HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Donald W. Welch

DONALD W. WELCH

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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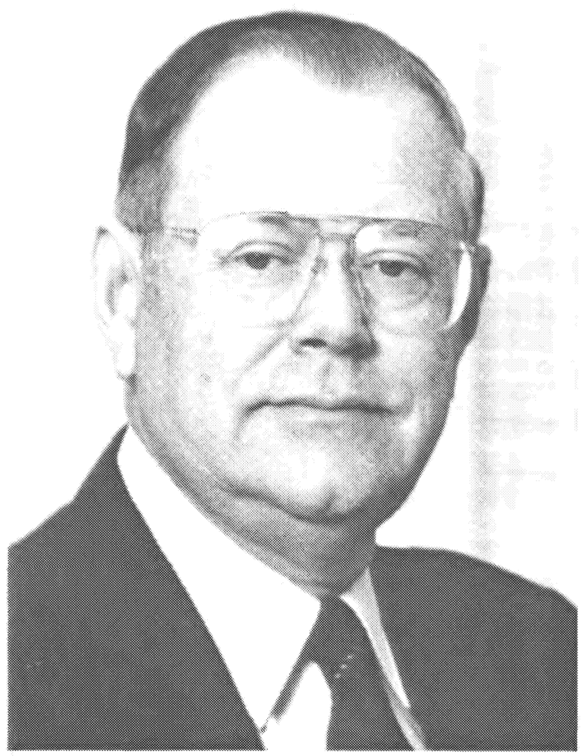

Donald W. Welch

CHRONOLOGY

1927	Born in Hastings, Nebraska, October 30, 1927
1946-1947	Military Service
1949-1952	Madison (Tennessee) Hospital, Director of Laboratory Services
1950-1952	Peabody College and Vanderbilt University, graduate work in business administration
1952-1961	Hialeah (Florida) Hospital, Administrator
1961-1973	Florida Hospital, Orlando, Florida, President
1973-1984	Adventist Health Systems/Sunbelt, Orlando, Florida, President
1985-	Adventist Health System/United States, Arlington, Texas, President

MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives, Fellow

Central Florida Hospital Council, Past President

Comprehensive Planning for Central Florida (HSA),

    Past President

East Central Florida Hospital Planning Council,

    Past President

Florida Hospital Association

    Member of the Board, 1967-1970

    Secretary-Treasurer, 1968-1970

    President, 1971-1972

Seventh Day Adventist Hospital Association,

    Past President

South Florida Hospital Council,

    Past President

AWARDS AND HONORS

American Protestant Hospital Association

Service Award

Florida Hospital Association

Award of Merit

Orange County Dental Society

Certificate of Appreciation

WEEKS:

Mr. Welch, in your oral history which is really an autobiography, I hope you talk freely.

WELCH:

It will be easier for me to talk about our organization than it will be to talk about myself.

WEEKS:

That will be fine. That is what I want to know. You were born in Hastings, Nebraska.

WELCH:

In 1927.

WEEKS:

Did you stay there long?

WELCH:

My father was teaching in an academy at Shelton, Nebraska. It was called Shelton Academy at that time, now called Platte Valley Academy. He was a Bible teacher and Dean of Men at this boarding academy. They went to Hastings because we had at that time an institution there called the Hastings Sanatarium. It has been closed up many years. I was born there and I lived the first six years of my life in Nebraska at this Shelton Academy.

WEEKS:

The next notation I have is of your military service in 1946-1947.

WELCH:

Actually after I left Nebraska, during the Depression times teachers had a hard time getting jobs so we left and moved to southern Missouri. We lived there two years -- really back in the mountains. My father taught school there. Then we moved to Nashville, Tennessee where my father became the pastor of the Madison College Church and in charge of the Bible Department. We moved there in 1936. In about three years he became Dean of Madison College which was a senior college. So, I grew up from about the time I was seven, all through grade school and academy and college in Tennessee -- and I even started working in the hospital at Madison. We had a hospital all on the same campus.

WEEKS:

All Adventist?

WELCH:

Yes, an Adventist institution, in what is now a suburb of Nashville. It was considered out in the country in those days. So I grew up there really.

WEEKS:

I have driven through Madison so I can picture it.

WELCH:

I started working in the hospital part-time when I was 13, squeezing orange juice. I have been involved in health care one way or another ever since.

WEEKS:

I was wondering about your preparation for administrator later on.

WELCH:

I kind of grew into that. I started working in various places. There were minor jobs while I was in school, in academy, and somewhat in college. During World War II there were more jobs for younger people than normal. I started working in the laboratory in the hospital, and in x-ray and took a laboratory and x-ray course.

I was well along in that when I was 18, and almost the day I was 18 I was drafted into the army. This was just the time the war was over. I was in the army close to two years. While I was there I was a psychiatric social worker. When I went in the army I was the only one in a group of about 400 recruits that had one day of college. I had finished one year and I had, and I don't know why, two courses in psychology. I had a course in general psychology and another course that followed general psychology. So when I got in the army and went in basic training -- six weeks in the basic training -- I was called up to the office. The psychiatrist called me down to the psychiatric clinic and took me out of basic training because I was the only one that had any training in college -- the only one in the whole group. Of course this was the end of the war and they were scratching the bottom of the barrel. So, I was in a psychiatric social clinic for most of the time I was in the army. I learned a lot out of that. I interviewed everybody in the post stockade of Camp Polk, Louisiana when it closed, and sent people -- either discharged them, sent them back to active duty, or sent them to the federal penitentiary in Leavenworth, Kansas. That was a very interesting activity for a young guy 18 years old that hadn't been too well acquainted with the world in general.

When I came back, I finished my college. I had a major in chemistry and history. I wanted to go to Peabody to get a master's degree. To do that in those days you had to have a major in education. So I took a few more classes and got a major in education as well as chemistry. At the same time I had finished the laboratory course there at the college and the hospital. In fact, I was the first person from that school, and probably from the Church that took the ASCP, the American Society of Clinical Pathologists, test for medical technologists. They started the course there. In about six months I was running the laboratory.

While I was doing that we had a number of changes in administration. We had a gentleman by the name of H.B. Thomas who really was retired but he came to help out at Madison. He had been a hospital administrator out on the West Coast at our Glendale Hospital which was sort of the flagship of all the Adventist hospitals in the United States at that time. He retired and came and ran Madison Hospital.

He encouraged me to consider hospital administration. It was at that time that I was taking graduate courses at Peabody College. I took a number of courses in accounting and business while I was there. I kind of served as an assistant administrator in the hospital, although unofficially. Then I got called by friends that I had known in Miami. A hospital had been started in Hialeah. It is a little hard to imagine how things were. This was in 1951-1952. In January 1952 I moved down there to be the administrator. This was a hospital they had started in an old hotel. In fact, it used to belong to the United Fruit Company. It was near the race track in Hialeah. They invited me down to be the administrator. If I had had any sense, I wouldn't have gone. If I knew what I was getting into. I had done a little study in a number of areas and visited some other small hospitals. I went down there and became the administrator of this place when I was 24.

WEEKS:

Is it a fact that there were only 19 beds in the hospital?

WELCH:

The place had about 19 or 20 beds when I got there. We really had some seven patients, I think. Then it fell off some. It was a very shaky situation the first year. We got busy rounding up physicians, getting people interested. The area was growing. Miami was booming at that time, particularly in Hialeah which was a bedroom community for working people in Dade County, and especially from the airport which was close by. All of my neighbors worked for airlines.

So, the hospital grew quite rapidly and we were able to replace some of the old buildings and grow slowly over a period of years.

WEEKS:

Did you build on the same spot?

WELCH:

Yes. We built a little piece at a time. It was all we could do, kind of replace the old units one unit at a time. The first major construction I had started in 1955, after I had been there three years. We pretty much replaced the old while I was there. It grew to be a fairly major hospital in the area. By 1961, when I left, they had close to 300 beds. It was the second busiest emergency room in all of Dade County. We had a large medical staff, probably 150 physicians on the staff. So, it was growing and had been profitable. It didn't have a high debt. We learned a lot there. We got involved in the hospital community. We got acquainted with a lot of good people. I think in 1960 I was president of the South Florida Hospital Council and was involved with that and was somewhat involved in the state association.

One of the friends I made there was a person by the name of Jack Monaghan, who, when I first went to Dade County, was running the hospital up at Fort Lauderdale, Broward General. He, a year later, went to the Florida Hospital Association and became the executive director. He was there for many years, still there as a matter of fact. He is retired as the chief man. He and I had a very close relationship for many years. Still do, but I don't see him very often. I received a lot of help from him, and guidance. I appreciated his friendship.

In late 1960, I was invited to go to our church-owned hospital in Orlando. Hialeah Hospital was operated by Church members, but it is not owned by the church. It is a private institution, basically which Church members on their own are involved with. Frankly, the Church, when the hospital was started back in 1951, looked at the hospital and said they didn't want it, that it couldn't make it. They said they didn't think they should be involved in it. It kind of inspired us for a lot of good reasons: some very dedicated laymen. Actually about the first year it operated there were five dentists, members of the Church, that opened up a clinic at the hospital. Each one of them saw patients there one day a week. They made enough money out of that clinic to support the hospital the first year. That kind of dedication was why what the Church predicted didn't happen.

WEEKS:

Basically your support came from Adventists?

WELCH:

As far as management of the board but not patients.

WEEKS:

I was thinking of the financing. You raised your capital through...

WELCH:

Well, somewhat. The opening capital, which was not very much -- this was before I got there -- they put up $5,000 cash and borrowed $35,000 and opened the place. That doesn't seem possible today. The rest of it was made out of operations. Then in 1955, and I'll have to give credit to B.C. Zeigler Company in West Bend, Wisconsin...

WEEKS:

The financing people?

WELCH:

The financing people. I got acquainted with them and made an application for a loan, and they approved one to us in 1955. It was rather small in terms of today's money. That was the first money that had ever been borrowed in a public way by any of the Adventist hospitals. It kind of started a chain that has worked kind of successfully since then. We did, through the years after that while I was at Hialeah borrow some money on a short term from a bank -- just like two or three years. Of course, the tax exempt bond wasn't heard of in those days. Zeigler sold conventional bonds. We did sell some of those. That gave the capital to help build the facilities there at Hialeah Hospital.

WEEKS:

Was the loan made to the hospital separate from the Church?

WELCH:

Yes. The Church was not involved in any way at all at Hialeah. It is still a private institution. Now the town of Hialeah is a big city but it is 95% Cuban. Most of the physicians and most all the patients and everything else at Hialeah Hospital are now Cuban.

WEEKS:

Did you have a fairly good representation as far as church in that area?

WELCH:

Yes. There are several S.D.A. churches in the area and one very close to the hospital.

WEEKS:

Going back a little in time, I note that you did some graduate work at

Vanderbilt.

WELCH:

Peabody is now a part of Vanderbilt. At that time they were separate universities, but if you were enrolled at Peabody you could take classes at Vanderbilt. Since then Peabody has become a department of Vanderbilt. One of the reasons I went to Peabody was it was close and handy and my father had gotten his master's degree there. He then got his Ph.D. at the University of Chicago. They accepted the credits from Madison College without any question, which at that time was helpful. So I attended Peabody but I never did finish. I got called to this job down in Florida at Hialeah before I finished. I got so busy working there and in subsequent jobs that I never did get my master's degree. I should have, but I didn't.

WEEKS:

You probably got more than the equivalent.

WELCH:

I finally got to the place where I thought I would like to get it, but it isn't going to do me any good at the present. And, of course, the schools of hospital administration were just getting started in those early days, in the fifties.

WEEKS:

Our Michigan school didn't open until the late fifties.

WELCH:

I think the University of Minnesota later had a course.

WEEKS:

Chicago was the first of the presently existing programs.

WELCH:

The University of Chicago -- I am sure they did.

WEEKS:

Northwestern University was one of the first, if not the first, but it closed down after a short time. Chicago survived. It was started in about 1934.

WELCH:

Some of my colleagues -- about my age -- went to Northwestern. That was the main place at that time.

WEEKS:

For some reason the Northwestern hospital administration course didn't continue.

WELCH:

I think the man that led that, Ray Brown, went to Duke. Maybe when he left there wasn't somebody there to popularize it.

WEEKS:

Ray Brown was an unusual person.

WELCH:

He certainly was. I did attend in the fifties a few short seminars by Ray Brown, and other programs that were put on. I was active in courses of the American College of Hospital Administrators as early as I could. So, I had quite a little extra besides on-the-job training in hospital administration.

WEEKS:

You were active in AHA when Dr. Crosby was there, weren't you?

WELCH:

I remember him quite well.

WEEKS:

I never had a chance to talk with him. He died in 1972, I think it was.

WELCH:

It has been quite a long time ago.

WEEKS:

Before I started this oral history program, or he certainly would have been on my list.

WELCH:

Yes, I am sure he should have been.

WEEKS:

How did you happen to change from Hialeah to the Orlando hospital?

WELCH:

The hospital in Orlando was one of our old-time institutions. It started in 19Ø8. It was owned and operated by the Church. I had been fairly successful down in Hialeah. Of course, they were looking for people to make this institution successful. It had never completely become a general hospital satisfactorily following World War II. It had kind of gone down hill. The buildings were old; most of them there had been built in 1912. It didn't have the world's greatest reputation. The Church was aware of this. They endeavored to find someone who would go there. At a meeting of their board they elected three people in kind of a priority and I was the third one.

The first one was the man from our Washington hospital, in Washington, DC. He came down and looked at it and said, "No." He didn't want to get involved. He said, "It's going to go broke."

The second man turned it down, and it finally got to me. I looked at it. I was interested in getting into our organized Church world. I always have been. So, I accepted the challenge and went to Orlando and started January 1, 1961, at what we call Florida Hospital. It was known then as Florida Sanitarium.

I have to go back in history to tell how some of our institutions evolved, and some of the terminology like "sanitarium." It was an institution that had been there many years and was moderately successful, but it had been allowed to run down. It hadn't had the administrative leadership it needed. It was, I believe, a 190 bed hospital when I went there. As with many of our institutions it had been more a health resort than a hospital originally. It had been a favorite place for a lot of people up North -- New York and places like that -- a place to come and spend the winter. They had quite a lot of those people. Then they also had life care patients, people they had contracted with to take care of them for the rest of their lives for "X" amount of money. We had probably a couple of dozen of those people there. They had an active medical and surgical program, but it was not specialized at all. The specialists had gone over to the other hospital in town, Orange memorial. Florida Hospital had been a more general practice type of institution. There were specialists there, and specialists came, but it was dominated by the family practitioners. They even had programs for on-the-job training for surgeons. You came there and they had a training program, not a residency as we know it today. There was on-the-job training with people there watching you two or three years then you would get privileges to do surgery. By 1960 that was an outmoded practice of medicine. The specialty and the formal residency programs were taking over. They had not got into that yet. So, we had a lot of medical staff problems. That was one of the very major problems that faced the administration when I first went there -- to rework the medical staff and to get it reorganized, and to get confidence in the medical staff and the board of trustees. There was kind of a feeling that the board would let anything happen. It wasn't as bad as its reputation, probably, but it wasn't high standard either.

We were two or three years developing a medical staff and getting trust in the board, and the board getting trust in the medical staff, getting the organization working like it should be.

There again, Orlando, like Miami when I first went there, began to grow and our institution began to develop. We became more specialized, got highly qualified specialists in charge of departments, and began to expand.

I went there in January of 1961 and I started the first new building in May, which was a grant from one of these life care patients, Mr. Morgan. He had left $800,000 in his estate. We built the first new building. In that we specialized in rehabilitation. We had a very good physical therapy department and rehabilitation. This was the first in Central Florida for this type of facility.

We were able to follow that with one new building after another, til essentially the whole place was rebuilt. By 1965-1966 we replaced all of the old buildings except one little part of one that was built in the late 1950s. It was for obstetrics. During that time I believe our size increased to about 350 beds. Basically we quit the resort type situation and went entirely to acute care. Also in 1963 we canceled out the life care program because with the increasing cost of health care it was almost impossible to tell a person how much to charge them to take care of them for the rest of their lives. You might get someone in who was 80 years old and figure a certain amount of money but if they live to be 100... We had some who did. We quit in 1963 and the last one died about a month ago. That one we had taken care of all these years. So we canceled that out in 1963 and became an acute care hospital.

Ever since then specialization and acuity of care and all of the other things tended to accelerate the situation until today it is one of the busiest hospitals anywhere and one of the most specialized. Actually it is the second largest hospital in Florida, and the largest of our Church anywhere in the world. It is within the top ten within the whole United States in two areas: one is in cardiac surgery, the other in Medicare reimbursement. It is a very busy hospital today. It's highly specialized, and doing very well.

WEEKS:

You have gone into a satellite system too, haven't you?

WELCH:

Yes.

When Medicare came along in Florida that was somewhat controversial. There were some hospitals that did not want to give at all to Medicare. There is one down in Palm Beach, Good Samaritan Hospital, that at first did not get involved in Medicare, and didn't until the last two or three years when DRGs came out they felt no longer Medicare controlled. It's a different philosophy, so they now have changed. One of our competing hospitals that had been built in the fifties, is in Winter Park, a suburb of Orlando and close to Florida Hospital. It really was built because Florida Hospital wasn't doing what it should medical staffwise. Some of its doctors were disappointed and went over and got this community hospital started. It's been successful. They refused to take Medicare in 1966 when Medicare started.

WEEKS:

Yes, Medicare started in 1966 and most hospitals signed up.

WELCH:

At Winter Park they weren't going to take it. We at Florida Hospital studied the situation and felt there was no way we could exist without taking it. We had to do it. We were a community hospital sponsored by the Church and our mission and responsibility forced us to do it. So, we started planning for medicare. In fact, our Medicare cost report numbers in the first ten in the United States, at Florida Hospital. Our competitor there in Orlando refused to take it. Their doctors were all on our staff too.

We had to set in place policies that required the physicians who wanted to bring us Medicare to bring us most of their other patients. Over a period of about six months the other hospital decided it was in their best interest to also take Medicare. As I said, we felt we had no choice because of our community responsibility and our Church mission but to take Medicare. We thought it was in our interests.

You also asked me about the development of the satellites.

WEEKS:

Yes.

WELCH:

In 1969 we were becoming so busy with Medicare and other specialization programs at Florida Hospital that we felt Seminole County, the county to the north, was becoming a bedroom community but it had almost no doctors in the area near us. It would have a hospital eventually. We decided that we ought to be the one to do that so we bought land in a cow pasture in what turned out to be a very strategic location. We developed an institution there and opened it up in February 1973. That institution, about after six months, became quite busy. It has grown; it has developed. Today it is a very major institution with nearly 400 beds. It, Alta Monte Springs, is licensed as a part of Florida Hospital. All as one institution, one Medicare cost report, one medical staff, one administrative overhead and leadership program. It has worked very satisfactorily. We did this after research and visiting places like Baptist system in Houston, Fairview Hospital in Minneapolis, and a number of other places. We feel that it has been a very great success there.

In 1975 we were asked to take over a small county public hospital at Apopka which is 12 miles northwest from our main hospital and 8 or 9 miles northwest of our satellite in Alta Monte Springs. This is a small hospital with 50 beds. It was in a commercial area, industrial, agricultural. So, at Florida Hospital now we have three institutions. All three have different levels of cost and of specialization. We are in the position of being able to contract with HMOs and others and have facilities other than our high priced, expensive, highly specialized main hospital to serve them.

WEEKS:

Does your medical staff coverage extend to the third hospital?

WELCH:

Yes.

WEEKS:

It is still one corporation?

WELCH:

It is one organization, one hospital, one medical staff. Each one has tended during the years to become a little more of its own institution serving its own community.

WEEKS:

How about sharing some of the expensive technology?

WELCH:

Yes. We have a system of taking not only supplies, food, and that type of thing and delivering it to the satellites, but we also have an ambulance system for bringing patients back and forth. So any patient in any bed of the three institutions has all the services available to him. If patients are in need of highly intensive care we would move them to the main hospital. If they are going to have certain services that are only there — heart surgery and some of those types of things. We would move them there, but that is not a discharge. That is just a move from one room to another. That's worked pretty well.

WEEKS:

That's unusual. Have you done anything about these ambulatory walkin clinics like we see in some of the cities?

WELCH:

We have at Florida Hospital in the last three or four years developed a very large ambulatory care center in which almost every kind of service is available. We have a surgicenter. It's in a doctors' office building in which there are about a hundred doctors' offices. We also have a residency -- a large family practice residency -- which we started in 1969. That has a large clinic that is a part of all this.

WEEKS:

This family practice is now a specialty, isn't it?

WELCH:

Yes.

WEEKS:

Was the federal government urging hospitals to do this sort of thing?

WELCH:

Yes, I think particularly back in the late 1960s and early 1970s the government was doing a lot of things to enhance family practice particularly. Our Church organization through our medical school in California at Loma Linda was also interested in developing family practice residencies. They helped about five of our hospitals in the United States start family practice residencies. The one at Florida Hospital is the largest. We have 36 residents. It is one of the most successful. It has been accepted. There was some question whether the specialists on our staff in the highly specialized services would accept this, but they have. It has worked quite well. I would say that it is an exceptionally good working relationship.

WEEKS:

I want to go back to Mr. Morgan. You named the rehab center after him, didn't you?

WELCH:

That's right. The Morgan Rehab Center.

WEEKS:

What has been your experience on referrals from your satellites? Do you refer back the other way sometimes?

WELCH:

Yes. In fact, when the satellite first opened up we sent a lot of patients from the main hospital out there that didn't need the intensive care we had in the main hospital, but still needed to be hospitalized. They are still having some transfers although medicine is becoming more specialized.

You have got to be very sick to be in any hospital. So, there has been less of that in recent years. They go home now from the main hospital rather than being sent to one of the satellites. That might happen occasionally, but it's not real frequent today.

WEEKS:

I think, before we started taping that you said something about utilization. In this hospital are you up in the high sixties in percentage?

WELCH:

Florida Hospital has been up in the 70s and 80s in percentage utilization. We have even run in the 90s. In the last two years there has been quite a lot of reduction in patient days in length of stay, even though the acuity is high, but more admissions. Our admission level has never gone down. We went for 20 years never having anything as far as census or patient days less than the year before. It has grown to be the major hospital in all of Central Florida during that period of time. But in the last two years the length of stay is reduced and we have less patient days but we have as many admissions. So the DRGs and the philosophy that's taken hold today has affected us. it is not as marked as in most other places, one reason being that Central Florida, Orange County, Seminole County, where we serve is a very highly growing area, one of the most rapidly growing areas in the United States. So, even though the total market is going down some, the increase of the patients because of the growth has kept utilization pretty level. We have been gaining market share, as recently as the first six months of the year at Florida Hospital even though the total market has gone down — for which we are very thankful.

WEEKS:

The total number of beds must be over 1,000, isn't it?

WELCH:

Actually we have on line the possibility of 1,100 beds. They are not all completed, and because of staffing. Frankly, a shortage of nurses for intensive care has kept us from opening everything we could use -- but they are making progress on that.

I talked to the hospital there just yesterday and their census yesterday was 842.

WEEKS:

That's marvelous.

WELCH:

That's up in the high 80 percents. Only about 990 beds are open now, open and in use.

I might just mention on the name of the institution: When I went there it was called Florida Sanitarium. Sanitarium was a name that was coined by John Harvey Kellogg, M.D. He saw it in England. He liked it and back in those times, the 1880s, hospital wasn't a very good term, a place where you went to die. "Sanitorium" -- I am not sure that was in use then. Dr. Kellogg didn't like it, so he called our institutions "sanitariums." Many of them went by that for many years. But through the years as we got more into acute care the word hospital became better understood and known. It (sanitarium) became more a liability some thought than an asset. So most of our institutions changed. I had a little hard time getting our board at Florida Sanitarium to change. It was always called Florida Sanitarium and Hospital. Over a period of about five years I kept getting "sanitarium" smaller and "hospital" bigger. Pretty soon it was gone. Nobody ever said anything. Since about 1970 it has been called Florida Hospital. Now they have changed it, in the last three years, and call it Florida Hospital Medical Center. That is the main campus: Florida Hospital Medical Center.

WEEKS:

I am interested in your use of the word "campus." I am running into this. Ford Hospital uses this word, too.

WELCH:

To get back a little bit to Dr. Kellogg, when our institutions were started they used what was then unique therapy. It is hard for us to understand what was going on then. medicine was strychnine, mercury, bismuth and a lot of drugs that kill people. They were still draining blood out of people to help them. Hospitals were really not much. Dr. Kellogg had the idea -- we believe some of this came from inspiration of our Church -- that sunlight and fresh air and hydrotherapy and good diet were the things that would bring people back to health. And he specified those things. He always believed in using medicines that were rationally developed. He always believed in surgery. In fact, Dr. Kellogg was quite an eminent surgeon. So, those were things that were done. We specialized in these other things that everybody accepts today.

Part of the philosophy behind that was to have a nice campus where you had lawn, grounds, maybe gardens where patients could get out and spend time in the sun and fresh air -- maybe some of them could go work in the gardens. do things of that type. Florida Sanitarium had a farm. In fact, if you look at the records, there was more in the board minutes in 1912 -- which I read when I went there -- there was more about the dairy cows, how much milk they gave, but don't say a word about building a large, new building. So, some of those things were apparently important. Many of our major institutions have rather large campuses. We think that has been an asset. Even today when some of the modalities of care are different. People today, if they can go outside and sit under a tree, can go home.

It still has given us land and space which we have been able to use in a number of ways. We like for institutions to be in a park-like area. I think that adds to the overall healing process. at Florida Hospital the main campus has about 100 acres, between two lakes. Of course, that has allowed us to expand, which would have been very difficult without all that acreage. When we went up to Alta Monte Springs we originally bought 20 acres. Since then we have bought about 30 more acres. if you go to a lot of our major institutions like Hinsdale, Illinois or Kettering, Ohio, Washington Adventist Hospital, and many more you will find a park setting. We still follow that practice when we can. We can't always do it.

WEEKS:

That's interesting to know. I wondered about the use of "campus." For instance, I telephoned to Mr. Stanley Nelson, president, the Henry Ford Health Care Corporation at the corporate office in Troy, Michigan, a suburb of Detroit. The switchboard operator said, "Oh, Mr. Nelson is at the main campus today." This was my first experience with the use of campus in connection with a hospital.

WELCH:

That is a term that is being used in our institutions as well as in others, like the one you just mentioned. They are more than hospitals. There are a lot of other facilities: all kinds of outpatient clinics, therapy, diagnostic facilities, surgicenters. There are educational facilities. We have lots of programs for health education. There are thousands of people who come to them so we have a lot of facilities to handle those things. We also, in most of our major institutions have facilities for schools of nursing, schools of medical technology, and in some cases even junior colleges on our campuses. Some of our institutions are on campuses with senior colleges, all on the same major campus. Campus is a term we use quite a bit.

WEEKS:

I think it is good because you have a group, with separate facilities, but together.

We talked about the Florida Hospital but I neglected to ask you about the clean-air surgical suite for orthopedic joint replacement.

WELCH:

One of our orthopedic surgeons, Dr. Louis Brady, had been to England and had been very much involved with Dr. Charnley. Dr. John Charnley invented the artificial hip. He was using it over in England. A number of specialists from the united States had gone over there. Dr. Brady wanted to start it at Florida Hospital, so we sent a team with him over to England to Dr. Charnley to study how it was done and the equipment and facilities that were necessary. Infection was something that was very, very important. He had developed a program over there that had this fresh, sterilized air equipment. We developed one in Orlando; we built a special operating room for Dr. Brady for him and his associates to do that. It was one of the earliest ones in the United States. That hip operation became very popular. Still is. Now knees and ankles, wrists, elbows and lots of other things. I got a lot of enjoyment out of that. I saw people come in that hadn't walked in many months or years and have that operation and walk out. Some of them come back and tell you how they had been dancing, all types of things. It is really a miraculous operation. A very traumatic operation, in fact more trauma than in heart surgery.

When this was being done around 1970 or so -- it may have changed some by now -- it took blood, and there was a lot of trauma because basically it cut the bone in two. It had to be done very exacting. Infection was a catastrophic problem. If they had an infection they had unbelievable trouble the rest of their lives. They had to make sure the patients had no infections. That became a very strong program at Florida Hospital. They have done literally thousands of those hip replacements. It has expanded into all kinds of other things. Of course that operation is done all over now. People hope that they are going to cut down the cost of health care, and reduce it, but the ingenuity of man keeps coming up with other things. If you think about orthopedists and what they do today compared to what they did 20 years ago, there isn't any comparison. There used to be fractures and trauma; now it's things like total hip replacement, total knee and all kinds of things, rods down the backbone -- all kinds of things. I expect to see things like that accelerate in all kinds of specialties.

WEEKS:

What kind of approval is necessary for a new type of treatment such as this?

WELCH:

In that case obviously we had to get the facts and the costs, the medical possibilities and present it to our board, and, I think also, to the medical staff. We probably presented it there before we did to our board. We had the board approve it. We also had to get the state board of health because we had to construct a special operating room, and they had to know about that. We had to get their approval.

WEEKS:

Does the Joint Commission on Accreditation of Hospitals enter into anything like this where you are starting a new project? I realize...

WELCH:

I don't think so at that time. They would look at it later. They didn't really look into it in advance. I suppose, if you had a lot of trouble with one, they would hear about it. You might be in trouble at their next inspection.

You do have to get people like Medicare and Blue Cross and organizations like that to agree to pay for it. That sometimes is a big problem because they are slow to accept new costly procedures.

WEEKS:

In Florida you do have an older population with a higher incidence of that sort of thing, I suppose.

WELCH:

At first they would not do that operation on a person over 60. They used a special plastic cement and they didn't know how long that was going to last. They were a little hesitant to do the operation on somebody in which they might have a bad result when they were 70 or some age of that type and maybe couldn't operate on them or correct it some other way. We started out really on younger people, 60 and under and followed them for a number of years. Now they operate on most anybody. They now have other types of programs, ceramic if you want something that is coming in now.

WEEKS:

That is something I have heard a little about without knowing how it works.

WELCH:

I don't know either.

WEEKS:

We were just talking about the Joint Commission. Somewhere I saw that you have a "first" in 1961. That was in the early days of the Joint Commission, wasn't it?

WELCH:

They started in the middle fifties.

WEEKS:

I know they worked and studied for two or three years before they started operating their inspection program so they could set their goals.

WELCH:

They took over from the American College of Surgeons, probably around 1956.

WEEKS:

What does the "first" mean?

WELCH:

I am not sure. The only thing I know of is that in 1961 I had gone to Orlando from Hialeah in the middle of January and they didn't have somebody to replace me officially yet so I went back down there and was present for their actually first Joint Commission inspection. The first time ever. Dr. Peter Adams, it seems like it was, inspected for the Joint Commission. We went through it all. They didn't tell you whether you passed or not, but you generally know when they leave. We had a good presentation, everything went nicely.

Then, of course, I went back to Orlando where I had already moved. two weeks later he came up there and inspected again at Florida Sanitarium and Hospital. Same man. So I got him twice in a month's time. At that time they had only one physician on the team. Now they have quite a number of people on the team for large facilities.

WEEKS:

You have had a helicopter ambulance service at Florida Hospital since 1961, I believe.

WELCH:

No, that's probably 1971. We started a helicopter ambulance at Florida Hospital in 1971 which we used with the ambulance organization of Central Florida. We built a helicopter pad. It was very active for quite a long time. They still have a helicopter program there. It has changed some. Basically now the program isn't so much for accidents as it is to go out to hospitals and pick up patients that need to be brought to our tertiary care facilities. So they go to the hospital within a hundred miles or so and pick up a heart attack patient that needs to have service from a major institution and bring that patient to the hospital. It is more for that use now than it is for accidents.

WEEKS:

We mentioned Ed Connors of the Sisters of Mercy Corporation during lunch. The Mercy Hospital in Saginaw, Michigan recently had a demonstration of a helicopter ambulance which they were thinking of purchasing, and they had a fatal accident.

WELCH:

I saw that in the news but I didn't know it was one of Ed Connor's hospitals.

WELCH:

I think it was St. Mary's Hospital in Saginaw.

One of the TV networks recently showed a documentary on helicopter ambulances with the high incidence of accidents.

WELCH:

Our university hospital in Loma Linda, California had a tragic accident about five or six years ago. They were picking up some kind of emergency up in the mountains. Somehow they hit something with the rotor in taking off and killed three people. A very tragic situation. There is a bad record for health care ambulances. That television program pinned some of it on the fellows working too many hours. They also go into very hazardous places, at difficult times.

WEEKS:

I have a note that Florida Hospital has programs in health education.

WELCH:

Florida Hospital and many of our other institutions do a lot of preventive health programs. We have programs we put on in every type of health area: stress, all kinds of specialties like diabetics, blood pressure, cooking school, prenatal courses of all kinds. A great effort in health education and prevention.

WEEKS:

I have noticed particularly among the community hospitals that many have names with Protestant connotations: Presbyterian, Methodist, Lutheran, Baptist, etc. I suspect that the churches do not give large financial support to these hospitals. I suspect with your hospital there is a close connection with the Seventh Day Adventist Church.

WELCH:

Most of the Protestant hospitals, and Jewish for that matter, are more in name than they are officially organized as religious institutions. We quite jealously guard that in our church, both the clergy and the health care people. There is a fear that the institutions -- colleges, universities, and hospitals -- could be separated from the various church programs. We don't want that to happen and we work hard to keep that from happening.

WEEKS:

Your next move was from Florida Hospital to the Sunbelt group, wasn't it?

WELCH:

Yes. A little previous history to that: We had a number of hospitals in Florida that had been started. Basically our hospitals through the years had been operated through jurisdictions of the Church like a conference. The conference is normally the Church's area in one state or a part of a state. There are some instances like in the Dakotas where there are two states in one conference. They had operated hospitals. Then we have what we call union conferences which is a union of four or of five or six conferences that work together to do things that one conference can't do on its own like run a college. They had run institutions, hospitals. So our hospitals had been basically operated by these church organizations. their boards were dominated by clergy, and Church leadership people. Through the years, particularly in the sixties when Medicare came along, that type of governance began to break down a little. There was not just the know-how nor the time for those conference people to spend on institutions that were becoming more technically complicated, and a lot more expensive. The dollars were becoming millions of dollars. So, it became evident that we needed to be managing our hospitals in a different way.

Some of it came about a little by accident. In 1969 a hospital in Punta Gorda, Florida that had been operated by a local board, a community board, got in tremendous trouble between its medical staff and its board. It's quite an unbelievable story. There has been a book written on it. It couldn't be resolved. It just seemed as if they couldn't solve it. I was acquainted with the administrator through my activities in the Florida Hospital Association. He called me up one day and wanted to know if I would come down and see him. He said they wanted to give the hospital to the Seventh Day Adventists. The Church had taken hospitals in various places through the years, in the previous 10 years or so. We looked into it and talked with our Church officials. You have got to remember we were in the process of building a satellite at this time at Florida Hospital.

They said, "We are willing to take it over but the Church can't be responsible. If the Florida Hospital will do it, fine."

So, they invited us to get involved. We went down there one night and their board resigned one by one. When one of their board members resigned, they elected one of ours. In about an hour their board of 13 members resigned and we had a board of 13 members, and we owned it and controlled it. Subsequently we changed the bylaws and the articles of incorporation and developed it into our pattern.

We found the hospital in great chaos and disorganization but we brought people in and got it reorganized. It's been a fine institution ever since.

That was added to Florida Hospital. We were beginning to get a small system, with that and the satellites. About the same time another one of our hospitals in Florida, Walker Memorial Hospital in Avon Park, about 85 miles south of Orlando -- it had been an Air Force hospital in World War II, and we took it over after World War II and developed the hospital. It had originally been in an old hotel. The Air Force had modified it, and our folks had worked on it some, and in subsequent years had improved it, but it needed a new building. They got a Hill-Burton grant for $1,200,000, but they had to match that. So, they sold a bond issue to match it. It was operated by a local board that was controlled by the Church organization. They used a company in Nashville that sold bonds for nonprofit agencies. Between the time they sold the bonds and two days later when the bond money was to be turned over to the trustees, the Security and Exchange Commission came in and closed up this bonding company and put them into receivership. The hospital in Avon Park was in a position of owing for a million and two hundred thousand dollars in bonds, but they never got the money. That board appealed to the Church structure for some help. We went down there and looked into it and decided we would be willing to help them and save them. In fact, the Church was about ready to close the whole place down because of this problem.

I called up some of my friends that I had worked with through the years at the B.C. Zeigler Company to see what they suggested. They said they would loan us the million two, on our signature.

So, we got the Hill-Burton money and the building under way and got it built. As a result now Florida Hospital had the responsibility not only for its own satellites but for these two hospitals. This all evolved kind of by accident. So we had the mechanism there of a small five hospital system in

Florida that kind of developed by accident.

At the same time the problem of operating hospitals all over the South under what was called the Southern Union Conference was getting more difficult because of Medicare. I had kind of served as a consultant to these others -- about nine other hospitals, four in Tennessee, one in Kentucky, a couple in Georgia. We had kind of served as an unofficial consultant. I served on some of their boards. As a result of that, along with the hospitals in Florida, we were able to sell to the Church organization the development of a small system in the southern part of the United States. Our leaders of the Church in that area approved it. We formed what was known as Southern Adventist Health and Hospital System in 1973. We also, in order to do that, had to go to the general Church leadership in Washington, D.C. and get approval. They approved that type of structure, as a permissible structure to be done everywhere in the United States because they didn't think we were the only area who could do that.

So we organized this system and I became president of it and left Florida Hospital as administrator in 1973, actually January 1973. I started to form this system. We had offices in Orlando which we moved into. We started very small and developed it with some staff. We didn't try to develop a tremendous organization. This system evolved over a period of time and became a stronger organization, giving more services.

At the same time, elsewhere in the United States we had eight different union conferences each of which covered a region like the Southeast or the Southwest. These other areas also started to develop regional systems. In a period of about three years in the middle seventies we ended up having eight regional systems. The one in the South where I was involved was the first.

Very soon thereafter the one out in California, West, was developed as the second one. Almost all at the same time. The others slowly developed. The one in the South and the West, what we called Middle America developed to become fairly strong organizations. We had three that were very small. They really didn't have the strength to be an organization.

We developed quite a lot of services in each one of these systems -- things like cash management, reimbursement help. President Nixon's price freeze took a lot of expertise that most of our small hospitals didn't have. So, we helped with that as these things developed.

Then in 1978, the Church saw these systems developing and realized what they were doing but realized they were a little bit small. Some of them were not strong enough. So, they agreed to allow us to expand across what is called Union Conference lines. That is something that had never been done in the Church. Every jurisdiction like the southeast which was called the Southern Union Conference felt the lines between them and the Southwestern Union which is Texas, Oklahoma, New Mexico and Arkansas were kind of sacred. The Church had never done anything across those lines. Each one of the Union Conferences had their own college, and a lot of their own facilities. So, that vote was a very major change in our Church to allow something to go across jurisdictions. That was voted in '78. There again we combined the Southern Union which had been the Southern Adventist Hospital System and the hospitals over in the Southwestern Union, which were not very well organized and had a system more in name than fact. That's actually when we changed the name to Sunbelt. It became the Adventist Health System, Sunbelt. At the same time, or subsequently thereafter, this happened out in the West, it happened in Middle America. Instead of having eight systems, we had four systems, each of which was a little bit stronger and better.

We had always done things together in certain areas of the United States. The Church had had a coordinating committee out of the General Conference in Washington in which the chairmen of the board were clergymen and the major hospital leaders were members. We had done a lot of things together through that. So it was kind of a national organization. In 1974 because of that and also our systems development, we developed a national purchasing program. Also in '74 we organized a national malpractice insurance -- there was a malpractice crisis then as there has been ever since. So, as we developed our institutions were doing more and more things together. These were becoming more organized, more sophisticated.

These four regional systems did things in different ways. Some were more centrally organized than others. Some were loose affiliations. In some of the areas like Sunbelt they actually all became one corporation and sold bond issues with trust debentures with all the major hospitals included. Some of the other places had difficulty raising money. Of course, you recognize that during this time other organizations like HCA, Humana, and AMI were all developing too. We were kind of following the same trend, and, to some extent, the same philosophy in expansion. We expanded a great deal in the late seventies and the early eighties: added a lot of hospitals, built new facilities, added on to the ones we had.

Around 1980 it was realized that we needed to be working to gather these four systems because they were having the tendency to go their own ways. So, the Church, through some of our structures agreed to set up a national organization. Actually we passed action authorizing it. We developed bylaws and articles of corporation in 1980 to found AHS/US. We had some major planning programs, we used consultants, and took about two years studying what we wanted to do -- sometimes arguing about what we wanted to do because not everybody saw eye to eye.

In 1982 we formally formed and put into practice Adventist Health System/US. I was elected president of it. However, at that time, we didn't go quite far enough. I was still president of Sunbelt. I had both jobs for two years. We didn't formally organize a separate office and a separate organization of AHS/US until July of 1984. Since July of 1984 I have been the full-time president of Adventist Health System/US. A person was elected to take my place in Sunbelt.

So we have been developing this organization. Really it has been growing from the bottom up for about 13 or more years, from the late sixties. It developed quite a lot in the seventies, in the eighties we have been developing our national organization and national staff and various policies and programs on a national level. Each of the four divisions still has a very major part in the operation of their subsidiary institutions. We work together very carefully. We made a lot of progress. We are of today having a certain amount of adversity. That probably brings us together more. Some of the philosophies we had, as well as others are not such good things today. We expanded quite a lot of small rural hospitals to fit in with out mission of service to people, not having all our work in one place but spreading out as much as we could. So, we expanded quite a lot. Some of these small hospitals have been very successful, but others are not very successful. We are having to divest ourselves of some of these now.

We also have gone into the nursing home business quite extensively. We have about 80 nursing homes now throughout the United States. We have a number of retirement homes of various types. We have thirty some home health agencies. We have a lot of other services that are operated either by one of our divisions or by one of our hospitals like surgicenters.

WEEKS:

Have you gone into hospices?

WELCH:

Yes, we do have some hospices. We have one here in Michigan that is headquartered in St. Joseph, Michigan. It is not affiliated with one of our hospitals. But a number of our hospitals have hospices.

We are involved in urgent care centers and a lot of other things of that type throughout the country. Our assets now are over three billion dollars. That's on an original cost basis. On our books 80 some acres of Florida Hospital were bought in 1908 for $8,000, and still show that. The assets are very much under market. That's the way accounting is. Last year we did 2.4 billion dollars in gross business. When you take off the contractual, bad debts, and charity it was 1.9 billion, close to 2 billion dollars total business.

WEEKS:

What is your policy on charity?

WELCH:

Basically our policy is that we don't turn anyone away for reason of finances. You can only go so far, but we have a lot of deliberate charity. A lot more of bad debts than real charity. That's a rather high burden to us, our system -- many, many millions of dollars.

WEEKS:

When you talk about Hill-Burton and talk about charity, the ruling of two or three years ago that hospitals that had ever taken Hill-Burton should continue to give charity.

WELCH:

That's probably been 10 or more years.

WEEKS:

Has it been that long?

WELCH:

It didn't affect us too much. We were doing that charity in most places. It was a headache because of the recordkeeping, but it really didn't affect us too much financially.

We had a great burden in our Church organization about Hill-Burton. We didn't take any money for many years. We had certain fear of church and state relationship, a great fear of taking money from the government. We finally came to the place that we felt our institutions basically served the community not our Church except indirectly. As such, those people deserved as much help as anyone else, so we did take Hill-Burton. probably the first 10 years of Hill-Burton we didn't take the benefits.

WEEKS:

Since you referred to federal money, let me ask if you ever apply for federal research money.

WELCH:

Yes, our university medical school has quite a lot in grants in specific research kinds of things. They do not take capitation payments for medical students out there. They felt that interfered so much with our basic philosophy of the Church that we couldn't take that. So that hurts.

WEEKS:

It hurts, but I can understand.

WELCH:

We felt we couldn't do it.

WEEKS:

I think you are wise.

Some of the things you mentioned bring questions to my mind. What about the cash management system? What does that entail?

WELCH:

Several of our divisions have cash management systems. In the Sunbelt we installed one. Frankly we got this program from Catholic Sisters. Sisters of the Incarnate Word, in Texas. They have 23 hospitals. This was involved in concentrating all the money on a daily basis of all of our institutions in one bank account. Every hospital wrote checks on that bank account. It had a small account within a big account. We could also have it tied in with our line of credit so if all our cash were used up it went into the bank's line of credit that we had. We borrowed money at a much lesser rate than was normally available. We were also able to invest money with many of our smaller hospitals who would not have been interested or couldn't. It had a lot of good things about it, and still does. I was just at a meeting of our west division in which their cash manager showed that last year their cash management program either saved them or earned them over 3.5 million dollars. If they had not been on the cash management system they wouldn't have had that money.

WEEKS:

HCA must have something like that.

WELCH:

Yes, they have a tremendous fund.

There are some dangers in it. We have learned some hard lessons.

WEEKS:

I am sure you have.

WELCH:

There are dangers that every hospital president in the system in a way doesn't have to meet his payroll like you do when you are on your own. When I first went to Hialeah I sweat out the payroll. There have been times when I didn't take my own check, times when I went out and asked department heads not to cash their checks for a few days, maybe until the Blue Cross check came through. Under cash management some of that pressure is not there. We learned a few hard lessons in that area. It is something nearly every commercial company in the United States uses.

Another theory we had: A lot of people were concerned that the local bank would be unhappy about it, and it would hurt the relationship in the community. We didn't find that to be the case. In fact, most of the banks wondered why we weren't doing it because they were used to K-Mart and everybody else doing it. It turned out not to be a problem.

WEEKS:

Did you find any new secrets in your group purchasing? This seems to be one of the first shared services?

WELCH:

We started our group purchasing in '74. It has been very helpful; we saved money. The secret of being successful then is equally true now as 10 years ago. It is to have discipline so that you know that when you sign a contract with a vendor, he knows that your hospitals are going to commit to buy from him. Without discipline on that commitment, you don't have much. That's one reason a system like ours, which is rather small compared to the VHA or HCA, and some of the others, can do well because we can commit our hospitals where sometimes an organization that is an association, not a corporation, cannot commit their hospitals. That's the key to being a success.

We have about eight people in our purchasing program today. They negotiate contracts. We don't buy centrally nor do we warehouse centrally. They negotiate contracts. Those contracts are available to our hospitals and other institutions who may buy directly from the vendor or wholesaler. It's worked very well. It's had good leadership. I think it's saved us a lot of money.

WEEKS:

Has this meant that as a corollary to group purchasing that you have standardized inventory, items in the inventory?

WELCH:

We more and more have to agree on using one specific vendor for say syringes. Originally we went on the practice of having dual vendors so the hospital had the possibility of buying from two vendors for syringes or surgeon's gloves, or whatever it is. But with competition it is becoming more and more single vendor. We have quite an intricate organizational setup in which each of our hospitals have some say whose equipment or supply they want to use. At least they get input. Then we decide who will give us the best price and which one we will use. That's quite important.

WEEKS:

I was interested in reading about your shared services in general. We talked about cash management, we talked about group purchasing. I was wondering on your computer systems, have you gone to so-called total computer...?

WELCH:

We did in Sunbelt, but we have not done that nationally. We had lots of discussions over that through the years. We are now coordinating our computer systems nationally but we don't have a national system. Each of the divisions has its own program. We are pretty much standardized on the equipment, using much of the same things.

Putting Sunbelt together back in the early seventies, quite a lot of things had to happen. We had to standardize on accounting. We had a certain amount of standardization that was recommended through the Church, but it wasn't followed too carefully, and was not kept up to date. So, we had to standardize on accounting. Then we standardized on auditing -- we got one auditor for the whole system. I felt quite strongly then that an integrated computer system that every hospital was involved in, and had to meet the deadlines and goals or discipline needed to operate. So, we did develop an integrated system that every hospital was involved in. It was difficult because we had hospitals from 29 beds to 900 beds. The needs were very different. It did give us the discipline that was necessary to get a lot of financial statements, statistics, and a lot of other reports done on a timely basis that we couldn't have done any other way.

Today the equipment is so much different that everybody can have their own little computer and do those things and tie them all together. Outside of

Florida Hospital which has the biggest thing IBM has, and needs, most of the other hospitals have an IBM 38, in some cases a 36, using standardized software, in some cases software that was bought from Baxter-Travenol or one of the other companies. We are coordinating that. We have national contracts to buy the equipment.

WEEKS:

Is Baxter-Travenol in software? I didn't realize that.

WELCH:

Baxter-Travenol has bought out four or five computer companies. Just Baxter, they have dropped the Travenol name.

We were working with a company in Sunbelt called the Space Age Computer Company. That company was bought by an organization called Compu-Care. They were facilities managers primarily, they had software. Baxter-Travenol bought out Comput-Care and they bought out four or five other companies. They do have a very major computer service now.

WEEKS:

A tremendous outfit now.

WELCH:

Of course since they combined with American Hospital Supply they also have combined with a lot of other companies. They have quite a management information program.

WEEKS:

I hope to talk with Mr. Bays.

WELCH:

He isn't there anymore. He resigned from Baxter. He now is the president of IC Industries.

WEEKS:

I am way behind.

WELCH:

Mr. Loucks, who is the top man and president at Baxter, is still there but Karl Bays is gone. This happened about three months ago. He resigned and went in as president of a major industrial corporation called IC Industries.

WEEKS:

What are you putting on your computer now: billing, inventory, patient data?

WELCH:

We have all kinds of things on our computers, almost anything you could think of in our major hospitals like Florida Hospital. All kinds of patient information, naturally for billing, inventory, diet, controls in things like pharmacy, reporting systems on places like x-ray, laboratory. Just about everything you can think of is on the computer these days.

WEEKS:

Do the physicians use the computer system?

WELCH:

They are coming more and more. At the American Hospital Convention just a week or so ago there were quite a few exhibits of computer companies trying to use a bedside terminal. These do exist in hospitals. Everything is done at the bedside module. The physician puts his order in, nurses report what they do. I think that's coming. I am not sure that it is here yet. They tried to get physicians to put orders in 20 years ago and it wouldn't work. But there is a new breed now brought up with the computer.

WEEKS:

I would think so as long as this service is available.

WELCH:

One of the systems I was looking at, I believe came from Michigan. You don't have a chart like you do in most places. It's all on the computer now. You can get it printed out, if you want it, but it's really very nice. It's a coming thing, I believe that.

WEEKS:

Then a physician who wanted to see a chart would just press a couple of buttons.

WELCH:

We have quite a few places where we are endeavoring to get the physicians tied into that computer in their offices. They admit the patient through the computer. They put the orders in. They can any time see a lab report, x-ray report, all from the office. Of course that ties them in to that institution. It's a lot easier to do that than go to some other hosptial where they don't have that. So we have programs to do that. We are doing it in a number of our institutions.

WEEKS:

Have you done anything about office buildings for physicians?

WELCH:

Yes, we have a lot of office buildings. Almost all of our hospitals have some office buildings. We have accelerated a lot in that in the last five years.

WEEKS:

That's a good way to tie your medical staff to you.

WELCH:

You can't hardly have a medical staff anymore unless you have medical office buildings, either that you own or make possible adjacent to the hospital.

WEEKS:

What about your regional plans? Is there any way to bring specialist services to the outlying hospitals or do you use that ambulance service to bring them in?

WELCH:

We use the helicopter ambulance to bring them in, but we do quite a lot of educational things. In Florida, for instance, the medical staff of the Florida Hospital -- the cardiologists, the orthopedists, some other group like the urologists, the transplant work -- they will go out to other hospitals and put on programs for their medical staffs. They will do educational programs which ties things together, ties the referral network.

WEEKS:

It acquaints the one with the other.

WEELCH:

That's right. For instance the hospital I mentioned in Punta Gorda, that's 145 miles away from Orlando, but we get lots of referrals for heart surgery down here in Orlando. Most of it was because our surgeons went down there and got acquainted. In one case I know they went to one of the hospitals in a small rural area and taught the guys how to put monitors on the patient, how to insert pacemakers. Taught them how to do that, so they could do it there. That type of relationship helps to tie us together and brings us referrals. That's part of the situation.

WEEKS:

If the patient came in for repairs, the doctor would be right there.

Am I asking you a lot of unnecessary questions?

WELCH:

Not as far as I am concerned. I don't know whether they are necessary for what you are doing.

WEEKS:

How about pediatrics and obstetrics? Are all of your hospitals maintaining those services?

WELCH:

We do have hospitals that do not have obstetrics and some that do not have pediatrics and we have some in some areas where we agree that we will do one thing, somebody else will do another. Today that's posing a problem. You probably have read or heard about the arrangements in Denver, Colorado between our Porter Hospital and the Swedish Hospital. We have a joint medical staff. This was set up back in the seventies and worked quite well. There has even been a book written on it. They were doing in those days programs to help the hospitals not compete with each other. One would take OB, the other take pediatrics, one would take emergency room, the other heart surgery. Probably this was done in Denver more than anywhere else. Today that's breaking down because in order to go out and compete with HMOs and companies for contracts to give services to their employees, you have got to have every service. You can't go and sign up a company like in Orlando -- Disney World -- and say, "We are going to do everything in our hospital except obstetrics, for that you have got to go over to another hospital." The companies won't buy that. They want every service at the hosptial you contract for. In Denver, for instance, we gave up obstetrics probably 15 years ago and we are now putting it back in because it is a necessity under the contract provisions we are faced with. That's happening a number of places. Not only to us but a lot of other people too. That may not be so good in some ways, but it probably isn't so bad as it might have appeared at one time.

WEEKS:

Talking of obstetrics makes me think of malpractice. I don't quite understand how you handle malpractice insurance especially in Florida.

WELCH:

It's terrible.

WEEKS:

Are you setting up your own insurance...?

WELCH:

We have had our own malpractice trust since 1974. Our malpractice for our system -- and all of our hospitals are included but two, one of them is a university hospital in California, and the other is a major hospital in Kansas where there is a law that they couldn't be included. Our malpractice has gone from about five million dollars cost five years ago to this year it is 57 million dollars. That's how much it has cost us. That's how much it has gone up in five years. We have our own trust. All our premiums are paid into our own bank account and invested. We handle our own claims. We use other people to help us. We probably have been one of the leaders in developing that thing. We are in a better position than some. We are one of the few that still has occurence insurance. Most everybody has had to go to claims made. We still have occurence. It has been a hardship on some of our hospitals to increase it so much. One of the costliest areas is in physiciains. Some places the malpractice for people like obstetricians, orthopedists, and anesthesiologists is prohibitive. Florida being the primary one. Fortunately most of that is down in Dade County, southeast Florida. Orlando is bad, but not nearly as bad as that.

WEEKS:

I didn't understand what you meant by occurence.

WELCH:

The old time insurance policy that we all had for many years -- if an accident or something happened in 1987, you were covered, really forever for that, by the policy you had in 1987, that covered you in 1987. If someone sued you five years from now you were still covered by that '87 policy. The statute of limitations might have run out so they couldn't sue you, but they have a way of getting around that. For a person like a newborn the statute of limitations may run 21 years. So that policy covers you no matter when the claim is made.

That is very risky from an insurance standpoint because things may come up five years later or twenty years later. The economy is so much different and there have been so many changes in the law and the way people feel about malpractice that they may get stuck very heavy. They usually do. So, insurance companies, St. Paul Insurance Company, the primary one, have popularized this called "claims made." That means if you buy a policy in 1987 this means that it pays claims only for those made in 1987. If an accident happened in '87 but the suit was made in 1988 that policy won't cover you. So when you buy this it obviously is a lot cheaper, but then you have got to buy a tail for every year down the road, and that's very expensive. Theoretically the claims made with the tails you can buy totally come out to the same amount of money as an occurence, but it doesn't work that way because inflation gets the tail. Most hospitals have had to go to claims made. There are only a few left under occurence. We are one of the few. We may have to change too.

WEEKS:

You are funding your own insurance. Does this cover just the hospital? Does it cover the medical staff also?

WELCH:

At the present time it covers only the medical staff persons that are under contractual relations to the hospital. It may cover some emergency physicians, some radiologists, some physicians of that type that are under contract to the hospital. We tried the other way but we lost our shirt trying to cover the physicians. The primary reason being that we didn't have a way to mandate that all the physicians come under our insurance, so we got an adverse selection. Just those physicians who couldn't get a policy somewhere else would come and get under ours. You can't do it that way. It just kills you.

You hear a lot of talk from lawyers and others about terrible insurance companies that are taking advantage of everybody -- and I don't necessarily trust them all either, but the truth of the matter is that the crisis is not just with those insured by the insurance company, it is also with those who have their own trust like we do. Our claims have gone up the same as other people's. No insurance involved. So that's really just talk. Our rates and our loss ratio are a little bit better than the average but not much. We have quite a few hospitals in high priced places in California, Florida, Illinois.

WEEKS:

A lot of people must think you have a lot of money, with big buildings, or you have insurance with deep pockets.

WELCH:

It's a very major problem. Nobody has found an answer for it yet.

WEEKS:

Is it any easier to get malpractice insurance for midwives?

WELCH:

I don't know the answer to that. I don't think so. I don't think they are insured very easily. A lot of them don't have insurance. They don't worry about it. They don't have anything anyhow. I know obstetricians who don't have any insurance. We have a requirement in our hospitals that they have to have a half a million dollars insurance to be on our staff. That's helped us quite a bit. Otherwise, if you allow physicians to be on your staff with no insurance and they get sued you have to pay all the losses in the hospital. In most all our malpractice, physicians are involved. Most of the big losses have something to do with the physicians, what they allegedly did or should have done, or didn't, or missed out. It's not patients falling down in the hall, falling out of bed, getting burned by a hot water bottle, getting the wrong medicine, or those kinds of things as in the sixties. Now it is a very major area, in some extent guaranteeing the person's health.

WEEKS:

I am wondering if it isn't going to get too expensive to have a baby.

WELCH:

It costs us $200 for the malpractice insurance for every obstetrical patient. We may not collect a penny but the malpractice costs us $200. Nowadays we have product lines that we promote and sell. We have one for our system that we put in many of our hospitals that we call "Special Editions."

It's a product line for obstetrics that has a special club for future mothers and does things for them, helps them in the hospital, helps them when they go home. It's a selling mechanism, makes people want to come, and doctors use our facilities. Our risk management man said, "O.K., if you guys want to do that, but you are going to make me an empire in the malpractice area because every one of them is going to cost you $200." If he had his way, we would close down all this. We know we can't do that.

WEEKS:

We were talking about the computer and all the data you collect. Is this made available in any way to research groups? I am thinking now about Michigan where they are trying to set up a research center, a data center, with input from various organizations or hospitals.

WELCH:

No, we haven't really done that. There may be some of it used, but I don't think there is much.

WEEKS:

We were talking about Hospital Corporation of America (HCA) a few minutes ago about their cash management. I think they went very extensively on their computer project tool. It must have cost them a lot of money.

WELCH:

They have been through several programs. I am not up to date as to where they are. They ran all of theirs. They did not have a tremendous computerized system, as far as I know. Some of the other companies like Humana have had much more than HCA.

WEEKS:

When I was talking with Dr. Frist, Sr. a little over three years ago they seemed to be in the process of setting up a terrific computerized...

WELCH:

We are all always in that process, and never quite get there.

WEEKS:

We haven't spoken about this up to this point. Either in your regional or national group what building and planning services do you have available? For instance, if you wanted to build a new hospital in Ann Arbor, would the local group be able to go to a regional or the national board for help?

WELCH:

Yes, to some extent we have done that on a regional level. In Sunbelt we had architects that we worked with exclusively. We also used HBE, a company in St. Louis who did quite a lot of our hospital building. They built at least four new hospitals for us. We don't have a national program in that area. Frankly, right now we are not building very much. We have done some assistance in that area on a regional basis. We would try to reduce the cost by central knowhow, by using plans in more than one place, and that type of thing.

WEEKS:

I was also wondering about who represents the Adventist hospitals. Does the Seventh Day Adventist Hospital Association represent you in Washington, for example, or don't you need representation?

WELCH:

We have something under discussion right now. We, obviously, support the American Hospital Association, who, we hope, and I believe now more accurately than ever in the past is doing a good job in that area. We also belong to the American Health Care Systems, which is an organization kind of like the VHA

(Voluntary Hospitals of America), a competitor, in which there are 36 systems. The Detroit Medical System is part of it. They do various things together to help each other. One of the major things they have is an organization in Washington called American Health Care Institute which a Dr. Monty Duval heads. You may run into him sometime. A very fine individual and probably one of the best lobbyists in Washington. He represents us and represents our systems, all of us. We use him quite a bit. We also on occasion use specialized attorneys in Washington, when we feel like we need something a little special done. Our Church also has a lobbyist, although he does very little for us. He looks out more for things in the religious liberty area, education. He will help us and send us information. He sent me a lot of information on the hearing on taxes that were held a month ago.

WEEKS:

The reason I was asking the question was that a few years ago I was talking with Kenny Williamson shortly after he left as head of the Washington office of the AHA. When he was at the Washington office he said that the AHA had difficulty in being all things to all people. That's why the Voluntary Hospitals, the American Protestant Hospital Association, and your own people, might feel you had a need for some advice or help that wasn't in the general line.

WELCH:

I will say that Carol McCarthy, our new AHA president, has done more to bring our people together than has happened in a long time.

WEEKS:

I haven't met her yet.

WELCH:

A very capable lady. I think she has pointed out what happens when we fight among ourselves. So there have been programs of bringing together organizations like the Federated Hospitals, who represent the profit-making hospitals; the Protestant hospitals.

Actually there are five different organizations that have joined together in a program up there including AMA, AHA, the AARP -- the American Association of Retired Persons, a huge organization -- to sponsor a number of things, and she has got them together. I think that is a major accomplishment.

WEEKS:

There are so many people who are trying to spread an umbrella to get organizations that normally would be AHA participants.

WELCH:

Actually we just voted in our organization not to pay dues to anybody except for AHA or a subsequent unit of AHA in a state or metropolitan area wherever it is. Which means we probably are not going to belong to the Protestant Hospital Association. There are a number of things like that. We just can't afford to belong to too many things.

WEEKS:

There shouldn't be need if Carol McCarthy can do the things she means to do.

I meant to ask you: How did you happen to locate your main office in Texas?

WELCH:

It's a fairly complicated story. I was in Orlando. I lived there 25 years and hated to move but we thought we needed a centralized location to better serve all the United States. The Dallas airport seemed to be a great asset, so we opened an office nearby in Arlington, Texas.

WEEKS:

I want to ask about policy making for your hospitals.

WELCH:

As a system we have meetings and put on symposiums, but usually it is the local institution that makes the final decision.

WEEKS:

Do you have a hospital in San Francisco?

WELCH:

No, we don't.

WEEKS:

That would be a big problem if you took AIDS patients.

WELCH:

We do take AIDS patients. In fact, I was in a board meeting in Florida Hospital a month ago. We had eight AIDS patients in that day. We have had several die. That has gone on all over the country.

WEEKS:

What was the last estimate? 38,000?

WELCH:

What is scary is all those that are in the five or six years of incubation. You don't know it. A tremendous catastrophe. One of great concern.

WEEKS:

I think somewhere you have said something about professional staff development. How does that come about?

WELCH:

Well, we are not doing enough in that area. We do sponsor a number of programs at colleges and universities in medicine and nursing and other areas of that type. We have an organization of our personnel directors who work together in putting on programs. We don't have a national program in that area that's ongoing.

WEEKS:

We were going to talk also about the structure of the hospital: the trustees, and so on.

WELCH:

We have three levels of governance at the present time. First, there is the local hospital board. That board of trustees is made up of about three different categories. One of the categories is Church leadership. Another category is really local church members, and, in most cases, our hospital president is a member of the board. Essentially, most of our local hospitals have about a third of the board members who are not members of the Church. Usually they are leadership people in the area. Also, in addition to that, it is mandatory that we have representatives from our medical staff. In most cases it is president of the medical staff, president-elect, and, in some cases, some others. We have physicians on all our local boards.

WEEKS:

Are they ex-officio?

WELCH:

No, they have a vote. They can vote as much as anybody else and have input. Our local boards have, I think -- though some of them might disagree -- quite great latitude of responsibility. They are responsible for a lot of important things. they are really responsible for quality of care. They are responsible for the medical staff approval and credentialing, along with the medical staff. Those are tremendously important areas for a local board to be responsible for. They are responsible for overall operation of the institution.

We then, at another level, have division boards. There are four divisions. They have boards that basically serve as the membership for each hospital. They elect that local board and approve it. They could throw it out if they had to, although that has never happened. They elect that local board. This division board has the responsibility for making changes. It varies a little by division. A major building program will come to a division board. If somebody wanted to sell an institution, they would come there. Major financing and indebtedness would come there. The appointment of the chief executive officer is done from that level. It is done with knowledge -- we don't put somebody in the local board doesn't want. It usually is a mutual thing, but it is the responsiblity of the division board. The division board approves things the local board and management do, such as their annual plans, their strategic plan, marketing plan. They are involved in looking at their audits, and things of that type.

The AHS/US board which is the top level board has responsibility in several areas -- major philosophical kind of things, strategic planning on a national basis. Anything over five million dollars has to come to this board. They may reduce that a little bit to be honest about it. Anybody who is going to spend five million dollars on a project comes to the US board.

We are involved with the financing nationally at the US board. We approve new corporations which is a major concern. We are involved with quite a number of major situations that affect everybody like wage scales and that kind of thing.

So we have three levels of governance. We are in the process right now of doing a major study of what diversification activities we should be in. We may have gone a little overboard like some other people in those areas. We kind of restrict the diversification into things that are close to our core of business and what capital-wise we can afford.

WEEKS:

I was interested in hearing you say that the board of an individual hospital was chosen not by popular vote.

WELCH:

It is appointed really by the division board. This varies a little in different divisions. The individual hospital boards are chosen by the division board. This division serves as the membership of this board. In nonprofit corporations of course you don't have stock, and you really don't have ownership, but you have control. So the division board can control the local board if it wants to. We have bylaws at both levels which conform together and even up at the US level. These have retained powers from the US board to the division board to the local board. We try to conform them so what it says here, it says there, and there.

WEEKS:

Now to get down to the practical standpoint and the operational standpoint, how do they choose the public members? This would be most difficult to select. The Church members and the Church membership members would be relatively easy to choose because you would know those personalities. But the public members, how do they choose the public members?

WELCH:

In general here, the public member is recommended by this board, or maybe the management. They usually are people who have been very interested in our hospital for one reason or another, community people. They get involved for various reasons; they have known us for many years and understand our policies and supports -- but not necessarily agreeing with everything we believe in, but they support us. Quite a number of our institutions have very strong community people on their boards. They help us keep in touch with the community. We didn't always do this. This is something that has just been in vogue the last 10 years. It keeps us tied into the community more than if we didn't have community members there.

WEEKS:

The board also could probably recommend some individuals.

WELCH:

This board has a nominating committee that recommends to the division board.

WEEKS:

I see. That seems like a reasonable way, to choose community leaders. You probably have had interaction with them in the past.

I am interested in knowing more about this nursing home chain and other services for the aged.

WELCH:

We have had some nursing homes for years, operated by some hospitals or by a conference. In the last few years we have felt that that is an important diversification and it is necessary for hospitals to have a place to put people that don't need to be in the hospital but have to go somewhere. So we have endeavored to have nursing homes really with all our hospitals. Either we own them or we have a contractual relationship. Now we are more in the area of developing our own nursing home company called Adventist Living Centers. We have expanded that quite rapidly. We have about 80 nursing homes now, probably close to 90, all over the country. In some areas like Indiana that's the only health care work we have. We don't have any hospitals, we just have nursing homes. Our goal, though, is to have them in an area where we have a hospital first, and then if one comes along in another community, and we can afford it, and if it can be profitable, we'll take it. Our priority right now is to have them in relationship to other health care organizations. So we are trying to build our clusters.

WEEKS:

Does this come under your...

WELCH:

It might be under a division, but it comes under our general overall program. There are nursing homes operated by our conferences yet. Originally when the Church voted the hospital system they mandated that the hospitals all be under the system, but they didn't mandate the nursing homes. In the last 15 years most of them have come in. There still are a few around that some conference has; maybe they are profitable and no big problems, so they have kept them.

WEEKS:

How about the so-called congregate living homes, homes for the retired?

WELCH:

We have a company headquartered in Kansas City called Heritage Centers of America. It has built quite a number of retirement apartments. These are facilities which you don't buy but that you rent by the month. There might be some contractual arrangement longer than a month. Basically you pay by the month and you pay for the service you get. They have different services in different areas. In some it is what they call congregate living, others people take care of themselves, and someone looks in on them every once in a while. Some may get all their meals in the cafeteria, some might get one a day or two a day. Some have their laundry done, some have some housekeeping -- there is a variable there. You contract for what you need and what you want, what you can pay for. We have built quite a number of these and they are working quite successfully. We also have some in which there is what is called "life care," where people come and they buy their house, their apartment, or whatever it is, and pay for it. The estate may get some money back when they are deceased, or they may not. They vary. We found those a little harder to justify. There is tremendous competition in those. In fact, we are selling some of those right now that we don't feel we can get the return to justify the high capital you have to put in.

WEEKS:

HCA, or a subsidiary, has a retirement home in Michigan now where they have three levels of care: ambulatory, wheel chair, and nursing home type on a rental basis. It's fairly expensive. Do you have means tests on any of your...?

WELCH:

The means test comes in where there are HUD grants... The Church has some of those that they are involved in. We don't have any of them in our health care system.

WEEKS:

We have a retirement home in Ann Arbor which has been in existence quite a few years. Your income has to be below a certain level before they will rent you a place or apartment.

WELCH:

That's because the federal government is subsidizing it. We have several of those near our hospitals that we have helped but we do not own.

WEEKS:

I have heard another term in connection with retirement living called "equity financing" where the person coming in puts in a certain number of thousands of dollars into a fund and then after the person leaves in death or in health that money is taken out and returned to the estate or person. In the meantime the institutions has the use of the money, interest free.

WELCH:

We have one like that in Arizona in which the people basically buy their unit and the money is ours as long as they live or until they want out, then they get 80% of it back at that time. Those are a little harder to operate and take a lot of capital. We probably won't be doing any of those in the future. Capital is going to be short and we feel like the nursing home is a better diversification for us than that type of retirement home.

WEEKS:

There is no question the aged are going to be more and more of a problem because we are going to have older and older people.

WELCH:

There is a need. I know from my own parents that those apartments and homes work pretty well. My parents retired from Africa. My father was a

Church leader over in Africa. In fact, he was president of a college there for a while. He was one of our conference leadership people. He retired from there and they went to a little town in Georgia and lived there about 10 years. Then their health got so they needed to be near some of the children and near health care that was better than where they were. They moved into a retirement program that was operated by our Church in which you bought the apartment. The apartments were quite reasonable. They lived there 10 years until they passed away. It was a good thing; it worked well.

WEEKS:

I think they need to be near people, talking and conversing with people.

You haven't gone in for specialized care like psychiatric care...?

WELCH:

We have six hospitals that are specialized. Battle Creek now is all psychiatric.

WEEKS:

I didn't realize that.

WELCH:

It has been that way for two or three years, maybe four or five years. There just wasn't the need for medical-surgical hospitals there. In fact, the other two hospitals are merging right now.

WEEKS:

Are they Community Hospital and Leila Hospital?

WELCH:

That's right. One of them is Ed Connor's hospital. They are merging in some way, I am not sure how.

WEEKS:

They are right across the street from each other.

WELCH:

I understand that Kellogg kind of mandated that they merge.

WEEKS:

Could be.

WELCH:

They are in the process of merging.

We have a psychiatric hospital in Battle Creek; we have one, Fuller Memorial in South Attleboro, Massachusetts; we have one in Ohio. We have a hospital known as Beech Grove in New Hampshire. We recently acquired it, about two years ago. It is basically a psychiatric, and alcoholic, and drug abuse. We have a hospital in California near Oxnard that we changed over from being a small general hospital to an adolescent drug abuse facility. Then we have a hospital in Reading, Pennsylvania that is totally rehab. That's all they do, and a very successful place. So, we do have some freestanding specialty hospitals. We have most of those specialties in our other hospitals. Many of our hospitals have very active psychiatric and rehabilitation programs.

WEEKS:

This is basic to your philosophy, isn't it?

WELCH:

It is an outgrowth of our original philosophy, and still is. We have stressed that. Many of our hospitals, particularly the major ones have very large mental health and psychiatric programs. Some have drug abuse in the general hospital in one way or another. We have had quite a few services of that type in our system. In fact, we are putting together a network of rehab organizations to contract nationally with insurance companies. Adding into that our nursing homes because some of these companies we were talking with have over 200 people each year that have to be permanently taken care of in some kind of long-term facility -- millions of dollars of care. So we are endeavoring to work through the rehab program, certain kinds of nursing homes on contract for people across the country. We are finding insurance companies very interested. They don't know where to put people. They are looking for somebody they can trust with good facilities.

We still think that is one of the benefits of the system. There are things we can contract for nationally, but not as much as we thought.

WEEKS:

We have been speaking about services nationally. There are national accounts for big companies that want a term of service like HMOs. What do you think is going to happen in the HMO picture? Blue Cross is trying to set up a national HMO network, and I think some of the insurance companies, maybe even Kaiser Permanente, which is spreading out more and more. Whether they will go national or not, I don't know.

WELCH:

There is a lot of disagreement about what is going to happen. Today I believe people think that HMOs on a national basis are less likely to happen than we thought three or four years ago. They are more likely to be regional or statewide, or in a standard metropolitan area. I do personally believe that HMOs are going to continue to grow. You will notice that they said last year that health care increase in cost was around 15 percent for all health care, while in HMOs it was 3.8 percent. That tells you something. If they can continue that kind of cost control, they are going to get more and more of the business. How many will be able to do it on a national basis is very questionable. I think eventually some will, but it is a long way away.

WEEKS:

There may be a handful of national networks or ownership -- three or four or five.

It seems to me that one of the problems that HMOs must have is finding CEOs who know enough about the business to run one.

WELCH:

Obviously there hasn't been anybody in that business. Insurance people don't seem to necessarily fit into that job. Probably hospital people don't either. Most of them that have been successful have been of entrepreneur types.

WEEKS:

I am sort of jumping around here a bit in my questions. Can we talk about nursing education? I notice that you have quite a few nursing schools.

WELCH:

Yes, we have 10 schools of nursing in the United States.

WEEKS:

Are they bachelor degree courses?

WELCH:

Most of them are bachelor degree, although we have two year programs. Some of them have both. We probably have too many schools, but in one way not enough. Our enrollment has been down the last year or so.

WEEKS:

There are so many competing career offers today for women. They can go into almost any profession today.

WELCH:

My daughter is taking accounting. Her mother was a nurse. My daughter wasn't interested in nursing.

Our nursing schools are important to us. We do feel that one edge we have a little bit -- it's not a big thing -- is our own schools, our medical school, we have quite a lot of medical technology schools, physical therapy, our Andrews University here in Michigan at Berrien Springs has a school of physical therapy. They have a nursing school, too, by the way. Those schools do help us. It does give us a little edge. We spend quite a little time selling those schools, selling people to go to them. We start working on our young people in grade school about it: get them in working for the Church, one way or another in our health care program. That pays off.

WEEKS:

Has this been a big program -- the Church school system?

WELCH:

Yes, we have, I believe, the largest Protestant education system in the United States. We have a very extensive program of grade schools, high schools, and colleges and universities. Most all of our churches have schools involved in some way. We have academies, high schools. We have day academies, and for many years we have had boarding academies. Every conference, like here in Michigan has two or three academies. Then we have colleges. We have 10 colleges of which two are universities. The Church sponsors those a great deal. We feel that's the greatest evangelistic program we have -- keeping our own kids in the Church.

WEEKS:

As I see it, your Church has missionary goals, educational goals, and health goals. I think these would be the three major thrusts, wouldn't they?

WELCH:

That's right. You might add another one that kind of complements those. The Church is very strong in its clergy programs, mission programs, its educational programs -- both for the Church and others -- its medical programs and its publishing. We have a lot of publishing work: literature, magazines, and books. That's all over the world.

WEEKS:

Have you gone into radio and television too?

WELCH:

Yes, we have a number of programs here in the United States. You probably have seen some of them. There are really three different television programs. They kind of go in different areas. We have a program known as "Faith for Today." It's more for secular. Then we have another program called "It is Written." Pastor George Vandeman is the evangelist there. More doctrinal and more for people that are already religious. Then there is another program called "Breath of Life," which is primarily for blacks. It is a black program. Then we have a very major program called "Voice of Prophesy," that's been on the radio longer than any other religious program, since 1927, or something like that. That's a very extensive part of our Church's evangelistic program. A number of those have different outreaches: Bible schools, Bible studies that are given, courses that are given, that type of thing.

WEEKS:

Do you recruit blacks for membership?

WELCH:

Oh, yes. Our biggest growth in the United States, and in the whole world is in minorities, so-called, blacks and Hispanics. In fact, the largest division of our Church is what is called the Inter American Division which is Mexico down to the northern part of South America. There are over a million members in that area. We are growing faster there than anywhere. In the United States 18 to 20% of our members are black.

WEEKS:

Maybe we could discuss membership and population.

WELCH:

Our Church has over five million members total. In the United States we have about 800,000. There are many members in Africa and in South and Central America. We are quite strong over in the South Pacific, not too strong in Europe. We have about 50,000 members in Russia. We are just beginning to find out where it is in China. Our Church has been very evangelistic -- for 100 years health care being a part of that. We are in health care work all over the world. My jurisdiction is only here in the United States. We have hospitals all over, some very fine ones. One of the nicest ones is in Australia. In northern Europe we have quite a lot of what you would call health spas. In Africa and places like New Guinea we have quite a lot of hospitals — some of them are exaggerated when you call them hospitals. We have three hospitals in Japan, seven in the Philippines, a major one in Thailand. In all those countries over there we have some representation. It used to be -- I don't think it is so much now -- many of the American companies, particularly in the Far East that did business over there, would tell their people to go to one of our hospitals. I had the privilege to go to China to visit a year and a half ago. I was talking with the embassy personnel in Shanghai. They told me that whenever they could when an American got sick they sent them to our hospital in Hong Kong. We have two hospitals in Hong Kong. In many other places there are lots of clinics and things of that type. In a lot of places in Africa they found it was better to run a clinic in health prevention than it is to run a hospital. The hospital is just not needed as much as the other things. We have had a lot of hospitals taken away from us.

WEEKS:

Expropriated?

WELCH:

Right. In places like Baghdad, Libya, Ethiopia, Nigeria -- two taken away from us there. An interesting thing though, Qaddafi took the one away from us in Libya which we really built there in cooperation with the Exxon Oil Company when they were working out there. We served a lot of people like that, and served others. He took it away from us. The Church put in a claim, and of course they didn't say anything, but all at once about five years later they got a check for it. So, we have had a lot of experience in those things.

I would say that many of our institutions, particularly in the Far East are going down hill because the countries are becoming independent, financially stronger. Many of them have socialized medicine in which they support health care. It is more difficult now for a mission type hospital.

WEEKS:

Do you have a hospital in England?

WELCH:

No, we don't.

WEEKS:

The reason I asked, HCA and others are going in and building...

WELCH:

Some have been. AMI is the one that's built the most. I haven't heard in the last year or so how they are doing. At one time some of them were doing very well.

WEEKS:

I think probably they are smaller institutions because they are appealing to people who don't want to use the National Health Service.

WELCH:

That's right. And in areas like heart surgery, of which there is a long waiting list. A person is willing to spend this money and not have to wait too long.

We have quite a number of institutions in Brazil: hospitals and a number of other connections.

WEEKS:

It must be difficult running hospitals in those countries that have high inflation.

WELCH:

In general now, hospitals overseas are run by the local jurisdiction. In Brazil, the Brazilians run them. In fact, there is a man down there by the name of Alfonso that has a Blue Cross-type organization that he runs personally. It is the largest organization in Brazil. He is a member of our Church. He tried to give it to the Church, but they were afraid to take it.

He has a lot of hospitals of his own. We have a medical school in the United States but we also have a medical school in Mexico. The people in the Philippines want to start one but the Church has vetoed that one. They didn't think they could do a good job, and couldn't afford to do it.

WEEKS:

I have a few personal items before we get to the historical part.

Let's run down the list of some of your memberships. I see you are a Fellow of the American College of Healthcare Executives.

WELCH:

I have been since 1968, I believe.

WEEKS:

You are also a member of the Seventh Day Adventist Hospital Association.

WELCH:

Yes, I have been president of that. That's a voluntary organization. Frankly, our system is kind of replacing that.

WEEKS:

I would think so. You are at the cutting edge.

WELCH:

When our institutions were all operated separately, it was quite active, but since we have a system nationwide... It still exists, but it is not real strong.

WEEKS:

I suppose the same thing is true of the Florida Hospital Association.

WELCH:

I was a member of that. In fact, I was president of the Florida Hospital Association in 1971. I was on the board there for years, and much involved.

But I am not at all anymore.

WEEKS:

The South Florida Hospital Council and the Central Florida Hospital Council, how did they differ from the Florida Hospital Association? Just regional?

WELCH:

More like a metropolitan... In Florida the hospital association covered the whole state. Then there were about four or five regional organizations. Dade County, Central Florida, there used to be one in North Florida, and there still is.

WEEKS:

Planning has been sort of a rocky road, hasn't it?

WELCH:

I don't know whether it has done any good or not.

WEEKS:

In Michigan I don't think it has accomplished too much.

WELCH:

It has done even less in some other places. The idea behind it is good. I am kind of a believer in the market program even though it is rough. It's hard on us, those of us involved in different times, have a hard time understanding it and working with it. I think in the long run -- at least at the time right now. After World War II it probably wouldn't have worked. Now I think the competitive market program is best. It can save us money in the long run. I know you will see some overbuilding. We did that under Hill-Burton. Planning agencies didn't really stop much.

WEEKS:

There is a story told about Governor Frank Murphy of Michigan in the mid-1930s. (He later moved on to become an Associate Justice of the United States Supreme Court.) Murphy went to Washington during Franklin Roosevelt's first or second term. He was trying to get money to build a little hospital in the Northern Peninsula of Michigan. He couldn't understand why he couldn't get the money. His request had been referred to Ig Falk, then very prominent in Social Security and a promoter of liberal causes. Falk's answer was, "The money isn't a problem. You could build a hospital in that remote place, but where would your doctors come from, your nurses come from?" The governor couldn't answer because they had not sought advice from physicians or nurses. This was pre-Hill-Burton days. I suppose even then there were some hospitals built where there was no need for them.

WELCH:

There was. A lot of them were built where they couldn't get physicians. We still have that problem. We are getting rid of an institution right now that needs to exist really because it is eighty-some miles to the hospital, but we just can't make a success of it. Basically it is because we can't get physicians to move there. There is a so-called glut of physicians, but they are not necessarily spaced where they are needed.

WEEKS:

At the University of Michigan we once did a study in a little town about 30 miles from Ann Arbor. We tried to help them recruit physicians in that area, but it was a rural area, the biggest town was 5,000 in a county of 35,000 or 40,000 population. We tried to show physicians that they were only 30 miles from Ann Arbor, 30 miles from Lansing, the capital, only 40 miles from Flint. A central location. But the wives who married these doctors and came to look at the town asked, "What is there in the cultural sense here?"

WELCH:

I know that. I have been through that many, many times.

WEEKS:

"What about the school system if I want to bring up my children here?"

WELCH:

One of the biggest things I did as president of Sunbelt was recruit physicians. We had people to help us. We spent a lot of time getting physicians to go work in a lot of little towns. Very difficult, although it is easier now than it was. They are more willing to go there than a few years ago.

WEEKS:

May I just mention some of the awards you have received? You have an award from the American Protestant Hospital Association? And one from the Florida Hospital Association? One from the Orange County Dental Society?

WELCH:

That isn't important. That was because we started the first in-hospital dental surgeon service.

WEEKS:

Was this at Hialeah?

WELCH:

No, this was at Florida Hospital.

The one at Hialeah that was started by the dentists was a regular dental clinic. Just like anywhere. The one at Florida Hospital was a regular operating room.

WEEKS:

That is one of the questions I have: Do you have staff privileges for dental surgeons?

WELCH:

Most of our places do, although more and more of that is being done as outpatient service now.

WEEKS:

As a sidelight that may interest you: My dentist in Michigan is Dr. Thomas Kellogg, the grandson of the dentist Dr. Richard Kellogg, who was one of the many children adopted by John Harvey Kellogg, M.D. John Harvey Kellogg, of course, being the doctor of Battle Creek Sanitarium fame.

How about your medical staffs? Do you have osteopaths on any of your medical staffs?

WELCH:

That came about slowly in different places. Most of our hospitals are open to osteopaths now on some basis. Florida Hospital now, if they have had a residency, they will accept them. Out of 800 physicians on the staff they maybe have 10 osteopaths.

WEEKS:

Osteopaths are much stronger in Michigan.

How about chiropractors? I notice that they are trying to get into hospitals.

WELCH:

I don't know any of ours that have them.

WEEKS:

Didn't they sue AHA?

WELCH:

The AHA got a settlement by putting ads in the journals. You probably have seen them -- saying they are not necessarily against them. I don't know of any of our places that have contracts with them. I know some chiropractors that are members of our Church. I kind of think if they would stick to the back they would be all right.

WEEKS:

I would think so too.

Shall we talk about the historical side of this now? Is there any place you would like to begin?

WELCH:

I think to understand our health care program you need to understand a little bit about our Church and how it started, and how it got into health care work. I notice you have read quite a bit about it.

Our Church is a relatively new church in many ways. It really was first officially started in 1863. It came out of a religious experience that went on in the 1840s here in the United States in which a lot of people thought that the Second Coming of Christ was going to be in 1844. Many people came out of the Protestant churches at that time into this program. They expected Christ to come then; he didn't come. There was great disappointment. A lot of the groups restudied what they had tried to figure out. Many of them went back to the churches they were in. There were two or three denominations that developed out of that. One of them was the Advent Christian Church, that you see around some places. It is not very big. Another one really became the group of people that kind of grew spontaneously in New England then over here in Michigan, and New York, and was developed into the Seventh Day Adventist

Church in 1863. It had only 3,000 members in it when it started. You mentioned Mrs. White. She was a lady who was involved in this group, a kind of leader along with several other people, and was a major founder of the Church with her husband who was a clergyman. It was felt that she was inspired of the Lord to do certain writings and to give certain reports. She never claimed to be a prophet, by the way. She never made that claim. Other people felt that she was. She gave a lot of inspiration and guidance, wrote many, many books of how she felt the Church should develop and how it should carry on.

Not long after 1863 one of her major presentations had to do with health care. She saw that so many things that we were doing with diet and medicine and health, the way people lived, were wrong. It developed in the Church partially because the Church members were so sick themselves. You read about it back there and it seems about all of them were sick. There developed in the Church a desire to improve health, and to make it a very major part of our ministry. It was felt that when Christ was here on earth he spent a lot of time healing. Unless people can have their hurts taken care of they don't think too deeply spiritually. You kind of have to take care of the one before you can get to the other. Mrs. White stressed this a lot.

As a result they wanted to start an institution of health care partially for our own people. The first one was started in 1866 or 1867 in Battle Creek known as the Western Health Reform Institute. It had that name for a few years. It started quite small and really didn't start to grow until they acquired Dr. Kellogg, John Harvey Kellogg. Apparently for that day he had pretty good training. He trained in New York at Bellevue. He was quite a salesman and a personality. He came and the Institute began to develop. He changed the name before too long into the Battle Creek Sanitarium. That was a word that he coined from some suggestions he got from England. He didn't want to call it a hospital because that was a bad name. He stressed a lot of things that we all accept today; fresh air, sunlight, good water, rest, proper diet, using medicines that were rational and specific, that you knew worked. He also believed in surgery in some cases. He was quite a surgeon.

Battle Creek Sanitarium grew very rapidly and became a very major institution. In fact, they had literally thousands of patients there sometimes, not only living in the institution but also in all kinds of homes in Battle Creek. It became a very major institution. Dr. Kellogg sponsored and helped start other health care institutions. It wasn't long before one was started out in California, that was the second, started in 1875. One was started in Boulder, Colorado in 1876. There were many of these institutions but they were mostly one doctor type facilities. Some doctor would be one Dr. Kellogg had trained or inspired. They would go out and get some nurses and start this institution. They were very much health resorts more than we would call a hospital.

These institutions spread quite rapidly and developed. The Church sponsored them. Dr. Kellogg ran to some extent a medical school with his program. He expanded even outside the country in other areas. The Kellogg name became very famous. Part of his desire to have better diets, he was looking for better breakfast foods and invented corn flakes. As I understand it, it was an accident; it happened while he was doing something else. Of course that grew into W.K. Kellogg's, his brother's business. C.W. Post also started a breakfast food business with products such as "Postum," a coffee substitute, and "Post Toasties" similar to corn flakes.

John Harvey Kellogg started a health care system which he had going there in the late 1890s and early 1900s. There were quite a number of institutions which he endeavored to control through the Church.

About 1895 to 1900, to 1906, Kellogg and the Church kind of got on different paths, basically separated. He had control of these institutions and took them out of the Church. There was litigation and problems over that for years. I don't know all of the history of that. The Battle Creek Sanitarium he continued to run and it grew and developed. I think in 1927 hard times hit and they went bankrupt. Of course during the war it became Percy Jones U.S. Army Hospital. Sometime after World War II, it was given back to the denomination.

Around 1906 with the breakup of Dr. Kellogg's organization and the Church, emphasis on health care kind of moved to California. Church leadership out there, with Mrs. White actively involved, started a number of institutions in southern California. One was in San Diego known as Paradise Valley Hospital. One in Glendale is known as Glendale Adventist Hospital today. They actually started a school of medicine and a hospital at Loma Linda, California, which is near San Bernardino. Health care activities kind of moved there, yet other institutions were being started by the Church throughout the country. Quite a number of those that were started in the Midwest were based on one person. When that person retired or died or left, or the economy became bad in some of those places like where I was born in Hastings, Nebraska, those institutions closed. A number, though, of very major institutions continued to grow and develop until we had quite a few fairly strong institutions throughout the United States in most all areas. Many of these institutions had problems; generally they were operated by a local church conference leadership. After the war many of them had plants that were built around the turn of the century. They needed to be rebuilt. Probably a greater management concern was their medical staffs. Most of these institutions had been build with closed medical staffs. Members of our Church who were physicians worked in the hospital and had their practice there. In most cases before World War II they worked on a salary. The institution collected the fee and paid them their salary. This started to break down during the thirties. Some things were changed to allow for the private practice of medicine.

One interesting thing I read in the minutes in Orlando: In 1933 the medical staff at the hospital there started a prepaid program like Blue Cross. For a dollar a month you could be guaranteed all of your health care -- physicians, hospital, and everything else. It became very popular. They had clinics out in towns 30 and 50 miles away. It became a scourge of the medical society and the society threw all the doctors out who belonged to this in 1934.

WEEKS:

This included both hospital and medical service?

WELCH:

They threw the physicians out of the medical society but they couldn't do anything to the hospital. That developed some great bitterness in Orlando and a similar kind of thing developed in other areas between the closed, inside staff. In the thirties they started to let private physicians in town, with their own offices also practice in the hospital. Often the doctors that were on the payroll with office in the hospital were treated better than these other people who were kind of tolerated. The same sort of thing universities have with gown and town. This caused a lot of bitterness in a lot of our institutions. That affected us a great deal for many years. In some places we have got over that only in the last 10 years.

After World War II many of our institutions were rebuilt and they changed their medical staffs to open medical staff controlled, and became more specialty institutions. Many of the institutions that were started early... some of the plan was that it was better for the institution to be out in the country rather than downtown because they were somewhat health resorts and to get fresh air and out of the pollution. The reason was there for that but surprisingly in recent years many of those institutions have been very well placed in nice, growing suburban areas. Literally several dozen of our hospitals that we have now that were started in 1900 are still on the same piece of land, and it's a good piece of land. I don't know whether it was providential or luck, or what but it worked out pretty well.

We had growth starting in the fifties in institutions that were added to, and new institutions that were started. This accelerated some in the sixties, then with the development of our systems that I already mentioned to you. Starting with 1970 we had quite rapid growth of hospitals in many areas, new facilities. Institutions that we have had for many years became very major institutions. Our medical schools totally moved to Loma Linda in 1966. It has become an asset of the Church. Other institutions like where I was located in Florida became major institutions. Institutions like Kettering, Ohio, which has a very interesting history, was developed from nothing in 1961. It is now a very major 600-bed teaching institutions with lots of facilities.

I'll tell you how it came about. The Ketterings had homes in Dayton and

Kettering, Ohio. They also had homes in Hinsdale, a suburb of Chicago, and probably a lot of other places. They lived in Hinsdale quite a bit. This was old Boss Kettering who developed General Motors and did so much. In the early fifties, Mrs. Kettering was a Pink Lady at Hinsdale Hospital. It was one of our early hospitals and was growing old. While she was a Pink Lady there, there was a polio epidemic. We have forgotten how those were by now. There really was a panic in town with dozens of kids in the hospital.

WEEKS:

A bigger panic than AIDS.

WELCH:

That's right. A bigger panic than AIDS because with AIDS you kind of figure that if you take care of yourself and watch out, you are not going to get it. But anybody could get polio. Nobody knew why really, or how.

Mrs. Kettering was in the hospital when there was a tremendous panic. There were patients there with polio and she observed employees working extra hours, doing all kinds of things to help these people and their families. She was very much impressed. In fact, she did a lot for Hinsdale Hospital. A lot of the time she went out and bought equipment for them and things to help them. Later on they built several buildings there. As a result of that and other relationships there they decided they wanted an Adventist Hospital in Kettering, which was a growing suburb of Dayton. They flew three plane loads of doctors and community leaders from Kettering over to see Hinsdale. Out of that they invited our Church to start a hospital in Kettering and they gave us 14 million dollars to start with. The community raised more money. So we built a brand new hospital there starting in 1962. It has become a very major institution. It is a very interesting story.

A similar story, in a way, is the hospital in Denver known as Porter Memorial Hospital, which is one of the major institutions in Denver. It was named for Mr. Porter who had been a patient in some of our institutions on the West Coast. This was back in the early thirties. He was a patient there and paid his bill. He had a credit balance of twenty-five cents and they mailed him a check for that twenty-five cents. He liked what he saw there and appreciated the integrity of the people. He asked them to build a hospital in Denver and he gave a lot of money for the hospital. That's how that hospital was built in the thirties. Those are some of the things that developed some of our institutions throughout the country in the last fifty or sixty years. So we have a chain of many very fine institutions. We added a lot of smaller institutions in rural areas in the seventies and eighties when expansion seemed the thing to do. Some of those have been very successful, others have not been. In fact, we are divesting of some of them right now, along with a lot of other people. Those people who used to go to small, rural hospitals don't go to hospitals anymore. It's a fact of life we have to face. In the last seven or eight years, maybe ten years, we have been diversifying quite a bit. We have been diversifying in nursing homes, into home health agencies, into surgicenters, into urgent care centers, things like hospices. We have built a lot of buildings for doctors. We have millions of dollars in assets in physicians' office buildings. We have done those kinds of things to expand our system. We continue to endeavor to do that although expansion now is in a little different kind of way than it was previously. We are probably expanding more now into things like managed care: insurance companies, HMOs, PPOs, and those type of things. That's the capital investment of today where buildings were 10 years ago. I expect to see that continue.

WEEKS:

I have often read of the American Missionary Medical College that you mentioned that Dr. Kellogg started in Chicago. I understand that it operated about 10 years and graduated about 100 M.D.s, but I never heard what became of it.

WELCH:

I am not real well versed on that. I have read about it but it has been quite a while ago. I think that institution phased out.

WEEKS:

It phased out. I think it may have become a part of the University of Illinois.

WELCH:

I am not sure what happened to it. That's possible. It wasn't doing very well.

WEEKS:

It was a small school. As I understand it Kellogg would bring some of the students to Battle Creek for short periods for clinical experience, then rotate them, I suppose.

WELCH:

I understood that it was sort of a combination of Battle Creek and Chicago. I don't know too much about it except that it didn't last.

Our Church felt that they needed to start a medical school. Basically about 1910 they endeavored to start one in Loma Linda, California. We struggled with it quite a while, but it did grow and develop. It really is the largest, private medical school in the West. They have about a hundred forty-some graduates every year. And they have a dental school.

WEEKS:

Are they thinking of reducing the size of their medical class? Because of the glut?

WELCH:

It is being discussed but it hasn't happened yet. The requests for enrollment have reduced some, while they still have four times as many applications that are good as they could accept. Five years ago they had ten times as many as they could accept.

WEEKS:

As you say, the cost of tuition has risen so much that...

WELCH:

It is discouraging people. They don't want to reduce from the 140 they have now because it affects the whole economy of the institution. We have a dental school there too. I am not sure of the enrollment. We have a school of public health which is very much involved with our ministry and missionary work throughout the whole world. It is one of the largest schools of public health anywhere. It also is a big financial drain. The institution became better known when Dr. Bailey out there tried to transplant a monkey heart into a human. He has had very good success since in human transplants on babies. Loma Linda is the primary place in the world doing that. Others are doing it now, but he really started the transplants on babies.

Just now we have a program in which we are in partnership with Fermi Labs in Chicago to build the first clinical proton beam accelerator -- a 40 million dollar project. We are going to get the first one at Loma Linda, then Harvard and Stanford are the next two.

What I am told, and I have to admit I don't understand all the physics of it, proton beam is so much better than any other kind of therapy because essentially with the new technology that has come along you can pinpoint where that radiation goes without destroying the tissue on either side of it which linear accelerator, cobalt, and all the x-ray have. To one extent or another they are limited by the fact that you destroy so much normal tissue and you can't really kill the tumor. This doesn't have that problem. They are starting that right now. In fact, they had a program on it last week. We are having the ground breaking on it out there next week.

We feel that tying together the university medical schools of various kinds and our hospital systems, and other medical training, as well as nursing is a very great advantage to our program.

WEEKS:

There are a couple of questions that come to mind. Is the hospital, the medical center, operated separately from the university?

WELCH:

Yes and no, in a way. The hospital medical center is operated by our system, and it's one of our divisions of the Adventist Health Systems. The university is operated under a separate corporate body, but they are all intertwined.

WEEKS:

I was wondering about the management.

WELCH:

We separated the facilities a number of years ago for a number of reasons: Medicare, accounting, cost control, and a lot of things of that type. The university has about 5,000 students in total, with a high percentage enrolled in some type of medical program. Not all of them, of course, but a lot of them. One here in Michigan, Andrews University, has four or five thousand students, and is more involved with seminary, business, and general liberal arts on undergraduate and graduate levels than the one out in California, which is more medically oriented.

WEEKS:

This answers a question I had in my mind: Are your seminaries an integral part of your colleges and universities?

WELCH:

We have only one seminary in this country. Really it is for the whole world but they do have others overseas. The seminary is on the campus of Andrews University. It is affiliated, but kind of separate.

WEEKS:

Probably similar to the situation at Yale Divinity School or at Princeton.

WELCH:

Probably, I am not sure how that is organized. The seminary has its own leadership, its own program, and to some extent, its own board. It's all very much involved in Andrews University.

WEEKS:

That originally was the old Battle Creek College, wasn't it?

WELCH:

Yes. In Battle Creek, where the Church really started, there was developed a very large educational program with Battle Creek College. There was developed the Sanitarium, which became very active, and the Review and Herald Publishing. These all grew and our Church was growing in Battle Creek. Counsel came from Mrs. White and others that we needed to expand out of there, that we were getting too much of a center in one place. They didn't do much about it. Both the Review and Herald Building and the Sanitarium burned down, which forced them to move.

WEEKS:

I didn't know the Review and Herald and the Sanitarium burned at the same time.

WELCH:

They weren't the same night but they were within the same year.

WEEKS:

About 1902? Back around the turn of the century?

WELCH:

Yes. Close to that, and closer together. Out of that there was disagreement over the college. A man by the name of Edward A. Sutherland, Dr. Sutherland, became president, and he would counsel for Mrs. White. Against a lot of other people's desires, he up and moved it down to Berrien Springs. He was president there about two years. He was president of a college we founded in Walla Walla, Washington before that time.

The college in Battle Creek went on for a while.

WEEKS:

There were two or three rebirths.

WELCH:

They tried to keep it going.

Dr. Sutherland moved it down to Berrien Springs but there was so much political uproar about moving it that he was thrown out as president after about two years. With Mrs. White's help he moved down to Nashville, Tennessee and started Madison College which was not an official institution of the

Church, but it was supported by Church members. He and another professor from Berrien Springs came down here in 1904 and started Madison College. He was interested in health care. He and a Dr. Percy T. Magan rode on motorcycles from Madison down to Vanderbilt and took a medical course and became M.D.s at Vanderbilt. Dr. Sutherland stayed on at Madison and was president of it until 1946. Dr. Magan, about 1917, went out to Loma Linda and really made the medical school there. He was the dean of the medical school for quite a few years. He took over after they had been struggling along for a number of years and developed the medical school. He was known for that.

WEEKS:

When you look back on some of those pioneers, they were pretty rugged characters, weren't they?

WELCH:

They were.

WEEKS:

I was interested to learn somewhere that Loma Linda was first called the College of Medical Evangelists.

WELCH:

It was called that up until 1952. That was the name of the medical school. A lot of people didn't like the change in name. It wasn't understood by the outside world.

WEEKS:

Are most of your physicians members of the AMA?

WELCH:

Yes. For years, since 1920 most have been members of the AMA and other kinds of professional groups -- involved in specialty groups.

WEEKS:

I'd like to talk about what you see down the road. We mentioned HMOs a little bit.

WELCH:

I believe we are going to see what we call "clusters." In metropolitan areas or market areas we are going to see these integrated clusters in which one organization, either through ownership or contracting, will have not only a tertiary hospital but will have primary hospitals or secondary hospitals, they will have clinics, nursing homes, they will have every type of health care. They will contract with organizations that basically sell insurance to the community for them to take total health care. These will probably be competitive. In an area like Detroit there might be five or six clusters or three or four, which will be in competition. I think these clusters that are developed will probably be somewhat different. Various consultants have nice charts of these clusters. I don't think any of them will look like those charts. They will vary because the areas vary, and the people who put them together vary. We feel in our organization that we can develop in the United States about 16 of these. We have a very good opportunity in a half dozen where we already to some extent have clusters -- like Orlando. We are really predominant in health care there. We have 35% of all the market. We have it there now, we just don't call it that. We can organize it better. We feel we have around 12 to 16 places that we can develop some of these clusters. Other places we have single institutions. Where I live, near Fort Worth, we have one hospital there. It's a 150 bed hospital -- and that's all. We will probably arrange to be in somebody else's cluster and work with them in that area. That's how we will keep that hospital alive, be a part of their cluster, support their tertiary hospital and other facilities.

WEEKS:

But retain your corporate identity?

WELCH:

We will retain our own ownership and our own mission, and basically our own operation. We will be involved in an overall cluster -- maybe seven or eight different ownerships in this cluster. That's going to happen in some places. I think if we develop these clusters and have somewhere between 12 and 16, some very good, and some not so strong that with a national organization we will be able to support these clusters with national things they cannot do on their own. Financing may be one, national purchasing contracts, malpractice program, overall strategic planning, things of that type. Tying all together gives strength. Decision making and entrepreneurship and basic control as much as possible will remain locally. That's what we are really trying to do right now.

WEEKS:

I see this as a wonderful opportunity to handle advanced technology.

WELCH:

That's another very important part because technology is going to be so expensive that in this metropolitan area you can't afford to have but one of some things.

WEEKS:

You can't afford to have competition.

WELCH:

If everybody is involved in that in this cluster, they can all feel that it is theirs. Probably in a large metro area where there are three or four clusters and three or four organizations, one of them might be governmental, one might be a religious organization, another might be a nonprofit, another might be a for-profit like HCA or Humana -- one of those. They will compete together and I think that competition will be good. If they compete too much and all buy everything and it's not needed, then one of them is going to drop out. The market is going to force them out.

WEEKS:

Do you see the cluster taking on insurance too?

WELCH:

Yes. I believe this cluster is going to have to have an insurance arm.

WEEKS:

Henry Ford Health Care Corporation is something like a cluster. They have and control an HMO called Health Alliance. It's probably a good thing for them. When you mentioned the cluster idea, I thought that Ford Hospital and Health Care Corporation is organized like a cluster.

WELCH:

They are.

WEEKS:

Do you see the clusters embracing satellites 15 or 20 miles away?

WELCH:

Yes, I see them embracing some kind of relationships with facilities even farther than that away to assure their referral pattern. Those institutions out 50 miles away but still closer to you for tertiary care than anybody else, you are going to have relationship with. You are going to do things for them and they are going to send you patients. That's developing now all over. We are getting involved in that quite a bit.

WEEKS:

In the old days, as an example, the University Hospital in Ann Arbor, which has everything, I think, was depending on patients from all over Michigan to come. Now they find their patients are coming mostly from southeastern Michigan.

WELCH:

Because other people are treating those patients and developing them. There are a lot of things happening there. The hospital in Orlando, for instance, has a full-time person that does nothing but work in the Caribbean. we get significant business out of Puerto Rico, Jamaica, and other countries down there that come to Orlando to have heart surgery, total hips, kidney transplants, and some things of that type. For instance the last AHA Journal had a picture of Larry Mathis of Methodist Hospital in Houston. They get a lot of business from Mexico and Central America, and they work on that.

There is a lot of that happening and there are some organizations like HMOs contracting with one organization somewhere to do all their heart surgery. They will think nothing of flying people with their family clear across the country to have heart surgery where they have a contract. Some of that is going on. You mentioned a while ago about insurance. I believe every cluster will have to have an insurance arm of some kind, either their own or be involved with an insurance company or an HMO -- someone to handle all of this.

One of the things that is going on right now that we are doing in Chicago is a good example. That's a huge place and nobody can make a dent on it because of so many people there. We, there, are joining up with the Evangelical Hospital System, John King. They have four or five hospitals and we have four hospitals and we have taken in a number of other hospitals. We have gone into an organization with about eight insurance companies. Together we are developing an HMO. That HMO is going to be a generic HMO in that all these insurance companies and the Evangelical people and our people and the other hospitals that were taken in all consider that they own it. Everybody is going to be in it. That way we can afford it. By taking in about eight insurance companies, they have all got big books of business that they will roll over into this managed care company, hopefully giving us all increased market share. This is a little different concept that we have developed, that we are using in the Washington, DC area -- there with Fairfax Hospitals System. We are endeavoring to do it in Orlando, and in fact, maybe the whole state of Florida with Sunbelt group and the HMO in Winter Haven. We are working on it in Denver and southern California. It's a little different philosophy but it's one you don't have to put up millions of dollars to make go, but it works.

WEEKS:

People thought the ultimate had come with DRGs and HMOs. I think we should begin looking ahead immediately because what is here isn't going to remain. It is not a static situation.

WELCH:

The DRGs are a very unfair situation. We have hospitals that are making a fortune on it, and others that are going bankrupt. It is no fault of theirs. Of course they are ratcheting them down a little bit every year. The contractual writeoff is a very major part of our concern. It varies in the country. Our hospitals in California have about 30 percent contractual deductions. In Florida it's about 27 percent. Here in the Midwest -- Ohio, Illinois, and Missouri -- it's about 11 percent. So the hospitals in California start out giving away about 17% more than the others. Very difficult. That percent is probably going to equalize over a period of years. Everybody is going to have their 27 or 30 percent. So hospitals that are doing very well here in the Midwest right now, their time hasn't come yet. It's going to come.

WEEKS:

The more you talk about the alignment here, pulling hospitals into clusters and services into clusters, it makes me wonder what is going to happen to the unaligned hospitals in the future. It's going to be a pretty tough road, isn't it?

WELCH:

I think so. There will be very few hospitals that don't get involved in that cluster system, or some kind of system, that are going to have a hard time unless they have some program like the Mayo Clinic sitting next to them. Some of those kind will be able to be successful. The people who are riding high and away right now are people like the Mayo Clinic and the Cleveland Clinic because they have a combination of physicians and doctors working together. That's got to come. That is above and beyond the cluster. When it comes, those are the people who are going to be successful, I think, in the future. I am hopeful that our institution will have the ability to do that. I know, it's hard to do that.

WEEKS:

The physician's role, I am sure, is going to change. The effects of the 15,000 graduates a year from our medical schools is catching up with us. As you say, maybe more physicians will be going into group practice or other group activities because it is safer maybe with a salaried income.

WELCH:

The biggest money to be saved in hospitals right now in my opinion -- I shouldn't say this on tape probably -- has to do with hospital-based specialists: radiologists, pathologists, and in some cases anesthesiologists, and others of that type. Those people are really making in many, many cases way beyond what is fair, and way beyond what other physicians in private practice are making. I have been in hospitals where we had a radiology department where not one of the radiologists made less than half a million a year and they really didn't work hard to get that. That's going to change. I don't know when or how but I know it is going to change.

There is tremendous savings in that area and there are lots of inefficiencies because of the way hospitals or physicians work or don't work. That can be developed and it is going to be developed, I think. It's just a matter of time.

WEEKS:

Maybe what we need and eventually will get will be a writer who will bring the dirty linen out and put it on the line so you can see it. When the public begins to look down at these things with disfavor...

WELCH:

It is what it takes sometimes to solve these problems. I am not against physicians making money. They need to make good money, but it is way out of proportion in that area.

WEEKS:

The cost of health care is what you are worried about basically, I suppose.

WELCH:

My wife had surgery in March. I am amazed what people will put up with. She went to our hospital and had a hysterectomy. I got a bill from the hospital and I got a bill from the surgeon, got a bill from the anesthesiologist, got a bill from the radiologist, got a bill from the pathologist, and there is somebody else I missed. All of those bills! I am amazed that people put up with it. We didn't have those bills -- at least half of them -- previous to Medicare. Medicare developed this Part A and Part B and everything a doctor does in a hospital he has to bill under his name, and what the hospital did is billed separately, instead of just charging for an x-ray, or a lab test, or an EKG. That increased the costs unbelievably. All those doctors billing separately costs money, and the rates went up.

WEEKS:

I have been told by people who were supposed to be on the inside that this was a compromise to allow the radiologists and the others to bill directly instead of going through the hospital.

WELCH:

Whether it was a compromise or a sellout, I am not sure. It sure increased the cost. A whole lot of the increased cost in health care was in the first 10 years after Medicare went into that kind of stuff.

WEEKS:

On top of that, put defensive medicine in there.

WELCH:

There is a lot of that. No question about it. You have to do things to be defensive now. I don't blame the doctors for that.

WEEKS:

Is there anything else you would like to add?

WELCH:

No, I think I have said all I need to say.

Interview August 13, 1987

Detroit Metro Airport

Hilton Hotel

INDEX