HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Stuart A. Wesbury, Jr.

STUART A. WESBURY, JR.

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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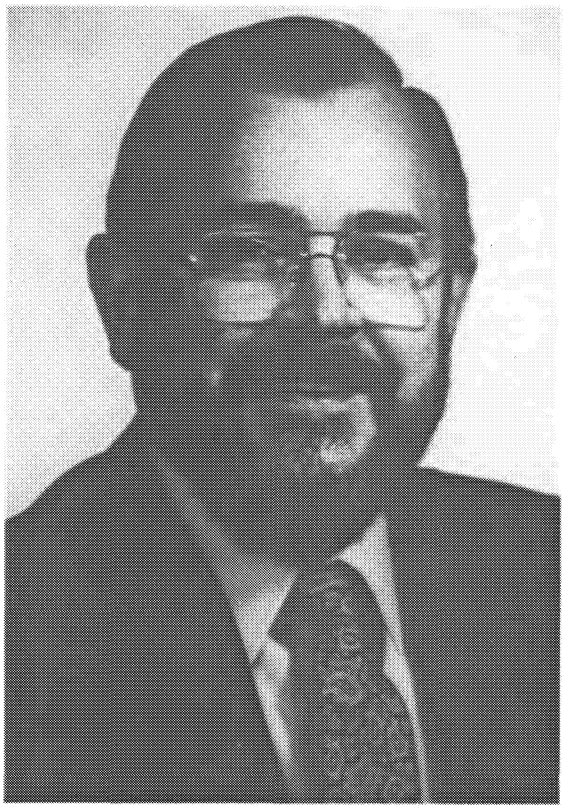

Stuart A. Wesbury, Jr., Ph.D., FACHE

CHRONOLOGY

1933	Philadelphia, born there December 13
1955	Temple University, B.S., Pharmacy
1955-1956	USPHS Hospital, Baltimore, Hospital Pharmacy Resident
1956-1957	USPHS Hospital, Savannah, GA, Assistant Chief Pharmacist
1957-1958	USPHS Outpatient Clinic, Cincinnati, Administrative Officer, Chief Pharmacist
1959-1960	Delaware Hospital, Wilmington, Administrative Resident
1960	University of Michigan, M.H.A., Hospital Administration
1960-1961	Delaware Hospital, Wilmington, Administrative Assistant
1961-1966	Bronson Methodist Hospital, Kalamazoo, Assistant Administrator
1966-1967	University of Florida, Shands Teaching Hospital and Clinics, Associate Director
1966-1967	University of Florida, Graduate Program in Health and Hospital Administration, Assistant Professor
1967-1969	University of Florida, Shands Teaching Hospital and Clinics, Director and CEO
1967-1969	University of Florida, Graduate Program in Health and Hospital Administration, Associate Professor and Associate Chairman
1969-1971	Computer Management Corporation, Gainesville, FL, Project Director
1970-1972	University of Florida, Graduate Teaching Associate in Health and Hospital Administration
1972	University of Florida, Ph.D., Economics and Management
1972-1975	University of Missouri, Columbia, Section of Health Services Management, School of Medicine, Director and Associate Professor

CHRONOLOGY (continued)

1975-1978	University of Missouri, Columbia, Section of Health Services Management, School of Medicine, Director and Professor
1979-	American College of Hospital Administrators, President and CEO (Now American College of Healthcare Executives)

MEMBERSHIPS & AFFILIATIONS

Accrediting Commission on Graduate Education for Health Services Administration, site visitor

American College of Healthcare Executives, President and CEO

American College of Hospital Administrators, Fellow; Research Committee, Member; Book-of-the-Year Award Committee, Member

American College of Nursing Home Administrators, Honorary Fellow Award

American Hospital Association, Member

American Medical Record Association, Advisory Council, Member

American Public Health Association, Member

American Red Cross, DuPage District Board of Directors, Chairman

American Red Cross, Mid-America Chapter, Board Member

Association of University Programs in Health Administration, Past Chairman of the Board

Boys Club of Gainesville, Florida, Past Member Board of Directors

Boy Scouts of America, Scoutmaster, Troop Committee Chairman

Department of Health, Education and Welfare, Region VII Center for Health Planning, Project Director

Hospital Administration, Editorial Advisory Board, 1973-1975

Hospital Management Systems Society, Member

Kellogg Foundation grant, conduct of a Consortium for Health Services Management Training Through a Program of Undergraduate and Continuing Education for Health Care Administration, Project Director

Long Term Care Administration, Editorial Advisory Board, Member

Methodist Church, Member; Chairman, Administrative Board and active participant in education and music programs

MEMBERSHIPS & AFFILIATIONS (continued)

Mid-Missouri health Consortium, Board of Directors, Executive Committee, Member

Missouri Public Health Association, Member

State of Missouri, Office of Comprehensive Health Planning, Certificate-of-Need Task Force, Member

State of Missouri, Office of Health Manpower Planning, Technical Advisory Group, Member

University of Missouri Education Group under contract with NCHSR, Coordinator

Research Group, Inc., Technical Assistance Panel, Member

Rotary International, Club President and Secretary-Treasurer

United States Public Health Service, Special Traineeship Grants Program, Technical Merit Review Committee, Member

WEEKS:

Dr. Wesbury, this is your oral history. Before we begin talking about your present endeavors, possibly we could talk about your background. I note that you were born in Philadelphia and that you have your B.S. from Temple University in pharmacy. I noted that you went on to some pharmaceutical jobs. Will you tell me about those and about how you happened to go into hospital administration?

WESBURY:

The story is like anyone else's. It is kind of complicated. My earlier thoughts were of medicine. When I say earlier I mean nine or ten years old, twelve years old. This was partly because my father was a hemophiliac. We had many linkages with the health care system because of his problem. He was hospitalized many times so I was snuck in to see my father when I was a very young boy. Somehow or other my linkages with the health care system started early. It probably was about the age of twelve or thirteen that I got involved with the corner drug store. The old gentleman who ran the store had two daughters, neither was interested in pharmacy. They were both married to persons who were not pharmacists, so he was looking for someone to take under his wing and literally adopt. I happened to be that person. So my thoughts of medicine dissolved into pharmacy. I worked right on through at that store doing literally everything until I was sixteen. Then I got my apprentice license and put that on the way. It really appeared that my career was already established, and that I would be on that corner for the rest of my life.

I went on to pharmacy school as a natural outgrowth of that experience. I guess it was my second year in pharmacy school that I realized that being a

corner pharmacist was not the thing I wanted to do. The hardest part of that was talking it over with Mr. Leesing, describing that I had some other ideas. I did take an optional course in clinical hospital pharmacy as part of the undergraduate program at Temple University Hospital, a few blocks down the street from the pharmacy school. I really enjoyed it.

At that point I had one other tug, that was management. My father was an accountant for a dairy in Philadelphia, and managed office branches from time to time as problems developed at those branches. So I kind of liked the idea of running something. So there were parallel movements of the professional, technical aspects of pharmacy versus this interest in management, watching my father in his involvement. In addition, my mother was employed in several office management roles. Her career also had significant impact on my outlook on alternative careers.

I applied for graduate education in pharmacy and a fellowship to support that. I was admitted to Ohio State University's graduate program in industrial pharmacy management. They had one of the early programs to train people to manage in the industry -- manufacturing and so forth. My view of that track was that I might end up working for Eli Lilly or Parke, Davis, or some other pharmaceutical firm.

On the other hand I was interested in hospital work, a throwback to my father and all those linkages. So, I applied for and was accepted for the U.S. Public Health Service hospital pharmacy residency. This would serve a couple of purposes. I could do my thing in pharmacy in a hospital, I would get a commission in the U.S. Public Health Service. It was a three-year commitment so I chose that over the Ohio State potential.

I still didn't lose that interest in management so that in my first few

months on the job in Baltimore, Maryland at the U.S. Public Health Service Hospital I entered Johns Hopkins University at night and took courses in accounting and management and continued that interest.

The chief administrative officer in that hospital happened to be a pharmacist so he became my link with the hospital administration side and my interest began to develop there.

I was transferred to Savannah, Georgia as assistant pharmacy director and continued my interests although there were no courses that I took down there. I began to badger my superior for my next assignment to involve some kind of administrative role. I was transferred a year later from Savannah to Cincinnati where I had a joint position as an administrative officer in running the outpatient clinic there and the chief pharmacist in that clinic operation. It was during that year that I became totally convinced that my future lay in management not in hospital pharmacy.

I tried to get the U.S. Public Health Service to support my graduate education. What happened was that they approved me for graduate education in pharmacy. They would make me the best pharmacist in the world but they wouldn't do anything to change my basic discipline. So, after my three years and early in my fourth year with the U.S. Public Health Service, I resigned and went to Ann Arbor to join the graduate program at the University of Michigan. That describes my entry into the health field. It's clear that at various points the management interest began to significantly overweigh the professional and technical side of pharmacy.

WEEKS:

The Michigan program was relatively young at that time, wasn't it?

WESBURY:

Yes. This was 1958. I believe I was in the third or fourth class. Clearly it was very early on.

WEEKS:

I went there in 1962. I can remember meeting you about that time. You were at Kalamazoo, weren't you? Did you do your residency there?

WESBURY:

No, for my residency I went to Wilmington, Delaware. Richard Griffith, the father of John Griffith, was my preceptor. I spent two and a half years there -- a year as resident and a year and a half as an administrative assistant.

Then in 1962 I went to be the assistant to Dan Finch at Bronson Methodist Hospital in Kalamazoo. Shortly after my arrival there, I was elected to the presidency of the University of Michigan program alumni association. That got me on a track of running back and forth between Ann Arbor and Kalamazoo. So that's when we first met.

WEEKS:

I think your next big move was to Florida. How did that come about?

WESBURY:

We had an understanding -- Dan Finch and I -- that I would be at Bronson three to five years. He had just taken over. The previous administrator had died suddenly. There was a lot of rebuilding to do, many, many changes that had to be accomplished including the starting of a new building program, and some other things. It was clear that I would have a superb opportunity to be involved in a large number of things. I committed myself to that three to five year period. It was just he and I in those days. It was a very small

administrative staff. To make that long story short, it was a superb experience for me because I ended up managing a very large portion of that organization as Dan got very much involved in the community -- building and financing, and so forth. It really gave me that opportunity to broaden out.

Two things began to happen during that time frame that had a bearing on what was to come. The first was that I had decided early on that I wanted a variety of experiences, that there was no one kind of hospital, no one kind of environment that intrigued me totally. I was going to be looking for different kinds of experiences in my career. The second thing was that I became more and more interested in earning a Ph.D. I had decided not to early on. One interesting sidelight is that Jim Hamilton, who just died...

WEEKS:

Did Jim die?

WESBURY:

Jim died this past Sunday.

WEEKS:

I am sorry to hear that.

WESBURY:

Jim was an occasional speaker at the University of Michigan program, with Walt McNerney bringing him back. He provided an opportunity to any of the students who wanted to talk to him about careers to make an appointment. So I did. I talked about Ph.D. He recommended I get involved in management and learn a little bit more about hospital administration. So if I was interested in a Ph.D., let it happen later on. I considered that to be good advice although today I would encourage people to go right in and get their doctorate quickly. But in those days it was not difficult to get a good job and move

quickly in the management ranks.

By the time I hit Kalamazoo that interest started bubbling up again. Toward the end of my four and a half years there I did take courses at Western Michigan University. In fact, I was enrolled as a doctoral student knowing full well that I probably would be gone before I could finish. It did get me back into the discipline. I scheduled myself for early morning classes. I was able to get in a full day's work. The balance didn't bother Dan and it worked well for me.

Roughly at the end of that four years I was getting itchy feet. I was beginning to look. I let the program at Michigan know that I was interested in moving on. Shortly the faculty got Dan Olson and I together. Danny was a Minnesota graduate, a good friend of nearly everybody on the faculty at Michigan. He let me know that he wanted a number two person in his hospital which was the University of Florida's teaching hospital, Shands Teaching Hospital and Clinics. He had just arrived there a few weeks before and saw some need for reorganization. Almost the entire administrative staff had departed with the previous director so there was plenty of room to create some new structures and bring in fresh blood.

We met, I was interviewed, and ultimately offered the opportunity to be the associate director at that hospital. That job served both purposes that seemed to be bubbling up previously. The first is that it took me to a new kind of hospital in a university setting, in a university teaching hospital, so that was good. The other thing was that it obviously was on a university campus and the opportunity of continuing my education might be available. Also I was going to have a faculty appointment and the opportunity to do some teaching. It really was a bonanza, a utopia, if you will.

I moved to Gainesville and began to do everything all at once. I started to take some courses, started teaching, started to do my job in the management role in the institution. The first thing that happened was that I found taking courses and doing everything else was almost impossible. So, I took only one three-hour course and that was the end of that. I could not fit any more in after that point. One interesting sidelight to that was that Medicare was introduced about that time. For our hospital in Florida that was a significant addition to our activities. That in itself took a couple of years out of my life, because we did things to accommodate that influx of patients. We expanded services to retirees. That was one of the major elements in that process.

As luck would have it, in retrospect, Dan soon got an offer from Burlington, Vermont to run the Medical Center of Vermont. After a search, I was appointed to take his job. I would say in terms of a high level position, I was very fortunate in my younger thirties to end up being the director and CEO of that university hospital.

The academic health center of which the hospital was a part was in a state of turmoil at that time. There were many challenges in that job. I spent roughly three years just absolutely over my head at times as we all tried to work through our many funding problems and diverse plans for a significant addition to the J. Hillis Miller Health Center of which the hospital was a part. It was a remarkable time to be in that role with a remarkable set of learning experiences for me.

What transpired relative to my future activities was that I became even more interested in the academic community and realized that if I was going to become part of that I had better earn that doctorate and have the appropriate

tickets for full entry into the university family. The only way to do it, I was convinced was to do it the way I got both my bachelor's and master's and that was to do it full time. I did have a wife and four sons, and had to work very carefully around the financial arrangements, but a combination of things prevailed and allowed me to resign my job and become a full-time student in a doctoral program in economics and management.

The things that worked it out for me were several. One, I became part owner of a computer company, a computer management corporation. I was hired by that company to run a major government project for which that needed an appropriate health-related person. It made me about forty percent of my previous income, which assured bread and butter. I was a consultant, in addition, to the provost of the health center. I worked with him on a cost identification program. I won't say "cost accounting" because what we were trying to do was really focus in on costs of medical education and the related issues and costs from a teaching hospital perspective. It was all a part of an AAMC study that was going on. Also I did some individual consulting work beyond that, so we were able to keep about everything going except the piano lessons for the kids. They didn't object to giving those up. Things worked out pretty well. I finished my course work, the dissertation proposal was approved. This would have been roughly in 1970-1971. In that period I began my research for my dissertation. After collecting my data, everything was all together: the committee was satisfied with the results of that data collection and analysis and I started looking for employment knowing I still had to write my dissertation, but I had the hard work all behind me.

Fortunately the University of Missouri-Columbia was recruiting for a director of their graduate program. I was lucky to be appointed to that

position. in early 1972 we moved to Columbia, Missouri. Another fortuitous time and place, and so forth, because the program was well established but we were entering into a phase where we really needed to emphasize the linkages with the other academic units on the campus. I think my experience at Florida, and certainly to some extent in Kalamazoo, where I had worked with many departments in the university structure with many linkages like the business school, the engineering school, the medical school helped me by expanding the things I could accomplish. We were successful in building many of those linkages with joint degrees and other efforts. We created, for one thing, a national center for health planning selected by the HEW for the region incorporating Iowa, Nebraska, Missouri, and Kansas. We were the center for health planning for those four states. It got us regionally hooked in. The W.K. Kellogg Foundation was kind to us and supported the creation of an undergraduate external degree in health administration. The emphasis there was on long-term care and in areas other than hospital administration. To make that long story short, that experience helped me into a number of specialty areas of administration, as well as the broader perspectives of the linkages in an academic community with a variety of disciplines and schools. That experience was just plain superb.

That leads on then to the presidential search committee, of the then American College of Hospital Administrators.

WEEKS:

You were active in the college previous to your being appointed to this job, weren't you?

WESBURY:

Oh yes, I was a student member in Ann Arbor in the late 1950s. Because

of Richard Griffith's interest, his fellowship, and his undying determination that I was going to be a part of the college one way or the other, I was somehow imbued with the feeling that I was going to be a fellow at the earliest possible moment. That's exactly what happened. In 1968 I became a fellow of the college, and considered the college to be my basic and only professional society. I met Dean Conley (ACHA CEO, 1942-1965) on a number of occasions. Certainly Richard Griffith was important in terms of discussing the history as he knew it of the college and what it had done for him. Another lucky break was going to Kalamazoo. Dan Finch was extremely interested in the college and ultimately became the Michigan regent. Another sidelight is that Ron Yaw who was chairman of the college basically at the time I went to Kalamazoo, was only thirty-five or forty miles away in Grand Rapids. We met with him occasionally. That was during the period of the transition between Dean Conley and Dick Stull. So he kept us up to date on the recruitment and all that was going on in the college. I felt, now in retrospect that I was in a number of places where I was really privy to some good solid inside information and got a good understanding of some of the top leaders of the college as to what the professional society was all about. I was very, very lucky in that respect.

WEEKS:

You served on the editorial board, didn't you? The reason I say that is that I think the editorial board of the college is much more active than many editorial boards of so-called scholarly journals -- they are merely figureheads. My understanding of the college is that the editorial board really works.

WESBURY:

That's right. There is no question about it. I felt privileged because you get a chance to read the manuscripts from a wide variety of people. It tends to keep you on the cutting edge of many developments. I guess for five years I was in that role. I was also on the Research and Development Committee, that's an advisory committee to the Director of Research. There were a few other ad hoc assignments.

As I said, a number of fortuitous things happened with respect to my knowing some of the leaders of the college. I got to know Dick Stull during that time. There were a couple of outside temporary appointments like being advisor to the American Medical Record Association, a research project, and things like that. I was more active than the average person in the college affairs. I was lucky that my name was on a list that Dick Stull kept somewhere in his desk. I got calls on a variety of things. What linked me even closer to the college during the time I was in Missouri was that, getting to be a full-time faculty member as compared with a part-time faculty member in Florida was getting involved in AUPHA affairs. I became chairman of the AUPHA board of directors in 1977-1978. Then I was past chairman 1978-1979. My term was cut short because of my appointment here at the college.

WEEKS:

Were you going to say something about the search committee?

WESBURY:

When Dick Stull announced his retirement through a notice to all affiliates, we found out very quickly that he was retiring early at about age 62 rather than wait until later because of a series of illnesses and operations. Those problems convinced him that he was going to enjoy

retirement now rather than wait until later. For himself he made a very good decision, and, I think, for the college as well. He saw his health was impairing -- to some extent -- his total involvement in some of the things he wanted to be doing. He decided to retire early and the search committee was appointed, and information did go out. Obviously they asked for nominations -- self-nominations, or nominations of others.

I seriously looked at the job opportunity at that time. I had the basic qualifications, having had experience in hospital administration, as a CEO, and now as a CEO of a graduate program. I had looked at the world through both sets of glasses. It was interesting to me, but I looked at my family and my tenure at Missouri where I was only in my sixth year at that time and it takes ten years for a pension. At the ten-year point my youngest son would be out of high school. At that point two out of the four sons would have graduated from college. Everything was focused on my staying in Missouri at least until roughly 1982. I looked at that letter from the college that every affiliate got. I took it home and showed my wife and said, "Here is an opportunity that is now or never. I can try for it, or it never will come back again. Here are the reasons I think I should not try." After discussing that I crumpled the notice up and threw it in the wastebasket, and just forgot about the college's presidency.

Several months later, an interesting series of developments occurred. This was after a presentation I had made, my actual swansong at the AUPHA as chairman. The topic I chose to speak on was the interface between the practice community and the academic community. I was very concerned that we in academia were not doing all that we should to encourage this interface development. So that was my pitch. I sent a copy of my presentation to Dick

Stull because we had talked about it and he wanted a copy. I later learned that he had copies made for the search committee and the board. I don't know whether he said they should talk to me or what. Whatever, it wasn't long before I had a call from Norman Burkett who was chairing the search committee. He was also chairman of the board of the college at that time. He said that the committee wanted to talk with me.

I said, "Let me tell you my thoughts about the job." I went through the fact that I had thought about it and decided that it was the wrong time.

He said, "Well, all right, that's fine, but we still want to talk with you about this paper you gave because these are some of the issues we feel that need to be addressed by whomever takes over in that role."

I said, "On that basis, I will come, because at this moment I am not a candidate and I don't want to waste your time, but I will come and talk about that set of issues."

The date was set, some several weeks later, four to six weeks later. It started a period of deep introspection and thinking again on my part as to what really I wanted to do. It was then clear that he was willing to look at me as a candidate, if I so chose, in addition to talking about this paper and its implications for the college.

So, the thought process started rolling again. One of the major things that helped me focus attention on the decision was a series of residency visits I had set up for that period of time. This was early summer of 1978. I made two swings. One was a northern swing to hospitals: to Bronson where Dan Finch was a preceptor for us, to Michael Schwartz in Pontiac, then to Rich Schripsema in Flint, and finally to Bloomington, Illinois with Bill Dunn. I purposely spent time with each of those administrators talking about the

college. Each one of those was an affiliate of the college. I just wanted their feeling and to find out what they had to say. I talked to them seriously about my potential candidacy. Dan Finch, of course, was a Regent of the college. I know he was supportive of my candidacy, even before I told him I was a candidate.

My next swing was south and I went to visit hospitals in several cities all the way down to Orlando, Florida with Gary Strack. I really began to think about it all the way down. By the time I finished that trip, I was convinced that I was a candidate for the job.

It was with that attitude that I went for the interview with the search committee. I did tell Norman Burkett that my mind had changed and that, in addition to talking about that paper, I was also going to be a serious candidate for the position. That was at the tail end of the process of recruiting, it was hardly 72 hours before that process was all over and I was offered the job. I met with Norm Burkett in his office a week later to settle some of the details about the appointment. So literally it all happened almost over night. Once I really made up my mind that I wanted this job. I feel very fortunate. One thing that smoothed the transition, from the period August through December in 1978, I spent two days every other week in Chicago in the office talking to Dick Stull, meeting the division directors and other leadership, and just kind of going through ideas and picking thoughts for the future. I certainly was trying to gain from Dick Stull all there was to share. So, when I arrived January second 1979 to take over, I felt as though I had been here for some time. We were able to start running from the start.

WEEKS:

Before you start talking about the organization as you found it, and what

you have done since you have been here, and what you hope to do in the future, I was wondering if it might be good to take a quick look at the different presidents, their personalities, their modes of operation, their ideas of what they thought the college should be. I have read your histories about Dewey Lutes and the Chicago people who got together. What was their motivation, do you think, basically?

WESBURY:

I believe that they all found themselves in hospital management positions, jobs, for which they had no training or experience. They were learning day to day. Many of them accepted those positions just to help somebody out for a little while or because of a financial problem that needed financial expertise. They were willing to help straighten out the books. So, for a wide variety and in some cases for weird reasons they all found themselves as CEOs of institutions. In fact, I guess CEOs is an overstatement in the sense that in those days there wasn't much to be a CEO over. The nurses, the physicians, were the kingpins. In most institutions it was the nurses and the doctors who were really running things. In some institutions, however, there were opportunities for real leadership. So the Robin Buerkis and the John Mannixes, and the Lutes, et cetera, had focused on the idea that there was something special in the job, and they needed to find a way to tease that out and to identify that what they were doing was different, and that they could help each other.

It was also an outgrowth of AHA's early days, because the AHA actually began as an organization of hospital superintendents, almost a professional society, not a trade association. In time the AHA evolved more into the trade association in characteristics. It kind of left a void on the professional

side, so, I think, that bubbling needed to be addressed as well. I think what really brought them together to create this organization was the need to deliver a message to a variety of publics.

One was the universities: look, we have a field here that has evolved. For heaven's sake, do something about it. Create some educational programs. Let's make people prepared for this job.

The second one was: we need to help each other, we need some education, even if it's not a degree in a university. We ought to start some educational programming for ourselves.

The third one was -- I think they already saw the handwriting on the wall -- you couldn't be a physician and an administrator at the same time, or a nurse and an administrator. Somehow they had to find a way to identify the qualities of management, or superintendent, whatever that position was called, and promote the fact that people should be appropriately prepared to fill that role and that a professional society would be the way of creating a mechanism for credentialing and moving that field in that direction. I think they had very high purpose and with Dr. MacEachern's help and other they created a structure that allowed them to accomplish what they really wanted to do.

WEEKS:

Did you have the privilege of knowing him before he died?

WESBURY:

I never met Dr. MacEachern.

WEEKS:

He must have been an unusual person. When you look back to that period, the 1930s, there were a lot of giants.

WESBURY:

There really were.

There were those who were not totally happy with what was going on. I chided Jim Hamilton on occasion that he was not one of the charter fellows of the organization. His comment was that he didn't think those guys were going to pull it together. He didn't want to be part of something that wasn't going to succeed. As he pointed out later, he quickly turned around when he saw that they were doing things that he was proud of. He became a very early member, and became the college chairman in 1939.

WEEKS:

When I interviewed him a few years ago he spoke of this very thing. He tried to talk Mannix out of being in the first group but I think John Mannix was one of the charter fellows. I think O.G. Pratt was another one Jim tried to keep from joining early.

Someone has said -- maybe it was Duncan Neuhauser -- that the people in the Northeast felt that this college was just a wild idea of the guys out west. Basically do you think these people were trying to elevate their jobs to a professional status?

WESBURY:

No question about it. They said that this job was special in the health field, and that it needed to be elevated in everybody's eyes, if, in fact, the hospital or organization was to be effectively managed. One thing I describe, any time I have a chance, is that our profession was really created by the professional society. In all other cases -- medicine, nursing, and on and on -- the profession was accepted by the public as a profession before the creation of society. So I think that was kind of a unique contribution. To

me it speaks well of the people who founded the college.

WEEKS:

This was at the very beginning of hospital administration education. It was about the time of the start of the Chicago program.

WESBURY:

The Chicago program started in 1934, which was one year after the ACHA was founded. We like to say that the goal of creating educational programs was successful in less than a year after the birth of the College. Now we have been so successful that many are talking about why can't we close some of these programs. There may be too much supply.

WEEKS:

I hope we can talk to that point before we are through. It is something I think all of us are wondering about. Dean Conley during his tenure had the convocation take on the cap and gown. This was significant, wasn't it?

WESBURY:

I am not sure when that came. We need to go back a little bit. You did mention that you wanted to talk about the CEOs. I don't want to skip the first two. There have been five people in this role, with a variety of titles -- secretary, executive secretary, vice president, and now president. The first was Dewey Lutes. It was purely a part-time effort for him, without pay, because he was running a hospital in the community. In fact, the early history shows that he spent a lot of his own money to do the work of the college. There was a great deal of investment of time and dollars in making the college go. In those early days there was not a staff at all. There wasn't an office. It was just operating out of Lutes' institution.

The first paid exec was Gerry Hartmen who did the job part time while he

was a graduate student at the University of Chicago. Clearly he was chosen because of where he was, and what he was, and his eagerness to develop an academic/professional linkage and to make sure that this professional society was associating itself closely with the academic sector. For him it was purely a part-time situation.

The first full-time CEO of the college was Dean Conley. It was he who created the linkage with the academic community in a significant way, and, in addition, made it very clear that this organization stood for significant continuing education, that, in fact, it was going to make sure that opportunities for education were provided, and that, to the extent possible, we would incorporate our educational programs with universities. Much of the early education occurred on university campuses. A thing one has to remember is that in those days many of the administrators had no degrees at all. Certainly the number with master's degrees was infinitesimal. So, the linkage with the university campus was important. This gave many of these people their first campus experience. The history of educational programming in the college was totally wrapped up in universities. You go through those lists and there are universities all over the country that were very much involved. That is where all the education took place.

WEEKS:

The programs were so-called institutes?

WESBURY:

That's correct. Each one had a number and a location. That became a phenomenal element in the early educational ventures of our college.

WEEKS:

Was there much repetition? I noted you had one at Harvard. Did this

become an annual affair with the universities?

WESBURY:

In many of the schools it did. In another situation it may have been a one-time or two-time affair. In a number of schools it went on for many years.

WEEKS:

Was there some continuity to the establishment of a graduate program? I never looked at it closely enough to determine that.

WESBURY:

I don't necessarily connect it up with program development. I think it might deserve some research some time to see if one thing led to another. Even in all the research that was done for the history book a year ago there is no identification of linkage between those institutes and the creation of a graduate program.

WEEKS:

It certainly was a source of publicity within the profession. Here was an effort in continuing education at a university level, university-connected. It must have given a lot of prestige.

WESBURY:

That was important for the field then because many of the people participating in the institutes were not educated at the level the field is today. That linkage gave credibility to both sides of the coin.

When Dick Stull arrived at the college those things were in place but another phenomenon had now taken over. That is, the master's degree in the field had clearly taken over and had become the standard. The need then to combine continuing education with the universities began to decline. It was

just a natural process. Once you had spent five or six years on a campus, you no longer needed the thrill of being a part of the activity of the academic community. Other kinds of educational needs were arising. The real practical applications, the increased use of consultants and their ability to focus on specific issues and problems and to create educational courses -- two and three day workshops on given issues -- began to replace the campus environment as the primary focus of education for the college. I think at that point we began to move into the continuing education concept as I see it today, rather than the more basic educational concept that the institutes carried out. So in Dick Stull's tenure he moved this organization clearly into a full-fledged continuing education organization with multiple courses. You could pick and choose not only the course but the city in which it was going to be delivered. That brought phenomenal opportunities.

WEEKS:

Dick Stull was quite a fundraiser, too, wasn't he?

WESBURY:

Yes. He took over at a time when the finances of the organizations were at a relatively low ebb and made fundraising and financial stability one of his primary tasks. In fact, I have often said that there were two things that he did that were irreplacable contributions to the college. One was that when he left this job we were in excellent financial condition. The second one was that he created in everybody's mind the dominance of professional development as the real focus for this college, that one had to be concerned about education all through his or her career. That was clearly established when he left. Fortunately with the financial support of many individuals we were able to create the Richard J. Stull Memorial Learning Resources Center. It really

focuses on that concept.

WEEKS:

Will you tell me something about that?

WESBURY:

Yes. When Dick died it was clear that the college wanted to do something very special to memorialize his contributions to the profession and to the college. As I said, there were two things he was noted for -- finance and professional development -- and it's difficult to define what one can do to identify his financial expertise and what he did financially for the college, so it is clear that we needed to look for something in the professional development side. At the time of his death, we had created and put into place the self-assessment program, which is an examination where one can determine his or her strengths and weaknesses. This is relative to the knowledge and skills needed to practice health care management. You need a lot of other things to support that program because once you discover what your strengths and weaknesses are, you need some help as how to correct the weaknesses identified.

Several of our ideas of completing that circle of total professional development starting with self-assessment kind of just fit in place in terms of conceptual framework. We decided to call it the Learning Resources Center and incorporating in that a number of specific products and services. So, that center is now responsible for delivering a Learning Resources Directory which provides access to information, books, journals, seminars, tapes, or whatever dealing with the very same areas that are the makeup of the self-assessment exam, which has eighteen components. So, if you find you are weak in component number thirteen, the learning resources center has a section

thirteen which describes all the things one might do to beef up their knowledge and skills in that particular area.

In addition to that we created a program called "Career Goals and Objectives Articulation and Educational Planning." It's a process by which you articulate your goals and the educational activities that need to be carried out to meet those goals. It follows also, the self-assessment program. It clearly pinpoints where you should put your efforts. It helps you determine whether a given area of knowledge and skills is really important to you in the long run. It also tells you how you can get there so you can deal with the high payoff items, rather than wasting your time on the low payoffs. There are a number of other services and products in that learning resources center that will be coming out over the years ahead. The critical element and why we thought it was appropriate to name that center as a memorial to Dick Stull was that it emphasized the individuality of professional development, that we were not after canned courses and programs. What we were really after was: How can this be individualized for you and your needs? That was a point that he made on many occasions. We have got to focus on the individual. This set of services and programs allows that to happen. We have collected roughly $60,000 and I think there is more to come. What that will do for us is underpin and focus on the real reason for our being and that is to support the needs of our individual affiliates, and focus their attention on the appropriate educational programming.

WEEKS:

This self-assessment seems to be a very clever idea. How do you market it? How do you get persons to assess themselves?

WESBURY:

It's difficult. People are not interested on a routine basis of assessing themselves. We are having a difficult time now in marketing that program. It was not hard in the beginning because out of our 15,000 dues paying affiliates there were better than 1,000, that proverbial ten percent, who were willing to jump in and get themselves involved. So, we reached twelve or thirteen hundred people very quickly -- I mean the first year and a half or maybe two years. Since then it has been like pulling teeth to get more and more people in for that program. It's clear they don't understand its value. We are trying different ways of telling them that, and I think we are seeing some minor upswing. We might be reaching some people. I am convinced that we have a good product that is difficult to sell. However, there is another activity in process that may change that.

We started investigation into the concept of recertification about a year ago. We created an ad hoc committee to look at this thing. The board was concerned, as was I, about once a member, always a member or once a fellow, always a fellow. Can we not do something to provide some requirements for continuing affiliation? Some other professions now do that. Some of the medical specialties do. Pharmacy in some states requires that you do so many hours of continuing education. We didn't like that idea. What can be done to assure that our people are maintaining competence? One way is to create another exam and say, "Okay, you passed an exam in 1970, you have to take another one in 1980" or whatever. That doesn't make sense either. Our field is changing so much. So, with the ad hoc committee, and now with another committee, we are beginning to prepare specific proposals for our Council of Regents which will incorporate self-assessment in the recertification process.

What this means is, if the program envisioned now is carried through and approved, is that if you as an affiliate at certain points in time -- it might be six or seven years -- sit down and take the self-assessment, you will find out where your weaknesses are. Then on an individual basis, with a counselor from the college, identify what you are going to do to overcome those weaknesses. When you do those things, you will be recertified. One hundred percent individualized. You may know all there is to know about governance or financial management, so why in the world take a test and pass it, and read books, and whatever. If you are weak in another area -- planning, or whatever -- then, in fact, it is probably to your advantage to do something about it. So the process becomes totally individualized. That instrument allows us to do that.

WEEKS:

I don't know whether there is a movement to license hospital administrators. I think there are one or two states that have licensing. I was wondering if there was any movement toward this. If there should be a movement toward licensing, this, in my mind, would be a complete answer. There would be no need for licensing because the profession had taken care of its own needs.

WESBURY:

The facts today are that only in the Commonwealth of Puerto Rico is there a licensing process. Minnesota had it and had canceled it. Legislatively they dropped the program. We were involved in that. we said, "We'll be glad to help you. We already have this process in hand. We would be happy to have you find a way to use it, if you wish." We also recommended that they forget it. They did. That's gone. Tennessee had rumblings. We were an expert

advisor, if you will, over the phone. They wanted a lot of questions answered, you know. We told them what we were doing and that licensing was a bad idea. We never heard from them again. The program never got started. The federal government started a process ten years ago, starting with medical records, occupational therapy, physical therapy, and a few others of the health-related professions. They began looking at competencies to determine what they might do, not in the traditional licensing sense, but to determine if a person could fulfill the requirements of that specific profession. Did they have the knowledge and skills to practice, not did they graduate from the appropriate program. The movement began pretty quickly because Medicare forced some of that. Many of those professional groups get direct payment from Medicare. The government was a little shaky on providing a basis for payment that was dependent on certification or licensure from non-controlled, non-government bodies. Certainly nurses and physicians are all licensed through state organizations but these other groups were not licensed, but they are certified and the government is always queasy when they are allowing some non-governmental body to certify these people and then pay these people on that basis. We learned that they had issued a contract to an organization to do preliminary work in health administration. We joined together with AUPHA, and our sister professional societies and quickly stopped any further movement in that regard. It was pretty clear to us that the people who were issuing the grants and were encouraging groups to apply for them had no knowledge as to what the societies themselves were doing. I think we were able to convince them that those things were already being taken care of.

I believe in this point of time, outside of Puerto Rico, there is no movement anywhere to think about licensing hospital administrators.

WEEKS:

As I said, you have the best answer for not having any licensing at state level.

WESBURY:

We think so.

WEEKS:

Is there anything more you wanted to say about Dick Stull?

WESBURY:

Dick, too, was involved in AUPHA, and he founded a graduate program, so his views of the world were somewhat similar to mine. I think that was important for the college as well. As the college moved away from these institutes, losing that point of view, and as more programs and faculties of the graduate programs began to come from disciplines other than health administration,it was important then, as it is now, for the incumbent in this position at the college to have an academic linkage and understanding. Stull's background allowed him to understand a good bit about that, and he did an effective job of liaison with the graduate programs. I hope we are continuing that at that level. To me that was another significant contribution of his.

WEEKS:

You came to the college in 1979. You had an understanding of the role of the college. Did you feel that you wanted to add emphasis to some part of it? New ideas?

WESBURY:

Quite a bit. This really started with the search committee. It was clear that the search committee was not satisfied with the total direction of

the college at that point. There were a lot of internal difficulties and specific persons. I would like to talk about them.

I think the set of circumstances that needs to be recognized and appreciated is that Dick's last five years were shaky years because of his health. As a result, his ability to run the organization on a day-by-day or a month-by-month basis was impaired. A considerable amount of the leadership fell to the gentleman who was the finance director rather than an experienced health care manager. I know that was one of the factors that led Dick to decide to retire early and allow someone new to come in and move more aggressively in new directions. Unfortunately without that leadership the divisions were not pushed to create innovative things. The real force and push that should have been forthcoming from the executive office wasn't there. While the maintenance functions were carried on, the provisions for the future were not evolving as they should have.

When I came to the college it was clear that it was time for a significant turnaround, a real movement forward. The search committee wanted that, it was a part of our discussion and, in fact, the search committee asked what I thought of the name of the college -- should it be changed? My answer in 1978 was, "Yes, it should be changed." I had many reasons for that. We did talk about the programs, activities, and services. There was no question that when I arrived, the college was in excellent financial condition, the day-to-day operations of the basic activities of all the divisions were being carried out well, but what was lacking was: Where do we go from here? What new activities and services should evolve in the future? To me that was the best of all worlds. You don't have to worry about the machine running today, and it is now time to focus on where we are going to go from here.

From the point of view of our leadership within the organization -- the majority of the division directors were sixty or close, about sixty years of age and were clearly preparing for retirement, some had already picked their dates. So there was no doubt there was going to be significant turnover in our internal leadership. In fact, four years after my arrival there were no division directors in place who were here the day I arrived. We also put in place a new vice president so our entire leadership had totally turned over in that time frame. Fortunately, most of this happened in a very smooth fashion.

One of my management techniques and styles is that I do not like to go in and stir up an organization. I think you can do good things with existing people while you are waiting through the process of change. Literally that's what happened. We were able to make many forward strides with existing staff. Our recruitment for replacements was made on the basis that we were ready to move on and do some exciting things. To make that long story short, a transition period of some three to four years got started on January 2, 1979, and as I said, four years later there was a total turnover.

That meant that the board and the Council of Regents had to be caught up in this process. Eventually we were able to orchestrate that and get everybody involved.

The first major event was one that did get started in the last two years of Dick Stull's tenure. That was the concept of self-assessment which was already mentioned. This seemed to be a joint venture of several divisions of the college. A number of division directors had written papers supporting the concept of self-assessment as it might apply to the Division of Education, the Division of Membership, and the Division of Research. When I arrived, the proposal had already been submitted to the W.K. Kellogg Foundation. All I had

to do was reendorse the proposal as the new CEO and suggest ways that it might be implemented. We were fortunate that three or four months after my arrival that grant was approved. That immediately started us on the new venture.

WEEKS:

You spoke of a learning resources directory. Is this a computerized directory? Is this an actual volume -- is this printed? For instance in the self-assessment you find you are weak in number 13. Do you turn to a page or do you turn to a computer to find out...

WESBURY:

Right now you turn to a page which is totally reprinted every year from a computer. All the information is stored there. We have three updates a year, so it's a continually current item. Ultimately it will be -- actually it's available now. If all you want is number 13, we punch a button and print that out for you today. That is a service, but we prefer to sell the whole package because it does provide references for a whole variety of things. It becomes a good reference source for the institution.

WEEKS:

You sell it to the institution rather than...

WESBURY:

We sell it to anybody.

WEEKS:

Are you focusing on the individual who is taking the exam or are you assuming the institution is large enough so that several persons would be using it?

WESBURY:

We would hope the latter to be true, because we feel the Learning

Resources Directory is far more than just a one-person thing, something the institution as a whole could invest in every year to have available this updated series of references. It serves both purposes, individual and institutions.

WEEKS:

Some institutions or chains of institutions have their own educational departments, don't they?

WESBURY:

Yes, this represents another challenge and an area of future activity for the college.

WEEKS:

I was wondering if this directory could be channeled through an educational department.

WESBURY:

It can. The problem is that you are competing with them. They may feel that they are the ones who are supposed to go out and find where in the world those resources are, and don't want the canned program.

Back to the issue of when I arrived. Clearly we needed that "oomph" to get things started to broaden programs and activities and create initiatives. The other thing was that the search committee and the board were really concerned about the college's visibility. Dick's illness had kept him off the road. The staff didn't travel that much. We were not very visible in various state meetings and other places. I immediately got involved in a travel schedule that I have maintained now for seven years that keeps me on the road about half the time. This time of the year it's about sixty or seventy percent of the time, in the summer and the holiday time frame it's much less.

There is no question that I was given two objectives. One was visibility, the other was new programs and initiatives. Luckily self-assessment was instituted shortly after I got here because the planning work was done. Then it was up to us to start working on a number of other kinds of program. At that point we were installing a computer in-house to take over the functions of the service bureau. That was another major effort which was a godsend as it turned out to be ideal in terms of allowing us to move into new areas without hiring a lot of people. On top of all that we really began to get aggressive in creating some new educational experiences and making some very major revisions in the Congress on Administration. I can't pinpoint the date but it would go back roughly to 1957 when the congress was first held. This was considered to be an outstanding meeting from the beginning. When I came here we had some 2,300 registrants at that meeting and we were turning people away. One of the first problems was to find a way to accommodate these people and make room for expanding that program. We did develop the concept of the dual Congress -- back-to-back Congresses -- and to make a long story short, in 1985 we were able to accommodate over 4,000 people at the Congress in Chicago that year. So that growth has been literally phenomenal. We also saw a significant gain in improving our recruitment of new affiliates. We weren't stagnant but we weren't growing at the rate we should have so we became far more aggressive in recruiting affiliates. For seven years now we have had significant success. In fact, the number of dues paying affiliates in that seven years has increased about fifty percent. The growth has been at the five to nine percent level each year.

WEEKS:

I remember a few years ago at the Health Administration Press when we

used your mailing list, it was about seven thousand.

WESBURY:

Now it is 24,500 dues paying affiliates and growing rapidly. When we add students and life members and Fellows, and the honoraries such as yourself, we have over 20,000 people on that mailing list. We got very aggressive there. I personally began a program of involving myself with the graduate programs and with our young administrator groups. That added to the travel schedule, meeting frequently in campus situations with students and others. All I can say is that a number of areas of the college really became the focus of rather substantial expansion and attention.

WEEKS:

Were some of these things in the paper you circulated?

WESBURY:

No, the paper dealt with the need for faculty, we are speaking here of the AUPHA speech I made, to bring practitioners into their programs. It was kind of pounding on the faculty to involve themselves in the world of practice. I wanted more faculty to join the college, but we have not been singularly successful in that regard. This summer at the Council of Regents among other things we approved a new category of affiliation called faculty associates, which I think will attract many more faculty. They won't have to sit for the membership exam. Many faculty don't feel they are prepared for it because their basic discipline is economics, sociology, or what have you. I agree with them. Now we have a way for them to affiliate. My biggest concern in regard to the graduate schools and the undergraduate schools was the student and our linkage there. So we got far more aggressive in our student associate program and we created and have had for about two years the student

chapter concept, so there is a focus and a certificate on the wall, some visible linkage with the college. When I look back over those early developmental years, we were really building fires under many areas of programmatic activity to get some new excitement and enthusiasm behind those programs. They pay off handsomely. They paid off financially and they paid off in the building of numbers, and in the willingness to try some new things.

A couple of other areas of concern: When I came to the college, the college had a policy of non-involvement in political affairs. We were not a lobbying organization. That was a position taken after a task force report stated that we would not get involved legislatively. The extent of our involvement would be to have educational programs for our affiliates and to encourage them at the appropriate time to take the message of the field to their legislators or the Congress, as the case may be, and to work with the AHA and state associations. We examined that position on a couple of occasions and clearly felt that things had changed, that the federal government was deeply involved in health affairs and things were different, and the college has a role to play in the public policy arena. So we did develop the beginnings of a public policy activity and developed an accord with the American Hospital Association to assure them that we were not going to be battling with them. All of that has worked out. We eventually appointed a public policy committee. Now we have policy statements on a number of basic issues such as ethics, ethic committees in hospitals, coalitions and the need for our affiliates to be involved in coalition activities. We have supported federal funding of graduate education. So we have begun to focus on specific issues, and feel we have a role to play making the world aware of what hospital administration is and what we are as a

professional society.

One other element -- a major difference -- is we also agreed that we needed more visibility. I have already said that meant I travel a great deal. We have expanded considerably the division we used to call "public information and publications." We now have a Division of Communications and that staff has more than doubled -- the professional staff -- which is producing many, many press releases and other things. We are now on the phone call list of writers and reporters of the Wall Street Journal, the New York Times, the Chicago Tribune to provide input and background information on health-related subjects. So there is a much greater intensity of involvement in a broader set of issues today than there was in the beginning of 1979.

WEEKS:

Would you care to say more about your code of ethics? I am interested in this because a few years ago we were trying to find an author who could write a good book on ethics in the hospital. Not the doctor-patient ethics but more related to the hospital setting for hospital administration and management. How did you go about adopting a code of ethics? Did you have a committee work on it?

WESBURY:

That is a piece of ancient history primarily because the code of ethics has existed for quite some time. Not quite from the beginning (1933) but unfortunately I can't pinpoint the precise date. That was one of the early developments. It has been revised from time to time. The current edition is seven or eight years old. Currently it is under revision again because it is felt that competition and other issues in the field emphasized the need for the code to be more current in terms of these major movements. It is a

committee function.

WEEKS:

Just as an example, this past week or two, in AHA's weekly newsletter, a statement was made that attorneys are saying that malpractice suits were involving hospitals more and more even though physicians were the prime target. It seems to me that somewhere along there that there would have to be a look at what is good practice and what is malpractice as far as the hospital is concerned, which would, of course, involve ethics. I think it is a clear problem at this time.

WESBURY:

It is a very significant problem. That is why we are looking at this thing again. The hospital gets involved because the hospital is where the money is. If the patient is going to sue for an untoward effect or an outcome they didn't want, the tradition in the courts is to sue everybody you can identity. So the hospital does frequently become that added organization because they have more money.

WEEKS:

I suppose the administrator might even come in.

WESBURY:

Yes, except that in an employment situation they are covered under the hospital's insurance program. Relatively seldom is the administrator singled out unless he or she is directly involved in a set of activities. It is unfortunate that the public is getting stirred up. I'll tell you the concept of making it big with a malpractice suit is becoming far more acceptable in the public's eye. It's a sad commentary.

WEEKS:

It is almost as popular as state lotteries.

WESBURY:

Probably a better chance of winning something in the negligence suit or malpractice suit than winning in the lottery. That's unfortunate.

WEEKS:

This is sort of out of the stream here, but when I interviewed George Bugbee we talked about his coming to the AHA in 1943 and the fact that they held retreats to decide what the goals of the AHA should be. He came up with three: representation, education, and research. I was thinking we will cover these three objectives in the college also.

WESBURY:

I think the difference one has to understand is that we are trying to serve the individual practitioner. The AHA serves the institutions. That's where the difference lies. There are gray areas. It's not easy to separate what is institutional and what is professional and personal, yet we try to work through that difference.

WEEKS:

I don't know whether this is a good time to bring this up or not. I do have a question I would like to ask you about membership. We talked about Fellows and other affiliates. Do you have any oversight of these people? Do you have any time you might want to reprimand any of these people for unprofessional behavior?

WESBURY:

Oh, yes. There is an ethics committee.

WEEKS:

This comes under the ethics committee?

WESBURY:

That's right. The only way for a reprimand is through the grievance committee process that deals with alleged unethical conduct. The only way we get involved is alleged unethical conduct. We are required to follow up on any alleged unethical activity that is reported either from a press clipping, a letter from somebody, a phone call, or whatever. We also have the requirement that once we begin an investigation it carries through to the end. There is only one exception to that process and that is if the affiliate under investigation resigns from the college. Then, our responsibility ends at that moment. If that individual ever desires to come back as an affiliate with the college, and that prior investigation has not been completed, it is restarted again before that individual will be offered the opportunity to come back to the college.

Each year there are a number of people who are investigated and who are dealt with very seriously. By that I mean they are dropped from the college completely. In other cases they might lose their fellowship, they might be removed from office, or they simply might be reprimanded and censured in that the behavior, while it is not flagrant violation, it does indicate that bad judgment was used and the college wants it known that it is unhappy.

What happens more often than not, two out of three times when a person in involved in a legal issue where the person is jailed for whatever reason, it's evidence on the face of it that that person was wrong, and clearly that's unethical behavior. Normally when that person is advised that we are instituting an investigation , they will resign right away. In most cases

they will never attempt to reapply. So to make a long story short, our code of ethics and our ethics committee do work and each year there are up to ten individuals who are identified as potential violators of the code. Personally I don't think we are touching all of the potential cases that we should get involved in. That's because many of them can occur without anyone knowing about it. We do not have investigators out in the field looking for these things. We respond whenever we are told. In other cases somebody may know but choose not to say anything about it. That's just the same as not knowing. We do follow up on every one we get. We publish the numbers each year. For example, we might say when the year started we had five open cases and eight more cases were brought to the attention of the committee, ten cases were resolved following actions and we ended the year with three open cases.

WEEKS:

No mention of names.

WESBURY:

No mention of names.

WEEKS:

I have a few questions about memberships. Would you like to make an opening statement about the kinds of memberships, what steps there are in the various gradations? Then possibly you wouldn't mind responding to a question or two I might have after your statement.

WESBURY:

There are three levels of affiliation as we describe our membership. We consider all the people on our rolls who are paying dues as affiliates. The reason is that the word member is used to describe one of the categories of affiliation. Where an organization would say we have so many members that

word has a very special meaning to us, so we would say that we have so many affiliates.

The first level of affiliate is nominee. That is essentially the level at which the individual is theoretically observed, serving his or her apprenticeship as it were and after three years in that role they are eligible to take the membership examination, which is a written and oral process, along with extensive peer review, as well. Successful completion of that allows them to leave the level of nominee and become a member. Nomineeship is not a permanent category. It's a five year time frame, you might extend that another five years on a special request, if you don't feel comfortable about the exam or if you don't feel prepared or they want more time. They are given that time but the maximum time frame is ten years. At that point if they have not passed the membership exam they are dropped from the rolls. There is no category of affiliation for them any longer. So it's either up or out for the nominee.

To repeat, one is a member after completing the exam process and successfully going through the peer review. That's a category of affiliation that has a minimum term of six years. This is a permanent rank. One could stay there forever and not have to advance to the next level which is fellowship.

Fellowship is designated as that level of affiliation that recognizes an above average contribution to the field both in terms of leadership and participation as well as skills and knowledge, etc. One has to write a thesis in order to qualify or write a number of case studies that are reviewed by a committee of Fellows. The purpose of the case studies is to demonstrate one's ability to analyze and solve problems. It is a distinct methodology that has

to be followed to allow the committee to come up with the feeling that that individual does have that set of skills and can, in fact, articulate the process of decision-making and problem-solving in the organization.

The three levels, then, are essentially the three steps one would follow in achieving the rank of fellowship which is the highest earned designation we can provide. Our affiliate base is probably -- it changes each year just a little bit in the number of people in each of those categories -- like this: the Fellows have represented about 12% of the organization; the numbers of members and nominees shift a little bit with the largest of these groups being membership.

Beyond Fellow there is no other earned designation that is provided. When one retires after having paid dues for x number of years one has the privilege of applying for life member or life fellow as the case may be. This is not longer a dues paying category. It is recognition of their service, their dues paying is over.

On the other end of the spectrum we do have a couple other categories of affiliation which are not permanent and which really do not directly lead into the nominee-membership-fellow ranks. One is student associate. That is a category of convenience to a student to get them on the mailing list so they receive their mailings and educational opportunities, insurance benefits and those kinds of things. In addition to that we have candidate for nomineeship. Rather than to get into all the details, not everyone is eligible to become a nominee as soon as they get a job in the field. That privilege is only offered to graduates with a master's degree in the field. Others have a waiting period of somewhere from one to three years. So the candidate for nomineeship category with reduced dues payment is for those people so they can

keep in touch with us and we with them while they are earning their tenure in the position and become eligible for nomineeship. Now we recently established the faculty associate position. It permits them all the rights and privileges except for voting and holding office. Again, it's an important link with the field.

We have the category of honorary fellowship which is offered to individuals with outstanding service to the field who otherwise would not have been affiliates of the college. It allows us to recognize those contributions. We have recognized people who have been superbly effective trustees, all the way to persons like yourself who have been outstanding in literature and academic communities as well as in the political arena. We have had a wide variety of people honored in that category. That's it. That covers all the bases.

WEEKS:

The question has risen in the past few years about the fractionation of the profession; planning experts, financial experts, and so on. What if they don't fit into the examination procedure? What if the examination doesn't really examine their ability?

WESBURY:

This requires going back a few years. From the very beginning of the college in 1933 the only individuals eligible for any involvement with the college at all were hospital administrators, by whatever title. This carried on into the early 1970s when advancement in the college from nominee to member and member to fellow could occur only if you were in a hospital-related position. So the college definitely restricted movement in its ranks to only those people who were "hospital administrators," or those on hospital staffs

working up to the level of CEO. It was in the early 1970s that the rules were changed that people other than hospital administrators would be eligible. One interesting coincidence is that in those early days even if you were a graduate program director turning out students for hospital administration you were not eligible. The reasons clearly were that this was an exclusive professional society and so on. Many of the graduate program directors were fellows of the college but they became fellows while they were still hospital administrators, which was the case with me. My fellowship came in my next to last year of involvement as a hospital CEO. Others quit the college in a huff because they could not advance. They were very disturbed that they were not allowed to pursue this, and were very mad, very upset. So in the 1970s those rules were changed. Over time an interesting mix started to evolve. By the time I arrived at the college in 1979, we had affiliates from literally every health-related management job you can think of in all kinds of specialty situations: home health, nursing homes, ambulatory care, consulting, government, association work, whatever. Our affiliates were doing everything. There was a natural outgrowth of the growing complexity of the field itself.

Many hospital administrators were moving to become nursing home administrators or moving to become ambulatory clinic managers, were moving back into the hospitals into a faculty position. Literally, the career progression that we knew in the 1950s and 1960s had totally vanished in all the new opportunities that offered themselves. We were fortunate, I believe, that many hospital administrators were willing to leave that particular role and to move into something else like Blue Cross/Blue Shield or AHA or some other job.

However, what was not happening was really the recognition that that was

happening. So there was no specific programming developed for those people outside hospital administration -- nothing special. It was still a generic effort under the aegis of the American College of Hospital Administrators. It gets back to the point that as early as my interview with the search committee in 1978 the name of the college was being questioned, and should we not change it to reflect what we already were. To carry that line through quickly, four years ago in 1981 there was an attempt to change the name of the college to "The American College of Health Administrators," which would have allowed us to retain our acronym ACHA. That was defeated. It required a two-thirds vote; roughly 59% supported so that wasn't sufficient. That was okay, we weren't ready. I felt that when this passed I wanted at least an 80% support, because you don't change a name with a 51% support.

We continued on admitting people to the college from a wide variety of roles knowing full well that we were having a difficult time recruiting those people who were not hospital administrators as the organization title said "Hospital Administrators." It became progressively more difficult to recruit those individuals.

Data from AUPHA said that the percentage of graduates going into hospital work was going down constantly. Today it is a little over 50% of the graduates of the graduate programs that enter hospital employment. The others are in a whole variety of other roles.

Four years after the lack of success in 1981, the process for a name change began again and it was successful in the summer of 1985. The Council of Regents did approve the change of name of the college to the American College of Healthcare Executives, "Healthcare" being one word. In the intervening four years the American College of Nursing Home Administrators

changed their name to the American College of Health Care Administrators, with two words for "Health Care" and they kept the word "Administrator." Therefore, using our previous choice of "Health Care Administrators" wouldn't have been a good one because of the similarity of the one chosen by the nursing home administrators. So we had to look for something else.

There were a number of alternatives but it appeared that the word "executive", or I should say the word "administrator" was as much of a problem as was the word "hospital," so "Healthcare Executive" carried on the new, broader concept.

The name change, as I look on it, is more to reflect what the organization already was on the day of the name change rather than reflecting what the organization would be in the future. I continually emphasize that this does not represent a shift on our part to allow more people in, so to speak, but it really tells the world what we already are. That will make it easier to bring some other people in, but it does not connote a major shift in our responsibility and the way we view our role.

With respect to subgroups within the organization, that is the identification of specialty areas, that evolution is slow because there is significant concern about creating subgroups and the implication then of are we going to divert attention away from hospitals to something else. How much attention are they going to get? We are trying to be very careful. We are also assuring ourselves that we are developing a variety of educational programs that will service our broad affiliate base. So you will find, for example, in our congress educational brochure programs dealing with HMOs, medical group management, university health center administration, risk management, so that we feel we are providing a broad spectrum of specific

services for specific groups without separating them or categorizing them, or putting them in a separate room. It is still all being accomplished under a single name, a single rubric.

One thought that is occurring which I think will have significant importance for our own future is that we now manage the affairs of two other professional societies. We have management contracts with them -- The Association of Mental Health Administrators and the American College of Addiction Treatment Administrators -- two subspecialty groups. They have their own boards, but for whom we provide an executive director, a chief executive officer.

We already have created tracks in our membership exam to serve those special organizations. So a mental health administrator does not take our total exam. They take our modified exam for mental health administrators.

WEEKS:

Is he a part of ACHA, or ACHE as it is now?

WESBURY:

No, they are still separate.

WEEKS:

Still separate but what you are doing is setting up examinations for them similar to what you have with variations to take care of their peculiar needs?

WESBURY:

The specific environment of mental health administration. We already have a track of our exams for the Canadians and we are going to be preparing others. We now have a confederation of some eight organizations to deal with the next generation of our exam. Every year it's modified a little bit and every five years it is totally modified. We are coming up on the total

modification and this confederation will create a core exam. Then if those organizations want specific tracks we will work with them to develop those tracks in their area of specialty. So we have put into motion the steps that are needed to create that core exam and a process to be instituted to create those special tracks. In that way we think we can accommodate these groups not as mergers, but in a sharing of services. The Association of Mental Health Administrators is interested in merger and we have to deal with that in the not too distant future.

One of the items on our future agenda is how we deal with the issue of subspecialty groups to allow them in with sufficient oversight and control over educational programs and other services for people in that specific area without destroying the concept of the generic health care executive we are trying to promote. It's a touchy balance in the situation. There are those that want to preserve the concept of a single fellowship, a single exam. There are some who would like to see us become categorized so we could put people in various specialty areas.

WEEKS:

If you are going to have an umbrella there will have to be some concessions made for various special interests.

WESBURY:

I think that will come. I am a firm believer in time solving most of your problems.

WEEKS:

There seems to be a time when things work and a time when things don't work. You just have to wait for the right moment.

WESBURY:

In fact, you might even know when to predict when that right moment will be there, but my attitude is that we have all these things moving. They are all in process. When the environment is right and we can accept those things, we'll be there with the program that will allow it to happen.

A prediction that I would make is that within ten years there will be only one, single professional society. One way or another through subgroups or full amalgamation, we'll all be in the same boat. So, whether you are running a long-term care organization, a medical group or whatever there will be one society serving our total purpose. I think that's generally accepted as an outcome. In the meantime there is a major set of concerns because right now our standards of affiliation are different. Certainly there is the feeling that a hospital is more important than a clinic or a nursing home. I think the lines between those organization are being erased. I think we are coming to grips with the fact that we are talking about pure executive roles; sometimes it takes place in a big organization and sometimes in a small organization, sometimes it's a hospital, sometimes it's a clinic, and that we will be moving toward an organization of healthcare executives.

WEEKS:

It seems to me that you are approaching this by the right method by offering your administrative services to these other groups. In the meantime you are looking them over and can suggest they raise their standards so that by the time they are ready to merge or federate with you they should be in fairly good shape.

WESBURY:

Already on the way.

WEEKS:

I can remember the mental health administrator. Didn't that start in Michigan? Wasn't there a man in Lansing who was the head of that group? He was a friend of Bill Foyle then at the University of Michigan. It doesn't matter but I have a recollection of talking with him on the telephone in the early days of the organization.

WESBURY:

Way back about fifteen years ago was when they started. They are a high class group and very concerned about good management. Most of them have their master's degrees. They just chose to go that direction. Unfortunately that was not mainstream hospital. They got off to the side, so to speak. I think we are seeing a significant loosening of identification or mainstream versus specialty administration. What's helping that is many people, including myself, once were an administrator in a hospital then moved to something else. It is no longer inappropriate to move from one kind of organization to another. I would like to see us erase that false dichotomy among all these groups.

WEEKS:

You might end up with certain sections as APHA has. Some of those are quite diverse.

You mentioned the Canadians. They started their own college.

WESBURY:

It is important for us to recognize that they were a part of the founding fathers.

WEEKS:

They can still be members?

WESBURY:

Absolutely.

WEEKS:

And fellows if they go through the procedure?

WESBURY:

They were and still are full 100% affiliates of the college. We are still serving them as a group of people that need help.

WEEKS:

I have always been amazed at how many Canadians there were in those old days: MacEachern, Agnew, MacLean.

WESBURY:

Swanson — the whole group. They were unbelievably strong leaders, and were major elements of the leadership of the American College. What happened though in the 1970s, the movements in Canada toward a greater feeling of nationalism and their own national spirit did move them to create the Canadian College of Health Service Executives. One other movement, of course, was the national health care system and insurance system individualized by province but certainly fostered by the federal government. What happened was they felt that in order to meet some of the political realities of Canada that health care executives ought to join Canadian organizations. So they did create the Canadian College. John Phin was the founding CEO and was involved with them the first eight or ten years. We worked very closely with them in helping them get started. We created joint programs, educational efforts, and other things, and shared a great deal of expertise with them right from the beginning. We have always had a very close working relationship.

In recent years that relationship has become a little tenuous. The

reason is that as they grew and developed they have seen that we are an impediment to some extent to their continued expansion. Many of their leaders have dual memberships and affiliations with both organization. There is no question that to some extent we prevent them from fulfilling the total role because we are serving that role for many of their people. We have tried to work our joint programs. In fact, they have now utilized our exam as their own credentialing instrument. They have decided to create one for themselves so they are not a part of our confederation, which disappoints me greatly. We do have the problem of how aggressive we want to be in Canada to seek our affiliates. Should we take our educational programs to Canada without regard as to the Canadian college? What about research and our role of maintaining the state of the art in Canada? So there are a number of areas where there are conflicts now with the Canadian college. We are approaching it from the point of view of an area of significant problem and concern. Shortly we will be meeting with our elected regents in Canada to take a new look at our role there. Ultimately I hope that leads to high level discussions with the Canadian college so that we can re-create the close working relationships that existed several years ago. We need to reexamine that relationship.

WEEKS:

It is good that you still have close relations with them and are willing to work with them.

WESBURY:

We participate in each others major events. No problem.

WEEKS:

I was looking at the number of women who are students of hospital administration. Then I began thinking about how many women you have in the

college. You do have quite a great number, don't you?

WESBURY:

Oh, yes.

WEEKS:

Physicians the same way. Quite a number of physicians.

WESBURY:

About a hundred.

WEEKS:

Is that all?

WESBURY:

That's all.

WEEKS:

In the beginning there was a larger percentage?

WESBURY:

Yes.

WEEKS:

About 40%?

WESBURY:

I am not sure it was quite that high, perhaps one out of three in those early days. That number was decreasing from the day the college was created.

WEEKS:

One thing I have been thinking about lately is the physician "glut," as some author has called it -- the number of physician graduates and the increase in ratio of physicians to population which is going to creep up on us by 1990. What is this going to do to hospital administration? Are many of those likely to decide to go into hospital administration?

WESBURY:

We don't have any evidence yet that gives us a clear picture of where that is going. There are a lot of opinions. I tend to feel there will not be a major influx of physicians into the highest levels of management in our institutions. When you start from the beginning the physician chooses that profession because of specific interests and management doesn't fulfill that set of interests. They are interested in the patient, of doing something for the individual and there is little individual linkage with the day to day role of the hospital administrator. Physicians have not been trained for management and psychologically are not prepared for the role. That is not to say that there would be none who would be. Certainly there are some outstanding administrators who at the same time are physicians. We will always have it because of that fact that some people want to do it and they are capable. I don't think we are going to see a significant movement in this direction. I think, more and more, they have come to realize that if they want to be an administrator they have got to get some education in management. That means taking time off, and going through some formal educational process. Some will do it, most will not. In the long run I don't see us facing the situation...

WEEKS:

They are not likely to go back to school for another two years.

WESBURY:

That's right. Let's face it, I feel as though my experience as an administrator was enhanced because I was a pharmacist, that I was able to understand the gobbledygook about patients and a lot of other things very early on which took some of my classmates quite a few years to learn. I was

better prepared. If I had been a physician, I would have been in even a better position to understand all that. I would not have understood management until I took the courses and gained that experience. So, again, I think we are dealing with the fact that being a physician does not make one a manager. In fact, a case could be made, I believe, that by choosing medicine they identify a set of interests that are not compatible with the broader role of the administrator who doesn't make decisions on an individual patient but on a broader scope. The evidence that we have so far is that there has been a slight increase in physician CEOs of hospitals, by that I mean a very modest increase. We are looking at this thing every year just to see what the change is year to year. We are not surprised at the results.

WEEKS:

I used to think ten years ago or more, maybe twenty years ago, that physicians were likely to remain as administrators of medical centers, university medical centers, but this hasn't proved to be true either. When Ed Connors broke the spell at Michigan, I think everyone up to that time thought there would be a physician in that job. Harley Haynes and Kerlikowske wouldn't be succeeded by anyone but a physician. That's changing now.

WESBURY:

We know it's changing. You can identify the hospitals in each community and in certain areas of the country, where physician follows physician follows physician. The number of places where a CEO is not a physician is replaced by a physician is still very small. It still happens from time to time but the reverse is happening too where they say they need a trained administrator in that role.

What we do know — and I think this gives most people a level of concern

about physicians coming in -- is that hospitals are moving very quickly to createa position for a physician in the executive ranks maybe called "Vice President for Medical Affairs" or something like that just as they are promoting a nurse to be "Vice President for Patient Services," just like they are promoting a personnel director to be "Vice President for Human Resources," or whatever. As each one of those things happens, what we are doing is putting at the very highest level, perhaps the number two level of the organization, a physician, who in any organized structure might become the CEO when the current CEO leaves. So, I think, if you look at the opportunity created for that to happen, the physician to move to CEO, we are making more of those possibilities apparent. But I still don't see evidence that there is going to be a significant movement of physicians from that number two level to number one.

WEEKS:

Paul Ellwood has some ideas. He calls it MESH. I don't quite understand it but it's a method of bringing the physician into hospital management.

WESBURY:

It's more than that. It deals with the linkage of services and programs -- primary care, delivery, and other things -- into a more unified program. I learned a couple of days ago that there are only eight or ten of those MESH in existence. As a matter of fact, as a concept, it is not likely to be a significant contribution to organizational management. The successful physician who makes that transition essentially ceases to be a physician. Just like I stopped being a pharmacist, like a nurse stops being a nurse. You have to decide what you are. My only request of individuals is, if they want to be that CEO, that they learn all that role is all about and dedicate

themselves to that position. If they don't, everybody loses.

WEEKS:

You spoke of Canada. Do you have any other international objectives?

WESBURY:

No real objectives. I come at this from two perspectives. The first is that we do have a sizable group of affiliates around the world. They are around the world for a couple of reasons. In some cases they are U.S. citizens who are currently working in other parts of the world. The best example is Saudi Arabia. We have approximately forty affiliates working in that country right now. That is simply because the Saudis many years ago felt that they really wanted to improve their health care system. The best way was to buy help. By golly, they have bought help. So that's a significant number of people. What is happening in that country is that as they train Saudis to take over management roles in the institutions, those people are also joining our college. We do have an accommodation for them. Chances are they will not take our membership exam but they will remain linked with us for a period of time. Likewise in other countries there are people who are U.S. citizens who are working.

With respect to citizens of other countries, we have seen an increase of the number of foreigners attending master's programs in our country. Those individuals, because of their training, are capable of taking and passing our membership exam and of joining the college as one of their own professional experiences. So, we do have an increasing number of individuals who are joining the college even though their citizenship and work is in other places in the world. We are not encouraging that in a direct way because we don't have specific things to offer them. When you have only three affiliates in a

country like India there is not too much you can do. Anyhow, they are getting our publication and other information. It is interesting, occasionally they will find their way back to the States and will attend an educational program.

We also have a large number of military affiliates in other parts of the world. That's another important group to us so we work hard to service them. For example, every year we offer our membership exam in Europe and have many military and non-military people taking the exam. We now, for the last three years, have had an educational program, one of our regular programs, delivered in Europe. Luckily the Army or Air Force, as the case may be, will contract for that program so we are not at risk in sending somebody overseas. So that's working out well. All I can say is that we have those people. Most of them are in other parts of the world on a temporary basis. Right now we have close to 300 affiliates who are overseas somewhere outside the U.S. or Canada.

We have another way of involving ourselves with the international scene. That's exciting also. That is through our international seminar program where we do have a program every other year in a nation or several nations where we take 40, 50, 60 people and conduct a seminar where we can learn about the health care delivery system of that country or countries. In recent years, we have done New Zealand, which was fascinating and exciting. We were back to England. We spent time in Scotland and in London as a followup. in two years we expect to be in the Scandinavian countries. This is a continuing effort in that regard. We are also active in the International Hospital Federation at their annual meetings. We try to get together with our counterparts around the world.

We are not aggressively trying to create chapters, programs, or whatever, butwe do have an ongoing relationship with these organizations to the extent

that we know each other and occasionally help each other out. That much is going on. Not much more. It's expensive. I am unwilling to take to the board a proposal where we spend a lot of money to become internationally famous. There is really little payoff in that.

WEEKS:

I think Gary Filerman has run into that in AUPHA trying to get into Latin America and Europe.

You were speaking of Saudi Arabia. This makes me think of Dr. Frist, Sr. of the Hospital Corporation of America who was mentioning that they were interested in running King Faisal Hospital. That made me think: Do you notice any difference between the flow of affiliates from the average nonprofit hospital versus those from investor-owned chains?

WESBURY:

We studied this question because we were wondering the same thing. Are we penetrating that market in the investor-owned industry as we penetrated in the not-for-profit area? Clearly we discovered there is no significant difference. There is similar penetration in those two areas. Part of the reason is that many administrators in the investor-owned hospitals have moved from the not-for-profit side. They continue to maintain their affiliation with the college. On the other hand, and just as important, is the fact that the investor-owned companies are encouraging their administrators to belong to the college. They are willing to pay the bill. That's part of their overall expenses and they expect to do that. I have been chided by some of the investor-owned affiliates that there are not enough investor-owned affiliates on committees. They look at lists; they want more representation. We are working to establish parity in that regard. The feeling I have is that the

investor-owned portion of our industry is just as supportive of the college and its programs and purposes as those from any other sector.

WEEKS:

The elder Dr. Frist seemed to lay great stress on good administrators. They wanted to hire the best. They are very eager to have schools recommend candidates to them.

Somewhere I read about a young administrators group. Is that something you think you should comment on?

WESBURY:

Yes. I think the young administrator groups represent one of the dilemmas in the field that has surfaced through the creation of those groups. It is easy to look at a professional society, such as the College, and by identification of the elected leadership -- regents, board members, chairmen, officers, et cetera -- you conclude they are older than the average in the field. It's not unusual. That's the case in any professional society. It takes years to become recognized and ultimately to be elected to these various roles. This then leads to the question the young affiliates have: What can I do to be involved in this business? It's going to be 10 years before I can be elected to something. One of the natural outgrowths is the joining together of young administrators in various communities for the purpose of networking, talking with each other, having joint programs, dealing with common issues, etc. In a sense, creating for themselves a network that exists for those in the upper levels of management and those with more years of experience. This phenomenon goes back probably fifteen years. These groups spontaneously erupted or were created and want a linkage with the College because most of their members also belong to the ACHA. To make a long story short, they have

tended to want to be alone rather than be absorbed into the political and governing structure of the College. That's the way it has been all the way along. In fact, task forces have looked at it and have come to the conclusion that arm's length relationship is best because if we took it over the nature of that group might change and they may no longer serve the purpose that brought them together in the first place.

We now have a request from the Council of Regents to look at this once again. We will be creating a new committee to look at our young administrator groups. Many are extremely active, meeting once a month at luncheon or dinner, having speakers, etc., for the fellowship, camaraderie, and educational service.

WEEKS:

Is there any national organization? Or are these spontaneous groups?

WESBURY:

There are over a hundred from one end of the country to the other. In addition to that we have had a more recent creation, a women's network. We helped that movement along through an ad hoc committee on women. This committee made many recommendations to the College which have been implemented concerning women's careers in the field. One of the exciting developments is the concept of women's networks. For example, in Los Angeles-San Diego area there is a women's network that has now over 200 that belong to it. There are needs for people to communicate, to be together, to associate together, and to help each other. These networks, or young administrators groups, or whatever they are called are really key elements in that process.

WEEKS:

Can you remember when you were a student at Michigan? How many girls

were there in your class?

WESBURY:

Zero.

WEEKS:

Today it is at least 50%. I talked with someone -- Howard Zuckerman, I think -- who said that if they took all the candidates who came that were qualified they could fill the whole roster with women. They try to keep it about 50-50.

WESBURY:

They try to keep a balance.

WEEKS:

Can these women be placed in jobs?

WESBURY:

I believe the answer is yes. I think women are demonstrating significant success in moving along towards positions as chief executive officers. The numbers are still relatively small but they are growing, I believe, at a relatively rapid pace. Women have proven obviously capable of filling these roles. There are more and more jobs being created in the field. Obviously women are right on the line, applying for and being appointed to those positions. My long range view of success of women in the field is extremely high. I have no reason to believe that as time goes along they are not going to be an increasing percentage of the CEOs of this nation. College statistics are a little bit interesting in that regard. Right now I would guess that between thirteen and fourteen percent of our whole group of affiliates are women. Among our fellows it is probably twelve to thirteen percent are women. The number who are members is probably a little less than ten percent. The

reason for that is that many of our fellows are Sisters. So, the number of non-nun fellows is very, very small. Even among members the number is still small, but when you move to nominee, better than twenty percent of our nominees are now women and more than half our student associates are women.

WEEKS:

The trend is in their favor.

WESBURY:

The trend is for women to become far more involved. I am sure that each year the percentage of women in the ranks of members and fellows is going to be shooting up at a very, very rapid rate. This is in spite of the fact that women unfortunately tend not to be joiners. They tend to lay back a little bit relative to jumping into a professional society and really getting involved. No two ways about it. In general, the evidence is that women don't get involved in a professional society. I think they need to be challenged more to become part of the society in the very beginning because that's where the contacts are made -- recognition gets started. Unfortunately if a committee appointment becomes available for one of the younger affiliates, the one who is picked will be the one who has made himself or herself visible and involved. If it's not a woman many times it's because there weren't any that had surfaced at the point of discussion. So, my hope is that this large number of women who are student associates will transform themselves into very active nominees, members, and ultimately fellows to coincide with their swift movement to high management roles in our institutions.

WEEKS:

The same phenomenon is happening in pharmacy, in medicine. I wonder if this is going to follow -- the professional life of these women -- is going to

follow the pattern of the nurse. You look at the nursing staff today and you have the young nurse, shortly out of school who marries, drops out to raise a family, and then comes back. Do you think there will be the same thing among women hospital executives?

WESBURY:

I think to a significant extent they will. I read some data in just the last couple of days that the average active nurse practicing her profession will by the age of fifty have dropped out seven years. There will be a hiatus in her career primarily for motherhood. That has some serious implications for continuity, promotion, and everything else. I believe we will face some similar numbers in health administration, but perhaps not as high an impact. The reason is that many nurses are earning less than their spouses. Therefore, it is more easily decided who stops working for a couple of years to stay home with the kids. When you start talking about women in executive roles who, in many cases are earning very significant salaries -- they may in many situations be the highest wage earner -- the decision of that individual to drop out of the work force has much more serious implications financially than the nurse who drops out. To some extent that is going to be a balancing act. I think we will still have the women who will drop out, but I don't think the impact will be as great as in nursing.

WEEKS:

Probably our society will adjust and have better child care facilities for the mother who wants to go back to work.

WESBURY:

That's happening. Many hospitals do have day care centers. In fact, in our own organization, we have had the case of a staff member who had a baby --

two staff members in fact -- both gone for about six to eight weeks, getting adjusted to the child and getting the day care situation straightened out. Now they are both back on the job. Organizations are making that possible. Certainly years ago when you went to have your baby, you left. Today we have found ways of making sure that those jobs are retained. In fact, in both cases these women were consulting over the phone a few days after the delivery. They just did not want to lose track of what was going on, asked for material to be sent home so they could read, and not lose out on what was happening to the state of the art. I believe there is much more accommodation, and that's going to help.

Let's face it, there are several other things that are happening. Many women choose to be childless. Certainly that's their choice. But others are finding a way to have that child and have it impact very little on the continuity of their career. I don't know what the long-term movement will be in that regard. There are some now that speak of the pendulum swinging back again. The force of moving women into the work force may reduce itself a little. Maybe it wasn't all that great anyhow compared to full-time motherhood and housewife role. There's a lot of debate on that issue.

WEEKS:

The education level has risen so much. Women are thinking in terms of their personal careers. It is never going to be the same as it was.

What about job placements? Do you do anything in that line?

WESBURY:

To respond directly to your question, we do no job placements at all. Placement we define as actually working with the employer and prospective employee and actually trying to find a fit. We do not do that. We do not

want to compete with the search firms. We feel that is a role that we should not play. On the other hand though, we have job referral activities that serve a very specific purpose: to encourage potential employers to register their job openings with us, then we have a list of affiliates who are interested in looking at that list on a subscription basis. We do publish that list every month. That's as far as we go. There are occasional individual phone calls asking if we know anybody who will fit this or that role. There is a constant servicing of the field by sharing names, but we are not in what I would call a formal placement business at all. I don't think we ever will be.

WEEKS:

I think you are approaching this in the right way.

WESBURY:

I need to amend that response and say we are in the outplacement business, which is a relatively new concept in the area of personnel administration, or human resources administration. Industry, outside the health care arena, has used outplacement as a function for years. Outplacement is that process by which an individual who is fired or displaced from his or her role, or by common consent decides, "I'll leave the organization six months from now," or whatever, gets specific counseling, testing, and intensive service to help him or her to identify strengths and weaknesses, problems in their role, and where they might go for their next job. That function has existed for some time.

We have just purchased a company called "Career Decision, Inc." that was created for the sole purpose of health-related outplacement activity. We bought that company because it fulfills a function that we wanted to fulfill,

that is to help that individual affiliate who is now displaced, sometimes rather suddenly, to find a way to give them support and service, and help them move on to further employment. It's an expensive service, for which there is payment, usually from the employer of the individual fired or otherwise displaced. It is an important addition to our range of services. It's highly specialized, highly focused, and very intensive. It seems to be working out very well. That ends usually with a person getting a job somewhere, but that service does not assure placement. It's up to the individual to go looking and using his skills.

WEEKS:

This company can prepare them psychologically...

WESBURY:

There are two basic support systems. One is to get them over the shock of getting fired. The second is the psychological support when one takes a hard look at oneself and decides maybe he was in the wrong job.

WEEKS:

You were going to talk about...?

WESBURY:

Programmatic thrusts. In the first year that I was with the College, it became clear that there were many good ideas already on paper, and already partially worked through committees. It meant rather than start out with a strategic planning process or an extensive brainstorming period that we really needed to go back and see what was laying on the table and what might be brought forward as some good ideas for the future. That turned out to be a very successful set of activities. We did find a number of projects, programs, ideas, that were partially developed that we folded into a program

that was launched in 1981, called "Programmatic Thrust." This combined initiatives in a wide variety of areas. For example: self-assessment was part of that along with the potential of developing some tracks for self-assessment. Right now we are engaged in a contract with the American College of Medical Group Administrators to develop a self-assessment track applying to the ambulatory care field. We also wanted to develop things like the Learning Resources Directory that we talked about earlier, and other services linked in with the program of self-assessment itself. We knew that we needed to do more things for young people, our younger affiliates. So, one of the programmatic thrusts dealt with creating a task force on beginning and early career development. That turned out very successfully, putting out a set of reports relative to the discussions of the committee, creating guidelines for the development of postgraduate clinical experiences, called "Fellowship Development Programs." Then we also produced a directory of fellowships and postgraduate experiences of the management development type. We moved ahead to identify ways we could be very helpful to young people.

We got more aggressive in the arena of governing bodies. After all, all our senior administrators in the field reported to somebody, most of the time it is a board of directors or a board of trustees. We wanted to get some materials created for them. That led to the development of several monographs, contracts for chief executive officers, the role of the chief executive officer, how to evaluate the chief executive officer. Those were items that were really needed by governing boards.

We got very excited about movement into some new areas of technology with respect to teaching. One of the outcomes there was our first teleconference. We did get involved in nationwide television. We repeated that again just a

few months ago with a teleconference on the future of health care. We got ourselves involved in a number of television and tape cassettes delivering messages about the College, about how to get a job, various elements of service within the College, all expressed very neatly mainly on cassettes so that moved us into that whole new technology.

We were very concerned about research. We wanted to identify some new areas of involvement. Transitions took place: Carroll Mickey retired, we hired Peter Weil to be director of that division. He has a great interest in the whole area of career patterns in health administration. What it boiled down to with programmatic thrusts was that we were able to identify seven or eight major areas of development that we proposed to carry on for the next four years and developed a schematic which identified when each of those planning processes began and how they would move to fullfledged programs. We found money to finance those programs. That guided the development of new programs and new services for roughly a four year period just ending in the latter part of 1985.

That was important for us because -- like any planning process -- it allowed us all to focus on specific, needed programs for the field. We viewed it as our capital investment where business would buy buildings and machines, we have to buy or create products and services. So, that gave us the outline of those new products and services. By the way, pubic relations and public policy were a part of Programmatic Thrusts. What Programmatic Thrusts demonstrated was that the College, even though it wasn't creating a lot of new things in the 197Øs, was in fact creating a lot of ideas. Programmatic Thrusts caught the essence of those ideas and became the board's plan of action for the next four years. Of course, that meant staff work for the next

four years. For the most part we accomplished what Programmatic Thrusts intended for us to get involved in.

We then moved into a period that kind of overlapped a little bit, called our strategic planning phase. The board, under the leadership of Al Pickert, who was then chairman, became dedicated to the creation of a strategic plan. They said Programmatic Thrust was great if it evolved out of previous activities of the College, but now we have got to elevate that planning process a little bit higher and involve people in a more formal sense in really assessing the future, emphasizing that environmental assessment is needed to underpin the creation of new programs and services.

We hired a consultant and entered a period of twelve to fourteen months of a strategic planning process. That ended early in 1985 with the publishing of our strategic plan. There are nine specific elements to that plan.

WEEKS:

You said 1985?

WESBURY:

1985, this year. That's the overlap with Programmatic Thrust which we are just ending. Programmatic Thrust would end in 1985. Strategic planning was started in 1984 to finish in 1985 when we would have a new blueprint to take over where the previous one left off. So, in fact, there was that overlap as we phased from programmatic thrust to the strategic planning process.

There are nine elements in that strategic plan which describe the general major areas of effort -- creating nine functional areas of activity for the future, all the way from professional activities development to a relook at ethics and our code of ethics, that is, how we are going to deal with the many

changes in the health industry, especially in view of the competitive nature of the industry now. It was very broad and gave us a significant blueprint for the future. One of the elements that needs to be emphasized in terms of having an overall impact of the field in the future is the emphasis on our relationship with other professional societies. It recognizes clearly that the field is becoming more complex, that people slip and slide from one area to another, cross lines of long-term care to acute care, back again and whatever, and that we need to be more attuned to creating working relationships and interfaces with this wide variety of professional societies. Clearly the strategic plan supports our management contracting efforts with other societies, it supports the joint educational programming that we are carrying on, it supports the joint development of self-assessment tracks and membership tracks, and literally encourages us to get more involved with those other societies so we all know what each other is doing.

The strategic plan doesn't say we should merge, that we should end up with only one society, or anything like that. We stop short of trying to be that predictive, or specific, but it is clear to me that if we do all the things that I have already mentioned and more that are suggested in the strategic plan that, in fact, that some day we are going to wake up and say, "Why aren't we all together in one umbrella organization or society?" If we don't end up at that point, I think we will lose a monumental opportunity to focus on the strength of the larger role that can be created. That will allow us to be far more influential on the political and legislative scene. More important than that, it can be more valuable to the career development of the people in our industry. There is no reason to believe that in the long run it takes any less knowledge, skill, or whatever to run a nursing home than it

does a hospital, than it does a clinic. I think the closer we come to realizing that we all are doing essentially the same thing but in slightly different environments -- at that point we will come of age.

Another significant reason for that movement is that many of our institutions are hospitals with an umbrella organization for all those things. we are literally reflecting what is happening out there. The hospital administrator today probably has a nursing home administrator, an ambulatory care administrator, a home health agency administrator reporting to him or her today. All we are saying is that all those roles are roles that health care executives perform. Certainly at different levels of complexity and responsibility but yet focusing someday on the top of that pyramid with all of those individuals feeling that they could fill the CEOs chair one of these days. So, I think the movement that is in place is really non-threatening in the sense that we have not announced that we are taking over the world but that we are working clearly for those opportunities of working together as synergy permits us both to gain something in that process. If, in fact, it leads to merger, that's fine. If it leads to some other level of mutual involvement, that's fine too.

Again, I can't overemphasize that I believe somewhere, five or ten years out, we have got to see evolve a single umbrella society that brings us all together -- gives all of us the opportunity to be as strong as possible as a professional society. There are other elements to this strategic plan but I think they pale in long-term significance. So, for the most part we are moving down that line and now our plan identifies a series of interests and goals that do have the ultimate impact identifying the future with one umbrella society.

The other areas of the plan, I believe, are important but don't have the ultimate significance these others do. The purpose of the planning process is to get all our leadership involved so that as we begin to embark on these efforts and ventures that we can utilize the plan as the base and be able to recognize that what we are doing does fit in that overall plan. One example of the impact of the plan is that we changed our name in the summer of 1985. The plan did not say we should change our name, but the plan laid out clearly that we are moving in various directions, and that hospital administration per se was being reduced significantly in its impact throughout our organization and nation and that we had better be prepared to accommodate a wide variety of other health-related professions. The name change is purely an outcome of that process.

We intend to update our plan every two years. Its implementation is totally folded into our budget process so that the whole staff is tuned into the plan as it needs to be the driving force for what we plan to do. We no longer have surprises. Everything we intend to do is identified clearly.

Not only in this strategic plan but preceding in Programmatic Thrusts, back to my discussions with the search committee all dealt with the visibility of the College in the world at large and the ability of the College to represent the interests of health care administrators in a variety of ways all the way from legislative issues in Congress down to what is a hospital administrator and how can we tell the world what we are.

Much of my personal effort, over the last three years at least, has been spent in the direction of expanding our ability to represent, influence, and upgrade the visibility of the profession as a whole. The basic thrust of the College from its beginning until just a few years ago was to quietly go about

its business serving its affiliates, perhaps being active as a voice within the health care industry itself but doing very little to extend itself beyond the boundaries of its own affiliate base. We did that very well, but we were carefully avoiding the broader community at large and making waves in society as a whole. I think the time is here when we as health care administrators, health care executives, by whatever title -- we must be more effective spokespersons in our communities most importantly, but also in our states and regions, and the nation. The reason I say that is that years ago, especially when I came into the field, there was very little need to be too public. Let's face it, when all your costs were being paid by Blue Cross or government, or something, you could do a lot of things without any worry about how it's going to be paid for. The system just grew that way. We had to be careful what we did. There were limits, of course, but yet it did not require a great deal of effort to convince a community that something should be done, or whatever. A hospital was free of criticism, complaint -- it was a relatively calm environment. Today in a competitive world where now we know that resources are finite, in fact hospitals are beginning to close, the way health care is delivered is changing, moving from solo practice of physicians into clinics, "doc in a box" services on every other corner -- we are in a totally different environment. I believe that the health executive, the professional in our field today has to be far more public in his or her actions because now I believe the key elements for improving health care and health status of people will become organizational change, not adding new professionals and spending more money as we did in the past. Today the focus is on doing whatever you are doing cheaper or taking the existing money and spending it more wisely.

We are talking about organizational change. That means, from my perspective, for the first time in history that the healthcare executive is in a position of leadership. If you look very quickly, in the first half of the century the leadership in improving health status and health in general was the public health person -- improvement of water supplies and sewer systems and dealing with communicable diseases, the creation of effective vaccines. Those things really improved health. We certainly were able to heal broken legs and cure this and cure that, but for the most part the major changes, the real leadership in improving health status was from the public health perspective.

Immediately after World War II the trend changed to the heavily scientific, technological orientation. So, leadership shifted from public health to the researchers and physicians. They were the ones coming up with all these new ideas. We had to build all the buildings, the administrators had to find the money and hire all the people, but the real leadership didn't come from us, it came from people other than us, primarily the research community and the physicians who were implementing all that new and exciting technology.

Today, organizational change has replaced technological change as the key tactic to improve and expand the delivery of health care. We are the only profession that is educated, trained, and mentally prepared to see the big picture and to move the health care system as a whole into new alignments and new organizational structures. We are responding by creating more organizations. We are responding by creating all kinds of delivery systems -- ambulatory surgery, one-day surgery. We are responding, but we are on the spot for the first time. We have to be the ones delivering those ideas. To

me, that puts a whole new light on what the role of the healthcare executive really is. It's no longer just running an organization smoothly and reacting to technological change and the implementation of new services. It really is looking at the system and seeing how it can be run and organized better. When you accept that you must also accept the fact that there are no people better trained than we are to do that particular job.

We have moved from the four walls manager to the community leader, with respect to health care services, where our affiliates are taking charge and making things happen. To me that's exciting, that's responsive to the challenge and opportunity today. That's where we have to be. I hope that the College has proved itself by virtue of Programmatic Thrust, strategic planning, our new-found relationships with other professions and societies so that we can work with each other to implement these more effective and broader programs to be sure that we are not missing the boat and that, in fact, we are picking up and moving our people into that leadership role.

I buy that set of changes 100%. I think that's what makes us different from the other health professions, because implementing change is what it is all about. To me that's the theoretical foundation of our organization. That's why now we find ourselves writing public policy statements. That's why we write letters to congressmen and senators. That's why we are willing to be in front of a Senate committee testifying about something. That's why we are willing to take a stand and say, "This should happen because..." We are doing it from the perspective of the leaders of the field. We feel as though we have the right and responsibility to speak up at certain times and certain places.

The representation issue to me is all wrapped together as a challenge of

the times and the role our people ought to play. In fact, we think our administrators ought to be out there making something happen in the community. By golly, we ought to be in Washington and other places making sure that things happen as well.

WEEKS:

Sounds like you have a duty you should fulfill.

WESBURY:

To me, that's the command. We have two roles in that. One is to follow it with our programming. The other side of the coin is that we can't let our own affiliates forget that that's their duty. If they forget, somebody else in that community is going to step in. By the definition that I see of the role of our people, that person stepping in will not be anywhere near as qualified as one of our people. Somehow we have got to see that we continue to press for our people to be aggressively involved in a leadership role in their particular community.

WEEKS:

Your affiliates must be feeling, judging by the way they turn out for your Congress, the way they have a show of interest in all these things. Certainly you are reaching them. They are listening.

WESBURY:

Oh, yes. They are coming. They are listening. We need more evidence that they are applying all these things. The one issue we can't forget is that they, like myself, have something to run at home. a good portion of their time has to be spent making sure that you are still providing high quality patient care for those patients coming to your institution, but we have really got to work to see that we have that extra time available to do

the things that need to be done.

WEEKS:

Would you care to say something about research you are doing?

WESBURY:

Research is an area the College has been involved with for probably twenty years. That's the length of time that there have been qualified researchers on the staff. Carroll Mickey and Peter Weil, two excellent examples of solid research-oriented individuals. I do need to say though that the amount of research has not been as great as we might have had simply because the amount of resources devoted to research has been fairly meager over the years. This is an area that can be debated. After all, universities exist for research as well as education and community service. So, how much of our budget ought to be devoted to research? We would be debating that forever. The point is that we do support research as a basic function. Right now there are four individuals involved full time in research or supporting the research activity in our organization. One thing Peter Weil and his staff do get involved in is applied research. it supports ongoing staff efforts. It means that membership might want an analysis of certain characteristics of our affiliate body. Peter Weil and the staff would do that. That certainly doesn't allow them to do some more aggressive basic research for industry, but there is some time made available. Peter Weil's current interest is significantly associated with mine, that is, career patterns in the health field, in health administration. I think we will see more coming out of that mutual interest as we take a harder and harder look at where do people come from and go, changes that occur, so that we can be more effective in our counseling and advisement and move information to people who are doing our

educational programming. In addition, outplacement now brings us together with discharged professionals so that we can begin to focus on what are the facts, for example, that lead to one's being fired. How does one respond to that? I think we do have a number of opportunities with our own extensive data base as well as the inter-relationship with outplacement.

Peter Weil does have a number of important items on his agenda for research. he will be picking them off one at a time as time becomes available. He also will be developing proposals for funding where we might seek outside government or foundation support to accomplish some of that research.

I think we have to look at research as a two-edged sword. Certainly as a professional society we are expected to do some. I don't expect that we would be competing with the Michigans and the Chicagos of the world, but we do have to keep ourselves tuned in.

WEEKS:

You will do research within your own field.

WESBURY:

It's always a problem for a researcher in an organization like this to carry on a long-term and vested program because he or she is called on many times to be supportive of other efforts. It's not like a university where you can close the door for six weeks and emerge with a finished product. Peter doesn't have that luxury. Therefore, we are somewhat restricted in the kinds of research that we would go after. I don't want us to lose sight of the fact that we need to be on the cutting edge. That's the basic reason that we would invest in research. We are not going to lose track that research is a major element.

WEEKS:

Do you want to speak about the various College awards?

WESBURY:

The College has had for years a number of awards presented to a variety of individuals for a variety of accomplishments. There are three major individual awards that accrue to those people we want to identify as leaders in the field and recognize their career-long contributions. Certainly honorary fellowship is one of those. These are for individuals who are not eligible or who have not been eligible for affiliation with the College but who have worked in the health care field as a volunteer or a full-time employed person with contributions and impact to health care administration. This includes everything from trustees who have had not only local but regional but perhaps nationwide impact as a result of their knowledge and work, to those in the academic community who may be involved in the creation of the literature we use, or significant teachers that we have extensively utilized in our own education and programs. Government officials have also been so honored.

The other two awards are a gold and a silver medal. The gold refers to excellence in hospital administration. Silver is utilized to honor those who have produced excellence in management in other than in a hospital environment. So clearly we have a history of gold medal award winners going back many years of all the top names in the field that everyone would recognize. The silver medal has gone to a wide variety of people including Blue Cross and Blue Shield presidents to graduate program directors and other who, by virtue of their impact on the field, came to our attention and we wanted to recognize them as outstanding performers.

We do have several awards in the literature area. We honor the person who writes the article judged the best in our own journal each year. A second award has been created for articles appearing in other than our journal. That award is made every year. We have a book-of-the-year award so that we can pick the book that we think had the most impact on healthcare management in that particular year. It doesn't have to be a health-related book. Some times it is, some times it isn't. The point is that we want to identify the literature as an important source of education and information. By making those awards, we can bring everybody up to date with respect to the state of the art and to remind them that the literature is an important source of information.

I believe that represents the spread of awards. Other individuals are recognized for a variety of things, but in terms of our major awards, that's the gamut.

WEEKS:

I would be interested in hearing how you envisage the future.

WESBURY:

I think there is need to talk about the future and where the College may be going even beyond strategic planning. Not everything gets into a plan. Certainly things in a plan get changed, and new ideas evolve. We have alluded to some of those potentials, particularly our relationships with other societies, and the potential for a single umbrella organization in the future.

My biggest concern really deals with the role that the professional society plays in the professionalization of the people in the field as well as their obligation to the broader society. I like to believe we are different because we are involved in health care. Most of us came into this business,

if you will, because it does something for people. We had a contribution to make respecting the bettering of lives of individuals. Many of us are in it as individuals who got started as "hands on" health care professionals and moved into management and administration over the course of time. I still believe that the vast majority of people in healthcare executive roles are there because that role is different than running an assembly line at General Motors or producing boxes or tin cans, or growing corn, or whatever. When you really look at that it puts a dual burden on healthcare executives. You have the obligation to be sure the organization is financially successful or it won't be around for many years, but you also have the obligation to make sure that it is serving people.

There are some challenges now in the healthcare industry and growing problems dealing with making sure that our system as well as our individual institutions stay viable and find a way to serve more people. I believe it is going to become more important for programming our printed and spoken word to address itself to that dual problem to assure that we don't forget either side. We cannot run organizations poorly, because poor organizations provide poor care and won't last very long. At the same time we have got to find better ways of taking care of those people who do not have the resources to access the system. I am deeply concerned that we have got to keep the message up front and on top all the time.

To me the thing that makes a professional a professional is that they are doing something above and beyond the call of duty, that they do have recognition of the fact that if they just went to work eight hours a day and went home, that in the long run they are not going to be serving the best interests of their profession or their customer or their patient. They do

have the obligation to constantly think about ways of improving what they are doing, and reaching all the people that needed to be reached.

That's a difficult thing because in this country it is very political because it may involve jumping up and down and screaming with government officials and telling them they are not paying enough attention to this and that they need to put more money into healthcare coffers. It means we have got to jump up and down with our own employees and to make sure that they are effectively utilizing all resources that are available. It means an environment where we are dealing with DRGs and prospective payment. We have got to jump up and down with the physicians about the misuse of resources and the ordering of too many tests, et cetera. It appears we are doing a pretty good job in that area, the physicians have responded pretty well to that problem, but we can't let that one go either.

It also means that we have got to be straightforward in dealing with patients and patients' families and others by telling them that resources are finite, and that we are not interested in endangering anybody's health, at the same time we don't want to waste those finite resources when they don't have to be utilized. Therefore, the fact that grandma goes home on the fifth day after surgery instead of the tenth may not be to the detriment of grandma but it might screw up the household that might have to take care of grandma those five days that she might have been in the hospital. We have got to be willing to face those people and say that society is not prepared to do your duty in addition to the hospital's duty. We are not doing that well enough. we are allowing voices to overcome what I call rational thought and good decision-making by claiming that hospitals are discharging people too soon and that people are too sick. I think we are a nation of spoiled people.

We are not going to let our system be anything but the best in the world, but it is not going to be as easy as it used to be. A cost-based reimbursement system allows one to do a lot of good for a lot of people. Now that we are on a payment system that reflects negotiated rates and fees set in advance means much more sharper set of skills has to be put into place.

Everybody has got to know what we are dealing with. When you can't stretch another day out without putting the hospital in the red, then people have to be willing to accept the fact that they are going to have to do some home care themselves. it means we have got to get on the backs of government officials and begin to move society into a better understanding of what home health care is, where convalescent care or long-term care might fit the picture and that we make better use of integrated activities by making sure that each of those kinds of delivery organizations are linked together so that one can go from the physician's office to the hospital to the nursing home or home health agency, maybe to the hospice, depending upon the problem. People are going to have to get used to that. Right now they all think you blow the whistle and find that a surgical specialist shows up at the hospital any time that they want, that the hospital is ready to devote all that special technology to solve any problem. We shouldn't, but we do it only because we have gotten spoiled. Now I think we have got to find some better ways of doing it.

To focus more on the role of the College, we have to speak out on those issues. But even more important than that, we have to get all our affiliates to a level of understanding of those problems, and also to the level of being articulate about those issues in the community at large. That is our obligation.

Interestingly, one item we didn't talk about and which will be more than a footnote in our history twenty-five years from now is the joint effort we accomplished with the Arthur Andersen and Co. which was a Delphi research project applied to the healthcare industry on where we are going to be five and ten years from now. We have been phenomenonly successful for that document. Almost 40,000 copies have been sold. considering that single copies have been sold at $65, that is quite a feat. Multiple copies for educational programs were less expensive. The fact is that 40,000 of those documents are whirling around somewhere, being used and quoted. What this has done for us is that is has elevated public awareness of the College and certainly of Arthur Andersen as well. The predicitions in there have been widely quoted and utilized by people all over the world. in fact, I was fortunate enough to make an appearance on the Today Show. I was interviewed by Jane Pauley because of the Delphi -- a highlight in my own career. A lot can be said in four minutes. I thought that worked out very well. There were at least five other television appearances I was involved in as a result of that. We probably wrote ten articles in ten different journals, and the number of speeches I gave on the topic is now up to about seventy-five.

What this did was connect us with the future. We are now a source of information for people who want to know about the future. We don't know everything, let's face it. Just being involved in the request process and being able to respond has been an unbelievable experience.

I think we are moving the college to that position where we are clearly recognized by people outside the health care field -- many people outside the health care field -- and that they will look to us for information, will raise questions, will allow us to come in and talk to them. I think we will begin

to find ourselves in a role where we can influence many, many more things. We have got to turn that into our affiliates influencing things, not just the national organization.

I believe my comfort level in the success of the College will be when you see our name on a rather consistent basis in newspapers, magazines -- hear it on radio, and see it on TV -- or see somebody on TV who will identify as an affiliate of the American College of Healthcare Executives. When that happens on a regular basis I think we will have achieved that level of impact on thought processes one must attain if you are going to influence future developments. So many actors are in this business that we have to make sure that when actors are brought together on a stage that one of our people is there. When that doesn't happen, it is embarrassing. More important than that, that group assembled is losing something, because clearly we are in a position to do things that nobody else can. To make a whole long story short, the initial creation of the profession by the founding fathers was, I believe, an unbelievable perceptive series of decisions as they saw something coming. They wanted to be the creators of it. I don't think they had any concept what the healthcare system would look like fifty years down the line. I think the society they created is moldable and can change with the times. In fact, we are changing with the times. We are now prepared for that leadership role the new environment requires. To me, we are there! Now we want to be sure the professional society moves to help our people do what we think they ought to do.

If I may, I would like to make one additional point. My career has covered 30 years of employment and involvement in a wide variety of organizations in many different cities. I have been blessed with a wife

(June) who supported and encouraged those many moves and dislocations. Income went up and down and, from time to time, we had to make do with less than we wanted. But her interest and perseverance, along with our four sons (Brian, Brent, Bruce, Bradford) was the critical glue. A loving and supportive family made it possible. Now, June is a corporate executive with Alexian Brothers Health System pursuing her own career in the healthcare system. The boys are successfully pursuing their own careers but none in the healthcare system.

WEEKS:

Thank you for the interesting oral history.

Interview in Chicago

on September 12, 1985

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