled as hospitals merge. Trustee. 33(5):47-50, May 1980.

Johnson, R. L. Health care 2000 AD: the impact of conglomerates. Hospital Progress. 62(4):48-53, Apr. 1981.

Johnson, R. L. Emphasis on educational aspect. Health Care Management Review. 6(3):83, Summer 1981.

Johnson, R. L. Second thoughts on the corporate structure for hospitals. Trustee. 34(10):22-23, Oct. 1981.

Johnson, R. L. Alternative delivery systems to diversify hospital revenues. Topics in Health Care Financing. 8(1):49-56, Fall 1981.

Johnson, R. L. Performance review: essential tool for CEO, board accountability. Hospital Progress. 62(12):36-40, Dec. 1981.

Johnson, R. L. New systems taking over as field's keystone. Modern Healthcare. 12(1):47-50, Jan. 1982.

Johnson, R. L. Construction spending will be shaped by competition. Hospitals. 56(4):89-94, Feb. 16, 1982.

Johnson, R. L. The resurgence of a two-tier health care system. Action Kit for Hospital Law. Aug. 1982

Changing medical practice: implications for hospitals, physicians. Hospital Progress. 64(3):37-41, Mar. 1983.

Johnson, R. L. Should the hospital planning continue to be regulated? Health Affairs. 2(1):83-91, Spring 1983.

Johnson, R. L. Era of responsibility. Hospitals. 57(12):75, 79-80, 82, June 16, 1983.

Johnson, R. L. Hospital boards should abandon medical staff 'self-governance.' Modern Healthcare. 13(7):134-136,140, July 1983.

Johnson, R. L. Hospital computer trends for the 1980s. Computers in Healthcare. 4(8):36-37, Aug. 1983.

Johnson, R. L. What demographic changes do you feel a hospital should monitor as part of its planning effort? Health Care Strategic Management. 1(2):21,23-24, Nov. 1983.

Johnson, R. L. Shooting oneself in the foot: Congress may re-create two-tier care. Hospital Progress. 64(12):32-39, Dec. 1983.

Johnson, E. A., Van Horn, D., and Johnson, R. L. Negotiating Hospital-Based Physician Contracts. Chicago: American College of Hospital Administrators, 1984. Sound cassette.

Johnson, R. L. CEO must have authority to coordinate governance, management, medical staff. Hospital Progress. 65(4):49-53, Apr. 1984.

Johnson, R. L. Second opinion: the prospects of Medicare's Hospital Insurance Trust Fund. Hospital & Health Services Administration. 29(3):7-25, May-June 1984.

Johnson, R. L. Importance of CRT terminals in an OCS/MIS system decision. Healthcare Computing & Communications. 1(9):26-28, Oct. 1984.

Competition presents opportunity for not-for-profit systems. Health Progress. 65(10):31-35,60, Nov. 1984.

Johnson, R. L. Old memories and new dreams: economics for nonprofit hospitals. Health Matrix. 3(1):15-21, Spring 1985.

Johnson, R. L. Financial solvency under DRGs. Healthcare Computing & Communications. 2(6):48-49, June 1985.

Johnson, R. L. Patients are sicker, need more care than they did 3 years ago—survey. Modern Healthcare. 15(14):98, July 5, 1985.

Johnson, R. L. System evaluation criteria—hospital financial system. Computers in Healthcare. 6(8):24-26, Aug. 1985.

Johnson, R. L. System pricing criteria—hospital financial systems, part II. Computers in Healthcare. 6(10):41-42, Sept. 1985.

Johnson, R. L. On the edge: will the drive for productivity push hospitals over? Health Progress. 66(9):24-27,54, Nov. 1985.

Johnson, R. L. The day after. Hospital & Health Services Administration. 30(6):106-117, Nov.-Dec. 1985.

Johnson, R. L. Is it time to reorganize DP? Healthcare Computing & Communications. 3(2):32-33, Feb. 1986.

Johnson, R. L. Hospitals, medical staffs will be in adversarial roles under PPS. Modern Healthcare. 16(4):69-70, Feb. 14, 1986.

Johnson, R. L. Tax policy mismatch: whose ox is being gored? Health Affairs. 5(2):160, Summer 1986.

Johnson, R. L. Not from hospital association executives. Frontiers of Health Services Management. 3(2):27-29, Nov. 1986.

Johnson, R. L. Volatility and opportunity: industry forecast. Health Progress. 67(9):27-30,64, Nov. 1986.

Johnson, R. L. Re-organizing the organization: new roles lie ahead. Healthcare Executive. 1(7):41-43, Nov.-Dec. 1986.

Johnson, R. L. Myth of dominance by national health care corporations. Frontiers of Health Services Management. 3(4):3-31, May 1987.

Gill, S. L., and Johnson, R. L. Growing pains: twelve lessons from corporate restructuring. Health Progress. 69(4):26-32, May 1988.

Johnson, R. L. Is another change in healthcare reimbursement about to occur? Healthcare Computing & Communications. 5(6):24, June 1988.

Johnson, R. L. Radiology information systems are worth their cost. U.S. Healthcare. 5(9):48-49, Sept. 1988.

Johnson, R. L. Economic benefits of hospital system automation. U.S. Healthcare. 6(6):38,40,42, May 1989.

Hoffman, J. R., Hermann, T. C., and others. Compensation of hospital governing boards: a national survey. Healthcare Executive. 4(3):34-35, May-June 1989.

Johnson, R. L. Economic benefits of hospital system automation. U.S. Healthcare. 6(6):38-40, June 1989.

Johnson, R. L. Question of ethics. U.S. Healthcare. 6(7):27, July 1989.

Johnson, R. L. U.S. needs a new vision of national health policy. Health Progress. 70(6):24-28, July-Aug. 1989.

Johnson, R. L. Networking: the era of the '90s. Computers in Healthcare. 11(11):33, Nov. 1990.

Johnson, R. L. What times are these. Healthcare Informatics. 8(4):20-22, Apr. 1991.

HCMR interview: Richard Johnson. Health Care Management Review. 16(4):91-96, Fall 1991.

Johnson, R. L. Philosophy of administrative fellowships. Journal of Health Administration Education. 10(3):467-478, Summer 1992.

Johnson, R. L. The entrepreneurial physician. Health Care Management Review. 17(1):73-79, Winter 1992.

Johnson, R. L., and Johnson, E. A. Public trust: reclaiming or preserving? Health Care Management Review. 19(2):7-20, Spring 1994.

Johnson, R. L. HCMR perspective: the purpose of hospital governance. Health Care Management Review. 19(2):81-88, Spring 1994.

NEWKIRK:

Today is January 5, 1994. My name is Don Newkirk. It's a cold winter day on the plains west of Chicago, and we're in the office of TriBrook Group, Inc., one of the foremost national health care consultant firms. The purpose of our visit today is to interview Richard L. Johnson, the president and founder of TriBrook, but, more importantly, one of the premier authorities on health care management and policy. A provocative speaker and a prolific author, Mr. Johnson has agreed to share his thoughts with us in an oral interview. Let's hear from him now, starting at the beginning, May 11, 1925, in Chicago. Richard?

JOHNSON:

As you know, I read my twin brother's oral interview, and he picked up most of the information for the first 23 or 24 years of our lives.

NEWKIRK:

Who is your twin brother?

JOHNSON:

Everett Johnson, who directs the graduate program in health care management at Georgia State University. I can fill in some of the holes. One of the questions people always ask is how did you get into the health field?

NEWKIRK:

Well, Richard, let's go back, really, to—you were born in 1925.

JOHNSON:

. . . at Lutheran Deaconess Hospital in Chicago.

NEWKIRK:

All right. And where'd you spend your childhood?

JOHNSON:

I grew up in the northwest side of Chicago in the Irving Park area. I went to Carl Schurz High School. From there I started at Northwestern University and very quickly got drafted 1A and went into service in late 1943.

NEWKIRK:

1943.

JOHNSON:

1943. Thank you. And then was discharged at the end of 1944.

NEWKIRK:

What did you do in the Army?

JOHNSON:

Developed a lot of talent as a result of being a private in the 100th Infantry Division. Just prior to going overseas I was given a physical, because Everett was in the hospital with rheumatic fever. They found a couple of heart murmurs, and so they admitted me in the hospital. The division left, and they discharged Everett, and me, too, so we were back at Northwestern beginning in January of 1945 and continued going around the clock to the university. I graduated in June of 1947. My major . . .

NEWKIRK:

Major in what? In undergraduate.

JOHNSON:

Zoology. I was going to be a zoo director. I thought it was a great career, but as it turned out, running a zoo isn't much different than running a hospital as I subsequently found out. At that point, I really found out I was interested in management, but not necessarily the corporation type but certainly of a management activity. I talked about that with my father and with my brother. But first let me go back and explain a little bit—my dad was a dentist, and in 1917 joined the medical staff of Lutheran Deaconess Hospital in Chicago as their first dentist. In the spring of 1947, I was talking to my dad, and he said, "You know, I really can't help you decide what you want to do with your life. But let me set up an appointment with Ed Hansen," who was the superintendent at Lutheran Deaconess Hospital. Ed had been a school superintendent in Minnesota, and, as you know, a number of the school superintendents became hospital administrators in the Depression. So I went over and visited with him. He suggested seeing Dr. Bachmeyer. At the time, I didn't know who he was . . .

NEWKIRK:

Dr. Bachmeyer was where?

JOHNSON:

At the University of Chicago. At that time, he was the associate dean of the Division of Biological Sciences, which did not have a medical school as such. Academically, it was broader than just medicine and so they had artificially created a medical school. Dr. Bachmeyer was an associate dean of the medical school,

but he also had been the superintendent of the hospital prior to that assignment and was followed by Otis Whitecotton as superintendent.

So I met with Dr. Bachmeyer, who was in the last three or four years of his career before he retired. I went into the graduate program as a result. The number of students in 1948 was 12 in the class. Ray Brown was the associate director of the program and had just become superintendent of the hospital. At the end of that academic year, I went to Norwegian-American Hospital in Chicago for what was called an administrative internship, with Bill Bohman. Subsequently, Bill went to Middletown, Ohio, and ultimately was killed in a car crash. I spent a year with Bill, and toward the end of that year, Ray said that Dr. Bachmeyer was going to be retiring and would not be with the program. He asked if I wanted to come back and be his assistant superintendent and also the associate director of the graduate program in hospital administration. We used those titles at that time. I said, "Sure, I'd love to." So I wound up going back to the University of Chicago.

Ray had to wait for an opening to be created, and so—after the administrative internship—I spent about nine months at the American Hospital Association, which at that time was at 18 East Division Street in Chicago. George Bugbee was the director and Morris Norby was the deputy. While there I wrote the AHA admitting office manual, which was published, and at the end of the nine months, I then went to the University of Chicago, where I spent the next

several years as the associate director of the program, assistant superintendent of the hospital, and an assistant professor in the School of Business.

NEWKIRK:

Well, now, let's stop here. 1949-50 you were an administrative intern at Norwegian American Hospital in Chicago. '50-'51 you were a staff member at AHA. You were a Division Street regular. Is that correct? Is that what you call it?

JOHNSON:

Irregular.

NEWKIRK:

Irregular. Not regular. Irregular.

Okay. then in '51, you were an instructor in the School of Business . . .

JOHNSON:

A year later became an assistant professor.

NEWKIRK:

That was in Bachmeyer's program of hospital administration.

JOHNSON:

By then he had retired and Ray was the director. The program was run out of the hospital, but for academic purposes we were part of the School of Business. The school was in a different building on the campus. The arrangement went on for years. It's just the way it was.

NEWKIRK:

Dick, in 1951, what kinds of courses were taught? Do you remember?

JOHNSON:

Sure. I think they were very interesting courses. Prior to the graduate program, you had to have had basic accounting so you could take an advanced accounting course. Students took statistics, organizational theory, public policy—courses that even today in my judgment would stand up as solid approaches to the kind of a background you need for a career in the health field. I've always . . .

NEWKIRK:

Not a hospital accounting course?

JOHNSON:

No. We never did that at the University of Chicago. You took the straight MBA courses. Students were thrown in with every other MBA program student. And the degree that we received was an MBA degree. It was with a health care concentration, but you'll never find that mentioned on your degree.

NEWKIRK:

Okay. Now in 1953, '55, around there, you were an assistant professor in the School of Business at the University of Chicago. And assistant director, or assistant superintendent, of the hospital. So what did you do?

JOHNSON:

Ray and I used to split the teaching activity, and we devoted a lot of time to getting students lined up for administrative internships. We brought in hospital administrators for meetings because we wanted them, as preceptors, to have continuity in their relationship to the university program. We developed a seminar that we conducted every year in the spring. We evaluated students and worked with the admissions office in the selection process. For the 12 openings in the program, we would receive 100 to 125 applications. We had to go through all of them carefully and sort out the best. This was an add-on activity to the regular day of running the hospitals.

NEWKIRK:

Not unusual at that period of time.

JOHNSON:

Not at all. And, of course, Ray felt this was just a normal course of events.

NEWKIRK:

Which was what?

JOHNSON:

The lesson I learned from Ray was you had an obligation to write and stay in the forefront of the field, and so we (Ray and I) developed a book that the ACHA (American College of Hospital Administrators) published as Hospitals Visualized, a series of 3,000 questions divided by categories. This became a very big seller among graduate programs at that time. The way we developed

the book was that Ray and I would meet at his house on Thursday evenings at 7:00 p.m., and we would work until 11:00 p.m. and restrict ourselves to these hours. About 9:30 p.m., Ray's wife Mary would come in with a cup of tea and a cookie, and we'd stop for 10 minutes and then go back and keep on working. After Thursday night, I would get up in the morning at 5:00 a.m. and write with respect to what we were doing, until 7:30 a.m., then I'd get dressed and go over to the hospital and work at the hospital all day.

Once a week, I ran a seminar for the H.A. students where I would pick a topic for discussion. If you meet with students from that era, they'll remember this as an important part of their career. The topic, for example, might be what do you think of euthanasia? I would describe what euthanasia meant, and then it was open for discussion. And we never permitted a student to say, I read an article that said so and so on this subject. What I always said to them is what do you believe? What's important is what you believe, not what somebody else tells you is their opinion. That's okay to use it, but once you use it, it becomes part of you. If it becomes part of your decision-making process, then that's you. In your career, you're not going to find that any board member or physician gives a rip about what somebody else said about it. They want to know as an executive, what do you think about that subject. And students learned out of that process. We did this once a week, and it was a two-hour session where I would sit and take on the class, if you will, in order to teach them that

they had to rely on their own thought process to think through problems. Their conclusions might have to deal with political equations in the work environment so they had to understand they were responsible for their own behavior, for their own decisions. It proved to be a very useful technique.

NEWKIRK:

Nowadays they probably pick up the phone and call their house ethicist to talk about . . .

JOHNSON:

Or the corporate lawyer.

NEWKIRK:

Right. Okay. Now you left the University of Chicago in 1955. Is that correct?

JOHNSON:

I was 26 years of age when I started as assistant superintendent at the University of Chicago, number two in an 800-bed hospital. Crazy. Didn't have any business doing that. But that was the supply-and-demand situation at the time. So I was lucky. In 1955, I decided it probably was the time, at 30 years old, to get out on my own. I interviewed in three places. One was Ohio State University Medical Center—Milo Anderson was just leaving, the University of Florida, and the University of Missouri. After I'd had those three interviews, believe it or not, on a Monday morning offers from all of them dropped on my desk, on the same day. And I had my choice.

I took the University of Missouri and went to Columbia, Missouri, which was, in retrospect, a mistake. This was a university, in the middle of Missouri, that had not yet experienced the tremendous growth that all state universities experienced shortly thereafter. They had 8,000 students, and projections to go to 28,000 or 29,000 over a short period of time. They had started a medical school and hospital back in 1928, but when the economy collapsed in 1929, they closed it after one year. They decided to restart it in 1955 and had received funds in the early '50s from the state legislature to reinstitute a medical school. So I went there in July of 1955, as the first director of the University Hospital and with what was a courtesy title, I'm sure, of associate professor in the School of Medicine. I stayed there only a year and a half. The university was accustomed to only a few hours of work a day, no weekends, and always use vacation time. They didn't understand having to operate a hospital 24 hours a day, 365 days a week. I was always bumping heads with everybody in central administration, because they would issue statements that the university's going to close at 12:00 on Friday for a holiday, and I'd have to say, "My goodness, I can't do that. What are we going to do with our patients?" They never understood.

I'll tell you a story about that because it demonstrated the problem. I received a call one day from the controller of the university. He said, "Dick, why are you giving people money to go home on? Bus fare to go back to their town." I said, "Ray, these patients have had physicians write discharge orders. These

patients have no money. They're here because we have state funds that can support them in terms of medical care, but no money when they're ready to go home. What I've been doing is calling the county clerks in various counties asking them to put up the bus fare and send me the amount of money. I told him I didn't have any trouble getting the funds mailed to me. The county clerks all said they'd send the bus money. Ray said, "You can't do that. University policy prevents you from giving money out like that." He added, "Furthermore, everybody's got money to get home on a bus." I said, "You don't understand." I went on, "I'll tell you what I'm going to do. You keep your policy. I will abide by it, but I warn you, it's now midsummer, and when I tell a patient there's no money to send them home on a bus, they will start out on the highway. I will then call the state highway patrol and tell them to watch for that person. When the patient gets to the point when he/she can't go any further, I want the state highway patrol to pick them up, let me know, and bring them back here to the hospital. And then what I'm going to do is to call the newspapers and tell them that it's your policy." "Oh," he says, "you can't do that." I said, "You want to try me?" I never had a problem after that. That was an illustration of the kind of things that were constantly going on with the university administration.

NEWKIRK:

This still happens in universities. Not to that degree, but we still have problems with university policies in the flow of hospital operations. This is true probably in every university.

JOHNSON:

I would think so.

NEWKIRK:

All right. Now you are now going to come back to Chicago, right?

JOHNSON:

Yes, but I didn't want to come back to Chicago.

NEWKIRK:

This is 1956.

JOHNSON:

Yes, I had a call from Dr. John Bowers, who was then the dean at the University of Wisconsin Medical School. I had known John through some connection in the health field. John said, "Why don't you come up to Madison since Harold Coon is just retiring from the position of superintendent of the University of Wisconsin Hospitals, and we're trying to find a replacement." I said, "Fine." So I went to Madison and spent three days. I had met Dr. Bowers before when he was in Salt Lake as dean at the University of Utah.

At any rate, on the third day I went over and talked to President Fred, the president of the University of Wisconsin. In talking with President Fred, I said you know you have to put controls on the hospital operation, but you use a concept called "sum sufficient," which means when you're short of funds, you go back to the state legislature at the end of the year, and they give you a sum sufficient to cover the operating loss. I indicated you

can't run an organization that way because it's totally dependent on the goodwill of the state legislature. I asked, "Are you going to change that?" Well, no, he didn't think so. So I went back to John Bowers and indicated I needed to think about his offer.

On my way back from Madison—going through Chicago—I decided to spend the night with my parents. I also decided I ought to go downtown and chat with Ed Crosby. Ed was then the executive director of the American Hospital Association. Having known Ed from his years at Johns Hopkins, I went in and said, "Ed, I want to talk to you about the University of Wisconsin, because I don't think it's a viable situation the way they've got it set up." That was on a Friday. Ed said, "I think you've got a point. Let me think about it." He called me the following Monday, and said, "Rather than think about going to Wisconsin, why don't you come to the AHA as assistant director and run the Council on Administrative Practice?" Well, that looked to me like a pretty good alternative to the possibility of going from the frying pan into the fire, from one university hospital to another that was having problems. I agreed. That led me to come back to Chicago, where I never had really intended to return. I assumed the position of assistant director of the AHA.

NEWKIRK:

Good. Do you want to give me some experiences about the AHA?

JOHNSON:

When I came back to Chicago and joined the AHA staff, we moved, from 18 East Division Street, over to Lake Shore Drive,

where the AHA has been since that time, on a gift of leased land from Northwestern University overlooking Lake Michigan. That turned out to be an exciting experience.

Ed Crosby was a very complex person. I can tell you some things about him which I have found to be fascinating. Ed was one of the best politicians I've ever watched. For example, he decided that the financial formula under which member hospitals joined and participated in the AHA ought to be changed. At that time, the formula was based on so many dollars per bed in a hospital. He changed the formula to a percentage of the operating cost of the hospital. At that time, from the mid '50s on, there were huge escalations every year in the expense budgets of hospitals. So Ed had a revenue stream that just grew and grew and grew over the years. It was a very slick way because he didn't have to be concerned about his budget. All he had to do was step back and get out of the way from all the money that was flowing into the AHA. That gave him the resources to do lots and lots of activities. The staff of the AHA grew tremendously in those years as a result of that dues-paying formula.

Some insights on Ed may be of interest. One day I went looking for him in his office, but he was in the boardroom right next to his office. He was in the boardroom by himself. He had all of the nameplates for the board members sitting there in front of him. Every chair had a nameplate in front. He would sit at the back of the room, occasionally get up and move a nameplate from say, the second seat on the right, to the third seat on the left.

He did this because he knew that people, when in a meeting, lean over and talk to the person next to them. He was setting the kind of relationships that he knew would be favorable to the matters he was trying to get approved on that agenda. He did that before every board meeting. It was masterful in the way those items were handled.

NEWKIRK:

But he changed them at every board meeting?

JOHNSON:

Yes—according to the upcoming agenda.

NEWKIRK:

You didn't go in as a board member and sit in the same seat every time.

JOHNSON:

Not at all. You sat where your nameplate was placed; that's fairly innocuous. If you should walk into a room and see your nameplate, you'd just walk over and sit down there. Ed had it figured out, and it was fascinating to watch that kind of thinking.

I remember another time that I'd been looking at the cost formula for paying hospitals under Blue Cross. I matched all the costs with revenue. Again, I went to see Ed, and said to him, "Ed, we've got to make some changes in this formula, because it really doesn't provide enough funds for a hospital being paid by a reimbursement to have a profit margin, or reserve or whatever you want to call it. The formula does not permit hospitals to have monies to put aside for capital expenditures of sufficient

magnitude for growth." At that time, we had depreciation, which normally is good, but in a growth period, it's inadequate. So I said that ought to get changed. As I was talking with him about it, I came to the realization that Ed did not understand cost reimbursement. As the head of the association of hospitals in the United States, I had made an assumption that by having been at Johns Hopkins, he obviously understood cost reimbursement. All of us who had administered a hospital had to understand cost reimbursement. I found out that he hadn't the foggiest clue as to what cost reimbursement was all about. He had never had to deal with it in his career. So I was talking to the wall on that subject. It was an interesting, interesting meeting.

NEWKIRK:

There were many anecdotes about Ed that are interesting. I have a few myself, but this isn't my day, so go ahead. You were director of the Hospital Counseling Program at the AHA during that period. What was that?

JOHNSON:

The Ford Foundation had made grants to all the hospitals in the United States. I forget what the total amount was, but it approached $100 million. Every hospital received money out of that grant program. At the end of it, there was $1 million left over. Whoever was running the Ford Foundation at the time called Ed and said there's $1 million left over that hasn't been picked up by hospitals. Is there some program or project that you want the

money for? So Ed called me, and said put together a project so we can get this $1 million.

I'd always been concerned with the question of how do you measure the effectiveness of a hospital? So I put together a proposal, got the $1 million allocated to the AHA, and then set up what we called the Hospital Counseling Program. We wanted to see if we could measure the effectiveness of a hospital. The reason I'd been intrigued with the idea was because in business, you measured results of a corporation by the annual dollars in profit, or earnings per share. But a hospital being nonprofit, and interested in the health of the community, dollars were not a measure of success. So the question was how do you decide which hospital is effective and which isn't?

The conclusion came after a year's study. I had a staff of Bill Middlebrook, Bob Borzon, Ed Dean, and Elton Tekolste. We sat in a conference room for one solid year. We would come to work at 9:00 a.m., close the door, and open it at 5:00 p.m. in the afternoon. We were trying to figure out how you measure the effectiveness of the hospital when you can't measure the end product. The conclusion we finally came to was if you can't measure the end product, then you have to measure the way in which a hospital goes about its work. There are things which any organization does, in going about its work, that are better than if other ways are used. So we began to look at that. We developed a whole series of principles that we subsumed with ways of asking ourselves how do you determine principle A is met or not met? That

became a guide. We reached the point where two of us could go into a hospital for one week and really tell whether that hospital was effective or not.

At that time, Dr. George Graham was administrator of a hospital in the state of New York. George was on my Advisory Committee, as chairman. Subsequently, after he left the hospital, he went to the Joint Commission as its deputy director. The Joint Commission ultimately picked up the approach that we developed in the counseling program, and they still use it today. They set a principle, and they say how do you determine whether that principle is met.

NEWKIRK:

Was this perhaps the forerunner of outcome measurement, or was that—would you consider outcome measurement a clinical term?

JOHNSON

I think it's more of a clinical term. The Joint Commission, after Dr. O'Leary had been in the job as director for a few years, decided they were going to look at the question of a hospital's effectiveness. I really had to laugh as I listened to them talk about it because they had no idea of the complexities that they were beginning to deal with. They were going to start with clinical outcomes and chose the simplest one—OB outcomes. How many caesareans versus normal deliveries. That's about the easiest thing in the book. But when you get into the question of what is governance doing, and how good is the governing board, you discover you can't quantitatively measure the board. There are intangibles

that are very difficult, so you have to use a very different approach that's much longer and much more complicated. It's the kind of approach we had worked out through the Hospital Counseling Program.

The other aspect that developed out of that program was based on the work of the Duke Endowment. As you know, for years they had groups of same-size hospitals get together to share financial information. At each meeting, they would ask what is the relevance of this item versus that item? Out of the Duke Endowment approach and the Hospital Counseling Program, we set up HAS, Hospital Administrative Services. This was a way to compare one hospital against another, not using only financial data but also using statistical measurements for a whole variety of activities. What was the turnover in the laundry, for instance? We used all kinds of measurements. And that program went on for 25 years before the AHA finally let it die a couple of years ago. It filled a need for a period of time by providing a basis for judging how a hospital was doing compared to similar hospitals. Unfortunately, people tried to use the data in too definitive a manner. They should have been willing to look at the data as a broad gauge measure of what they were doing. It was an effective tool to determine magnitude, but it certainly was not the kind that you could use as a micrometer with respect to a hospital activity. I thought it was a useful step forward.

NEWKIRK:

Let's go back to the University of Chicago for a moment and look at your being a forerunner of a lot of things that are in common usage now and considered up-to-date science.

JOHNSON:

We were supposed to work 5-1/2 days a week, which meant till Saturday noon. Saturday noon never seemed to be over till about 4:00 p.m. in the afternoon. It was a learning time because that was when Ray, Irv Wilmot, Dick Wittrup, and I would sit down and just talk about things in general.

One Saturday, Everett, my twin brother, who at that time was administrator of Methodist Hospital in Gary, had come in for a bull session. Ray, Everett, and I were sitting around talking about that we thought ought to be changed at the ACHA. It was a problem, because the ACHA wasn't leading the profession and we really needed to beef it up. Out of the discussion that afternoon we conceived of the Congress on Administration. We decided that what the hospital field really needed was to have groups of administrators getting together where CEOs could sit down, have somebody frame a short synopsis of a problem, or an activity, or a policy, and then open it up for general discussion. We thought these discussions ought to be breakfast meetings. We decided a Congress on Administration made a lot of sense. So we asked the question, I wonder what time of the year it ought to be held? We went to the AHA Hospitals magazine, and in the front, on the second page, they always listed all of the state and regional hospital programs, the

location of the conventions, and when they would be held. As we looked at that page, it was clear that the states and regionals held their meetings either in the spring or in the fall, but not in the dead of winter. And so we agreed the best time to hold a congress is when people don't have other meetings to attend—in the winter. Then we asked ourselves, where should the meeting be located? We decided on Chicago, because it was central in the United States. The next step was to find a hotel that could accommodate 50 different conference rooms serving breakfast all at the same time. In Chicago it was the Palmer House, the only one in the Chicago area that could handle that large a group. So that's how the Congress got to Chicago in February every year. Everybody has hated that date in Chicago because it's the coldest month of the year. But we had deliberately selected February and then went with it. Dean Conley, who was head of the ACHA agreed.

The next thing the three of us did was to decide that the hospital administrative field needed a professional journal for administrators. And so Ray, Everett, and I cooked up the idea of putting together what has become the Journal of the ACHE. Those were always the fun things for a Saturday afternoon. It gave us a good feeling about what work was all about.

NEWKIRK:

And this again demonstrates that you and your twin brother worked hand in hand in a lot of very important things that happened in health care. So, Richard, you gave us a very interesting anecdote about the creation of some of the programs of ACHE. Let's

go back now to the AHA. In 1961, you were directing the Committee on Hospital Financing and Community Planning at the AHA. It sounds like another job Ed Crosby dreamed up. He didn't have anyone to do it, and he gave it to you. Is that correct?

JOHNSON:

Sure was. At one time, for a short period, I ran the Blue Cross Commission. Any time Ed had a problem, it seemed to be dumped on my desk. But that was the fun part of it. It was a whole variety of programs.

NEWKIRK:

What did you do in community planning? What in the world was that all about?

JOHNSON:

Well, that was in the early days following the Hill-Burton program. Everybody recognized that Hill-Burton was on the decline and we needed to develop community centers. Karl Klicka at that point was running the Chicago Health Planning Council following Vane Hoag. The program Karl headed subsequently developed into the certificate of need program. But at that time community planning was a voluntary activity where hospitals were supposedly going to get together and work things out on a mutual basis. At the AHA, we published a couple of manuals and held many institutes around the country on that subject, but the activity never really took off, in my judgment. It was the early forerunner of an attempt to foster rational planning. I remember squiring two people that had come over from England. England had been at the same point about a

decade earlier. I remember them telling me they were going to plan on 2-1/2 beds per thousand population in England, but were never able to reach that ratio because of the interests of local hospital boards. They were curious about what we were doing in the planning arena. Of course, we were going down a different road of voluntarism—and we used the word voluntarism a lot, as you well know, in those days. But voluntarism never really had any teeth in it, and as a result, it was mostly a theoretical exercise.

NEWKIRK:

In 1961, you were listed as secretary to the Council on Blue Cross and Prepayment for the AHA. Was that the period that you ran the Blue Cross Commission?

JOHNSON:

Yes.

NEWKIRK:

And what was the Blue Cross Commission?

JOHNSON:

It was to enforce the Blue Cross symbol that the AHA owned. There were certain requirements that were perfunctory, really, but the AHA had to make sure the plans were living up to it. We had a couple of cases where people violated the trademark, and we then had to get lawyers involved and make sure that we backed up our symbol. I remember a case in West Virginia where an organization was trying to use the Blue Cross symbol, when they weren't entitled to it. Overall, it was a perfunctory program.

NEWKIRK:

Well, couldn't anybody start a Blue Cross plan?

JOHNSON:

No, you couldn't.

NEWKIRK:

Well, how did you get one started? Suppose you wanted to start one in Illinois.

JOHNSON:

That goes back into the '30s and the early '40s when many were started, and it worked in two ways. Either hospitals and insurance carriers, or somebody interested in prepayment, got together and developed a bill, or an enabling act, to be passed by the state legislature. It was kept outside of the jurisdiction of the insurance commissioner of the state. In other states, the organizers were told they had to go through the insurance commissioner. So there was a mixed bag of Blue Cross plans across the country—80 some odd of them—some responsible through insurance commissioners, others totally independent of them. And that led to considerable differences among plans.

NEWKIRK:

That's where you got a problem.

JOHNSON:

Plans just cut the best deal that they could with the legislature regarding services, taxes, and ownership status—but they had to be nonprofit from the standpoint of the AHA program.

And one idea, which many people have forgotten, but was fundamental to the development of Blue Cross, was that hospitals in the area where the Blue Cross plan was going to operate, guaranteed the financial well-being of the Blue Cross plan. You remember that.

NEWKIRK:

Would you call that sort of a capitation plan?

JOHNSON:

No, I'd call it a guarantor for the plan.

NEWKIRK:

Okay, so you had these 80 some plans. Did they voluntarily join the Blue Cross Commission?

JOHNSON:

In order to use the Blue Cross symbol, they had to abide by the rules of the Commission. Every year they had to fill out a paper and affirm what they were doing.

NEWKIRK:

So you were in charge of the Council on Blue Cross at the AHA. The Council on Blue Cross and Prepayment. And that was sort of your last assignment?

JOHNSON:

Yes.

NEWKIRK:

You left the AHA in 1963? Is that right?

JOHNSON:

Yes.

NEWKIRK:

And where did you go?

JOHNSON:

As a result of having completed a number of hospital counseling projects in hospitals—probably 100 at that point—I was well aware of the difficulties hospital administrators had that were not of their own making, either medical staff problems or board problems—something of that nature. I decided that I didn't want to go back and administer a hospital, that my future would lie in going into hospital consulting. In the course of those years at AHA, I came to know persons in the general management consulting field.

In addition, I already knew those who were the grandfathers of health care consulting, Tony Rourke, Jim Hamilton, and Herman Smith. I knew that I was not interested in facility planning, which was the bread and butter of those three. All had started on that basis because they recognized architects had little understanding of operational space relationships. I was more interested in the management process. So I talked with Bill Brown, who was one of the vice presidents at A. T. Kearney in Chicago. Bill said why don't you come over and start a health care division for Kearney, which was one of the leading management consulting firms in the country. So I elected to do so and started their health care division. I became the first management consultant in health care on a professional basis.

At that time, when you went through a graduate program in health care you were expected to go into hospital management. You had to follow that course since that was what you were being trained for as a career. However, it was acceptable that I was an assistant director of the AHA because it was nonprofit, but when I went across the line and worked for a for-profit company, I had sold out to money and greed. It was a terrible collegial environment. In 1963, when I would go to a meeting you wouldn't believe the kind of diatribe from my former colleagues. "Are you burying the goldbricks in the backyard?" "When are you going to become a millionaire?" They thought they were kidding with these stories, but it reflected a concern that people had about anybody who would work for a profit-making organization. You just didn't do that. And so the first three or four years in consulting I really felt put upon by my former colleagues. I kept saying to myself, I can do more good (or harm) in what I'm going now, than I ever could before. Can't you people see that?

By getting into the management side of health care consulting, I had an experience I have never forgotten. One night, my wife and I had gone over to the Bugbee's apartment for dinner, with George and Karen. Just the four of us. That was when he was at the University of Chicago as a professor.

NEWKIRK:

Karen is George's wife?

JOHNSON:

Yes. George had joined the University of Chicago faculty as a professor to replace Ray Brown in the Hospital Administration Graduate Program at the university, and he lived in the Hyde Park area. I'd known George for many years when he invited us for dinner. After dinner, George and I were sitting talking, and he said, "What are you going to do now?" He added, "You're still at the AHA, but I understand from what you've been telling me that you're thinking about leaving." I said, "George, I want to go into consulting." "Oh," he said, "you don't want to do that." "You know who goes into consulting? Guys who've either retired or have been fired." He went on, "that's no place for anybody with any talent to go." Of course, I could understand him saying that, but from my perspective, that was, "Wow, what a golden opportunity that presents." And it did. It turned out that way.

And so I began to consult and gradually gained acceptance. I kind of chuckle these days as I look back. Many of the students today think the best career opportunities are in health care consulting. In consulting, we get the best students out of graduate health care programs—not the worst. But that's a 180° shift. And I like to think that over the course of the last 25 to 30 years, I've had a fair amount to do with changing the image of health care consulting. I've always considered hospitals important and believed that hospital administrators are in very tough roles. They need all the support they can get. I don't think I have ever varied from that particular standard.

NEWKIRK:

Your career has demonstrated that. You know, it's interesting that Ray Brown, who you mentioned several times throughout this interview, and I were sitting at Duke University and I said, "Ray, we need people—good people—in hospital association work." And Ray said, "Who would go to work at a hospital association?" And he ended up sending me some people who then reported back in glowing terms, like your experiences with George Bugbee. All right. You then went to A. T. Kearney in 1963, as vice president of health services, and on their board, of course. In 1972, what happened?

JOHNSON:

Beginning about 1970, A. T. Kearney had decided on an expansion program. I participated in reaching that decision. We decided to establish an office in New York, in San Francisco, in Los Angeles, and in Dusseldorf, Germany. Personally, I wasn't interested in the international side. Subsequently, A. T. Kearney has established several additional offices overseas. What was going on in the health division was that we were building a national practice from California to New England. With the introduction of regional offices, A. T. Kearney began to draw boundary lines. My fellow officers didn't object when I'd land a project in the New York area or in California, but they wanted me to staff it with their regional people, out of their offices because it was in their region. And their staff were consultants who didn't know anything about the health field. They knew consulting from a general management standpoint, but had no idea

about health care. I found that I was riding airplanes across the country, trying to put scrambled eggs back in the shells. For example, these staffers would start interviewing physicians or an administrator and they'd make, what to the physician or administrator, was an absolutely absurd statement because they didn't know the language or the mores. It was causing me all kinds of problems. And so at that point, I decided there had to be a change and decided I would be better off forming an organization that simply would do health care consulting unimpeded by having to live with others who didn't know anything about the health field. And that really is what led to my forming TriBrook.

NEWKIRK:

Tell us a little bit about TriBrook.

JOHNSON:

We started in 1972 with a card table, fold-up chairs, and three rented offices in Oak Brook, Illinois. I had two colleagues—a lady by the name of Kathryn Hansen, who was our administrative person at A. T. Kearney, and Ed Grube, who had been one of my chief lieutenants at A. T. Kearney in consulting. The three of us elected to leave, and so we set up shop. The cost to get started was $7,500.

The name TriBrook. I've often been amazed at the stories I've heard concocted about how we got the name. Initially, I decided that I didn't want a person's name in the name of the firm. I was tired of people using their own names to start firms. And so Kay, Ed, and I sat down and figured out what we would call our new firm.

We decided we would call our company the Tamarack Group. We thought the word Tamarack would stick in people's mind. Tamarack is a bush, or small tree in the southwestern part of the United States, but we would use the name Tamarack, because people would remember it. So we filed our corporation papers with the Secretary of State in Illinois. We got turned down on the name because there already was a Tamarack Development Corporation.

We had made a mistake at that point. We already had paid somebody $300 to develop a logo, and the logo had a T in it. So at that point we decided we could not afford not to use that word with the T in the logo. What were we going to call it? Since we were going to be located in Oak Brook, we decided Brook, and since three of us started it, we decided we'd call it TriBrook. And that's how we got the name. But the important part was, and I still believe to this day, you shouldn't use individual's names. It's just meaningless, and I would never have felt comfortable if my name had been involved.

NEWKIRK:

I think that makes a lot of sense. Well now, how about the company? How many people do you have here? What is the scope of your business? Tell us a few things about it.

JOHNSON:

Over the beginning years, we started with the management side and did not have a facility planning side. Let me go back first and recount some of the history of health care consulting. It really got started with, as I had said before, Jim Hamilton, Tony

Rourke, and Herman Smith. All of them had been hospital administrators who had found that architects didn't understand the functioning of a hospital, how it is operated. All three saw a need for somebody who knew how a hospital functioned in an operational fashion to work with architects so that the design of hospitals would be improved. As a result, all three independently realized there was something that ought to be done. All three did very well, because their services filled a niche that nobody else had recognized. It was a valued service to be performed. When I came along, everything in health care consulting was facility planning.

Because of my own background, I decided our firm was going to emphasize the management process side of consulting. We started with what today is called strategic planning. The first project was a long-range plan for Memorial Hospital in Jefferson City, Missouri. In the beginning, we developed many long-range plans. There was a huge need, but I knew we had to get into facility projects. Trying to find the right kind of person to head that activity was difficult. We finally did it with a University of Chicago health care graduate who was also an architect, Chet Minkalis. Chet started that activity, and today about half of our revenues are from that source, which are running close to $4 million a year. About half of it comes from facility planning and about half of it is centered around the planning process. We do consumer surveys, medical staff surveys, medical development plans, PHOs (physician-hospital organizations), and strategic planning.

The other half of our organization does functional planning and site planning activities. Part of this group also does equipment planning. At TriBrook we can equip a hospital from top to bottom. Quite often the strategic plans lead into facility planning. What's happened with firms that had started with facility planning was that they worked in the opposite direction and came back into management consulting. We had gone from the management side into facilities in order to have a whole range of services. The others have come the reverse way in order to offer a full range of services.

Today we have 22 or 23 professionals and another 20 administrative personnel in the organization with two offices, a small one in Tampa and the corporate office here in Westmont, Illinois. At one time, we were much larger. We had 35 full-time consultants with offices in Washington, DC; Birmingham, Alabama; and Walnut Creek, California. Subsequently, we pulled all of them back into this office and created an office in Tampa, Florida.

The field of health care consulting has changed markedly. Twenty years ago we could staff a project with a project director, a supervisor, a staff member, or maybe two staff members, and work on just one project at a time. Today you can't do that. The projects have become much more highly focused and require much greater in-depth experience to deal with problems. Budgets are much, much tighter, and you have to live with limited timeframes and turn things around more quickly. It is more restrictive than

20 years ago, and it's a very different set of circumstances in consulting.

NEWKIRK:

We've sort of ended the biographical information, Dick, and you've supplied an awful lot of good stuff along with giving us an idea of what you've done throughout your life. What other activities have you been most proud of? What things have we left out? What things do you like to do? Do you like to serve on committees? Do you like to serve on boards? You do so many things. Tell me about some of the other activities.

JOHNSON:

Well, probably, the most important would be writing. I've developed a number of thoughts, kind of a guidepost, relative to writing over the years. As I watched Ray Brown in the early years of my career, he was writing. As a hero to me, the things that he did were something that I would ask myself if I could emulate him. I remember the first article I ever wrote had to do with x-ray equipment, a linear accelerator. I was 26 years old when I published that article, and I've been publishing regularly over the years. I've always thought that as a professional, you have an obligation to share with others. That's been the guideline that I've always used. It is particularly important in consulting where you get an opportunity to see a whole array of problems across a large number of institutions. I think writing is an obligation, not something that you do for pleasure. It's an obligation to communicate to others in your field the things you're experiencing

and seeing. You validate by seeing the same things time and time again. You need to share these experiences with your colleagues so that they have an understanding of what is happening.

I've also taken a leaf out of Ray's book, which is probably less appreciated today than it was 15 to 20 years ago. As you encounter experiences, you internalize them and ask yourself what does this mean professionally. What's the significance or how can that activity be improved, or what needs to be done? Therefore, it's a result of your own thought process. I, frankly, have a great deal of difficulty with a lot of the writing that I see today, where every third sentence or so has a marker in it in which the author cites somebody else or a publication. The academic approach, to my mind, is a detriment, not of assistance in health care, where experience is of overriding importance.

So with the things that I write about, you won't find any citations at the end. It doesn't mean that I don't read, rather it means that I value my own thought process in thinking through a problem. That's what Ray used to do. He'd say to himself, what is the meaning of that? And then he'd start cogitating in his mind. That rubbed off on the way I've written. I've probably written 150 articles and five books over the last 30 or 40 years. But it's been based on what does it mean? I try to put it together in my mind.

As we were talking earlier, the last article that I just finished the other day is on the purpose of hospital governance. Nobody has written on that subject. Another article had just

preceded that paper. It is now in the process of being considered for publication and is about changes needed in the certificate-of-need law. It was written out of my experiences as an expert witness in CON hearings. I get very out of sorts with some attorneys at these hearings. You would think they are in fairyland in listening to them. Their questioning often has nothing to do with reality or why a CON application is being considered. CON applications are written to comply with state laws and their requirements. Testimony has nothing to do with reality. I think this is wrong, and I think we need to express our concerns about this lack of reality.

I've always indicated to the staff here at TriBrook that they need to write. They have an obligation to share with their colleagues what their findings are and communicate them to others. It's a guidepost I have always followed.

The other element of writing that's important is the personal one. It's not just one of satisfaction of having published an article. After you have published the first two or three, that isn't much of an incentive anymore. The incentive is to clarify your own thinking. To say, "Do I really understand this subject?" And if you write about it, and then go back and rewrite it, and then rewrite it the third time, you begin to have a much clearer perception of what you're thinking and writing about, and it helps you immensely in understanding a problem. So I'd say, if you ask me have I enjoyed writing? Yes. Have I found it worthwhile?

Absolutely, because it's clarified my own thinking and given me a sharpness of focus that I otherwise wouldn't have had.

NEWKIRK:

Well, what do you think, Dick, that your writing has done for the field? In other words, you talked about this as sort of an internal thing. It clarifies your own thinking, but in the meantime, somebody publishes that and you have foisted that upon the field.

JOHNSON:

That's true.

NEWKIRK:

I mean, gracious, what happens then? In other words, do you think you've influenced a number of people to think the way you do?

JOHNSON:

I've often wondered about that and in a serious way, I've come to the conclusion that the answer is yes. I'll give you an example. The other day a person called that I don't know and wanted to talk. He said, "You don't know me, but you wrote an article about using the Machiavellian approach several years ago." He added, "You wrote another one about the three-legged stool, which was an award-winning article nationally." He went on, "Those influenced my career tremendously as to what I did."

The conclusion from what people have told me over the years is that I write in rather simple terms that are very understandable. People don't have any trouble trying to decipher what I really mean. The words are rather clear and so are the concepts, and I

manage to put them in simple terms. It's always a relevant topic that, at the time, I believe is important. I'd say, yes, overall I think there's been some impact. After having received several awards, both for writing and from professional organizations, I believe I probably have had significant influence on a number of other people.

NEWKIRK:

You have a style that's very similar to one of my favorite authors, David Kinzer. I think that yours is a bit more scholarly approach then David's was, but you both say things in a manner that people can understand. Have you been criticized for a nonscholarly approach?

JOHNSON:

I would not have been criticized 20 to 25 years ago with what I was writing. Today, two things are different. The health field journals have changed tremendously over time. They are almost all news-type magazines these days with only a couple of exceptions, which I think has been detrimental to the health field, frankly. The other is that we're getting a lot of articles published by academic people, reporting on matters dealing with surveys where they've used multiple regression or some other technique.

NEWKIRK:

More scholarly academic approach.

JOHNSON:

Yes, and not necessarily relevant or perhaps relevant five years ago, or three years ago, but certainly not relevant today and

not predictive, or looking ahead to say what are we dealing with at the moment? I am fairly turned off by that type of literature in the field. The result is that the way I write these days is not nearly as acceptable as it would have been 20 years ago.

NEWKIRK:

Maybe you should start another journal, journal of practical management or something. Do I hear that?

JOHNSON:

If I was going to start a journal, it would be more along those lines. This newsy kind of reporting is not really significant.

NEWKIRK:

But things stick in your mind. I can recall a treatise of yours on ethics and the relationship of ethics to economics. I happened to do some work in ethics at Ohio State University and am chairman of an ethics committee in a hospital, on a hospital board. This is actually a very clarifying experience to read what I believe you were saying; that in ethical considerations do not shy away from the economic aspects, that they are very much a part of ethical decisions. And now there's Paul Hoffman saying the same thing, and some of these people who call themselves ethicists. So these things do make a great contribution. Tell me about your books. Or do you want to talk about ethics?

JOHNSON:

Books are fine. The way I have put them together was not to deliberately design them as books, but rather they come out of a

collection of articles that both Everett and I have written. We decide when to put them together and call it a book after finding a way to give them a semblance of continuity. This turns them into books.

There's one book that has not yet been published that's really my favorite, and I'm having difficulty getting published. I've called it Dr. Charles Evans, and it has 14 chapters. I've taken a 53-year-old internist and looked at what he's encountering in his practice. And they're exciting for me. I've written it as if I was that 53-year-old internist. It's almost like the play Harvey with the big rabbit. Dr. Evans is my Harvey the rabbit. He and I have a lot of conversations about all of his problems. He wants to bring in a new partner. What does he go through with respect to that? He gets sticker shock when he finds out what the young graduate out of a residency program expects to be offered. That's one chapter. Another has to do with Dr. Evans as the incoming president-elect of a medical staff who has to deal with a credentialing problem in the operating room, an internist trying to solve an operating room problem. It is an oil-and-water situation. This was a really fun book to write. It took me the better part of a year, and it's the only one I've written as a book per se. It's been to three would-be publishers. From all of them I get back the same statement: This is fun to read, but I wouldn't know how to market it.

I'm thinking now about the next book I want to write. I'm going to have an administrator become another Harvey the rabbit,

and go through all of the things that the administrator deals with in his career. Most people don't see what a hospital CEO has to deal with or many of the things that occur. A CEO can get a lot of brownie points as an administrator, but he also starts getting black marks along the way for decisions he has to make which are not popular. If a CEO gets enough black marks built up, the board finally says we've got enough of you, even though you're right. You're right, but you're out of a job. You've seen that as much as I have. But that needs to be written up, and I'll probably do that over the next two or three years.

NEWKIRK:

Dick, have you over the years had any special theme or favorite theme that ran through your writing?

JOHNSON:

Two themes. One has to do with governance and the management process and their relationships. The other has to do with trying to understand what's going on at a more macro level with regard to health care. I did a fairly major piece, which was unpublished because I needed it for my own thought process, looking at where the health field is headed. I came out with what you're hearing today, $1.7 trillion of health care expenditures in the year 2000. I made that same projection five years ago. To make this determination you have to consider the external environmental factors which most people don't take into account, but they become the driving force on the hospital field. We need to understand these external impacts.

NEWKIRK:

Any favorite articles or books? Anything that you wrote?

JOHNSON:

The one that was received with mixed reaction was the one that had to do with the Machiavellian approach of an administrator. The CEO thinks about operational problems as he walks through the hospital and deals with this doctor or that doctor, and he's always focused on maneuvering them, in order to get something done that needs doing. It's the reality of being a hospital executive. I remember talking about this subject at a meeting in Detroit. As I finished with the presentation about how Machiavellian an administrator has to be, Karl Klicka, who at that time was running People's Hospital Authority, got up and said, "I want you to know that's the most perceptive statement I've ever heard about the way the administrator has to function." When it was published, I received letters from several physicians saying how terrible it is if that's the way administrators think. This indicated to me they had no understanding of the process of management. That article was most satisfying. If I can get people on both sides, some for and some against, I guess I get more satisfaction than where everybody says, "Boy, wasn't that great?" I don't think I've steered away from controversy over the years. I don't duck a fight very often.

NEWKIRK:

What do you like to read?

JOHNSON:

Nonfiction. I really have never liked fiction. I read a lot of biographies. I went through one period of my life reading everything I could about the Civil War. But I passed that phase many years ago, thank heavens. I like to read about political figures and the problems they have. I do a fair amount of reading. For example, one of my favorite journals is Daedulus, which comes out quarterly, and it'll have something like what's going on in the reforms in China. That's interesting. Another, what's happening in our education system today. The editors select social concern topics, and I think that's more fun. I guess it's rather oddball reading to a lot of people, but I don't really much care for the typical kinds of reading that you see on the shelf.

NEWKIRK:

Do you read a lot?

JOHNSON:

Not as much as I would like, but I'd say during the course of a week I probably put in three, four hours of reading of that type. That's exclusive of newspapers and journals.

NEWKIRK:

Your service to organizations, I know, has been a lot. You've worked for AHA after you were employed there on a volunteer basis. The ACHE . . .

JOHNSON:

Let me interrupt you there, Don. One of the important elements to my mind professionally has been the membership exam of

the College. When Dick Stull was president, and in his last few years when he was not feeling well, he really couldn't get interested in revising the exam. I was increasingly distressed by the written and the oral exam of the College. It was so out-of-date. Even though I have been a long-time supporter of the College, I have never held any position of authority such as you and Everett have had, but I never really had a desire to hold office. I've always thought that the professional exam is what distinguishes a field, and it is therefore important. So I've spent the last 15 years or so serving on the exam subcommittee. I manage to get reappointed every time, and my concern is to make sure that we keep the examination current. Today, probably two-thirds of the questions that are on the membership exam are ones I have written, and I take a great deal of personal satisfaction from knowing the exam is up to date. We are now going through another difficult period with it. I thought we had it honed down pretty well until the health field world decided to come apart about two years ago, and now we've got to reexamine the whole exam process. We are in the process of doing just that. I feel very strongly about the purpose of having a health field membership examination and hope to continue working on that subcommittee for a long time.

NEWKIRK:

With the ACHE membership having become more varied, it must be quite a problem to have an exam that can be applicable to all the affiliates.

JOHNSON:

It's a very difficult problem. If you go back 15 years, one of the questions might have been about a law, its name, and ask for a description of it. We have changed that approach. What I have tried to do is to have the person taking the exam use his/her own thought process to decide a question. The answers should not be ones you can pluck out of a book or ask an attorney or question your accountant. That's not what we're after.

NEWKIRK:

Dick, let's talk about the education of health care professionals. Where do you think that is going?

JOHNSON:

I must say that I have been disappointed by what I've seen happen in the academic environment over the last 10 years. The pressure within a faculty is to publish and to be accepted by other faculty members rather than to be accepted by one's peers in health administration.

NEWKIRK:

So let me stop you there. Do the course directors—do the faculties of these programs consider health care professionals their peers? You made that assumption, or did you not? Or did you consider university politics and other course directors and other course faculty contributors?

JOHNSON:

It's the latter. Many faculty members seem to believe that they are the equal of or superior to health administrators. I

would argue that they see health care executives as secondary peers, if you will.

I'm not at all satisfied with what I see among graduate program faculty members. I liken our educational needs to a pragmatic field like general surgery. The professor of surgery doesn't teach surgery by just talking about it or sitting in the amphitheater directing a resident below to do the surgery. He gets in there, he gets his hands dirty, and he's doing the surgery, showing them what to do. That to me is a pragmatic field. Health care management is not a basic field; in health administration we draw off statistics, organizational theory, accounting, various kinds of social sciences, all of which are essential to an understanding of the profession. Therefore, you have to have an appreciation of all of these fields. I recall that the AUPHA, about two years ago, suggested it would be wise for faculty members to spend some time on what they called a sabbatical in a health care activity, particularly a hospital, so that the faculty would have some understanding of what goes on. To me it is crucial that faculty have that understanding, and they don't have it today. Lacking it, they place emphasis on things that have little meaning in the real world.

I can give you an example of a consultant we employed here at TriBrook a few years ago. This individual had come out of graduate programs and had no relevant hospital experience. Even though the consultant had graduated, this individual did not know what a medical staff was—a department of medicine or a department of

surgery. Well, that is absolutely fundamental to understanding health care. This student didn't understand the credentialing process which is basic, in my judgment, not just to hospitals, but to the whole health care activity. And they're not getting this knowledge at the university. It was made even worse when many of the programs did away with the residency. Everett, my twin brother, continues a residency at Georgia State, even though it puts a real burden on the faculty.

NEWKIRK:

There are a number of programs that still have it.

JOHNSON:

They're beginning to—they now call them fellowships. Programs never should have lost residencies to begin with. I go back—and this sounds like an old fogey and maybe it is—but I go back to the study that Herluf Olson did just after he'd retired as dean of the Tuck School of Business at Dartmouth College back in the mid '50s. We employed him at the AUPHA, which I was involved with at the time to do a study on graduate programs. Herluf was a very thoughtful person. He started the project on the premise that hospital administration is really administration comma hospital. It was the big A, as in administration, that was important, and, therefore, general management principles controlled. When he finished his study, he came away with a very different opinion. He saw the field of health care administration as a unique field with its own requirements. At that time, he cited the fact that we were the only field in the business world that had residencies. In his

judgment, this was a crucial difference and spoke well of the field.

And what did we do subsequently? Academics became more concerned with their peers in the university, and we got away from this concept. As you know, the administrative residency program, or we called it administrative internship years ago, got started because we were emulating the medical model of an internship and a residency program. It was the pragmatic real world that had to be lived in and dealt with. I've always felt that was the case and should be the case today. So today we can apply the old expression "what goes around comes around." We're beginning to see a resurgence, but we never should have gotten away from residencies. We did, and that's too bad.

NEWKIRK:

I agree. I've heard faculty members talk with disdain about being a trade school and that they should be more and more involved in policies and the more ethereal aspects of what they call management. I reply and argue that we need to be a trade school. Who is going to run health care institutions if all they know is how to develop policy? Can you imagine putting students who have just graduated from a two-year program into an organization that needs operating knowledge when all they've learned is how to set health care policy on a broad base? It doesn't work. We train surgeons on surgical patients. I presume those faculty members also look with disdain on medical schools and residency programs because that's a trade school just as well.

JOHNSON:

Absolutely. And that's the way it is. If that defines a trade school, I'm like you, I want to be a trade school. I think I'd prefer the term a professional school and a professional approach, and I think that's what we're training students to become.

NEWKIRK:

Yes, well the trade school is not my term. It's their term. I believe it comes from being uncomfortable with the fact that they don't know anything about health care, and, therefore, they just don't operate in that context.

JOHNSON:

Well, I had one young lady on our staff as a consultant for three years who then decided to leave. Her big plan in life, which I think was engendered from her university days, was to quickly become involved in setting health policy. I almost choked on that idea. I asked her what made her think she had enough knowledge to develop health policy? I then asked her where she could go and develop health policy? Somehow there was no connection between the reality of the world and what she wanted to do. To myself I thought she could set health policy if she spent another 25 years in the trenches. I believe to develop health policy you have to put in your time in the trenches first.

NEWKIRK:

We are not confusing the understanding of health care policy and how it's developed with going out and trying to find a job

fresh out of school. Developing health policies are very, very difficult if they are to be workable.

JOHNSON:

My opinion is the same.

NEWKIRK:

Okay. Suppose that what we've both articulated is a reflection of our age and time and is not appropriate.

JOHNSON:

I would definitely say it's a reflection of our age and the time we've lived through and the problems we have seen, but I would not agree that our thoughts are inappropriate. I think that we're going to have to get back to the more practical side of management. This has been proven in other industries as they've developed bloated staffs with floors full of people who really are of questionable value. Now they're cutting them out. Corporations cut out whole layers in their organizations. So I think we have to be careful that we don't follow that pattern and end up with the same problems. We already have a tough problem that will have to be dealt with. We're going to have more limited resources to work with in health care for both physicians and hospitals. If you look at a hospital, ask where has the personnel growth been in the last 10, 15 years? It's been on the administrative side of the equation. An example, a hospital starts off with one person in risk management and one person in quality control. Now each of those activities may have four, five, six people in it. We've

added public relations specialists with staffs of their own. As you look at what has happened, it is bloat.

I was over in Battle Creek, looking at two hospitals—Leila and Community—which had merged. They were trying to decide if they should operate on one site or two sites. As I was walking through both hospitals with the president, the thing that struck me was the realization that both hospitals had declined in occupancy rates and had closed nursing units. The closed nursing units were now filled up with people in administrative capacities. The hospital did not have the amount of space they thought they had because they had loaded up with alternative administrative services. If we are going to have more limited resources to work with in the future, the reductions are not going to come from the clinical side, they are going to have to come out of the administrative side. When we talk about bloated staffs of corporations, we're already there, in the health field. We're going to have to make the same cuts on the management side of the equation.

Last summer I had a herniated disc, was operated on in a hospital, and spent five days as an inpatient. Because I was in considerable pain, I was awake on all three nursing shifts in the hospital, and I had a chance to talk with the nurses. It was far different from the days when I was running a hospital. Years ago, the personnel on the night shift had an easy time. All you had to do was agree to be there—if you didn't object to working those hours. It was an easy shift to work. Well, let me tell you, on nursing services today on all floors, they're running hard all

three shifts. Of 34 patients on the unit I was on, only two of us had no complications. The other 32 patients all had complications. If you translate what I saw on the nursing unit into statistical and financial reports and appreciate that the intensity of illness rises about 5 percent a year, you won't find a 5 percent increase reflected in increased nursing service hours. In fact, hospitals are trying to reduce nursing hours. Nursing is a hands-on business and yet hospitals are trying to reduce man-hours in nursing. Rather than nursing, cuts will have to come from administration. We do have bloated management staffs today, and they are going to be reduced.

NEWKIRK:

I think sometimes, if we could turn out in the graduate programs 25 types of specialists, we'd be doing a much better job than we're doing turning out generalists. We have trouble finding what they're interested in, let alone what their career goals are likely to be. But what do you think of the information explosion, and how can we control that? Or should we control it?

JOHNSON:

Well, thanks to computers, you can spill out a lot of information that you don't need. You get cheap, cheap, cheap data that don't get looked at very much. So we're not thoughtful about what information we desire, because it's easy to obtain and we get more and more and more. That's going to have to change, but we also are going to have to revamp the kind of information that we receive.

As I work with health care professionals today and they talk about outcome measures, I mentally go back to the hospital counseling program where we developed measuring the effectiveness of the hospital itself. I recognized that we couldn't get total outcomes that we could measure. If you look at the medical literature, what you find are reports on a series of cases. The author will indicate that with procedure A versus procedure B, the clinical results were improved. The article doesn't say, if you use this procedure and these resources that it adds up to a savings of dollars along with an improved result.

In order to get to a combination of clinical and economic decisions, all that literature has yet to be developed. This is going to take 10 to 20 years to develop significant information. And yet we hear people standing up on the lecture platform every day in the health field saying we've got to have outcome measures, without any appreciation of the difficulty of developing the information that's going to be required. I think outcome information is essential in the years ahead. But it's a very complex, tedious, and long-term process.

NEWKIRK:

We hardly have input measures, let alone the outcome, which, of course, brings us to computerized medical records. This type of record to produce is both an expense and technology requirement that is a tremendous cost. So I guess we get back to the education process.

JOHNSON:

Let me hold you here for a minute.

NEWKIRK:

Go ahead.

JOHNSON:

Here at TriBrook in our facility division, we're now at the stage where we are going to put in keyboards (I guess, if that's how you say it) in a patient's room, so the nurse doesn't have to go back and chart everything to death. The nurse just punches a couple of buttons in the patient room, and it's automatically recorded. An ability to do this will save nursing time. But installations have to be done at the time when the unit is either rehabbed or is built as a new unit. All of the wiring has to go in at that time. I'm sure that we are going to get away from patient records as we know them today.

NEWKIRK:

I think we're the last industry in history that depends on paper as much as we do. It's incredible. Let's talk a little bit more about these organizations that you have worked with. You've received a couple of very prestigious awards. To change the subject a little bit.

JOHNSON:

Well, there are a couple of writing awards over the years, best article of the year, and then the silver medal from the ACHE for, as they titled it, distinguished service to the health field,

which I was delighted to receive but I thought they overstated the case somewhat.

NEWKIRK:

You're talking about the Dean Conley Award in 1980, right? And the Silver Medal Award in 1984.

JOHNSON:

Right.

NEWKIRK:

It must bring you a lot of personal satisfaction. I would rather have had those awards from that organization than any other professional society. Incidentally, my sister told me that in 1984 somebody put me up for the same Silver Medal Award, and then someone else asked me to nominate you.

JOHNSON:

Didn't know that.

NEWKIRK:

And I nominated you. I got the award the following year.

JOHNSON:

Yes, you did.

NEWKIRK:

What else have you done for ACHE? Now we've—I do recall we talked about some of the information on the exams, and so forth. You have served on committees and things like that. Is that correct?

JOHNSON:

Not really very much.

NEWKIRK:

With the exams, you work on the exams, and that's continuing, I guess, yet today.

JOHNSON:

And I still feel strongly about that.

NEWKIRK:

How about the Illinois Hospital Association? Did you ever have anything to do with that?

JOHNSON:

That was way back 35 years ago or so. I used to participate. I can't even remember the committees that I used to be on in that organization and in the Chicago Hospital Council. I remember the time we separated the Chicago Hospital Council from the Illinois Hospital Association. We made them two separate organizations after a battle. On the association side, I remember more clearly the association activities when I was at the University of Missouri in Columbia. We had a part-time person as the administrative person for the Missouri Hospital Association. Les Reed, who was the director of Presbyterian Hospital in Kansas City, Paul York, and I pushed the association to set up a full-time staff. As a three-member committee, we came back after six months of working over the idea, put together a business plan, and presented it to the members at our annual meeting. Our findings were that we needed a full-time staff. I was instrumental in getting Ted Lloyd to become the first full-time director of the hospital association.

NEWKIRK:

At Missouri.

JOHNSON:

. . . at Missouri. We suggested in our report that the membership spend the horrendous amount of $25,000 a year to operate the association. That, I think became a turning point. In those days of the '50s, we were shifting over from part-time association executives to full-time staff. That was an important movement, in the health field, when we went to full-time executives.

NEWKIRK:

How about the American Association of Hospital Consultants?

JOHNSON:

That was a very different kind of story, in my own thinking. Back when I went to A. T. Kearney, Leon Pullen, and Frank Briggs, who were partners at Herman Smith, suggested to me that I join the American Association of Health Care Consultants. I said I was not interested in joining a trade association. If you want to make it become a professional society of consultants, I'll be happy to join and participate fully and work as much as I can to make it a success.

Prior to that time, the AAHC had been an organization with two leading figures. One was Jim Hamilton and the other was Tony Rourke. Both of them believed strongly in the idea of trade secrets and not sharing information. Well, I thought that was a lot of baloney then and I still think it's baloney today. I said if we are to make it a professional organization, it's going to be

open and it's going to be one where we set standards. Consultants are going to have to meet standards and we're going to insist on sharing a lot of information and approaches. If any consultant does a bad job it hits the whole field and reflects on all consultants. I said I am willing to help any individual become a better consultant. If agreed, then I'm interested in participating.

The AAHC agreed, so I joined and became very active in it, starting what we called the Business Practices Seminars. I started these many years ago, so that the owners could get together and talk. We covered subjects such as how do you establish a daily billing rate? In those bygone days, many of the firms did not have daily billing rates. Because they were dealing with facilities, they took a percentage like 2 percent or 1 percent of the building cost as their fee. Daily billing rates were absent. I had come out of A. T. Kearney, where we had gone all through this process. Kearney had at that point about 35 to 40 years of knowing how to run a management consulting firm. By being a board member, I'd been privy to all of this information. I decided that kind of information should be shared.

AAHC developed the seminar on business practices. In addition the AAHC developed better speakers, better approaches to what we were doing. We set two levels of standards, one dealing with what it takes to be eligible for membership in the organization. The other was the standards that included being primarily available to the public, spending 75 percent of one's time in direct health care

consulting. We set forth these standards, and then we established membership levels with criteria. Later, I was able to get the AAHC to use the ACHE membership exam. In order to become a member of AAHC you had to take the ACHE exam. In addition, a consultant has to take a 50-question exam, for those who are health care consultants. We also require an oral interview where a report is presented to two colleagues. They decide if you did the job right. We go through what I think is a rigorous process that we set up nearly 20 years ago.

I take pride in the AAHC organization. We're having some problems these days, and I don't know when they'll get worked out. We're at the dog days of August at the present time in the organization, and we're groping a good bit. In an organization like TriBrook you can only remain in a AAHC leadership slot for so long and then you've got to have others in your organization be your successor. So Chet Minkalis became president, and then Mike Carroll served on the board, and now Don Davis is on the board. Chet Minkalas became president after me but he died while he was in office. That was tragic for us as a firm. He was our executive vice president. We keep on participating in the AAHC organization, but it doesn't have the thrust and the drive that it ought to have. I'm at a point where I'd love to go back and become chairman again. We could revamp and reroute the organization. But that's not in my future. Some of my colleagues here in TriBrook don't see the same needs as I see them. But I've been as strong an advocate of the AAHC as I am of the ACHE.

NEWKIRK:

Were you ever involved with the American Public Health Association?

JOHNSON:

I joined that organization, but I never really participated. I went to one or two public health meetings, didn't like it, stayed a member for a number of years, and just dropped out.

NEWKIRK:

Why didn't you like it?

JOHNSON:

Inspecting restaurants and river pollution is not something I'm very interested in.

NEWKIRK:

Let's talk a little bit about government in health care. What do you think about the Clinton plan? What do you think about the involvement of government? And let's take it from the Hill-Burton days, which you can remember well.

JOHNSON:

Sure do. A very important program, which we know, is largely forgotten today. That program was exactly the reverse of what people are trying to do today. It was a program to expand the number of hospitals in this country, particularly in rural areas. The Hill-Burton Program stemmed out of a study that Dr. Bachmeyer had led. He used the state of Michigan back in the late '30s as a project under the aegis of the Health Care Commission, which the Kellogg Foundation funded. That led to the development of the

Hill-Burton federal legislation to expand hospitals. It was an important activity and a very successful program. At that time, Blue Cross was an important factor in providing funding for hospitals. The fact that it was cost-reimbursed gave hospitals a lot of financial leeway. They never had this before Blue Cross came on the scene.

NEWKIRK:

Let me back up just a second. Hill-Burton was a construction program, wasn't it?

JOHNSON:

Yes.

NEWKIRK:

So what happened when we came out of the Second World War with a great need for capital construction and capital improvements. Hill-Burton took care of that. Overlaid Blue Cross then, with almost a blank check. All you had to do was apply. Hospitals could focus all of their attention on taking care of patients.

JOHNSON:

Blue Cross wrote the hospital a check for all of its costs of operation, including depreciation and interest expense on loans. The concept is now outdated but at that time it was in vogue.

NEWKIRK:

Is that correct? So you had the money.

JOHNSON:

Capital improvement through Hill-Burton.

NEWKIRK:

They had the overlay of Blue Cross, which provided a very good revenue source.

JOHNSON:

Absolutely. And those two were critical to the development of the health field and led to the technological innovation that has occurred. I have to point out hospitals originally depended on philanthropy. That stage was replaced by cost reimbursement and the Hill-Burton program, which became the funding mechanism. Once we got into the middle '60s, we went into Medicare, and then into DRGs in '83. When DRGs were adopted, hospitals lost the unlimited funding or blank check, it no longer existed. Years ago the public saw the hospital as a societal activity, where hospitals had social concerns about the community. Business concerns were not very important. That shifted to an even balance where business concerns and social concerns were on a par.

At that point, hospitals began to look much more seriously at controlling costs. Revenue streams for hospitals were less abundant, charity care came to be more tightly controlled in institutions. The business side and the social side began to balance out. What's happened since then is we have gone from inpatient care to more and more ambulatory care. We have had a technological shift. Today a hospital is a technological enterprise. It's a technological enterprise that is one of the largest employers in town. If a hospital fails, there is a tremendous unemployment problem in a community. We are not the

social institution that we were 50 years ago. We're a technologically oriented enterprise these days, and, therefore, it's the costs and revenues with which we have to be concerned. We're a business. We call it nonprofit, but we're a business.

NEWKIRK:

Well, wouldn't you say that even though we are not the same social institution, hospitals still have a social aspect in health care. A social aspect that says even though we have become more like a factory (there is a lot of technology around the place), we will have people who are very socially motivated. They think that nursing takes care of you in the middle of the night. So there are still social aspects. You're not writing that off.

JOHNSON:

Not at all.

NEWKIRK:

Okay. Good.

JOHNSON:

But the social aspects are occurring at the hands-on level in the institution. That should remain, and it is important to remain. It's also important that hospitals begin to reach out beyond the four walls of the institution. You're hearing a lot of rhetoric about reaching out these days. One of the difficulties with where we are today is that nobody has figured out how to pay for wellness. Traditionally, and still true today, a hospital is essentially a garage, and doctors are mechanics. In hospitals patients are fixed. That means something has to be wrong before

hospitals fix it. And now to change the orientation and put hospitals into reaching out for wellness, that's all well and good, but somebody has to answer the question, how do hospitals get paid for providing such services? If we have more limited resources coming down the pike all the time, wellness is going to remain a pipe dream. It's not going to be a significant factor until we learn how to get paid for those activities.

Capitation, as we begin to look at managed care today, offers some opportunities that we didn't have earlier. On the other hand, the difficulty that I'm having in dealing with the bulk of hospitals—not all of them, but substantially the majority of them—still think of producing revenue streams. Under capitation, you're not a revenue stream, you're an expense to the buyer. They don't understand that's a 180° different orientation. It's a very different world when you think of it as an expense.

The problem we're going to have over the next decade is that we're not going to have 100 percent capitation, we're going to have maybe, 50 percent capitation, with 50 percent going to some other form of revenue, one way or the other. When we have both capitation and revenue production, what do you tell a department manager? With half of what you do, you have to control expense, because that's what we're concerned with. On the other hand, for the other half, we're saying do everything you can because that's revenue production. We're going to give very conflicting directions to hospital managers, and they're going to be lost wondering what is going on. They will hear the CEO say we have to

have revenue, and then they will hear him say we have to control costs. The two approaches don't mesh well. They're going to be difficult to put together, in my judgment.

NEWKIRK:

You know a lot about hospital managers. Do you think that health care managers are under attack?

JOHNSON:

If they don't change, the answer is yes. They are playing games that are short-lived. CEOs are going to have to make changes. The difficulty for hospital executives are their dealings with governing boards. Most hospital nonprofit boards do not understand the depth or complexities of a hospital. The basic problem is that hospital resources are more and more limited. As you limit resources, the role of management becomes increasingly important, because of the operational and managerial decision-making, not strategic planning, which should be a board activity. It's a question of survival in the economic climate that we're in. What's needed are managerial decisions, and we can't permit governing boards to delve into these types of decisions. They don't have the experience, background, or day-to-day knowledge to deal with these problems. Management is going to have to have a much wider sweep of authority.

The present group of CEOs that have dealt with boards in the traditional way are going to have to relearn this relationship. They're going to have to learn to take risks. Most CEOs as I know them, because of their backgrounds and the ways in which they have

had to operate, are really risk-averse. In order to find risk takers, the present CEOs are either going to have to change their habits and behavior patterns or a new group will arise. As younger CEOs come along, they will behave differently because they have not been trained like their predecessors.

NEWKIRK:

Which again flies in the face of our discussion about education—what we're preparing.

JOHNSON:

Absolutely. You asked a question about the Clinton health proposal. A few weeks ago after the President's speech to the joint session of Congress, I obtained a copy of the bill and spent the weekend reading the 1,439 pages of submission to Congress. I went through the whole scenario. The text I read is not comparable to his speech to Congress, which he called a competitive model. It's not a competitive model. It's a totally bureaucratic model that takes one-seventh of the economy and puts it under the control of the federal government. I don't believe that it will work. I think it will destroy the health care system as we know it. My best guess is that over the years, Congress has learned to be leery of expenditure bills of this magnitude. The best that we're going to see out of it is probably community rating versus experience rating. In addition, access for people that don't have access today, and I think that's about where it will stop. I don't believe we are going to see health alliances. The process that

we're going to go through over the next 12 to 24 months is going to be a real wrenching of the health care system.

But we also see much evidence of physician-hospital organizations in various parts of the country. This is an interim step into something else, and I don't know what the something else is, but PHOs are not a solid enough base, in my judgment, to survive too long. They will have to develop into a variety of models, including closed models with large multispecialty groups. Physicians are as much affected as are hospitals. I have a lot of sympathy for the practicing physician today. I spend a lot of time interviewing them. They're concerned, and they're fearful. They consider themselves as small economic units. Many have the attitude, "I have to keep on doing what I can do until something really drastic happens, and then I'll have to adjust." When that time comes, they will react because they don't feel they have any control over the events of the day. And they probably don't.

NEWKIRK:

They're acting so crazy, too. A lady told me the other day that she was going to have elective surgery, and the surgeon insisted on a cashier's check two weeks in advance of the date of surgery. Now that is absolutely—I don't know whether it's paranoid or just acting crazy, but that's the kind of thing that goes on.

JOHNSON:

That's not typical, what you described, but it's fear, and physicians all have fear today. Hospital administrators are fearful today, and we're seeing it at the state level. Lots of

state activities are being pushed by concerns about federal activities. I don't have much faith at the federal level. I see too much evidence that all Congress is doing is trying to find ways to increase tax revenues so that they don't have to face the realities of cutting programs to the bone. They turn around and say (if you recall the words that have been used for the past several years) we have to keep the federal government budget-neutral. With that kind of philosophy, it's terrible to contemplate that the feds are going to control one-seventh of the dollars of the whole economy.

I've started another article on global budgeting as to why it doesn't work. You and I both know from our travels overseas, if you get sick, you want to either head for a U.S. Air Force base overseas or catch a plane home. I don't want care—except maybe in West Germany—but other than that, I want to come back to the States for care. I think we're playing with endangering the whole system of care that we've developed. We have tremendous clinical expertise in this country. I'm impressed.

NEWKIRK:

Dick, let's talk some more about government in health care.

JOHNSON:

Well, from your own experiences in running a state hospital association, you're familiar with the certificate-of-need process and what goes on. Let me give you a perspective of that aspect of government. For the past few years, I have spent more and more time providing expert witness testimony at CON hearings. Quite

often I am employed by a hospital to oppose an application. If TriBrook is doing a project for a hospital, we may do the submission for the CON and later testify with respect to the proposed project. On the other hand, we may be in a community where we are asked to review the application of a hospital and then prepare an argument as to why they shouldn't be permitted to have the certificate of need for whatever services they're applying for.

Out of these sets of experiences, I've come to a couple of thoughts that disturb me a great deal about the certificate of need. My primary concern is that it doesn't deal with the realities of what's going on. Today it's not unusual, as I see it, for a hospital to spend anywhere between a quarter to a half a million dollars either opposing a CON or being in favor of a CON. I think that amount of money for this kind of purpose goes for lawyers against lawyers. In essence, it is a judicial proceeding without any of the requirements of a court system with respect to it. The process is freewheeling. The hearings are much more so than within a court system. You deal with hearing officers that are assigned to hear these cases, usually by the attorney general of the state. He assigns one of his staff members to be the hearing officer. In most instances, you are dealing with a person who has no knowledge of the health field. Sometimes two to three weeks are devoted to the process of sitting there while everybody educates the hearing officer with respect to health care. It's a tremendous waste of time, effort, and money. It is a horrendous system that we have working.

The difficulty with the law itself is something that bothers me as well. Let me give you an example. A hospital located in a service area where its funding is predominately from Medicare/ Medicaid revenue puts the hospital in great financial straits. Therefore, the hospital tries to establish a service or activity at a remote location in a much more affluent area where the financial mix will be much more beneficial. The argument that is made in the course of the hearing is twofold. One, the beds are being transferred. Well, transferring beds is a euphemism. You'd think they were real beds. In effect, they have a licensed capacity of beds, but they operate maybe only 50 percent or 60 percent of those licensed beds. The unused beds are in rooms now occupied with administrative personnel. But for hearing purposes, they're saying they're transferring beds, beds that are fictional. They don't exist any more. They act like its perfectly legitimate to move beds. Everybody in the room, except maybe the hearing officer, knows these beds don't exist and that to build additional beds in another area simply increases the oversupply of available beds. They act as if it's no additional beds at all.

It's fairyland to sit and listen to these kinds of arguments. I find this an atrocious thing to permit. The other aspect deals with the reason the hospital is desirous of the CON. Because the hospital is trapped with its financial categories of patients, it wants access to a different financial category of patients, but this line of reasoning is unacceptable in the CON hearing. Needing a better financial mix is true. But the hearing officer and the

attorneys only talk about how much charity care is being provided. The hospital that's seeking the CON will say we're providing X plus amount of charity care while those hospitals who oppose us provide less care. The argument becomes one of charity care. The truth of the matter is that if the hospital requesting the CON is to survive in the area currently served they simply have to have the right to do something else in an area with a better financial mix. Of course, the hospital that serves that better financial mix goes in and opposes them on the grounds the beds aren't needed, which is true, but it would also siphon off excess dollars that would then go to the applicant hospital.

It's a terrible situation and nobody wants to address the issue of amending the CON laws in this country. Instead, we're talking about health care reform on a macro level and not looking at the level of where health care is really occurring. I think we need to take a hard look at the CON laws with respect to government. I'm sure you've seen this in your state, Don.

NEWKIRK:

Do you think the CON laws ought to be done away with?

JOHNSON:

No, I do not. I went through that process in my own head and, as you well know, there were 20-some odd states that did decide to do away with the CON law. These states are now gradually beginning to reinstitute the CON law. I happen to think that we need something like CON because I don't trust a completely competitive, free-enterprise system, nor do I think you can go totally

government. There has to be a blend someplace in the middle between what you can do as a free-enterprise system—capitalistic system—and the kind of government activities that are required. The middle ground is reached through the CON process. I don't think we should have uncontrolled building of hospitals at all. I think you should have to justify, but I think you ought to justify on legitimate, rational grounds, and not on spurious kinds of reasoning. Lawyers are simply trying to abide by the CON law as it exists, whether it's real or not. I think we have to make it real.

NEWKIRK:

So you go out and testify at these hearings?

JOHNSON:

A lot.

NEWKIRK:

That must bother you if you don't like the process.

JOHNSON:

I'm not afraid to step in as an expert witness and say to a hearing officer that the attorneys for both sides are not talking in terms of reality. Tell the truth. It's not in the CON law and lies outside the jurisdiction of what is being considered. Tell the hearing officer you think the hospital ought to survive, and it is up to him/her to look hard at the real problem. The client that I may be representing has to understand ahead of time that's exactly what I'm going to say. Usually the reaction I get is we'd much rather have you talk about the real world. That's what it ought to be.

For instance, I'm not in favor of unnecessary duplication. I can think of a situation where there are two hospitals in a good-sized city down south that have first-class—and I mean first-class—open-heart programs. And the third hospital wants to get into the business. They want to get into open-heart because they believe they can make a lot of money—surplus dollars—from that program. The truth is that they probably couldn't achieve the desired results because they would have had to take away the pump technicians, surgeons, and cases from the existing programs. The number of cases now being taken care of in the two hospitals still have excess capacity. So if you add a third unit, you've only increased excess capacity, and you've made it worse for the three hospitals. There are pluses and minuses. We are not dealing with reality in the CON process today, in my judgment.

NEWKIRK:

That's an interesting point of view and I think one that makes a lot of sense. In general, do you think the government is too involved in the health care system? Not enough? And separate, if you can, payments by the regulators.

JOHNSON:

I'm not disturbed by the regulation process if we once straighten out the CON situation. I don't think that it's the heavy hand of government at all with respect to the CON. I think the laws and the boards we have with regard to nurse and physician registration are probably okay. I think we've got to do something at the national level with the data reporting bank that's been set

up for reporting on physicians. More teeth are needed where malpractice is involved. But overall, I have to argue regulation is reasonable. It's when we get over onto the payment side that I begin to gnash my teeth rather badly.

Let me give you an example with respect to what's going on and the implications as I see it. If you look at the Medicare/Medicaid program, Medicare pays hospitals in the 80 percent range of operating cost, and Medicaid pays something less—it depends on the state. Sometimes it's 60 percent of cost, sometimes 70 percent, but certainly it's less in both programs—in terms of operating cost. That being the case, you have to say, why do hospitals take Medicare and Medicaid. Medicare nationally pays for 44 percent of all of the patient days of care rendered in the acute care system. And Medicaid probably adds another 3, 4, 5 percent depending on the hospital. So you're up to around 50 percent. Why does a hospital lose money on these cases? They do it because they have a social conscience and know that people need to be taken care of, and, second, they've got an out. The out is that they can cost shift into other financial categories of patients. Hospitals abuse the paying patient who pays dollars in excess of cost. As a result, we've had a lot of grumbling from the public with regard to hospital costs. Hospitals are out of line.

I was in the hospital as a patient for four days, and I had a bill for $10,000. How could that possibly be? The aspirin that they brought to me was charged at $10 per pill. This is the result of cost shifting. Cost shifting is done in order to keep the

hospital afloat, as well as making it capable of funding reserves for capital purposes. Now you extend this type of thinking to the proposal of the Clinton Administration with regard to health care reform, and you have to question what's going to happen? As I understand it, the basic thought is that government will use existing Medicare/Medicaid rates and apply them across the board under universal coverage. If this happens, what will occur will be a terrible problem. The hospital that does cost shifting today, does it because they know they have a financial category of patients that they can shift costs onto. That means hospitals are using a marginal-cost concept approach when signing contracts with Medicare/Medicaid. However, if every hospital is covered by the same program, and rates are less than operating cost instead of using the margin-cost concept, hospitals are going to have to start using an average-cost concept. And if you use an average-cost concept, and it's below cost, you have a much different problem than we have at the present time.

If hospitals are going to get paid less than average operating costs there are three opportunities to do something about it. The first is to reduce the amount of personnel in the hospital. If you think along that line, you quickly know you can't reduce staffing in the clinical areas. Reductions are going to have to be made in the administrative areas. Second, hospitals can take nonoperating revenues and apply them to make up the difference that is not covered. However, most hospitals don't have enough nonoperating revenue to offset these shortfalls. So you've got a problem. The

third approach when confronted with accepting a rate that is below full cost, the hospital takes it out of cash flow for the next year or two and hopes to survive. By doing this, they bet that by the end of one or two years, the payer will have to recognize it's not paying enough. A temporary stopgap of dollars would be infused and rates significantly increased. When reality sets in at the federal level, the dollars are then provided in a crash program.

These are the only three sources that a hospital can turn to: reduce staff, which means administrative areas; use nonoperating revenues; or let your cash flow run down. None of those three are very good alternatives. I don't think the federal government in their approach to federal health care reform understands the difference between using a marginal-cost concept and an average-cost concept. Hospitals simply are not going to be able to survive. I think the best we're going to get out of health care reform will be incremental changes in the health field. If the federal government attempts to do the whole thing in the way that has been proposed in the 1,439 pages of legislation, they will, in my judgment, bankrupt the system, probably within four or five years. And then hospitals are going to have to decide what to do. In this country, we never go back to where we were. Government never does that. It always finds a new program, which is their way of admitting a mistake. Government is not going to admit to anybody a mistake was made. New programs will be proposed that correct some of those errors, and then hospitals will be in the game of making more horseback decisions down the road.

NEWKIRK:

Or Draconian. Conservatives are saying that maybe that's what they want to happen—have the thing collapse and then hospitals will be the first to go.

JOHNSON:

Well . . .

NEWKIRK:

Is that paranoid?

JOHNSON:

No, I don't think so because I was in a discussion several years ago up at HCFA when Carolyne Davis was administrator of that program. She and four or five of her top lieutenants were present. I was saying to them if you don't pay enough, you're going to force some hospitals to go bankrupt. And the lieutenants sitting around said, "Well, that's fine. The country has excess capacity, and we need to get rid of hospitals." So I said to them, "I can understand reducing the number of hospitals, but the ones that are going to collapse are going to be in rural areas and the inner cities where the need is the greatest. You are proposing a meat-ax approach that is going to hurt the hospital system. You're going to hurt people far more with that approach than if you tried to do it on a rational basis."

NEWKIRK:

You don't think it's rational to concede that the people in the inner city are going to flock to the suburbs to go to the hospitals?

JOHNSON:

They're not.

NEWKIRK:

Let's change the subject, if you don't mind. Let's go on to governance. That's always been one of your strong suits, both in consulting and in writing. Talk to us a little bit about governance, about health care institutions.

JOHNSON:

For the last 10 years, I've stated publicly every time I dealt with a governing board, or at a meeting where we were talking about governance, that the Achilles' heel of the voluntary hospital field is the governing board. After 10 years, I still firmly believe this is the case. In hospitals, we credential and recredential physicians and we have quality-control measures, which means we measure performance, as loose or as poor as it might be. Nevertheless, it's a measurement system. We have annual evaluations of employees from the top on down in just about all hospitals today. But the one group that we don't measure performance on is the governing boards. We assume that if you sit on a governing board, then it's okay not to measure performance because you're providing voluntary service to the community. The myth is that voluntary participation equates with being worthwhile. Some members are and some are not. But the fact that you serve without pay has no relationship to performance. In my judgment, we'd be far better off if we paid all board members. Where I've been able to get hospitals to pay board members, there is a

significant increase in their understandings, their values, and in the decision-making process. Boards are far more effective if members are paid, as every for-profit corporation knows.

There are lots of stories I could tell you relative to board activities. For example, a board chairperson scheduled a meeting that conflicted with a bank board meeting, where several hospital board members were also on the bank board. They were paid at the bank. So the board chairperson went down to the bank to see who was going to that meeting. The chairperson found all of these hospital trustees were sitting in the bank boardroom. The bank paid them and the hospital did not. Just because you give of yourself is no criterion of competence, in my judgment. One of the best programs that I'm aware of was the one that Rush Jordan put in at Miami Valley Hospital when he was its president.

NEWKIRK:

Dayton, Ohio.

JOHNSON:

In Dayton, Ohio. The nominating committee met regularly, selected potential board members for what they thought were the needs of the board, went out and interviewed these individuals, and asked would you be interested in serving? If you are, you need to know two things. One, we're going to evaluate you as a board member annually, like everybody else in the institution is evaluated. That report will go into your personnel file, and you may or may not be reappointed. Two, don't expect if you get on this board, you're going to stay forever. For the first year,

before you are on the board, you will be sent all the information that board members receive but no participation by you. For a year, they had all the information but never attended a board meeting except for educational purposes. Rush considered it important to bring them up to speed before they sat on that board. That makes a lot of sense to me.

What makes even more sense is to have an annual evaluation of each board member, and I propose this very frequently when I'm talking with boards. What you find out is board members don't want to be evaluated by other board members. They sit there and if you say to the officers of the board, you ought to evaluate your board members they pause and say, "Now wait a minute. I have to live with these people outside of the hospital boardroom. I'm not about to do that." You find a great reluctance. Personally, I'm really very much against what the AHA has done on self-evaluation. They thought it was a half-step forward, and I consider it just a sop that has no meaning whatsoever. With that system, I'm not going to self-evaluate and say I'm a bad board member. Nobody's going to do that. So I think that's a step backward.

We have to develop honest evaluations, and we have to be willing to get rid of board members. Sometimes it's not because they are not capable people, but the set of skills that they have ought to be changed. In the environment that we're moving into, we need to change some board members. For example, we ought to have somebody on a board today that really understands managed care. I've often suggested to hospital boards that they should bring in

CEOs from outside their service area and put them on the hospital board. That you already serve on a hospital board in Ohio is appropriate. The board you sit on benefits by your knowledge and experience in health care management for over 40 years. That's a value that has considerable meaning. We need to do more of that with administrators sitting on boards. I've been able to achieve this a few times, where the hospital CEO flies in for a board meeting. It's an invaluable activity because the outside CEO is in a position to challenge the in-house CEO's thinking on some aspect, or to be highly supportive when other board members don't know enough about what's going on. It cuts both ways.

Certainly what's done in industry is to bring in knowledgeable people. We don't bring knowledgeable people into hospital boards. We seem to take the position if you really know something about a hospital, you probably ought not to be on the board. If you are a good citizen in the community and an upstanding one, that's reason enough. That's not near reason enough. Hospitals are one of the most complex industries and organizations that we have in our society, and to put somebody on a board that doesn't know anything about hospitals and think the hospital is going to get good results is rather fanciful thinking. We're running out of room to get good results in hospitals as the limitation on resources keeps on increasing. We need to have more and more sophisticated board members and management, that work hand in glove. This has not been the case.

I would change the name of the Nominating Committee of a hospital board to the Nominating and Evaluating Committee. That committee should collect information routinely about individual member board performance so that at the time a person's term is up, the person is either voted up or down based on performance and not on the number of meetings attended. This is a meaningless term in my book. The hospital needs to know if they contribute and substantially add to the decisions reached, and did they add value by their services on the board.

NEWKIRK:

I have a hospital client that asked me to process board evaluations, and do exactly what you're talking about. Each board member evaluates three other board members, and they're all put together. This is done on an annual basis and also redone when a board member is up for reelection. Some of them get bounced.

JOHNSON:

Has that, in your judgment, increased the competency and understanding of that board?

NEWKIRK:

I have no question it has. I tried that on other boards, and this happened to be a corporate board, talking about evaluation. I said why don't you people do this, and I explained what we did on the hospital board. One of the older board members came right up out of his chair. Nobody in this room is going to evaluate me. That was the end of the subject.

JOHNSON:

If he was a major shareholder, I guess that was end of the discussion.

NEWKIRK:

He was influential. Let's put it that way.

JOHNSON:

When it comes to board performance, I use four words. When you talk about governance, all too often people jump to organizational structure. How many people ought to be on the board? What should the composition be? How long should they serve? I use a word to describe this, the word CUPS. First is competence. How do we determine the competence of individual board members? Second, what are the understandings that we want them to have and to continue to learn? P is for Performance. Let's look at their performance. And then S is for structure. The structure is really far less important if you have the CUPS in line.

NEWKIRK:

Anything else on governance? Good stuff. I appreciate your comments. Well, let's move on to ethics. You are noted for doing some writing and speaking about ethics and, of course, bioethics or clinical ethics or whatever name you want to call it. Sort of a hot button right now. Ethicists are popping up all over the country. Give me some information on that.

JOHNSON:

Well, this is a subject that my brother Everett and I talk about a fair amount. By the way, we talk just about every day on

the phone for the past 40 years, with both of us in the health field. Obviously, our conversations revolve around what is going on in the health field. Quite often it deals with ethics. Both of us, I think, have come to an appreciation that ethics are conditioned by the economics that are involved. If you have a lot of money, you can be far more ethical about what you're doing than if you have no money at all. That is not understood in the health field. I think, for example, when we discuss management and ethics, the management equation should always give way to the clinical equation. Clinical ethics in my judgment are more important than management ethics. I'm not talking about conflict of interest and dealing under the table. But I am saying when you have a dilemma that presents itself, the ethical thing to do will be to answer the clinical question first, and then, once you've answered that, then you can go look, if you want to, at the other aspects. But they're all—as you know as an ethicist, all shades of gray that fit in here, and it's this gray area that we don't pay enough attention to.

NEWKIRK:

Nothing is ever all right or all wrong.

JOHNSON:

No. And that's the difficulty that we live with in this field. It's never all one way or the other. The easy questions to answer are those that are all one way. But it's when the proper tracheal tube size in the emergency room is not available, because a purchase order was stopped, that the ethical question arises. Is

that an ethical question or not? In my judgment, it's an ethical question. A lot of people would argue, I think the other side of that question. Have you got all the tracheal tubes you need in a hospital? To my mind, that's a good question to ask. But we don't tend to get into those kinds of things. We think of much broader issues at the social level. I'm sure you've had those experiences. Do you agree in your thought process that the clinical has precedence over the managerial or other aspects?

NEWKIRK:

Yes, a preponderance of experience has been clinical, and most cases have been written on the clinical side.

JOHNSON:

Of course, that slops over into the economic issue, which then again grays up the management ethics. They overlay each other in many cases. We're going to increasingly find ethical questions being raised as we get into more capitation and managed care. Managed care creates some serious ethical problems such as when a primary care physician is in a bonus pool. If at the end of the year, the amount of patients referred to specialists has been limited, the physician gets more of the bonus pool. If you think about it in a truly ethical fashion, that's an unethical practice in a clinical setting. If you think that a patient ought to be referred to a specialist, the physician has no right to let the economic side enter into his thinking. But it does. And the more we get into this bonus-pool operation for primary care physicians, the more we're going to see ethical questions arise.

NEWKIRK:

Or the harder the ethical decisions will be.

JOHNSON:

You bet.

NEWKIRK:

Okay. How about technology? We talked about ethics and technology, so we're touching on ethical problems, and it also touches on cost. It also touches on acuity, and it touches on a number of things. But talk to us for a while about technology.

JOHNSON:

Well, we can relate technology in two directions. One is to inpatient services and the other outpatient services. I think the more important issue is what's going on where Dr. John Kitzhopper in Oregon, who had been an emergency room physician and moved into the state legislature, became the Speaker of the House, and put in legislation that has become a trial run on a rationing system for health care. This program revolves around technology. How far is a hospital willing to go given the patient's set of circumstances—age, condition of the patient, and resources. This is all driven by technology, which has been all to the good.

One of the problems a physician faces, and I think rightly so, is when to ask for a piece of equipment from the hospital. It leads to a more definitive diagnosis. For example, an MRI is a much better tool to use than an X-ray machine. The physician knows this. So the physician goes ahead and orders an MRI on a patient. Very expensive—the difference may be between $50 for an X ray

versus $800 for an MRI. But the result makes the physician want the MRI. The physician knows the result is a much clearer picture of what has to be done. I can't fault physicians for wanting to use all of the technology that comes on the market. Now should we use all of it? Probably. The limitation is on the resources that are available. A brake on resources is probably needed but the truth of the matter is the physicians are going to keep on insisting on technology, and they're going to keep on using it, and I'm all in favor of it if I happen to be the recipient that needs it. I did need it last summer in a surgical procedure. I'm delighted they used an MRI. I saw the films from the X rays and the films from the MRI. After looking at both, I'm just as pleased as punch that the surgeon had the MRI results.

We can talk about health policy as an abstract activity as health care executives. A physician deals differently. He deals on a one-to-one personal relationship. In management, we aggregate what we do. Physicians don't. They think sequentially. First patient, second patient, third patient, fourth patient. They see things in a different light. In my judgment, we have to acknowledge that the physician's ability has been enhanced with regard to technology. So I'm in favor of all the technology that comes down the pike. Maybe you don't buy the first generation of new equipment. You wait three years and buy the second generation because it's better. But certainly we have to be receptive to technological innovations. Technology has made a difference. As you know, the health care systems you and I have looked at around

the world when compared to our system, come up short because of our technology. Much better clinical results are achieved here than in the rest of the world. Now when you go to rationing with the Kitzhopper approach we're going to have a tough time deciding whether a patient is a recipient or not.

We're now crossing over into sociological aspects and attitudes of people that, at least in the United States, we will have a great deal of difficulty trying to convince the public that they ought to accept a decision about care based on economic considerations. I think there's another side. Living wills that a number of people have are a willingness to terminate life-support systems, and they are appropriate. We need to rethink the whole question of when we permit a patient to die.

I don't think keeping a person alive makes a great deal of sense when death is imminent. Let me tell you a story about that. Granger Westberg was our chaplain at the University of Chicago many years ago. Granger is the father of holistic medicine in this country. He believed in the concept, in the whole man. I remember one day at lunch I walked into the dining room and sat down next to Granger. I said, "Gee, Granger, I heard this morning that your father died. I'm sorry he died. That's really too bad." Granger had a very interesting remark. He said, "Don't be. The quality of my father's life had disappeared, so he should die." This was from a minister who had thought about these kinds of issues. He made a very sensible statement with regard to it. People should have the right to die peacefully. On the other hand, to deny them the

resources is an ethical problem. I don't know where you draw the line. I don't think you can. And I don't believe what they're doing in Oregon is going to be replicated around the country. It's an interesting experiment. It's one I'm glad is going on, but I don't believe it will get public support in the future. So I have difficulty.

On the other side of technology is the question of moving from inpatient to ambulatory services. It's been great. When I think back to when I first entered on my career, if we had a patient that needed a cataract operation, their heads were sandbagged for three weeks until they recovered. Now it's an outpatient procedure. We do arthroscopes, as well on outpatients. We couldn't have done these procedures years ago.

Miniaturizing surgery makes a lot of sense. And we're going to do more and more on an ambulatory basis. What that is going to do, however, is to lead to difficulties in financing inpatient hospital care. Hospitals are going to have the intensity of illness keep on rising for services that can't be performed on an outpatient basis. When we do planning here at TriBrook on facilities, and are looking at operating rooms, we plan for 60 percent of the surgical procedures being performed on an outpatient basis and only 40 percent on an inpatient basis. That ratio is going to keep on changing toward outpatient in the years ahead. And that's all to the good. People are more comfortable with ambulatory care.

Sometimes financing and technology involve government. Let me give you an example that has bothered me. I was at HCFA and the subject that we were discussing had to do with cataract operations. The people around the table were saying the reason that physicians are doing cataracts on an outpatient basis is because it's an uncontrolled procedure and the ophthalmologist can make more money by doing it on an outpatient basis. I looked at these people, and said, "Did it ever occur to you that the patient may prefer it because it's a better procedure and has nothing to do with the dollars and who gets how many dollars?" The experiences I've had with physicians over the years has led me to conclude that the vast majority of them do not do what they do because of the amount of dollars involved. They do it because they've learned to practice good medicine, and they want to continue to practice good medicine which dictates why most physicians do what they do. It is not money. Sure, there are some physicians that chase the dollar, but that is not true of the preponderance of physicians in this country.

NEWKIRK:

Dick, let's talk a bit about the practice of medicine. Let's hear what you have to say.

JOHNSON:

Well, the practice of medicine is the basis of the whole health field. Over the years, I've come to appreciate the physician's role far more than I used to. When you manage a hospital, physicians quite often seem to be interfering with what

you'd like to do. Even though you may recognize that what they're doing is important and basic to health care, you still see them as problems. I've found in a number of instances, it's the CEOs who see physicians as the adversary. Certainly if they're an adversary, the CEO is not going to do well in a hospital. The most successful CEOs that I know have been very compassionate, very understanding, and want to be supportive of physicians.

Physicians give orders all the time, to nurses and patients. They say, do this or do that, or I want you to go purchase this kind of drug, whatever. But it's always a statement of "I want you to do something." They tend to behave in that same way when they get in the hospital and are dealing with other types of issues. I don't think we sufficiently appreciate that it's not their desire to behave like this on other matters but it reflects the system they live in every day. The physician is going to keep on behaving in this manner. And we simply have to learn to accommodate it. We can't take the exception of an obstreperous physician, who may give the CEO a very difficult time, and act as if it is the way all physicians behave. Out of thousands of interviews with physicians, I am very impressed with the medical profession in this country even though I know all of their warts and bumps as well.

My final analysis is that physicians have done a particularly good job in this country. They are people who care a lot about what they do and they work very hard at what they do. Quite often they work day after day, month after month, year after year, with no let-up in their activities. And we don't appreciate that

enough. I don't mean by that to say that they have to be loved or that we have to stroke them a lot. But I do say we do have to have an appreciation that these are people who are committed, who care a lot about what they do and, at the present time, are having a great deal of difficulty in this world. Most physicians, particularly younger ones, are very afraid of the future. They understand that their concerns are going to grow in the years ahead. Quite often I've heard them say I didn't go into medicine to have happen what's happening to me now.

Just the other day I was interviewing several physicians in a study that we were doing, and I asked each one of them what had happened to the ratio of professional income as part of gross billings of the practice. If you look at the AMA statistics of social characteristics of medicine, you find that over the years, income has been between 48 and 52 percent, quite often at 50 percent for professional income. Today, that number is beginning to erode. Often it's 45 percent or 44 percent and if you look at it over the last several years, there's a gradual deterioration. Like all the rest of society, once physicians attain a certain income level, they want to maintain it. A perfectly normal human desire. They will take steps that are legitimate and proper to protect themselves. For example, a physician institutes a service because there is new technology that can be used in the office which previously could only be done in a hospital. When started in the office, the hospital resents it, believing the physician is taking away hospital income. On the other hand, the physician's

position is that it is needed to survive. So these tensions are created. We are going to see more of the same in the years ahead.

I think we have to be sympathetic to physicians because administrators are not the backbone of the health care system. Physicians are the backbone, and that needs to be understood. There is a need to work much more seriously in developing relationships from a management standpoint with physicians.

We're also seeing a change between primary care physicians and specialists. This is a battle just under way in many communities. As health care moves more toward capitation and "the gatekeeper" model, the primary care physician decides when the patient goes to a specialist. That puts the primary care physician in the driver's seat, a position that he is not accustomed to. If you look back historically and ask the question who went into primary care, it was physicians who were either at the bottom of their medical school class or didn't have the money to go on into a residency for a specialty. That's changed. There are many physicians today in primary care because they love the diversity that exists. But the question they have to face, and pediatricians face it more than others, is the extent to which a person is willing to settle for the level of income of a primary care physician. In a specialty, a physician may earn five times the amount of money of a primary care physician.

In the future, there will be a shift where the primary care physician is going to tell the specialist what fees may be charged. And that will go down hard. I sat through meetings this last year

and watched the dynamics between specialists and primary care physicians. The specialists recognize what is happening and are very busy trying to develop group practices that include primary care physicians. They want to keep primary care physicians in the traditional role of feeding the specialist. It's an interesting dynamic. If you look at the ratios in Kaiser Permanente, primary care physicians need far fewer specialists for referrals than what exists in most community hospitals today. That's scary for most specialists. Specialists keep wondering how to protect a practice volume when there are other similar specialists available. There aren't any good answers to their concerns. Some of them are going to have to retrain in primary care and take substantial drops in income as capitation moves to the forefront.

So there is a lot of fear that exists among physicians. This will play out against hospitals from time to time. We have to appreciate that's going to happen. Many physicians see the hospital as a bureaucratic system, i.e., government. So they are going to lash out at the hospital, but hospital executives have to learn not to take that personally, but rather look beyond to find out what is causing them to behave in that way. Then solutions have to be sought and solutions are often missing.

One of the things that will change dramatically in the next few years is the concept of the medical staff. I think it will be abandoned. In its place will be contractual relationships between hospitals and individual types of physicians or group practices. As these develop, the medical staff is going to disappear. It'll

probably take 10 years for this to occur, but we're going to see a vast change in the hospital-medical staff relationships. The article I wrote years ago about the three-legged stool, which focused on the fragile nature of the hospital organizational structure reflects my continuing concern. The typical medical staff organization was designed by Dr. MacEachern in 1925 or '26. That fragile system is going to be replaced with contractual relationships between a hospital and a physician or group of physicians where the basis of the relationship is spelled out in the contract and not left to an informal process like we have today. Hospitals will spell out what the details of the relationships will be.

One thing that has always disturbed me with our CEO friends is hearing them talk about a physician's loyalty in terms of how often the hospital is used. How a physician uses a hospital is not the basis of loyalty; it's the basis of a business function. A business relationship is separate and apart from a question of loyalty.

NEWKIRK:

Perhaps hospitals will have in-house practices.

JOHNSON:

I think it could . . .

NEWKIRK:

More. More.

JOHNSON:

I think many hospitals will move in this direction. The reverse will also occur where group practices may own hospitals like the Mayos and the Cleveland Clinic or the Scott and Whites of the world.

NEWKIRK:

Let's do a name or so, and then we'll finish with the big subject, the future of health care. Ed Crosby. Just in a few words, give me impressions, anecdotes, whatever.

JOHNSON:

A driven man, great manipulative skills, great political skills, not well versed in understanding the health field, tending to be biased toward physicians without a balanced viewpoint with respect to the other components of the health field. A great asset in his role as executive director and then president of the AHA. I think he did an outstanding job in those years. I'm sorry that he died at an early age. He was a good influence overall.

NEWKIRK:

Richard Stull.

JOHNSON:

The first chairman of the Atomic Energy Commission, which most people don't know. Dick was a close personal friend of mine. I liked him immensely on a personal basis. I thought his career demonstrated flexibility and adaptability. He moved from consulting into administration of a hospital in San Francisco; then became a vice president of the University of California system and

then back to a professional role. He's one that I'd have to say was a true professional in health care management and contributed substantially to what went on in its development stages. He was particularly suited to his role at the ACHA when he was president of that organization. Good man.

NEWKIRK:

Ray Brown.

JOHNSON:

Well, now you're talking about my hero.

NEWKIRK:

Our hero.

JOHNSON:

A man that many people knew but not many knew well. I think I knew Ray well because we wrote one book together. I saw a lot of him, not only in the years that I worked for him, but later years as well. I always felt very comfortable with him. Ray appeared to be tough on the outside, but he was a marshmallow on the inside. He was always looking for ways to be helpful to people. Even though he occasionally had to take stern measures when he was running a hospital, they were always with compassion and feelings for others. That stemmed largely from Ray's background, having grown up as the son of a Baptist minister in North Carolina. Ray carried over many concepts and feelings of compassion as a result of his family upbringing.

I want to describe for you one incident that happened that personifies his judgment. I remember an incident in which the

university controller wanted to take all of the surplus funds from the hospital into university accounts. This was proposed in an informal conversation with Ray. Ray understood in no uncertain terms where that could lead. What started as a minor conversation led Ray to act as if it was a typhoon that had suddenly hit the landscape. He exerted all kinds of efforts, strenuous efforts, devoted a lot of attention to that question. He went around talking to people: the president of the university, the dean of the medical school, to everybody that ought to be talked to, to convince them that the university controller was way off base. Ray understood completely that there are some things that look like a gentle wind, but you ought to treat them as if they are a typhoon. He knew when those judgments had to be made. At first glance, you would believe he had gone off the deep end and was making a mountain out of something that was just a little molehill. Not at all. He knew how fast it could grow, and he took steps to prevent it from ever happening. One of the most sophisticated, bright, perceptive persons I've ever known in my life. Great compassion for people.

NEWKIRK:

A couple of people you worked with over the years. I don't often get into these oral histories. Jim Hague.

JOHNSON:

Interesting person. I liked Jim a lot. He grew up in England.

NEWKIRK:

Tell us who Jim was.

JOHNSON:

Jim Hague was the editor of the journals of the American Hospital Association. He came to the United States as a young man, did not get a college degree, but was one of the most well-read, literate people I have ever met. He was deeply concerned about the use of words and how they were used. He went to great lengths to make sure that everybody used words properly, or he took them to task. I think he brought a standard of excellence to that position, which had not been there before him at the AHA. He was a driving force in publications. Because of his lack of a college degree, he always felt a little inferior and that meant that he drove himself even harder. He was not inferior, but he felt inferior. He had a great desire to be a friend to Ed Crosby, who was then the president of the Association. Sometimes you had to be a little bit careful with respect to Jim, because he'd go hide behind Ed Crosby's skirts to get things done. Overall, I enjoyed Jim as a person who cared a lot about what he did in the publishing world.

NEWKIRK:

He was unique.

JOHNSON:

Yes, he was.

NEWKIRK:

Another. Bob Cunningham.

JOHNSON:

One of my close friends. I used to see Bob over the years about once a month. We'd go for dinners or luncheons, and I remember him from the mid '50s on when I first knew him. I was at the University of Chicago, and Bob at that time was the editor of Modern Healthcare, which was a competing journal to Hospitals magazine. Bob was regarded in this country as the best health care writer in his field. Great. He was a University of Chicago graduate of liberal arts. He was a literate man. He got his start in the health field by editing the publications for the American College of Surgeons. That was his first contact with the health field. Then he went from there over to Modern Healthcare as the editor. Bob always worried. Publicly he had one stance. Privately he had another stance, which was he was always worried about how much advertising he had in his journal versus the amount of advertising that Hospitals magazine had. In his judgment, Hospitals always had an unfair advantage because of its membership as opposed to just circulation.

One time he showed me one sentence he had written that had 200 words. It made perfectly good sense. A master of the written word. Great perception about the health field. Bob was, in terms of his leanings, a liberal in his viewpoint. He sensed matters much earlier than most people, and he wrote about them, which made him a controversial figure.

He took up the black issue at a time when it was an unpopular subject. He would write about the social conscience a hospital

should have and he didn't object to taking people to task who didn't share his convictions. Overall, Bob was very much of a lightning rod for the health field, spoke articulately, and had radical viewpoints. I shared many a speaker's platform with Bob over the years, and we were close friends. Just to think about him is an absolute delight today. The last few years of his life were difficult. He had a lot of personal problems in his life, but they never interfered with what was going on in the profession.

NEWKIRK:

To sort of butt in on your time, I have to tell you about my favorite quote from one of Bob's arguments. He was reporting in the magazine on a session of the AHA House of Delegates. This was a particularly nothing session, and his favorite was, "The wheels of progress ground so fine that we couldn't hear them."

JOHNSON:

He could turn a phrase very nicely.

NEWKIRK:

George Bugbee.

JOHNSON:

Another good friend of mine. Aptly described, I think, as an aggressive conservative. George had vision and was well disciplined. He had a lot to do with the development of the Hill-Burton program in this country since he fostered that program. He worked with Congress at a time when that was not often considered appropriate. George brought the AHA to full stature as an organization. Before his time, the AHA was floundering. George

became the first really first-class director of the Association. He brought in good folks and began to staff the Association properly. He has been a force in health care. I'd have to say George is a good man. When he looks in the mirror every day, he can take satisfaction out of the fact that he contributed far more than he ever took out of the field. He was a gentleman, a person who lacked the kind of vision that Ray Brown had, but he certainly had the drive and could listen well to people and take their advice.

NEWKIRK:

You're too young to remember Dr. MacEachern or haven't had any personal contact with him, but . . .

JOHNSON:

No, I did know Dr. MacEachern.

NEWKIRK:

Sure.

JOHNSON:

In fact, I last saw him about a week before he died at Passavant Hospital. Mac was quite an individual. After I first entered the field, I found out there were two people that really had led health care management. One was Dr. Bachmeyer, and the other was Dr. MacEachern. Both in very different ways. I would say that Dr. Bachmeyer was the intellectual leader of health management of his time, and Dr. MacEachern was the leader of let's get it done. Very pragmatic. Mac as you know was a Canadian by birth, believed in the nuts-and-bolts approach to life. He was the

one who put the organized medical staff together. He did this when he headed up the Standardization Program of the American College of Surgeons, which ultimately became the Joint Commission on Accreditation of Healthcare Organizations. He was the father of the JCAHO. Mac was a gentle person. He was a gentle giant in my book. Mac was probably six feet three inches, big frame, and whenever you think of Mac, the one thing you remember is the clump of academic keys in the lapel of his suit coat. Mac was a charming person. Over many years he rode a lot of trains, and he must have slept in many upper and lower berths on trains going from one hospital to another. A very dedicated individual who wrote the first textbook. The one that was a big red book called . . .

NEWKIRK:

Hospital Organization and Management.

JOHNSON:

Something like that. It was the only textbook that was available at the time. He was a person who thought he ought to write about how to manage a hospital. He was not an intellectual by any stretch of the imagination, but he was a hard worker, who cared about people. One of the things that I've always admired Ed Crosby for doing was when Dr. Mac had been terminated over at the American College of Surgeons when they gave up the hospital standardization program and formed the Joint Commission was to hire Mac as his special assistant at the AHA. Mac had an office, and Ed told him to do whatever he wanted to do. That was the right thing

to do for a man of Dr. MacEachern's stature. When I last saw Mac, he was past his prime by a long shot but still was a gentle person.

NEWKIRK:

Could we spend a few minutes, as we end this interview, on the future of health care. Do you have any comments in that regard?

JOHNSON:

I'm absolutely entranced with the future. I can't believe what it would be like to be retired at this point and not have an opportunity to participate in the activities that are going on. Everything that we've grown up with over the years is now up for grabs. We now have opportunities to create new schemes and new ways of doing things. It's a whole new world out there. I can't imagine anything more exciting than the possibilities that confront us today in the health field. We are beginning to answer in a serious way the one question that we've never examined. We have always designed the health care system to protect the provider's interest, whether it be the hospital or the physician. Now, we're getting to the point where our thinking has to start from what is in the patient's best interest. What is in the employer's best interest? That is going to open up new vistas and activities. It's going to be absolutely the greatest thing, the greatest challenge we could have. I can't imagine a more fun time than what we're looking at today.

I applaud the Clintons' interest in developing and bringing to the forefront the importance of health care in this country. Putting health care on the front burner has been needed for over 10

years, and the fact that it is there is a most important priority. The President has done a great service to this country by bringing it to the forefront. The opportunity it creates is to encourage rethinking of the way hospitals and physicians should conduct themselves in the public arena.

NEWKIRK:

Very interesting. A few steps down the hall from where we are sitting, there is a wall full of framed front pages of magazines containing cover stories by Dick Johnson. Those who read this interview will understand why his thinking is in so much demand. Our sincere thanks to you, Mr. Johnson, for making a very valuable contribution today to the history of health care policy-making.

INDEX