HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Albert W. Snoke

ALBERT W. SNOKE

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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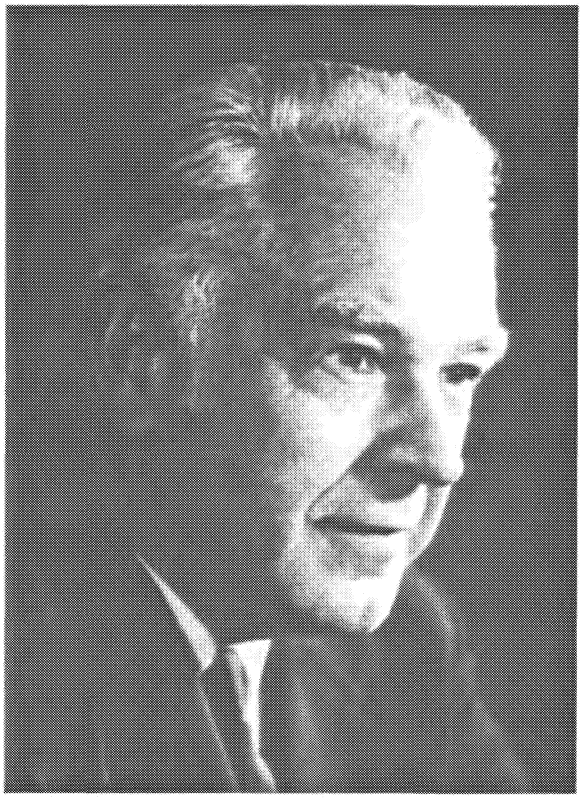

Albert W. Snoke, M.D.

CHRONOLOGY

1907	Born Fort Steilacoom, WA, July 19
1928	University of Washington, B.S.
1932-1933	Stanford University Hospital, Intern in Medicine
1933	Stanford University, M.D.
1933-1934	Stanford University Hospital, Assistant Resident in Medicine and Pathology
1934-1935	Stanford University Hospital, Assistant Resident in Pediatrics
1935-1936	Stanford University Hospital, Resident in Pediatrics
1936-1937	Strong Memorial Hospital, Rochester, NY, Associate Resident in Pediatrics
1937-1946	Strong Memorial Hospital, Assistant Director
1946-1965	Grace-New Haven Hospital, Director
1946-1968	Yale University, Professor of Epidemiology and Public Health (hospital administration)
1965-1968	Yale-New Haven Hospital, Executive Director
1968-	Yale University, Lecturer of Epidemiology and Public Health
1968-	Yale-New Haven Hospital, Consultant to the Board
1968-1969	New York Academy of Medicine, Committee on Medicine in Society, Secretary
1969-1973	State of Illinois, Coordinator of Health Services
1970-1973	State of Illinois, Acting Executive Director, Illinois Comprehensive State Health Planning Agency

MEMBERSHIPS & AFFILIATIONS

American Association of Hospital Consultants, Member

American Board of Pediatrics, Fellow, 1937

American Board of Preventive Medicine and Public Health, Fellow, 1949

American College of Hospital Administrators, Fellow, 1953

American College of Hospital Administrators, Regent 1957-1960

American College of Radiology, Chairman of AHA group on a joint committee, 1961-1965

American Hospital Association, Life Member

American Hospital Association, President 1956-1957

American Hospital Association, Advisory Committee for Developing Formal Criteria for Determining the Indirect Costs for Research Grants to Hospitals, Member 1961-1962

American Hospital Association, Advisory Committee on Public Law 89-97, Member, 1967

American Hospital Association, Committee on Listings and Approvals, Member 1959-1964

American Hospital Association, Committee on University Teaching Hospitals, Member 1959-1966

American Hospital Association, Committee for Medicare

American Hospital Association, Council on Hospital Planning and Plant Operations, Chairman 1945-1947

American Hospital Association, Council on Prepayment Plans and Hospital Reimbursement, Chairman 1950-1951

American Hospital Association, Council on Professional Practice, Chairman 1951-1955

American Hospital Association, House of Delegates, Member 1960-1963

American Hospital Association/AMA Liaison Committee, AHA representative

MEMBERSHIPS and AFFILIATIONS (Continued)

American Medical Association, Member 1936-

American Public Health Association, Fellow

Association of American Medical Colleges, Chairman, Medical School Teaching Hospital Section, 1960-1961

Carrier Corporation, Member of the Board 1962-1979

Civil Service Commission, Advisory Committee on Federal Employees Health Insurance, AHA representative 1961-1963

Connecticut Association of Human Services, Committee on Reorganization of Connecticut Government for Human Services, 1977

Connecticut Governor's Hospital Planning Committee, Chairman 1960-1962

Connecticut Hospital Association, Life Member

Connecticut Hospital Association, President 1954-1955

Connecticut Hospital Association, Council on Government Relations, Chairman 1959-1961

Connecticut-Quinnipiac Valley Health District, Board 1978-1984; Chairman 1978-1980

Connecticut Regional Medical Program, Planning Consultant 1967-1969

Connecticut Regional Visiting Nurse Agency, Member 1976- ; Chairman 1978-1979

Connecticut State Department of Welfare, Medical Advisory Committee, Title XIX, Chairman 1966-1969

Federal Council, USPHS, Member 1951-1958

Joint Commission on Accreditation of Hospitals, Member 1955-1964

Joint Commission for Improvement of Care of the Patient, Member 1952-1959

National Advisory Health Council, Committee on Clinical Research Centers, Member 1960

National Commission on Public General Hospitals, Member 1975-1979

New Haven County Medical Society, Member 1946-

U.S. Vocational Rehabilitation Administration, Medical Advisory Committee, Member 1963-1968

U.S. Public Health Service, Advisory Committee on Hospitals and Clinics, Member 1962-1965

U.S. Public Health Service Medical Care Advisory Committee, Member 1956

Veterans Administration Hospital Construction Advisory Council, Chairman 1963-1969

AWARDS and HONORS

Alpha Omega Alpha

American College of Hospital Administrators

Gold Medal Award, 1966

American Hospital Association

Distinguished Service Award, 1965

Chicago College of Osteopathy

Honorary Doctorate, 1972

Connecticut Hospital Association

Distinguished Service Award, 1972

Phi Beta Kappa

Sigma Xi

BOOK

Hospitals, Health, People. New Haven: Yale University Press, 1987

WEEKS:

Dr. Snoke, this is your life. We would like to talk about your professional life, the things you have done, the people you have met, the events you have had a part in, or have observed. We usually start out with the date of your birth which was, according to my notes, July 19, 1907. You were born in Fort Steilacoom, Washington.

SNOKE:

Yes, sir.

WEEKS:

Pierce County?

Usually when I talk with a physician I ask, "How did you happen to study medicine?" I understand you have some physicians in your family.

SNOKE:

I think I wanted to be a doctor since I was 12 years old. It undoubtedly was because of my father, who had gone to Cooper Medical School in San Francisco. It became the Stanford Medical School a very few years later. He worked in a pharmacy through high school, was in the Spanish-American War, and then he went to medical school -- still working in a pharmacy. After graduation, he returned to the State of Washington, to become the Assistant Superintendent at the State Mental Hospital at Fort Steilacoom. I was born in the frame house, which had been the home of Ulysses Grant, when he was stationed there prior to the Civil War. When I was two or three years old, my father started a private mental hospital in the neighboring town of Steilacoom, Washington. They ran him out of town, because they didn't want a mental hospital in their community. That's why he moved to Puyallup, Washington. I must have been about four at the time -- around 1911 or 1912.

There he started a private mental hospital for mental and nervous diseases. He was a self-made psychiatrist, who, for some reason, was also termed in those days an "alienist."

I admired him. He was quiet; he listened to his patients; and he obviously was concerned about them. Although I became a big wheel as a Boy Scout in the Pacific Northwest in 1920-1924, and was fascinated with hiking and mountain-climbing, my goal was always medicine. This was good in one way, because I had a very definite goal through high school and college. However, it was poor in another, because I wasn't interested in wasting time on such things as manual training, mechanics, or art, in which I was terrible anyway — or in English, the cultural or the liberal arts. I wanted to be in science, and of course, medicine. I didn't even discover girls until I was in medical school and found the nurses' home, and it was my wife, Parnie, who broadened my education and was my editor.

WEEKS:

You did graduate from the University of Washington, didn't you? What was your major there?

SNOKE:

I received a bachelor of science in zoology, magna cum laude. At that time, Washington had no medical school. They had planned to have one some years earlier, and had brought Dr. Worcester there to start it. All he had was a small, plain building, in which he taught human anatomy. I took all I could get from him, along with everything else that I could take in science. I took what I had to in such subjects as psychology and English -- the only C's I received were two hours in English. It was a number of years later that the present fine medical school came to the University of Washington.

WEEKS:

But you did go to Stanford. One thing I wondered about in my notes was the gradations in residencies of medical students. In one place you were listed as an assistant resident, in another place you are listed as a resident, and in still another as an associate resident.

SNOKE:

Stanford at that time did not give the M.D. degree until after a year of internship. I went through 1928-1932 in medical school. Then those of us who were the intellectual students, or we thought we were, applied for medicine as an intern. It was rotating at that time, men's medicine, women's medicine, neuro-psychiatry, pediatrics, and the outpatients. Two months in each. Then I wanted to be an assistant resident in medicine and I wanted to go on for the residency. I talked with Arthur Bloomfield, who was the chairman of the department. Arthur Bloomfield -- and I will never forget this -- said, "You are a good student. I would like to have you stay on, but as far as a residency is concerned I have already decided upon David Rytand -- (who was my closest competitor and my closest friend). He is the man I want eventually in the academic world. I want to have him go through the assistant residency and the residency."

I still recall this conversation and my reaction. I told Dr. Bloomfield at the time that I thought he was smarter than I, and that he was making a better choice, for David would be a better clinician and academician. Actually, David Rytand went up through the chairs to become Resident, Instructor, Assistant Professor, and eventually Professor and Chairman of the Department of Medicine of the Stanford Medical School. He was the first one to be named to the Arthur Bloomfield Professorship at Stanford Medical School.

Then Bloomfield asked if I would like to have some experience elsewhere, so I said, "Sure, where?"

He said, "How about Hopkins in pathology for a year and then come back here?" So he arranged that I would have an assistant residency at Hopkins in pathology. Then, in April Johns Hopkins wrote and said they were looking forward to having me come except -- this was the depth of the Depression -- except that they didn't have any money.

"We will be glad to give you your appointment and give you all the responsibility you would ordinarily have, but you will have to pay your own way." This was a little awkward.

I went and talked with Dr. Bloomfield, who was very embarrassed. He was one of the heroes and great men of Hopkins, and had come with several of his associates in Baltimore to make Stanford Medical School the outstanding medical school in the west. So he invented a position. I became an Assistant Resident in Medicine and an Assistant Resident in Pathology at the Stanford Hospital. As Assistant Resident in Medicine, I took care of the private patients of the faculty. These patients were in the private unit of the Stanford-Lane Hospital. Thus, I had essentially a full-time job in medicine, as well as a full-time job doing autopsies in the Department of Pathology.

During that year the pediatricians started working on me. I liked and respected Dr. Harold Faber who was chairman of the department of pediatrics. He asked me if I would like to be the assistant resident in pediatrics. The next year would be the resident. So that picked up four years. Two years of medicine, the second year being medicine and pathology, followed by assistant resident and then resident in pediatrics.

Theoretically, by that time, I was ready to have gone out into practice,

but I was getting fed up with the Easterners looking down on the West, and name-dropping Hopkins, Yale, Cornell, Harvard, etc. I was a little suspicious of all of this, but I thought that maybe they might have something. I wanted to find out -- and my guess is that I also wanted to be able to return to the west and condescend also. So the great minds at Stanford arranged to have me go as Resident in Pediatrics to Columbia-Presbyterian Hospital in New York City. This was to be my fifth year. Then about April or May of that year, it turned out that the fellow, who was completing his residency there, decided to stay another year. So, Dr. Faber got on the telephone, and as a result, I went to Strong Memorial Hospital in Rochester, New York as the Associate Resident in Pediatrics in charge of the outpatient clinic. It was purely by accident that these various things happened.

My wife and I went to Rochester in July 1936 and I ran the outpatient clinic. I got to know Dr. MacLean, the director, and his associate Dr. Joe Clemmons. While there, I learned that in the East they traded residencies back and forth, which we didn't do in the West at that time. So I traded the last six weeks of my associate residency in Rochester with an individual at Bellevue. He came up to Rochester and I went down to Bellevue in New York City for my last six weeks in pediatrics.

It was there, again by pure accident, that MacLean got me on the phone the night before my wife and I were leaving to drive up around the Gaspe Peninsula in Canada back to Palo Alto where I was going to open an office in pediatrics and work with my wife's father who was the head of the department of physical education, hygiene, and health at Stanford University.

MacLean asked if I would be interested in coming to Strong Hospital in administration.

I laughed at him and said, "No."

MacLean and Joe Clemmons were the only two individuals, at that time, in administration at Strong Memorial. Clemmons had been tapped to go down to Roosevelt Hospital in New York City to run that institution. I had written MacLean when I read about it in the newspaper. First, I said how I had enjoyed my year in Rochester. Second, I said that I hoped that when he got somebody to take Clemmons' place that he would get somebody interested in the ambulatory services and outpatient services, as well as the inpatient services. Whether that letter stimulated something, I haven't the slightest idea. He never told me, other than that he got the letter. Maybe he asked somebody else who had said no.

At any rate I got the telephone call. I said to him, "Hospital administration to me is sort of a dopey sideline. I can't see any sense in it. I am interested in people care and patients."

He said, "Why don't you come up and talk?"

I said, "Okay, I will." So my wife and I went up there, and we took about two weeks thinking it over. We talked with physicians and hospital administrators at New York Hospital and Massachusetts General Hospital, and then went up to Maine, where my wife and her family used to go for summer vacations, and debated. I am sure my wife had reservations, but she backed me up.

I made a deal with Dr. MacLean. I would come for two years. At the end of that time, we would decide. However, that fall in 1937, I still went to Boston and obtained my certification from the American Board of Pediatrics. Yet I found that I liked hospital administration. So at the end of two years, I decided to stay. When I went around to tell Dr. MacLean, I found that he

had forgotten completely about the agreement we had made for two years only. All he said was, "That's fine." So I stayed.

Again, completely by accident! Here I had gone through four years of college, four years of medical school, five years of residency training. Then without going into any practice at all, I went into hospital administration.

WEEKS:

Someone said to me, in talking about Dr. MacLean and Strong Memorial, that he worked without salary with the provision that he could have whatever time he needed for consulting. As a result of that, he was away from the hospital a great deal of the time. It put responsibility on the assistants and associates or whoever was running the hospital thereby giving them a great benefit of running a big hospital and making management decisions because he was away and allowed them to do it.

SNOKE:

That is not correct. Basil MacLean was probably one of the most sought after consultants in the country. Basil consulted with every one of the armed services: public health, army, navy, marines, and air force, as well as with many major hospitals. But as far as I am concerned, I never felt that he did not always have his hand on the operations of the hospital. Second, he was paid a salary. It was not a major salary, and he told me that the University wanted to increase it, but he felt that he did not want an increase because of his consultation fees. He involved his associates in virtually all of his consulting work, so that we were working with him, not only in the hospital, but in his outside consultations as well. He sometimes paid us something more, but we were doing it with him to learn.

As I look back at it (that was a long time ago), I don't think that I

ever felt during the time that he was director of the hospital, and consulting, that he didn't know what was happening at home. He truly was the director of the hospital. The only time this did not occur was during the war. I had enlisted in the Public Health Service and was to be a Major. I was going to work with George Baehr in the Public Health Service. As I was being measured for my uniform, I thought it might be appropriate to tell Basil MacLean I was leaving. He said, "You can't!"

I said, "What do you mean? I am being measured for my uniform. I have been appointed."

He said, "I out rank you." Then he told me he had been appointed as a special consultant, a lieutenant colonel in the Army Surgeon General's office down in Washington, and that I had to stay and run the hospital. That was the only time that he was really not running the shop. When he was down in Washington, I had complete authority.

As far as the rest is concerned, as I look back in my experience in about ten years there, I never felt that he was not on top of all activities. His consulting, while he was active in it, did not interfere with the operations of the hospital. That is something I will talk about later for it was a sore issue elsewhere as I discovered when I went to New Haven.

WEEKS:

Now that we are in Rochester, would you want to talk a little bit more about it, and too, if you would want to elaborate on Basil MacLean. Unfortunately we don't have any record of him.

One thing I was wondering about Strong Memorial. It is a part of the University of Rochester, isn't it?

SNOKE:

Yes.

WEEKS:

Has it always been?

SNOKE:

Yes.

WEEKS:

Maybe you would like to say something about Strong Memorial, what kind of hospital it is, what it does, and so on.

SNOKE:

I haven't the slightest idea how it got started. It may have been because of Dr. Albert Kaiser, a pediatrician, who also was the personal physician and friend of George Eastman. Al Kaiser undoubtedly had a lot to do with the stimulation of the medical school. For some reason or other, the University of Rochester got the idea of a medical school and a hospital together. Two individuals were brought in. The primary individual was George Whipple, a Nobel Laureate and pathologist, who was the dean of the medical school. The other was a very senior hospital administrator, Nathaniel Faxon. Dr. Faxon and Dr. Whipple collected a number of top-flight professors from around the East, mainly Harvard, Yale, Columbia, and Hopkins. Strong Memorial Hospital was built around 1926. Dr. Faxon was the director. He and Dr. Whipple did the primary planning, along with William McCann in medicine, and John Morton in surgery.

Several things were most unique. They planned for this to be a teaching hospital, in which there were not going to be any private patients, only teaching patients, who were to be termed service rather than ward. All the

faculty were going to be on salary through the medical school and university. This is what I was told when I came in 1936 -- but apparently it was a fine idea only until they started.

Although the university had brought in these very top-flight clinicians and their associates for teaching -- when the trustees, the community leaders, and the public heard of them coming to Rochester -- the community wanted to be cared for by these physicians as private patients. So these physicians and their subordinates soon started taking care of private and semi-private patients.

Within a very short period of time, it was decided that anybody, who was in a multiple bed room -- and nothing was built larger than four bed units -- was to be teaching material. Almost from the very beginning, the service patients, and the semi-private patients (those in the multiple bed rooms) were teaching material of the University of Rochester.

By the time I came in 1936 they were using all semi-private room patients for teaching. When we built the new wing "R" in the early 1940s, it was just taken for granted that everybody in Strong Memorial Hospital was a teaching patient. This was a major advance and was ahead of many of the medical schools in the country.

A second, very important factor was that at the time they were planning Strong Memorial Hospital as a teaching hospital of the University of Rochester Medical School, the City of Rochester was planning to build a Rochester Municipal Hospital. They even had plans for this hospital to be built some place in the middle of town. The Director of Public Health, Dr. George Goler, who was truly far-sighted, said, "I don't think this is a good idea. Why don't we build the Rochester Municipal Hospital as part of the Strong Memorial

Hospital?" This recommendation was accepted.

The city and the university developed a unique contract, which functioned for years to the mutual advantage of both. It spelled out how the university would run the Strong Memorial Hospital -- only it would be the Strong Memorial-Rochester Municipal Hospital. It was operated in such a manner that it would function essentially as one hospital, in which expenses for hospital operation were shared proportionately to the percentage of patients, who legitimately belonged in the RMH or the SMH. Wherever possible, there were single services, such as one operating and one delivery suite, one maintenance department, one dietary department, and one power plant. There was a clause in the contract that essentially was a "gentleman's agreement," and everybody used to laugh at it, but Basil MacLean considered it very seriously, and so did I. The clause said essentially that we were trusting each other, and that the university, through the hospital or medical school, was not going to charge research or teaching expenses to the city. Basil was meticulous on this, and considered that contract as a bible. Nursing education was a good example. In the thirties and early forties, there was no question but that the work provided by nursing students was worth far more than it cost the hospital to teach and support them. Basil would check the costs of the nursing school each year, to be sure that those expenses that were being prorated to the city were legitimate, and that the city was not paying for nursing education. In the same way, Dr. Whipple would check with Basil and go over all the medical school activities to be certain there were no educational expenses of the medical school in the costs of the hospital.

The unique aspect of the combined hospital was that it was a combination of a university hospital and a municipal hospital, in which the expenses were

shared on a pro rata basis. The food was the same, the operating room suites were the same, the anesthesiology, and virtually all support services were the same. The house staff took care of the municipal patients, just as they did the service patients at Strong Memorial Hospital, and the private patients. So did the attending full-time faculty.

There was also a community group of physicians, who were appointed to the hospital staff at Strong Memorial Hospital -- Rochester Municipal Hospital -- but only if they were members of the faculty of the medical school. Thus, there was a competent, selected group of community physicians, as well as the full-time faculty staff, caring for the city as well as the service patients. Some of the community physicians received a small stipend of $900-$1,000 a year. As a rule, they donated their services. They had the privilege of admitting their private patients to Strong Memorial, where they were available for teaching.

I am emphasizing this philosophy, because when I went down to New Haven to run the combined New Haven Hospital and the Grace Hospital, Yale Medical School was still insisting upon ward patients so that it could have teaching material. It was very hard for them to realize, even in 1946, that the world was changing. By this time, the University of Rochester Medical School was using ward, service, semi-private, and private patients for teaching, and had been doing it for years.

WEEKS:

How about costs? Were the teaching patients free patients or did they pay their way? Did it depend on their needs?

SNOKE:

Yes. As a rule, if a patient were indigent, the indigent patients went

into the Rochester Municipal Hospital designated divisions. The City of Rochester had a director of the hospital, George Dash, and a business office. I think maybe George had a few housekeeping people also, but that was just about all.

WEEKS:

Did the city pay for the indigent?

SNOKE:

The city paid for them. The patients were all admitted to the hospitals through a single admitting office at Strong memorial. If they were found to be indigent -- or on welfare -- they were sent to the Municipal Hospital floors, and George Dash would check on them to be sure we were all being honest.

To answer your specific question, a substantial number of the teaching hospital patients paid their way -- fully — or in part.

WEEKS:

Would you want to say anything about the UHEC?

SNOKE:

The University Hospital Executive Council (UHEC) was an informal organization, from which I probably learned more than from any other group, except its later counterpart, the Council of Teaching Hospitals, which I helped form when I went to New Haven -- and the two medical administrative groups that I will discuss later.

I had never heard of the UHEC until I joined the administration of Strong Memorial in 1937. After the AHA convention in Atlantic City in the fall of 1937, all of the UHEC members met in Rochester, New York. My first administrative assignment was to organize this meeting. The UHEC was made up

of the directors of the five state-owned university hospitals of Michigan, Iowa, Wisconsin, Indiana, and Minnesota -- plus three independent university hospitals, the University of Chicago, Lakeside Hospital in Cleveland, associated with Case-Western Reserve, and the Strong Memorial Hospital of the University of Rochester.

Representatives of the eight institutions would meet once or twice a year at one or another of the institutions. They would bring up those subjects in which they were particularly interested, and they would talk about them.

WEEKS:

Didn't they publish an agenda in advance?

SNOKE:

I don't remember any agenda. There may have been a list of topics sent out when they agreed upon the date and the host, but it was a singularly informal affair.

They also had a custom that I found extremely helpful. If any member had a question -- or a problem -- he would send out a memorandum outlining the question or problem, and what he was doing or thinking about it, to all other members of the UHEC. Each member would then respond to the original question -- but the response would be sent to each of the other seven members. The result would be a complete file of the responses in the possession of each UHEC member. I think it was a very valuable, collaborative effort. The subjects ranged from the inclusive rate, to how do you color oleo -- at that time, you couldn't buy colored oleo. There were no holds barred, and no one was either cagey or secretive.

WEEKS:

As I remember hearing, this group was composed of the executives. The

only time you would bring anyone along with you would be to bring along an expert.

SNOKE:

No, that is not correct. Basil made a point, and the others did too, of bringing along one or more of their assistants to every meeting. I went with him to Wisconsin, Minnesota, Iowa, and to Lakeside Hospital in Cleveland. That is how I first met John Mannix, when Dr. Bishop brought him to the first meeting I attended in Rochester, and is how I met Stanley Ferguson, who was an assistant to Dr. Arthur Bachmeyer in Chicago. It was also how I first met George Bugbee. Bugbee was running the Cleveland City Hospital at the time, and Dr. Bishop had invited him to the UHEC meeting when we were in Cleveland.

I started the same type of organization when I moved down to New Haven. Only we called ourselves the Council of Teaching Hospitals. It is very interesting that the AAMC stole our name.

WEEKS:

You pre-dated the Council of Teaching Hospitals of the AAMC?

SNOKE:

Yes. In fact, in one of the relatively recent publications of the AAMC and COTH was a list of various hospital groups and medical schools, in which they referred to the original Council of Teaching Hospitals.

WEEKS:

I do hope when we get through with this that we can go back to Basil and others there.

SNOKE:

Why don't we talk about Rochester and MacLean now and then we can come back and talk about the others later.

As far as I am concerned, Basil MacLean was a unique individual. I was interested in reading the book that you and Mr. Berman wrote about the history of AHA. There was little mention of MacLean. I have been puzzled, because from the time I became involved in hospital administration, MacLean and Buerki were considered two of the giants of that era. Others were Drs. Arthur Bachmeyer of Chicago, Harley Haynes of Michigan, and Benjamin Black of Alameda, along with Robert Neff of Iowa and Joseph Norby of Milwaukee. Most became presidents of the AHA. These were individuals who certainly had the respect of the younger generation.

I also can still recall MacLean talking to me about the lousy bookkeeping and accounting systems of hospitals, and how he had worked with Rufus Rorem on the first formal chart of accounts that was adopted in 1935 by the AHA. There is no doubt but that Rorem was the accounting brain of that team, but Basil (who knew little about the details of accounting) kept pushing for the acceptance of the first official outline of standard accounting by the AHA.

Basil attracted a number of delightful and competent individuals. I think the reason we enjoyed working with him was the way he ran his own institution, delegated responsibility and authority -- not only to his administrative associates, but to the senior nursing and admitting personnel -- and then backed them up. Much of the first part of my book (Hospitals, Health, and People - Yale University Press, 1987) is devoted to his philosophy of delegating responsibility, and of his concern for the proper care of the patient, as contrasted to the CEO being primarily concerned with inn-keeping and bookkeeping.

As I look back on my early experience in hospital administration at Strong, I recognize how much I patterned my own administration of the hospital

after that of MacLean.

Every weekday morning at nine o'clock, Basil MacLean would meet with the director of nurses, the director of admissions, and his various administrative associates, and we would go over what had happened the day before and that night. As far as he was concerned, and as far as I was concerned in the 10 years there, I don't think that he or I had any more than one or two or three telephone calls from the time we would leave in the evening until we came in the morning because the admitting and nursing staff were effectively running the place. We had delegated responsibility to them. The only call I recall during the 10 years I was there was a call from a woman who was in labor. She had been put through the hospital switchboard to me and I couldn't understand why in blazes she was asking me about being in labor. It turned out we had an obstetrician named Snow. She wanted to talk to Dr. Snow and they gave her Dr. Snoke.

MacLean's style of management was appreciated by his associates. His assistants, the chief admitting officer, and the chief nurse never had the slightest doubt but that he would back them up in whatever they did, and that he respected their knowledge and loyalty.

Although he was frequently involved in consulting all over the country, I never felt, during the ten years I was with him, that I was being left alone. We were always in touch, and yet the thing that impressed me the most was that I could depend upon him to back me up, even if I was wrong. He might give me hell -- but this would be done alone in his office. He never did it in public. I think that it was because of this that I -- along with his other associates -- never had any hesitation when we were in a meeting, in which decisions had to be made — or should be made promptly — of committing the

hospital, if we thought it was the appropriate thing to do. MacLean knew that we would always come back and tell him what had been done and committed and the reasons for it, and that we would be backed up.

This is the philosophy that I took with me to New Haven. I only hope that I was as consistent with my colleagues as Basil MacLean was with us.

MacLean was an interesting paradox in one way. He did not suffer fools gladly, and he had no hesitation to say what he thought, if he were in disagreement. However, his loyalty to his friends and subordinates was complete, and he would support them to the last ditch -- even if they were sometimes wrong or mediocre. He was always ready to support and advance his friends -- and sometimes they did not rate it. I know how he helped me throughout all our relationships -- I hope I deserved it.

WEEKS:

He was Canadian?

SNOKE:

Yes. He was born in Oshawa, Ontario, Canada in 1895. He received his M.D. and C.M. (Master in Surgery) degrees from McGill University in Montreal in 1927. During his medical school years, he worked in various jobs in the Montreal General Hospital, such as admitting, and when he graduated, he was appointed medical superintendent of that institution. In 1930, he went to New Orleans as superintendent of Touro Infirmary, where he stayed until he took Dr. Nathaniel Faxon's position as director of the Strong Memorial Hospital in 1935.

Basil was one of a number of Canadian physicians, who came to the United States in hospital administration during that period -- partly because of the influence of Dr. Alfred Haywood, head of the Montreal General Hospital. Dr.

Haywood later went out to the Vancouver General Hospital in British Columbia. Among the Canadians were Dr. Fraser Mooney who was active in hospital administration for many years in Buffalo, New York. There were also Donald Smelzer of Philadelphia and Peter Ward of St. Paul, who were also prominent in the AHA, and were presidents of that association, along with Basil MacLean. Another Canadian physician, Dr. George Graham, later came to be an assistant to Dr. MacLean in Rochester -- then went out on his own and subsequently was also a president of the AHA.

When MacLean was at Touro, it was at the depths of the Depression, and both hospitals and people were having great difficulties managing, because of finances. This was one of the reasons why he became so interested in Blue Cross, and during 1932, he helped start one of the first Blue Cross Plans in the country in New Orleans.

When he came to Rochester in 1935, he immediately became involved in the Rochester Blue Cross Plan, which was becoming one of the outstanding programs in the country. It was through him I became acquainted with the close relationship of the Blue Cross programs and the AHA. During all the years I was in Rochester, and when I went to New Haven, I became more and more impressed with the potentials of Blue Cross, the value of the various Plans to hospitals and the people of the community, and the role that MacLean, Robin Buerki, and others in the AHA hierarchy played in supporting this partnership of hospitals and Blue Cross Plans.

When Dr. George Whipple retired as Dean in the early 1950s, the atmosphere in Rochester changed. There was no question but that the University of Rochester regarded Dr. Whipple as the senior in the medical center, but Whipple and MacLean worked together as partners, with neither

dominating or interfering with the administrative responsibility nor activities of the other. Dr. Whipple's successor, Dr. Donald Anderson, who had been at the AMA, had a different style, and within a relatively short time, Basil MacLean felt that life would be more pleasant elsewhere.

The result was that in 1954, MacLean accepted one of the countless offers that he had been receiving from virtually every major hospital organization in the country, and went to New York City as Commissioner of Hospitals. During his tenure as Commissioner (May 1954-February 1957), Basil MacLean raised salaries of nurses and technical staffs, closed several tuberculosis hospitals and communicable disease hospitals, and directed the construction of four new municipal hospitals. However, MacLean believed it would be more desirable from both economic and social viewpoints, to grant some part of the tax dollar to voluntary, public-supported hospitals for the care of the medically indigent, rather than invest heavily in separate governmental institutions, which competed with the voluntary institutions. He also took a leaf from the home care program of Dr. E.M. Bluestone and Montefiore Hospital and created the equivalent of 2,400 hospital beds through a home health care program. This was remarkable from an operating expense point of view, but quite unpopular with the politicians, who enjoyed the returns from the construction of multi-million dollar hospital edifices.

He also seriously raised the question of the necessity of interns and other house staff riding on every call in the municipal ambulances, and for a while, was successful in removing sirens from the ambulances and making them obey traffic lights. (I utterly failed in removing sirens from the ambulances in New Haven.) It was from his position as Commissioner of Hospitals in New York City that Basil MacLean became president of the national Blue Cross

Association.

WEEKS:

Wasn't the main purpose of the national Blue Cross Association to find a way to service national accounts for the Blue Cross Plans?

SNOKE:

I don't know the inside details. I do know that the original Blue Cross Plans were closely associated with the American Hospital Association, and that there was formed the Blue Cross Commission in the late 1940s. This was an Illinois corporation, with headquarters in Chicago, and worked in very close association with the AHA.

Through all the developments of the original, individual Plans, such as in New Orleans and in Rochester, Basil MacLean continued to be active -- not only with the local Plans, but also with the AHA and its relationship to Blue Cross as it grew nationally. As long as I can remember, he was working with the AHA in the various transitions of the national Blue Cross organization, and I expect that it only seemed natural for him to be asked to head up the major new organizational step of Blue Cross. He was the first president of the newly formed association from February 1, 1957 until 1959, with its headquarters in New York City.

Douglas Colman, who had been director of the Maryland Blue Cross Plan, and Harry Becker came to New York to help MacLean. Unfortunately, MacLean later developed a cerebral vascular problem in which he had blindness in the middle of the eye, but some peripheral vision, and as a result, he could not work efficiently and had to retire. Jeb Stuart took over as head of BCA for a period, and then Walter McNerney assumed responsibility, and BCA was moved back to Chicago.

WEEKS:

The Blue Cross Commission, which predated BCA, acted as sort of a Good Housekeeping Seal approval of Blue Cross Plans kind of an operation and was almost a part of AHA. While Rufus Rorem was at the Commission it served its purpose very well. After he left there was kind of a vacuum, the same kind of vacuum there was after MacLean left. You take these outstanding figures and find they are very hard to follow.

SNOKE:

That's right. I think that Blue Cross was particularly fortunate to entice Walter McNerney to become its long-time president of the Association. He had the wisdom to recognize -- as did Basil MacLean -- that Blue Cross was, for a long time, a social program as well as a business program. This was one of the reasons I was so proud of it.

For years, the Rochester Plan and the Plan in Connecticut functioned on a community rating basis. I used to enjoy the irritation of my friends in commercial insurance in Rochester, because they couldn't get into companies like Bausch & Lomb or Eastman Kodak. They said they could offer a cheaper rate than Blue Cross. They were correct on an experience rating basis, but Eastman Kodak, for example, recognizing that they could undoubtedly get their hospital insurance for their employees cheaper on an experience rating basis, still supported Blue Cross because they thought it was better for the overall Rochester community.

WEEKS:

Would you like to talk about Rochester as a community? Was Folsom there when you were there?

SNOKE:

I was there when Folsom was there. Basil MacLean and Folsom were two who worked most closely together. I don't think I ever had anything to do, personally or otherwise, with Marion Folsom.

WEEKS:

On the whole, isn't Rochester an unusual community as far as health services are concerned?

SNOKE:

Yes. When my wife and I first came east to Rochester, we soon became fed up with being told that Rochester was different, and that Rochester was good. When we left Rochester after ten years, I still can recall our laughing at each other, because we would remind each other that Rochester was different. Rochester, at that time, was a city in which much of the industry was home-owned. Bausch & Lomb, Stromberg-Carlson, Eastman Kodak, Hickey-Freemand -- and these industries and the local banks were truly concerned about the Rochester community. One of my best friends was head of the Community Chest, Dick Miller. He told me how whatever amount was decided to be raised each year, the various industries and the Lincoln Alliance Bank took care of it.

It was different in New Haven, because most of the industries had become branches of companies elsewhere. As a result, New Haven had an infinitely greater problem in raising charitable funds than did Rochester.

Rochester was a smug community, but it had reason to be. At that time I had the feeling in talking with my friends in Cleveland that they were very much the same sort of home-owned industrial city that took a special interest in their community.

WEEKS:

I got that same impression in talking with John Mannix about Cleveland, and others I have talked with there. I can remember talking with people back in the forties about Cleveland and its cultural support and its universities.

SNOKE:

That was Rochester with the Eastman School of Music and the Eastman Theater. The cities were the same type.

WEEKS:

Was George Eastman alive when you got there?

SNOKE:

No, he must have been dead. I was there from 1936 to 1937 on the house staff, and then from 1937 to 1946 in administration. I had relatively little contact with the community leaders compared with Basil MacLean, but through him, I learned of the value of the close involvement of the lay community leaders in hospital and health affairs.

WEEKS:

What was the size of the hospital while you were there?

SNOKE:

I would think the total hospital must have been between 550 and 700 beds -- Municipal and Strong.

WEEKS:

Before we go to New Haven, are there any other specific items about Rochester or Basil MacLean that you want to comment upon?

SNOKE:

Yes. There are several things that I would like to mention.

I have to confess that I was one of the few, who indirectly gained from

the unfortunate administrative disorganization that resulted in MacLean going to New York City. John Law, who had been MacLean's executive officer, was asked to take MacLean's place. Law was unhappy with the developments in Rochester, and refused. I heard of this and leapt at the opportunity. I had been asked to become President-Elect of the AHA in 1954 or '55, and had declined because I did not feel that I had anyone to be my administrative officer if I were away from the hospital for any extended period of time. In those days, they usually expected the elected presidents to spend from 25% to 50% of their time roaming around the country to various hospital and AHA meetings, etc. I asked the AHA nominating committee if they would give me a chance later, and when I heard of the possibility of getting John Law, I went after him. To make a long story short, John Law came as the Associate Director of the New Haven Hospital, and I was requested the next year to be the President-Elect of the AHA, and accepted.

After John Law had come to New Haven, he told me that there were still some ruffles in the Rochester water, and so I went fishing again. This time, I was able to steal Dr. Nicholas Greene, and Dr. Alistair Gillies, who were the two top medical anesthesiologists at Strong, to come down to New Haven. The two of them built up a remarkable department of anesthesiology, which Nicholas Greene continued to head up until his retirement, and within a few years, Dr. Gillies went back to do the same thing at Strong Memorial. I felt mildly guilty about my thefts -- but not very.

I also had an unusual experience on regionalization of hospitals and health care during the period that Basil MacLean was in the army. During this time, the Commonwealth Fund announced a grant of $300,000 that they wanted to give to a university teaching center associated with a rural area. I was very

intrigued over this because it seemed to me that Strong Memorial in Rochester fitted this exactly. While Basil was away, my wife and I spent much of our time roaming around visiting the area hospitals, talking to them about the Commonwealth grant and about associating with Rochester that already had an excellent Rochester Hospital Council. As we did this, I developed a suggested plan of relationship of smaller hospitals and the larger university hospital along with the other community hospitals. Most of the hospitals were pretty damned suspicious of Strong and of Rochester. So I suggested that maybe we might be able to rotate interns. They were fascinated at the idea of getting this type of help for little money. I knew damn well that the chance of rotating interns through the smaller hospitals was remote, but at least, this gave me an entree. My wife and I drafted a regional plan, and Henry Southmayd and Dr. Lester Evans came from the Commonwealth Fund, and we spent a great deal of time talking and pipe-dreaming on this subject. When Basil MacLean came back from his tour of duty in the Surgeon General's office, he was very intrigued with the idea. However, when we brought it up to the medical school, the faculty just wasn't interested in any outside relationships. I was obviously disappointed that nothing was happening.

Then Albert Kaiser, the pediatrician, became the health officer for Rochester. He learned of our recommended program, and through his prestige, got the medical school to cooperate. As a result, the Rochester Regional Hospital Council was formed and received a major percentage of the Commonwealth Fund grant. I was offered the job to be the Director of the Regional Council, but by this time, I had been asked to come down to New Haven, which I then accepted. I think that Dr. Paul Lembcke was the first Director of the Council, but I am not certain.

WEEKS:

Had Dr. Lembcke developed his medical audit by this time?

SNOKE:

I don't know. I have a feeling that he had.

The Rochester Regional Hospital Council Program was somewhat pioneering. Some years later, Dr. Kaiser told me before he died that as George Bugbee and others were working in Washington on the Hill-Burton program in the early 1940s, that the planning my wife and I had done for the Rochester area had been of value as far as the planning for the Hill-Burton legislation was concerned. I have never read anything about this, but I have had a little smug feeling that I had something to do with the formation of Hill-Burton.

That experience and the introduction Basil MacLean had given to me of the value of hospital trustees to hospital organizations, such as existed in the Rochester Hospital Council, made a lasting impression on me. That education undoubtedly was the basis for my urging that lay trustees be an integral part of the Connecticut State Hospital Association, which made it such a strong and unique organization. I am convinced that carefully chosen lay trustees can be of tremendous value to governing boards of health organizations and programs.

WEEKS:

In other words, you prefer a hand-picked board, selected for their talents.

SNOKE:

Correct.

WEEKS:

I was wondering about this. A small hospital in which John Griffith and I studied a progressive patient care program had a board that was elected at

the annual meeting. Anyone who was a member of the corporation for dues of a dollar a year could have a vote in the election of trustees. It was a popularity contest. They didn't always get the best kind of people. I suppose in some hospitals, the board appoints new members as vacancies occur. That could have its advantages and disadvantages.

SNOKE:

Yes. You could have an ingrown board. When I was working with the governor of Illinois in Comprehensive Health Planning, doctors and others wanted to be able to elect members of the board of the planning organization as their representatives. I refused to be associated with that. I said, "We will come to you to ask for names and for advice, but you are not going to be able to elect these individuals. Of course they will be thinking about the medical profession or the orthodontists, or whatever special interest they were particularly acquainted with. But there must be a clear understanding that they are coming in as independent individuals who will make their decisions as they see fit. They are not going to go back to you guys to tell them what to say."

WEEKS:

How did you say they were finally chosen?

SNOKE:

By the governor and myself.

WEEKS:

So you could pick the best possible people?

SNOKE:

That's right. Like in hospitals: You will find in many hospitals that the chiefs of service are elected by the medical or surgical section, etc.

Sometimes it is good but sometimes it is bad, because sometimes the guys think they have to go back and get the opinion and approval of their colleagues, and then reflect these opinions only. This is a very important point to me, for we wanted our chiefs of service in our hospital to not only be the best physicians, but to be independent. Of course, we wanted the advice of the medical staff, and we arranged for means to get this. But we felt that the chiefs of service should be selected by the board for their clinical ability, their leadership, and their administrative qualifications through an impartial selection process. We recognized that the election process might still pick out the best and most appropriate leader -- but there was also a very definite possibility that election might merely produce a stooge.

I would like to make one more comment about Basil MacLean and the American Hospital Association. I have been interested, as I have read a number of the Oral Histories, that there has been little reference to the influence of Basil MacLean upon the AHA organization and personnel. Basil MacLean encouraged me to be active in the AHA from the time I first became associated with him, and I can still recall how doors seemed to open so easily for me, because of the regard of so many of the hospital people for my chief. I confess that I paid little attention to the internal structure of the association or to the personalities, other than when some issue of importance arose -- particularly in Blue Cross -- MacLean seemed always to be consulted. I was not even aware of the situation of Dr. Bert Caldwell during the time that there were efforts being made to expand the structure and activities of the AHA to a major, national, hospital organization of importance. it was only by accident that I learned of these problems, and was given one of my first examples of Basil MacLean as a combination of a warm human being and a

tough administrator.

I had been offered the position as director of the Evanston Hospital, and was most flattered that the retiring administrator, one of the women in the hospital field whom I most admired, Ada Belle McCleery, had urged me to accept.

I came back to Rochester to discuss this with Basil MacLean, and we had very frank discussions about this offer and his plans. In 1940-41, he was going to be president of the AHA, and he also wanted to get a Master's degree in Public Health at Johns Hopkins.

Basil then told me of his desire to advance the AHA into a greater national organization, and to provide a closer relationship with Blue Cross. He was very frank in his dissatisfaction with Dr. Caldwell in the long-range development of AHA. However, Bert Caldwell was his friend, and he did not want to hurt his friend. He also knew that James Hamilton was succeeding him as president, and could be depended upon to do what was necessary in dealing with Dr. Caldwell.

My decision was easy, as far as my immediate future was concerned. I was, of course, flattered about the Evanston offer, but my wife and I were having a good time in Rochester, we were building a new building for Strong Memorial Hospital, and I was having a fascinating experience learning about planning and construction. Also neither Parnie or I were sure we wanted to live in the "Heartland of the United States," particularly in the atmosphere of Colonel McCormick. So I informed Dr. MacLean before he had to make any specific decisions regarding Hopkins, etc. that I was staying -- and he went on with his other activities. Jim Hamilton subsequently arranged to have Dr. Caldwell retire and George Bugbee came on as his successor.

WEEKS:

Are we ready now to go to New Haven? Will you tell me how you happened to go, how you happened to leave Rochester?

SNOKE:

I haven't the slightest idea why I was selected. It was only by coincidence that I was offered the position as head of the Rochester Regional Hospital Council in the winter of 1946, at the same time I received a letter asking if I would like to come down to be looked over by the newly formed Grace-New Haven Community Hospital.

WEEKS:

Was that composed of two separate units?

SNOKE:

That's right.

So I visited New Haven, January 3, 1946 to find that the New Haven Hospital had been in existence since 1826 as the General Hospital Society of Connecticut, through a formal Connecticut legislative act. Yale Medical School had been started in 1812. Because of the need for a hospital, a number of the Medical School faculty stimulated the creation of this institution. They actually put up a portion of their own income for a number of years to support this hospital. Then they got smart and decided this was not the way to run a railroad. So they stimulated the formation of a community board. The institution has always been an independent community hospital, with a close relationship to Yale.

WEEKS:

This was called the New Haven Hospital?

SNOKE:

It became known as the New Haven Hospital. In the late 1800s a Catholic hospital was started, the Hospital of St. Raphael. Another hospital was also started in the late 1800s and frankly, I don't know why, was known as the Grace Hospital. It was not a religious hospital.

WEEKS:

It just had a religious sounding name.

SNOKE:

I think it was named after some person. So, here you had three hospitals: a Catholic hospital, a university dominated community hospital, and a smaller community hospital. By the early 1940s both New Haven and Grace found that they needed to develop major fund raising campaigns. The leaders of both New Haven and Grace -- whether they got advice on this or not I don't know -- decided they would get more money if they developed a joint fund campaign. They said, "Let's join the two hospitals and build a new Grace Hospital as part of the New Haven Hospital. As of the first of January 1946, I think, or around that period, they formally combined the two as the Grace-New Haven Community Hospital. This was also formally established through the Connecticut legislature.

The only thing they did at the beginning was to say that the two boards would combine as one board. So they had something like 70 or 80 individuals on this board. New Haven Hospital had a university service with a full-time faculty. That's a story in itself how Yale Medical School was essentially reorganized back in 1915-1918 after the advice of the head of Hopkins.

WEEKS:

Welch?

SNOKE:

No, Dr. Winford Smith, the Director of the Johns Hopkins Hospital. I have a copy of his letter. It is a beautiful thing. He talks about the Yale Medical School and the New Haven Hospital. I don't remember which he termed second rate and which third rate, but he obviously didn't think much of either the medical school or the hospital. A primary recommendation was that there should be a full-time, salaried faculty in the medical school -- particularly in the clinical faculty, and that the chairmen of the various departments should be the chiefs of service. That's why they brought Dr. Milton Winternitz from Hopkins to be the new dean. Milton Winternitz really remade the Yale Medical School. He and his associates were on the full-time system with the chiefs of medicine, surgery, pediatrics, OB-GYN, and psychiatry. All on salary. He stimulated the construction of a modern hospital, which was completed by 1933, and Winternitz and Yale University played a major role in getting the money for the new buildings.

When I came down to New Haven January 3, 1946 to be interviewed, I never asked any of the details regarding decisions about the existing administrators of the two hospitals. There was a committee of five: the dean of the medical school (Blake); two individuals of the New Haven Hospital board, Frederick Wiggin and D. Spencer Berger; and two members of the Grace Hospital board, Robert Ramsey and Robert Judd. These five met with me at the Quinnipiac Club in New Haven. We spent the morning talking. They wouldn't let me visit the hospital, nor would they volunteer anything about personalities. We had lunch and then they asked me to go into the library while they talked. After a while, they came back and asked whether I would like the job. That was all there was to it.

There was one thing that I still remember distinctly, and this goes back to our earlier conversation on outside consulting and Dr. MacLean. There was one question they asked me rather early in the game, "Dr. Snoke, what do you think of directors of hospitals doing consultations?"

I just burst out laughing, because I knew exactly what they were leading up to. And I expect that my attitude was one of the reasons why Jim Hamilton never quite approved of me. Jim was so much my senior. He had been President of the AHA. He was known throughout the country as a senior hospital administrator, and he also was one of the premier consultants of hospitals in the United States. They didn't say it in so many words, but it certainly came through clearly, that they were dissatisfied with Jim not paying enough attention to the New Haven Hospital because of his consultations. As I have already said -- all I did was laugh and responded.

I said, "I know why you asked me, and I'll tell you what I believe. If I am director of this hospital, this will be my primary job. That's the way it has been during the time I have been in Rochester for the past ten years with Basil MacLean. I have learned an awful lot when I would go out with Basil on consulting. And so has he. As far as your asking me what I want to do, I want to be available for consultation if I am asked, but beyond that, if I am asked to run this hospital -- that is my first job. I would want to do consulting only if I thought it would not interfere or hurt my operations in the institution. Beyond that, I am expecting my income to come from you guys, and not for me to try to get rich through consultations."

They seemed to think this discussion on consulting was enough, and they just went on to other things. After lunch, he offered me the job. I learned later that Dr. Charles Wilinski, head of the Beth Israel Hospital in Boston,

had been an individual who strongly urged that they take me, or at least look at me. He never said anything about it to me, nor did Basil MacLean. The only way I know that Wilinski played a role was because Mr. Judd later said, "I went up and talked with Dr. Wilinski, and he said we should go after Snoke."

The situation in New Haven was as awkward as hell in certain ways. I responded to the offer by saying, "I am very interested in this, but there are several things that need to be settled. The first thing is that I must be close to the medical school, for I have to work with the faculty. So far, all I have met is the dean. And I do not think I should be considered unless the medical school wants me also. I would want to be part of the faculty, and so I would need to meet them. Also, I want to talk with my wife. As far as I am concerned, she is my partner. I don't do anything of this sort without talking with her."

They said, "Okay, how about coming back next week, bringing your wife?" So we did. I had lunch with the medical board, the chiefs of the various clinical services and pathology, and I talked with each of the chiefs separately. Then afterwards, we had tea in the Beaumont Room, the fancy room in the Yale Medical School Library. This was the first tea they had there since the teas had been discontinued during the war. Parnie and I were then introduced to all the full professors.

WEEKS:

Your wife, Parnie Storey Snoke, was a physician, wasn't she?

SNOKE:

She was a physician. During that tea, they were all very cordial to us, and Ira Hiscock, who was the chairman of the Department of Public Health, came

up to Parnie and said, "Dr. Snoke, I was a friend of and admired your father." Her father was a really big wheel at Stanford University and in Public Health.

WEEKS:

What was her father's name?

SNOKE:

Dr. Thomas Storey. She almost broke down in tears after Ira spoke to her. As you can imagine, I had no difficulty in accepting the appointment. However, after I had accepted, I found I had an interesting personnel problem. Jim Hamilton had been the director of the New Haven Hospital for about seven years. Sidney Davidson was director of the Grace Hospital. Both of them had wanted to be the director of the combined institution. Jim Hamilton was the logical choice as Sidney Davidson was an older man, competent, a nice guy, but without the stature of Jim. The board had decided for varying reasons not to select Jim Hamilton which was why they went out looking for others. The interesting part was that Jim also had an associate professorship in public health in the university. This associate professorship had a five years tenure which did not end until the first of July. This was January. So from January to July, James Hamilton had an office in the medical center. In all fairness to Jim, although he and I battled on many things before and after, when I came to New Haven he never once, to my knowledge, ever evinced any disgruntlement or did anything that I was ever aware of to interfere with the new boy on the block coming in and taking the job he wanted.

After the first of July he went on to Minnesota, and you know his history from there on. I didn't come to New Haven to live until April 14, 1946. Before that I would come down for meetings now and then. During that period I got a call from Sid Davidson telling me that he wanted to be the

administrative officer of the combined hospital with me being the overall boss. I told Sid that being the administrative officer was going to be my responsibility. I wasn't being asked to come down there as some top figurehead. I was going to run the show.

I also got a call from some of his board members wanting to be sure that I would give thought to keeping him on. My response to that was very simple. I said, "Hell, he's been here for years, he knows the territory. I am coming down as the new kid on the block. I will be delighted to have him as my chief deputy running Grace Hospital which is a mile away, but I am going to be running the overall show." They were perfectly satisfied with that.

The other deal I made was with the Yale Medical School and its Board of Permanent Officers. The Board is made up of the full professors. When you are a full professor at Yale you have tenure, both duration -- until you are 65 or 68 -- and salary. I wanted to be on a par with these other individuals -- the professors in medicine and anatomy and so on. Francis Blake and I had long discussions about that.

He said, "As far as I am concerned, Al, I would love to have you be a full professor and be part of this medical school but a full professorship means tenure from Yale. What if the hospital fired you? What are we going to do?"

I came up with the suggestion: "Why don't you appoint me professor of hospital administration and public health contingent upon my appointment as director of the hospital? Then you are safe. If you fire me from the hospital, I am done at the university." That was what was done. It turned out to be a helluva helpful way because I brought many salaried guys on the hospital payroll who were truly outstanding — the chairman of radiology, for

example, I paid his salary and he was a full professor contingent on his appointment at the hospital. I did that in anesthesiology, psychiatry, clinical pathology, and so on.

WEEKS:

When you went there you had a building program ahead of you? Grace was going to be replaced?

SNOKE:

Grace was an old ramshackle hospital a mile away. They had already started planning for a new unit next to the New Haven Hospital and that is what I became involved in even before I moved to New Haven. I started meeting with the planning committee made up of trustees and the medical staff. To my horror, I discovered that their original plans, of which they had actual sketches by the architect, Douglas Orr, was going to be the Grace unit. They called it the Memorial Unit. But it was really going to be a new Grace Hospital across the street from the existing New Haven Hospital, just connected by tunnel. It was going to have a separate kitchen, a separate record room, separate x-ray, separate operating rooms, separate emergency, separate outpatient, etc.

I don't know how I got away with it but I started laughing at them. I said, "For God's sake, you are supposed to be combining two hospitals. All you are doing is moving one hospital across the street from the other. There is no more combination than the man in the moon."

I met with the -- I shall never forget this -- chiefs of the university and the community services and most of the medical staff one evening on one of my trips to New Haven in the spring. I discussed the problem of expense of operation and the potential confusion. I said, "We should have one outpatient

clinic, one emergency. I don't know enough yet about the kitchen, et cetera."

The telling argument that I gave them was, "Okay you guys are all on a combined staff. You go see a patient, or you get a telephone call from a patient, and you tell them that you will see them in the emergency. How are you going to tell them, or how are you going to be sure the cab driver knows, which of our two emergencies you will appear at and where your patient will appear?"

In retrospect, I am amazed at the cooperation as a result of that meeting. I was able before I came down on April 14 and during the rest of the year, to get the planning committee and the medical staff to consider the planning of one hospital. I could not get everything I wanted but we did consider the institution with one administration, one hospital, and eventually one kitchen. I had to have two suites of operating rooms. You couldn't wheel people back and forth too much, and therefore x-ray at that time had to be in both places. The record rooms were combined, the emergency was one place, the outpatient was one place. It was still a clumsy arrangement because we still had two hospital buildings -- separated by a street. There was also the problem of separate clinical services. The seventh floor of the new building was community medicine. Dr. Theodore Evans was the Grace Hospital chief of medicine and he brought his own residents from Grace. There was also the university department of medicine in the New Haven unit. The Grace residents did not rotate with the university service. They were sort of pariahs.

I even had three medical boards. I had the university medical board of chiefs of service. I had the private medical board of the New Haven Hospital, who were the chiefs of the community physicians that the New Haven Hospital and the faculty had invited to have privileges. They were outstanding

community doctors. Then I had the medical board of the Grace Hospital from across town who were also top-flight. I went crazy because I would go from one medical board meeting to the other. I finally convinced them after about a year that they were driving me nuts and that we were being buried in meetings. So we agreed -- first to combine the two community groups and finally to have one medical board. This would be composed of the the chiefs of medicine, surgery, pediatrics, and obstetrics-gynecology from the university and the community medical staff. This made eight. We also had one psychiatrist, one radiologist, one anesthetist, one pathologist, and later, one from physical medicine. What I could not convince them was who should be the chairman. Each side was suspicious of the other so, for X number of years, the chairman of the medical board of the Grace-New Haven Community Hospital was Dr. A. Snoke, the director of the hospital. I disapproved of it. I told them I disapproved, that I should be on the overall medical board, but not the chairman. It was not until they were able to agree to have a chief of staff, and we selected a very able man, that they were willing to have that chief of staff become the chairman of the medical board. My being chairman of the medical board for a number of years is perhaps a measure of the cooperation and the interpersonal relationships between me and the several chiefs of services. I was successful in having one combined and rotating resident staff within a year.

WEEKS:

Aside from trying to combine the services of the two buildings, you had to go through quite a planning process, didn't you?

SNOKE:

Yes, I did. I was able to get combined pediatrics in the New Haven

Hospital, because Grover Powers was acknowledged as the great pediatrician of that region. They all respected him. There was no competition.

As far as obstetrics was concerned, there was no problem about having all of obstetrics in the new building. They insisted however that there be a separation of community and of university services. The Memorial unit was X shape with separate delivery rooms and labor rooms in each wing but with a common nursing station. They insisted that one wing would be used to deliver the university service patients and that the other wing would be for the community patients. I said okay, but I knew damned well what would happen, and it did happen within a month. While we talked about the university obstetric services and the community obstetric service -- in practice, we had the obstetrics service. A woman would go into either wing wherever there was an empty labor or delivery room and the nurses ran it as one unit. We did have a university obstetrical patient floor and a separate community patient floor -- but the delivery suite functioned as one.

WEEKS:

As far as the ownership of the hospitals...

SNOKE:

It was a completely separate and independent community hospital that was the responsibility of the board of the Grace-New Haven Community Hospital.

WEEKS:

The arrangement with the university was just an arrangement?

SNOKE:

The arrangement with the university was based upon a series of contracts developed by the university and the hospital over a series of years -- with relatively little consistency or overall master planning. The whole block of

land between Howard Avenue and Cedar Street was owned by the hospital. But all the medical school buildings and about half of the hospital buildings on that block had been financed by Yale, were owned by Yale, but at the end of a 99 year lease, all buildings would revert to the hospital, because the hospital owned the land upon which they were built. This included the medical school clinical offices and research laboratories, and all of pathology and microbiology. The only thing really owned by the university were the pre-clinical buildings across Cedar Street on land that the university owned. The principles of this arrangement were developed around 1914, and this was one of my first problems to solve when I came in 1946 -- the land and building interrelationships between the university and the hospital.

There were two other problems. The first one I have already mentioned -- Yale insisted upon having ward beds for teaching. Part of the university contract was that the hospital had to provide from 250 to 300 ward beds for "teaching material." In return for the provision of the ward beds, the university had agreed to contribute up to approximately $206,000 a year toward the hospital's deficit.

The other problem came to light when the university brought Dr. George B. Darling, who had been president of the W.K. Kellogg Foundation at one time, as Director of Medical Affairs. When Darling came in August, I had already learned that the hospital board wanted more than $206,000 subsidy from the university, and that the university was wanting to cut it out completely. I didn't learn, nor did George until after he came -- I guess we learned together -- that there were serious conversations in the Yale Corporation about either closing the Yale Medical School or cutting it back to a two-year program because of this $206,000 subsidy to the hospital. That was a lot of

money in those days.

Then to my horror, I found that not only was I getting up to $206,000 a year in cash from Yale, but Yale was operating the x-ray department, the laboratories, and the pathology department, and paying for all of this because they considered them university departments. However, the hospital was billing and collecting the income. I went to see George Darling in shock one day, because our problem was not around a $206,000 Yale subsidy -- but approximately $500,000.

This has been discussed in more detail in the chapter on teaching hospitals of my 1987 book.

As I recall this episode, some 40 years later, I still am surprised and grateful that my board was willing to listen to me — a young newcomer on the block -- and to back me up. I told the board that I thought we should not expect Yale to use its educational funds to support patient care, and that Yale should not require the hospital to admit X-number of ward patients for teaching. I said that I felt we should face fairly the fact that we should be a self-supporting hospital, and that we should be paid by Yale only for those things that we could identify as educational and research expenses. The board accepted the principles despite a recommendation from a prestigious consulting firm that Yale should pay more subsidy. The board even challenged the consulting firm, and received a refund of a substantial part of its fee.

George Darling and I, along with the new dean of the medical school, Dr. C.N.H. Long, worked out an agreement by which, over a period of five years, we cut back the subsidies $50,000 a year. This was the Yale deficit cash subsidy, and in addition, the hospital took over the service departments, paid the expenses, and received the income.

The only way we were able to do this was that Yale agreed that the hospital would provide teaching beds or ward beds only to the limit of its financial capacity, and the medical school started doing what Rochester had done years before, using private and semi-private patients for teaching.

My other life saver was in being able to have the hospital be paid the cost for the care of welfare patients. About 25% to 30% of my patients were on welfare, the largest percentage of any hospital in the state. The other major city in Connecticut was Hartford, and it had a municipal hospital that cared for most of its welfare patients at that time. I had two or three times the percentage and numbers of welfare patients than any other hospital in Connecticut. The state was paying $5.00 a day, and my costs were $10.00. This is a story in itself, and I will discuss later how I was able to obtain payment at cost for these patients. If it had not been done in the late '40s and early '50s, the hospital could not have existed as a community and teaching hospital, and I would not have been able to have changed our contract with Yale.

In 1952 or 1953, the hospital and Yale made a major contractual change. George Darling and I worked this out so that the old 99 year lease arrangement was discontinued. We drew a line through the block, so that the land upon which Yale had built the buildings housing pathology, microbiology, surgery, obstetrics and gynecology was now owned by Yale. The hospital owned the rest of the block, and got full title to the patient care units, Tompkins, Fitkin, and the Clinic Service building that Yale had previously owned on the hospital property. There were still Yale buildings on hospital property, but we made provision for their complete ownership by Yale where it seemed appropriate.

There was an indirect effect that I didn't realize until later. As we

had developed our cost reimbursement formulae, depreciation was an item of cost. I could not include depreciation as a cost for the Tompkins and Fitkin buildings because we didn't own them. When we legally owned them, we were able to put the depreciation of these buildings as a cost item in our reimbursement formula. It helped us considerably.

WEEKS:

Did you fund it?

SNOKE:

We couldn't. We had to use the case for our accounts payable and for our deficit. Many of the Connecticut hospitals funded depreciation. I think Yale-New Haven Hospital does now. I don't think that we were ever able to fund depreciation. It was an expensive hospital to operate and to function as a teaching hospital. While we had a large number of patients that were welfare and we eventually were able to recover our cost, many were ineligible for welfare but still couldn't pay their hospital bill. They were what we termed medically indigent. The guy has a job and everything is fine until there is a serious illness, especially if it is him. I used to sweat blood over the problem.

WEEKS:

One thing that has occurred to me here is that you avoided one major problem, at least. Most of the university-owned medical centers have problems between the hospital and the medical school. This is one of the perennial problems. You avoided that somewhat by having your ownership separated. The university medical school, even if it owned some of the facilities, it didn't own all of them. How about the relationship between the medical school and your hospital over residents and any other kind of health labor that went from

the university into the medical center?

SNOKE:

Financial relationships between the medical school and the hospital were a continuing process. I think I had certain principles that I had gathered back in Strong Memorial. As I mentioned earlier, we had a contract with the City of Rochester, by which the city would share hospital expenses according to the percentage of patients in each institution. Basil MacLean and I worked like hell to be sure that we were not charging the city for things we shouldn't. I believe that I was always checking conscientiously on the need to be fair in allocating costs or assuming responsibility for activities in the medical center that were appropriate -- either for the hospital or the medical school.

Beyond that, there was a personal interrelationship, in which I was lucky, because George Darling and I had been brought to New Haven new, and at about the same time. Fortunately, we both liked and trusted each other. The same situation existed between me and the medical school deans -- Francis Blake and C.N.H. Long, who functioned as part-time deans, and then Vernon Lippard, who came on as the first full-time dean of the medical school.

I will give you an example of why I felt my working relationships with the administration of the university were satisfactory. The medical school and the university would pay the hospital's annual operating deficit up to $206,000 a year. The hospital would calculate the deficit at the end of the year, and would report this to the university. If the deficit were only $197,000, the university would then pay that amount. I suddenly realized after I had been there a year or so, when I was talking with the hospital controller in some idle conversation, that the hospital was putting in an

expense item of 6% of our charges as bad debt. I remarked to my controller at the time, "We are not doing a very good job if we have a 6% bad debt experience."

He said, "Oh, that's what we are charging in our expense statement. We actually collect 4% of this back during the ensuing year."

I said, "We put in our expense of operation for the hospital each year an item of 6% for bad debts. If our patient charges amounted to a million dollars during this period, 6% appears as an expense of $60,000?"

He said, "Yeah."

I said, "But we get back four percent. Is that offset?"

He said, "No, that is put in as miscellaneous income."

I was appalled. I went over and told George Darling. I said, "George, you are paying us six percent as a bad debt expense and we have been charging this year after year, when the actual net expense is only two percent. I don't know how many thousand dollars a year we got out of the university that have later been recovered. And we have never told you about it."

He said, "What are you going to do?"

I said, "I have stopped it as of now." Then I waited for him to ask about what we were going to do about the previous years. He didn't say anything, and I didn't say anything. He is now retired and he and I were talking about this a few months ago.

I said to him, "Why in hell didn't you try to get that money back? You needed it."

He said, "Al, you and I both knew that neither of us was responsible for that. You found it out and you came and told me about it. You told me you were stopping it. I thought you were not at fault. You are changing it,

we'll go on from there.

This was an example of the type of interpersonal relationships that we had. I think we were damned lucky.

WEEKS:

I believe here at Michigan there is a strain between the medical school and the hospital administration.

SNOKE:

I don't know about Michigan, but there are many academic centers in which the relationship between the university, the medical school, and the hospital administration have real problems. If I were to stick my neck out as to the best relationship between the universities and their teaching hospitals, it would be where there is a distinct separation, such as exists with MGH and Harvard, Johns Hopkins Hospital and the University, Presbyterian Hospital and Columbia, Yale and Yale-New Haven, Lakeside and Case-Western Reserve, and Barnes Hospital and Washington University at St. Louis. There are varying mechanisms by which you can do these things, but essentially they are two equal partners.

Of course there are many medical centers that are owned entirely by the university or by a political entity, such as a state. In these places, you have a dean, you have a director of the hospital, and maybe a director, vice president or chancellor of health or medical affairs. Very frequently, the director of medical affairs is also the dean. The inter-politics then is such that the director of the hospital may be subordinated to be merely the superintendent of the hotel services of the hospital. Some medical centers work beautifully under these arrangements — others are frequently in turmoil because academia, quite understandably, may have top priority. I personally

think that service to patients and the community is equally important.

WEEKS:

I think you have the answer in separate corporations.

SNOKE:

At a minimum -- having separate boards. In my case, I was responsible to my board, the dean was responsible to the President of the university and to the Vice President for Medical Affairs. We were able to work together.

WEEKS:

What was Darling's official title again?

SNOKE:

Darling came there as Director of Medical Affairs. This was a new position at Yale. I always teased him. I said that President Charles Seymour, and Dean Francis Blake, thought they couldn't counteract Snoke, so they had to bring in a full-time Darling as well, to protect Yale.

There was a certain value, because he was a full-time individual, responsible to the President of the University for the administration of medical affairs. Prior to 1946, Yale had had part-time deans, Winternitz, Bayne-Jones, Blake, and Long -- professors and chairmen of the academic departments of pathology, bacteriology, medicine, and physiology. By 1952, Yale decided to get a full-time dean. They selected Dr. Vernon Lippard, a Yale graduate, who was at that time full-time dean of the medical school at the University of Virginia. President Whitney Griswold offered him the position, and he accepted, with the understanding that he would report directly to the President of the University and there would be no Director of Medical Affairs. President Griswold agreed, and it was done. George Darling, who from 1946 to 1953 had been essentially a university vice president, thus

became a tenured professor in public health (human ecology).

As a result, George Darling spent two or three years as a full Professor of Human Ecology, and then was offered the job to go to the Atomic Bomb Casualty Commission in Japan for one year. It turned out to be 15 years. Darling was one of the very few Ivy League professors, who was given such an extended tenure by the university. I learned later that it was because the United States Ambassador to Japan and the scientific community in Washington and throughout the country felt that he was doing such a fine job in a sensitive and most important enterprise.

I did not learn until years later of two other things George Darling had done that not only affected my hospital, but academic health centers throughout the country. In the early fifties, he had written an article in the Atlantic Monthly, recommending that there be governmentally supported research beds in university teaching hospitals throughout the country, rather than just at the Clinical Center at Bethesda. I had helped Dr. Jack Masur plan the Clinical Center at Bethesda in the 1940s. In the 1950s, Drs. Jack Masur, Russell Nelson, and I had helped develop the initial reimbursement mechanism to the teaching hospitals so that the Public Health Service could pay for the cost of these research bed units. I haven't the slightest idea what influence Dr. Darling's Atlantic Monthly article had on the development of the program -- but I thanked him profusely for his pioneering thinking years later. George Darling's second contribution was much more meaningful to medical schools throughout this country. After coming to Yale, he shortly realized that all the research grants that the medical school was getting were not an unalloyed joy. The grants were being given to specific professors or departments. Thus, the professor of pharmacology, for example, would have X-

number of technicians who would be paid so much an hour according to the Yale salary scale. However, when he received a research grant, the professor would then have Y-number of technicians doing exactly the same work, and theoretically having exactly the same responsibilities, to whom he could pay a much higher salary, because he could do what he pleased with the money. The varying scales and perquisites were playing hob with the personnel programs of the universities. Darling also got the idea that there was nothing available for the increasing costs of overhead that inevitably resulted when the university received major research grants. As a result, George Darling thought that not only should the research grants be given directly to the university, but that certain added percentages should be given to cover the necessary overhead. He sold this idea to Basil O'Connor of the Foundation for Infantile Paralysis, and as far as he knows or I know, the first overhead grant to any medical school or university for research was one that he obtained from Basil O'Connor for polio.

WEEKS:

You knew he was a former partner of Franklin Delano Roosevelt, didn't you?

SNOKE:

No. I suppose that is how he became chairman of the polio foundation.

It would be interesting to know just how much truth there is to this tale of research grants and overhead -- but there isn't any question but that the amount of money that came to educational institutions as overhead has grown to a tremendous amount. I only hope that its value has been commensurate to the discoveries that the research grants were supposed to produce.

NOTE: On showing a draft of this manuscript to Dr. Darling in April, 1987, he told me more of the occurrences in 1950. Darling had given me a reprint of his article in the Atlantic Monthly of June, 1950, some years ago, and I had referred to this in my chapter on teaching hospitals in my book of 1987. Dr. Darling recalled that in 1950 President Charles Seymour of Yale University, without consulting him, had quietly arranged to obtain several hundred of the reprints of the article after it appeared. He then sent them personally to the presidents of all the universities having medical schools in this country. He sent a sufficient number to each university president -- so that copies could be given to their university trustees, to the faculty of their medical schools, and to representatives of the boards and administration of their teaching hospitals.

Darling's article emphasized the necessity for welfare payments to cover the cost of the care of the welfare patients (which had been my primary concern during the previous four years); the need for governmental financing of research beds in the teaching hospitals; and the payment of overhead for research grants to the universities. As far as George Darling and I can figure out, neither President Seymour, Darling nor I received a thin dime for our ideas or efforts -- but at least, we can say, "you are welcome," to the many recipients of the additional income received over the past 35-plus years.

WEEKS:

Did anything change in the Medical Center after Darling left?

SNOKE:

Yes, but I think it was a matter of pace and of changing times as much as it was individuals. Vernon Lippard was a different type of a person -- much more conservative, but a quiet gentleman. We were friends -- even though I am

sure I bothered him at times by pushing ahead on something that he wasn't sure should be done so quickly.

I must say that he truly impressed me when we had a vacancy in the Department of Public Health in Medical Care, because Dr. Franz Goldmann had gone to Harvard. I suggested Isidore Falk be invited to be a full professor at Yale. Falk was the epitome of the liberal in health care in this country, and was an anathema to organized medicine. In spite of this, Vernon endorsed his appointment as well as that of a later recommendation of mine, Dr. Richard Weinerman in Ambulatory Services and Public Health -- where Dr. Weinerman was also far from being a conservative. I was proud of being able to bring both Falk and Weinerman to Yale, and pleased that Vernon Lippard supported them for their academic positions.

Of course, Yale Medical School always had its combination of liberals and conservatives, as well as top-flight academicians, and that is why I enjoyed the atmosphere. I was lucky to have come in 1946, for I had the opportunity of meeting many of those who had participated in the renaissance of the Medical School, and in turn, the New Haven Hospital -- starting with Winford Smith's consultation in 1917-18.

I came to know Annie Goodrich, the first Dean of the Yale School of Nursing, and one of the greatest women in nursing I have ever met. The two subsequent deans, Effie Taylor and Elizabeth Bixler, were also powerhouses -- and Miss Bixler particularly stimulated my recognition of the value of nurses.

I was also fortunate that C.E.A. Winslow and his wife were still alive, and I got to know them. This was the first time I learned that public health was something more than being concerned with activated sludge or with the pasteurization of milk. Drs. Winslow and Ira Hiscock introduced me to the

fact that public health was really concerned with "people care" in the overall community and social environment.

Then Winternitz. Winternitz was perhaps the most misunderstood or suspected person on the faculty. He had been brought there to remake the Medical School, following the consultation of Dr. Winford Smith. Winternitz, who was in pathology at Hopkins, was appointed dean, and his charge was to reorganize the Medical School and to develop a full-time faculty. This he did over the years, and the result was a highly respected, full-time faculty, and a relatively modern hospital by the time I arrived in 1946.

However, Winternitz was by no means a gentle, diplomatic individual. He was a needling Wasp and the faculty had revolted to a certain extent, so that in the mid-thirties, he was deposed as dean and Dr. Bayne-Jones, the Chairman of the Department of Microbiology, was appointed part-time dean in his place.

I was lucky that Winter had mellowed by the time I had come -- although I still encountered evidences of his single-minded pushing ahead on things that he believed in. I felt him to be the most knowledgeable individual on the faculty in overall social and health care -- he just wanted to see that things would get done, and didn't worry too much about how they were accomplished. Fascinating stories are told about his early actions, when he came as dean, and they are typical of the Winternitz saga. I believe they are true -- they sound like Winternitz — and I heard them from varying sources.

One story I particularly enjoyed was when Milton Winternitz had arrived after being appointed dean, he asked his secretary, Lottie Bishop, "How many medical students do we have in the entering class?"

Miss Bishop said, "Doctor Winternitz, we don't have any. We have nine applications, but nobody has accepted the school."

"Well," said Winternitz, "send each one a telegram saying 'You have been admitted to Yale Medical School, you have one week to answer before we go on to other individuals. Please wire reply.'"

WEEKS:

Why did the Grace-New Haven Hospital become the Yale-New Haven Hospital?

SNOKE:

As I look back upon the development of the institution, it seems to have been a logical and inevitable progression. In 1946, the Grace Hospital plant was in terrible condition, and in comparison, the New Haven Hospital was wonderful. However, when the Memorial Unit was completed in 1953, it was so new and modern that the New Haven Unit almost immediately seemed cramped and second-rate. And there was justification, for most of the buildings had been built around 1933. So I started in the late fifties to plan for the remodeling of the New Haven Unit. I brought in the architectural firm of Perkins & Will -- particularly, my old friend Todd Wheeler, who I thought was one of the best hospital architects I had ever worked with, and we started developing a plan for the entire institution. I had raised the question back in 1946 about having everything in one building in one block, rather than having it across the street. MacLean came down and spent three days and agreed with me that it would be much more economical to do so. But my board wouldn't consider his advice.

They said, "What did you pay him in consultation?"

I said, "Nothing. He's a friend of mine."

WEEKS:

Free advice isn't worth much.

SNOKE:

That's right. As a result, we had the two units of the hospital separated by an old Catholic church and a street, so that it had to be connected by tunnel, and was admittedly more expensive to operate -- even though we had combined many units and divisions wherever possible.

After considerable planning, we came up with a master plan for the hospital that was estimated to cost $35 million for construction. I went to Dean Lippard and Kingman Brewster, then President of Yale University, and described the hospital planning and the estimated cost. I said, "We never in the world could raise $35 million. The medical school has been exploring various possibilities for expansion and remodeling, and my guess is that this will be in the range of many millions also. How about the University and the hospital going after a major combined amount for the Medical Center?" We had already developed a corporation of the Yale-New Haven Medical Center for joint fund-raising, and it seemed appropriate that this might be the vehicle for a combined fund-raising campaign.

Kingman Brewster thought this was a good idea, and asked that the Dean and I work out a joint program and a joint estimate.

After considerable planning and discussion, we came up with a combined package of about $80 million for the Yale-New Haven Medical Center -- for buildings and endowment. A committee was then formed, made up of the president, the dean, the treasurer, and the legal counsel for the university, and the president of the hospital board, myself, the chief of the medical staff (Dr. Courtney Bishop), and the legal council for the hospital.

Our first decision was relatively easy, and that was that we should go out in the name of the Yale-New Haven Medical Center.

The next problem was also relatively easily solved, and that was the name of the hospital. Kingman Brewster very logically pointed out that Yale University would have considerable difficulty going to alumni around the country asking them to contribute to a major fund drive, when half of it would be going to the Grace-New Haven Community Hospital.

I agreed, and so did the other representatives of the hospital, and Yale-New Haven Hospital was the number one choice.

The next issue was a little more complicated, but also relatively easily resolved. This was the matter of governance. Kingman pointed out that a board of 80 was unwieldy in the first place, and to have only two representatives from Yale on it would seem a little overbalanced. He and I had talked earlier about having a smaller board, and I had pipe-dreamed about the hospital attracting prominent industrial and political people from around the state, because I felt that our hospital was far more than just a local community institution. We settled on a board of 24, of which Yale would have the privilege of nominating one-third, and I can still recall my pleasure in this, because I felt that the prestige of Yale would obtain prominent wheels throughout Connecticut.

A more complicated problem was that of the medical staff. This was difficult because we had the university full-time chiefs of service, and we had the community group, and we were really a university teaching hospital, a community hospital, and a municipal hospital. And yet, the prominence of the institution did come from the Yale Medical School faculty, and our recruitment of resident staff was because of this relationship.

Dr. Bishop and I worked over a year on various alternatives, and finally came up with what we thought was a fair change in the medical staff bylaws,

which would give more authority to the Yale professors, but still preserve the input of the community chiefs. I know that Pete Bishop and I talked it over with our colleagues in both the medical school and in the community, and I frankly don't recall any substantive disagreement with this. However, some 20 years later, there was a two or three year battle between the community physicians and the university and the hospital, because they felt that the community physicians were being discriminated against, and I then learned that even in the early sixties a group of the community physicians had come to the hospital board and had protested against the new bylaws. Why I didn't know of this -- nor have any recollection, I haven't the slightest idea.

At any rate, the three points of: the name, the size of the hospital board with Yale appointing one-third, and the new bylaws were agreed upon, and in return, Yale University agreed to go out on the major campaign for the funds for the Yale-New Haven Medical Center.

This was done in 1965. We changed the name by legal steps. We changed the organization of the board, and we changed the medical staff bylaws. The development office of the university then appointed an individual, who was going to be in charge of the fund-raising plan for the $80 million, and he was given an office in the medical school.

I was mildly surprised and disappointed, when Kingman Brewster appointed the eight board members from Yale. The eight he appointed were the President, the Provost, the Secretary, the Treasurer, the Assistant Treasurer, and three members of the Yale Corporation who happened to live relatively close by, but who rarely came to the board meetings.

Our board meetings were interesting. A community representative was president of the board and presided, and I would sit next to the formally

elected secretary and keep the minutes. At the other end of the long table would be President Kingman Brewster. Our board meetings were primarily a discussion between Kingman Brewster and members of the community board, because as a rule the other Yale representatives would agree with their president. There really weren't any substantive arguments.

After about a year and a half, the individual who was the fund-raiser came over to see me and said, "I am quitting."

"Why?"

"We are not doing anything. They are not going to do anything as far as I can find out. I have laid out plan after plan, but nothing has happened."

Subsequently, Yale did start on a massive fund-raising program, but there was nothing in it as far as the hospital was concerned, and even the medical school was left out at that time. I was disappointed, and I fear that I showed this.

Along about this time, I got into a situation in which Kingman Brewster had a very legitimate gripe with me. Between the Memorial Unit and the New Haven Unit was a V-shaped plot on which was located a Catholic church, a Catholic school, and the home for the priests. This was St. John's Church, and I had gotten to know the monsignor who ran it, along with the young priests. We had become friends -- particularly after I brought on a hospital chaplain who started a school for hospital chaplains, and brought in Catholic priests, Jewish rabbis, as well as the various Protestant ministers for training.

When I started my original planning, it was still with the Catholic church on the V-shaped lot. While we were having our early negotiations over changing our university-hospital contract, Kingman Brewster told me, "I have

been talking with the archbishop in Hartford. He wants to get rid of that church. We have been talking about taking it over. What do you think of that? It would change the plans."

I said, "Yes, it sure would."

We discussed that idea in detail. A few days later I went over to see the monsignor about the planning that was going on and about taking over the church, school and so on. He said, "President Brewster never told me."

WEEKS:

The archbishop evidently didn't tell him either.

SNOKE:

So I discovered. I found out that I had told the head of the local church what the president of Yale and the archbishop were talking about. Kingman Brewster had told me and I had just taken it for granted the monsignor knew. Apparently he didn't and all hell broke loose.

All I could do was say, "I am sorry. I didn't know it was a secret. President Brewster told me and I was naturally interested because of what we would have to do in our planning." I can understand why this didn't endear me with Kingman Brewster at all.

WEEKS:

Was the building finally built?

SNOKE:

Yes. They tore down the church. The school was made into the Yale School of Nursing. The new hospital construction which was started years later makes the Yale-New Haven Hospital essentially one operating unit with only a few patient divisions and specialized radiology plus additional Yale medical services in the New Haven unit.

WEEKS:

Why did you leave Yale-New Haven Hospital?

SNOKE:

I suspect that there were all kinds of reasons -- some because of things I did or didn't do -- and some because Yale University and the hospital board felt that a change from A. Snoke to someone else would be more beneficial to the Medical Center.

I kept pushing for future programs and developments -- many of which I had watched enviously develop at MGH, Hopkins, Michael Reese, and Montefiore. I wanted to build a community doctors' office building near the hospital, a garage over the Oak Street Connector next to the hospital, an ambulatory treatment center with one day services for patients, which would be less expensive than coming into the hospital, a nearby motel or hotel, and a tie-in more closely with long-term health care facilities and home health agencies. Yale, at the same time, had plans for the entire campus, and this was closely related to planning developments in the city of New Haven.

I am sure that I kept pushing, and at times, I expect that the university felt that I was pushing too much and at the wrong time.

I know that I kept being bothered by the lack of Yale-New Haven Medical Center fund-raising program after the 1965 deal with Yale was made -- and I never seemed to be able to be diplomatically persuasive. In fact, I think that Charles Costello, the president of the hospital board, summed it up beautifully when he told me in exasperation one day, "Al, you have a genius for bringing up inappropriate things at the wrong time." Then Vernon Lippard retired as dean, and the individual whom I recommended to President Brewster as the next dean, Fritz Redlich, was appointed, and he told me within two

months of his assuming the deanship that he thought I was not a compatible person with whom he could work. He met subsequently with the president of the board, who eventually submitted a memorandum to the board of directors of which the opening paragraph says it all.

> At the request of Dean Redlich of the Yale Medical School, I met with him early in the month of November, 1967. He informed me that he had reluctantly come to the conclusion that he and Dr. Snoke were completely incompatible. He felt that it would be harmful to the best interests of the entire Medical Center if the relationship between him and Dr. Snoke continued.

I guess Dr. Redlich was correct, when he said we were incompatible, although there had never been any indication of this during the 15 or more years that we had worked together before. However, shortly after he was appointed dean, he was trying to get planning started for a neighborhood health center in an area near the hospital. He had appointed a committee of three to develop the preliminary plans. Nothing seemed to get accomplished. The three individuals he had appointed to the committee were all friends of mine: Dr. Richard Weinerman, Dr. Max Pepper, and his own executive officer -- a former student of mine -- Jack O'Connor. All three came to ask my advice at separate times -- and each told me the same story. Dean Redlich had talked with each of them separately; had asked them to serve on the committee; and had told each one of them separately that the person he was talking to was to be the chairman, and was to report back to the dean. Each individual asked my advice, because he wasn't getting cooperation from the other two.

When I heard this, I went over to see Fritz Redlich and asked him how in hell he thought he could get things accomplished by finagling with his associates and appointing each of the three chairman, without telling the others. Fritz did not like my needling. I guess perhaps we were incompatible.

As my wife, Parnie, remarked afterwards, "The divorce was messy, but the alimony satisfactory." My experience is not too different from many others in academic medical centers -- but I had twenty-two years of enjoyment, and helped develop a satisfying number of fine, young hospital and health administrators. And later, as I look back on my four years with the governor of Illinois as his Coordinator of Health Services -- which I have discussed in my 1987 book -- I had an experience that was unique, educating, and productive. I would never have had this experience otherwise.

WEEKS:

What I thought we could do was to go through the chronology, and then come back to different things like AHA. You mentioned your students in hospital administration. Is there anything more you would like to say about that?

SNOKE:

I covered much of this in the chapters of my 1987 book on "The Hospital Administrator" and "Education and Training of the Health Administrator." I am proud of a number of things about that program. By a unique coincidence, I was able to get the Kellogg Grant for the School of Hospital Administration to be given to Yale rather than Harvard -- after I had accepted the position in New Haven, but had not actually moved down. I confess that I have never been very apologetic to my Harvard friends in this regard.

The program in hospital administration and the students I worked with each year were major stimuli to me in recognizing that when we were educating individuals for hospital administration, we were really being concerned with health administration. I think that as I worked with the students, as well as my own staff, that the combinations were major factors in my recognizing that

we should be training students for "people care" and community health -- not just being innkeepers or bookkeepers.

I spent almost 22 years in seminars once a week, with a limited group of selected students, and I have been flattered over the comments I still get from my former students over the type of education they received in this manner. I brought them completely into my daily operations, and the only rule we had was confidentiality. They knew of problems that I was facing that day or the previous week, and they participated in working toward the solutions. I could not have existed in my administrative position in the hospital if they had not honored our confidential discussions. Frequently, I would present a specific problem and would get their opinions as to what should be done. Sometimes I would agree, and sometimes I wouldn't, but usually later I would bring back the results, and at times, I would eat crow, and sometimes it was the other way around.

I am also pleased that for the years I was there, my hospital was their immediate laboratory, and my administrative associates and my department heads were as open with them and as glad to assist them as I was. New Haven certainly was not unique in this relationship, but a number of programs throughout the country had to go outside their own medical center for their hospital laboratory.

Of course, I am proud of the students who went through the program. I think that many of them appreciated the potentials of a hospital caring for the patients as people -- even though marketing, advertising, competition, multi-corporations, and the bottom-line seem to be the primary concerns today.

WEEKS:

There was this point of contention by some people back in the forties and

fifties that a physician was needed as an administrator of a hospital.

SNOKE:

This is an issue that has come up repeatedly in this country and throughout the world. The Scots and the English administrators tried to get me into that battle in 1957, when I was President of the AHA, and attended the International Hospital Federation meeting in Lisbon. The Scottish hospitals were headed up by doctors, and most of the English hospitals were headed up by non-physicians, known as Group Secretaries. I refused to be drawn into that argument, for I knew that there were and are as many top-flight individuals who are Mr.'s in hospital administration as there are doctors -- in fact, a lot more damn good non-medical hospital administrators. I have repeatedly maintained that granting an M.D. degree does not automatically guarantee common sense or administrative ability any more than giving an individual a Master's or a Ph.D. in business guarantees the same qualities. In fact, I can recall talking with Scott Parker a few years ago about dealing with doctors when I was a hospital administrator, and remarking that the only thing that I felt was an advantage in having my M.D. degree was that it was easier to tell a doctor he was stupid or to tell him to go to hell.

WEEKS:

We want to talk about your AHA activities and possibly we can come back to your work in Illinois.

SNOKE:

My AHA activities started shortly after I became associated with Basil MacLean in 1937. It started to fade away formally after I left Yale-New Haven Hospital in 1967. Basil MacLean was the primary reason why I started becoming active in AHA. He sponsored me, and introduced me, and I am sure he is the

reason I was put on various AHA committees fairly early in my career. Most were on operational aspects of hospitals in the beginning. I still recall how important I felt to be chairman of a committee on standard insurance forms. I was asked to give a paper on this at an AHA convention in Atlantic City in 1943 or 1944. It was in a large auditorium, and I solemnly presented my paper to a huge audience of Tony Rourke, Jack Masur, and Roger DeBusk -- members of my committee -- and my wife, and no one else.

By the time I had gone down to New Haven in 1946, I was moving up in the hierarchy of the AHA and was Chairman of the Council on Hospital Planning and Plant Operation from 1945 to 1947. I enjoyed very much the work with the AHA in those days, for I felt that the various Councils and their committees were where the real action was. My first Council was concerned with the planning, operations, and construction of hospitals, and we started an accreditation program for hospital architects. This was a very educational experience for me because I had not met architects much before except for an occasional consultation with MacLean. I came to realize that there were dopey people in the architectural field, just as there were in hospital administration or anywhere else. But many of the architects were superb and the certification seemed to be of value at that time -- at least many applied.

The custom of the AHA at that time was to have the incoming president appoint the chairmen of the various Councils (Hospital Planning and Plant Operation, Professional Practice, Government Relations, Education, Prepayment and Reimbursement, etc.), and also appoint new individuals on the various Councils to replace those going off after their three-year term. The chairmen of the Councils made up the Coordinating Council that would meet with the board of directors of the AHA at regular intervals, and then the board would

have its own formal meeting.

In 1948, Graham Davis, the incoming president, came to me at the meeting and said, "I have to make my appointments of chairmen of the Councils, and I am going to drop you from the Planning Council, because you are a young man, and you will have plenty of chances in the future." So, although I had some committee appointments, I was off the Coordinating Council.

When Dr. Charles Wilinsky was appointed president of the AHA in 1951, he called me and asked if I would like to be appointed chairman of the Council on Prepayment and Reimbursement. Naturally, I accepted.

WEEKS:

Was this the second Council of which you were chairman?

SNOKE:

Yes. I was chairman of this Council in 1950-1951. It was an exciting and significant period. It is interesting that although the work of the Council was very important at that time, my most vivid recollection is that it was my next experience with Isidore Falk. My first had been with a "Young Turk" administrative group, in which I had had Sidney Garfield and Isidore Falk invited as guests.

The Council had the difficult assignment of developing the principles of reimbursement for hospitals that the American Hospital Association could present to the various third-party payors. In 1951, we invited representatives of every outfit we could think of to come to that meeting -- labor, Blue Cross, hospital associations, governmental agencies, etc. I don't believe we invited anyone from business or industry because they just didn't seem to give a damn about health costs back in those days. I have written in detail in my 1987 book in the chapter on "Reimbursement and Cost Containment"

about how I started out in this meeting. I had some very high-powered individuals of which Isidore Falk was just one. I was the chairman. The subject was principles of reimbursement to hospitals, which is a broad subject in itself. I found that I was up against a bunch of pros as far as parliamentary rules were concerned. After about a half an hour there were amendments and amendments to the amendments, points of order, rules of order, and all the rest of it. It was chaos.

Finally I said to the group, "I have one suggestion. We are not going to run by Robert's Rules of Order anymore. It's going to be the "Snoke's Rules of Order." I will introduce the subject. Then I will hear discussions. As long as there is discussion that makes sense, we will continue to have that discussion. When I have heard enough, I will then stop the discussion. Then we will have a recess while I write the motion. These are going to be the "Snoke Rules of Order." If you don't like them, you can go home, and if you don't agree, I am going to go home. To my amazement they accepted it. We spent two days and Falk was in the thick of it -- being most helpful. Before that he had been challenging everything. Now he was cooperative.

In two days we had a preliminary draft which we distributed to everybody we could think of. We had a second meeting in January 1953, and came up with the final principles of reimbursement that the AHA formally adopted in September 1953.

WEEKS:

Could you briefly say what that was?

SNOKE:

It was the statement on the principles of cost for reimbursement, in which depreciation was a specific item to be included. It followed the formal

chart of accounts that Rorem and MacLean had developed years earlier. Essentially, it was a reimbursement to hospitals on the basis of their costs. As I recall, there was only one big battle during the two sessions, and that was what should be paid to Catholic hospitals for the services of the Sisters, who usually received only their living. Father McGowan led the battle for the cost formula to include the equivalent of what other hospitals would pay for similar services. There was some bitter opposition to this. This recommendation was finally approved, so that if the regular salary for a hospital administrator was $20,000 a year, the Catholic hospitals put in their cost formula that amount for the Sister administrator.

Everybody was pleased. As I wrote in my book, we had a dinner at the end. Everybody was congratulating everybody else. Then McGowan got up and gave a long, flowery speech about what a wonderful job I had done in the two meetings and what a wonderful thing had come out of it. They had a present for me. I was handed an elaborately wrapped package. My wife and I knew exactly what it was. When I opened it up it was a copy of Robert's Rules of Order.

I have emphasized this episode because of its importance to hospital costs and reimbursement, particularly at the present time. Basil MacLean and I had many conversations about the principles of cost reimbursement, starting in 1947, when I was in such serious financial difficulties at the Grace-New Haven Community Hospital, as I have discussed in my chapter on reimbursement in my 1987 book. Because of the low payment by the state and local welfare departments for the hospitalization of welfare patients, I had gone to the governor of Connecticut in 1947 and 1948 and explained our situation. He appointed a committee. That committee eventually came up with a legislative

bill in 1949. The committee was made up of the commissioners of finance, welfare and health, and a layman who happened to be a trustee of New Britain Memorial. He and I are the only ones around at the present time and we recently discussed the episode. He believes the only reason he was picked was because he was with the only voluntary hospital in Connecticut that was making money off what the state was paying. All the rest were losing.

We came up with a formula by which the hospital would be paid their cost according to the Chart of Accounts of the American Hospital Association as developed by Rorem and MacLean. This was written into the law. Our Connecticut procedure was to first have our own auditors review the costs, then they would be given to the Connecticut Hospital Association for a second formal review. The law provided for the formation of a Hospital Cost Commission, made up of the state commissioners of health, welfare, and finance. I think it was just those three. The Commission had a small staff which would review our audited figures as submitted by the CHA. This was a straightforward Connecticut development, but all the time I was consulting with my friends in Massachusetts, New York State, and Maryland. We traded ideas back and forth. To my knowledge, this was the first law formally passed by any state relative to payment of costs for health care. Section 276A of the Connecticut Public Act of 1949 was probably the first legal requirement that such type of payments should be "costs or charges -- whatever was lowest."

WEEKS:

Did your Council of Teaching Hospitals come about through this?

SNOKE:

No. This was a personal, working relationship between friends in the

hospitals in the other states.

The law, when passed, provided for payment at $10 a day for two years, and only then according to the cost accounting system, because it would take some time for the hospitals to tool up. I was impressed with how seriously the state hospital association took its responsibilities. I sat in on meetings in which the CHA gave me hell because I had done something wrong, and I would have to go back and correct it. Other hospitals would make mistakes and the CHA wouldn't certify them. They were hard-nosed as far as the auditing was concerned, but it was their responsibility.

Basil MacLean and I knew that my hospital could not have survived if we had not been paid our costs. we worked like hell to keep our costs down. However, we agreed that there was potential dynamite in the principle of payment of costs. It is all right as long as you have 30% or 40% or 50% of your patients being paid on a cost basis. But what happens when it gets to be 70% or 80%? What is the incentive for economy? Basil recognized that and so did I. Somebody would come in, for example, and want to hire a new physical therapist. You could argue against it. On the other hand, if 60% or 70% of the cost were going to be paid by the third party, so what? This is one thing that developed into a weakness. At the time hospital costs were not out of line, we had not gotten all the new, fancy equipment, and so on. We could not have survived if we did not receive our costs, and part of it again was the bad debts and free care.

WEEKS:

What happened to you and AHA next?

SNOKE:

I was appointed to be chairman of the Council on Professional Practice in

1951, and that was probably as interesting a time as I had yet had in the AHA. However, during that period, about 1954, George Bugbee decided to go to another job at the Health Information Foundation, and so they were searching for a successor to Bugbee. The committee was Father McGowan from Washington, DC, Ritz Heerman of Los Angeles, and Ed Crosby, who at this time was the head of the Joint Commission on Accreditation of Hospitals. They asked me to come and they spent about a week laboring on me to take Bugbee's job. I was flattered, of course. Ed by this time had a home in Winnetka and there was this fancy New Trier High School that was most attractive for my boys. I talked with Parnie about this, but my own feeling which I expressed to Ed was, "Ed, you should be the executive director of the American Hospital Association. You have a temperament that can put up with stupid guys as well as smart guys, while I don't think I have. Also, you are already here in Chicago. I think you ought to be the director."

Ed took the job at AHA. To my knowledge Ed Crosby, Russell Nelson, and I are the only three presidents of the AHA who were not members of the board of trustees. Each of us came from being the chairman of a Council directly to president-elect. I have been criticized because someone felt I should have been on the board. I don't brag about it. I can only say that to me in those days the Coordinating Council made up of the various council chairmen, and the councils themselves were where the real thinking and the real activity of AHA seemed to be going on. We, in turn, would have our subcommittees, then our councils would make recommendations, and then we in the Coordinating Council would bring our opinions to the board. The most exciting responsibility to me was being chairman of the Council on Professional Practice. I had direct dealings with the AMA, and with organized nursing and dentistry. Whereas the

board was one step isolated. Also -- and this is blasphemy as far as the present AHA is concerned, and I know many of the present day great minds would disagree with me -- the board would get, or make, the recommendations which they would bring to the AHA House of Delegates and -- horror of horrors -- the House of Delegates would actually participate in the discussion. The minutes of the House of Delegates back in those days were fantastically more interesting. They are pretty bland today. I have heard more than one member of the House of Delegates say, "This is the most boring session I ever attended."

WEEKS:

They don't make any decisions in the House of Delegates?

SNOKE:

I suppose you can say they make the final decisions, but they seem to have been made beforehand. They are discussed by the board, they are discussed by the RABs. A representative from each of the RABs is on the board. So the House of Delegates today -- they can say it is not a rubber stamp -- but the record does not show very much that they ever do. This is where I must emphasize that this is none of my business for I do not know enough about the problems today. I must say that I enjoyed being on a committee when I was younger. I enjoyed being chairman of a council and being part of the Coordinating Council and meeting with the board. I refused several times to become a member of the board because I was having more fun as a council chairman and also felt I was accomplishing more.

They offered me the post of president-elect in 1955. I thanked them and I said, "I can't take it because I have my own job in New Haven. I know it takes time away from the hospital and I don't have an executive officer who

can run my shop. I hope you will ask me next year because I am going to get somebody." So I did. It was John Law. I was flattered that they took my "no" and then came back the next year and asked me again.

Then I learned that the president, the past president, and the president-elect would meet to choose where they wanted to go to the various hospital meetings throughout the country or to the International Hospital Federation meetings. I frankly didn't give a damn. I wanted to go to the New England Hospital Assembly, I wanted to go out to the West Coast, but I could easily be argued out of it. So, the first year when I was president-elect the other two guys had priority. I just sat back and whatever they wanted they got. They were Frank Bradley and Ray Brown -- they both loved to go to meetings. Then when I was president, I stuck my neck out for those meetings I wanted. I went to the International Hospital Federation in Lisbon, and to the Western Hospital Association, the New England Hospital Assembly and on a few others. I tried to cover the rest of the country the next year when I was past president. I liked to go where I could see people. It was very interesting to note the difference in attitude of the different groups throughout the country. The New England Hospital Assembly was really organized so that when the president came to town he was met, and almost his whole schedule was lined up for him. He wasn't left alone. In some of the other regional groups, my wife and I would arrive, we would check into the hotel where there was at least a reservation for us. I would go over and speak the next day and then go home. It was the difference between black and white, but it was fun anyway.

Those were exciting days as far as my AHA life was concerned. I thought they were exciting because of my opportunities to be on the various committees

and councils in an active role as well as in the executive positions, as contrasted to what seemed to me to be a passive role on the board. Today, there is an entirely different situation. It is highly inappropriate for me to talk about the "good old days," as compared to what I do not know of the present problems. All I can say is that I appreciate the generosity of the AHA inviting the past presidents and chairmen to the conventions and the meetings of the House of Delegates. However, once you are introduced at the beginning of the meeting -- the rest is rather pro forma. It is rare that any members of the House of Delegates have gotten up and argued about a damn thing. I will never forget when one of the past presidents got up to make an observation. It couldn't have fallen with a duller thud. You don't see any of the ancient or not so ancient mariners getting up to the microphone to make any profound statement since George Graham did it a number of years ago, and was received with polite indifference.

I compare this with the time when I was chairman of the Council on Professional Practice and brought in a recommendation on diploma schools of nursing. One of my best friends, William Wilson, who was running the Mary Hitchcock Hospital at Hanover and was in the House of Delegates, got up and argued against me. The more he argued against me, the more I agreed with him. When he recommended that this thing be sent back to the council for study, I endorsed it. Afterwards he came up very embarrassed because he had challenged me in public. Hell's fire, I learned from what Bill was saying. You can say you could get that out of the RAB, but Bill Wilson was telling me something I hadn't got otherwise. I bought it and we came back the next year with a hell of a lot better recommendation.

The International Hospital Federation meetings were excellent

experiences. I was lucky to be able to go to Lisbon. I don't remember meeting Miles Hardie there, but another Englishman by the name of Ives was running the International Hospital Federation at that time. He was an impressive individual, and I enjoyed seeing him later, when my wife and I went over to study the British Health System around 1967. We were helped immensely by what I think was called the King Edward's Fund.

WEEKS:

King Edward's Hospital Fund for London.

SNOKE:

Miles Hardie was the head of their hospital center. I have high regard for him.

WEEKS:

I do.

SNOKE:

He was becoming a little bit dissatisfied with that job there. He came to Chicago, while I was working with the governor, about the possibility of coming and working in this country in the health world and in the hospital world. The more I talked with him and his friend, Dr. Freeark, who was his host, and is now Professor of Surgery at Loyola, the more skeptical I was of Miles Hardie coming to Illinois. I was very honest, when I said, "I would like to have you come and work with me in the State of Illinois, but I would be the first guy to advise you not to come because you represent the British Health System. No matter what you say, you will be regarded with suspicion by the Illinois State Medical Society and the AMA. I think your throat would be cut whatever you did. For God's sake, stay away from any political thing in the health business in this country. I think others told him the same thing.

WEEKS:

When was Ives head of the International Hospital Federation?

SNOKE:

He was the Executive Director in 1957. Then some years later he was in a major train wreck in which several hundred persons were injured in England. He had some serious injuries and had to retire. I am sorry, because he was a valuable man, but Miles Hardie has made a substantial contribution since he took over.

WEEKS:

Do you want to say anything about your activities in the AHA?

SNOKE:

As far as the AHA was concerned, I think that Ed Crosby had his own way of running things. It was a fascinating twenty-year span. This was the time of the battles over the salaried physicians -- particularly the hospital-based specialties -- ethics, the Hess Committee, the Attorney Generals' opinions on the corporate practice of medicine, and group practice. I was in all of this, first through my Council on Professional Practice, then through the AHA hierarchy, and later because of personal involvement. I had battles with pathologists, particularly two in the Midwest. They led the battle for fee-for-service. They were the radiologists. I was in on that with major battles with the head of the American College of Radiology, Dr. Vincent Archer, and later Dr. Harry Garland. For some reason I seemed to be in the forefront of these things. One of my chapters in my 1987 book is on the "Salaried Physician" in which I discuss the issues, and the battles I had.

One of the most interesting was the Iowa Trial. Originally, the Attorney General from Iowa ruled that a hospital paying a doctor a salary and

collecting for his services was the corporate practice of medicine, and was unethical and illegal. It so happened they didn't have any physicians in the Iowa hospitals on salary, they were all on some kind of a fee-for-service from which they got a percentage of the net or gross. However, organized medicine had got the Iowa Attorney General to rule that it was illegal for a hospital to pay a doctor a salary, with the hospital then collecting fees for his services. The Iowa Hospital Association decided to fight this in court, although nobody said anything about the University of Iowa Medical School full-time faculty, the VA, or other full-time medical physicians.

Donald Cordes and his colleagues asked advice from me, and the Council on Professional Practice. Dwight Barnett and I, along with some other wheels of the AHA, met with the brass of the AMA and the Iowa people. This was the time when Walter Martin was the president of the AMA. He was a true gentleman. But his only contribution was, "I think all of you folks ought to go back and start all over again."

The Iowa Medical Society were not going back and start all over again, they had what they wanted. So, the thing went to trial. It lasted interminably because of delays. The Iowa Hospital Association would get a doctor lined up to testify. The day before he was to appear, there would be a telegram saying, "I am sorry, I cannot come." This happened one time after another, and they finally got the hint. Physicians did not want to stand up against their colleagues. The Iowa Hospital Association representatives finally came to me and asked if I could help them. I was still the Chairman of the Council on Professional Practice at that time, and of course, I was in Connecticut.

They also explained to me one of the tactics they were using on the

advice of one of the AHA staff members, who by this time had left the AHA, Dr. Charles Letourneau. This approach raised the question as to whether radiologists were really doctors, because they don't diagnose and treat. The point that was made was that a radiologist just looks at shadows on film, and he then gives someone else his opinion as to what those shadows mean. The real doctor, the attending doctor, takes this information and other facts, and then puts them together and makes the diagnosis and carries out the treatment. He is the doctor. My recollection is that the same argument was used toward most of the work of pathologists. Radiologists and pathologists weren't doctors. You can imagine how the radiologists, the pathologists, and the AMA took that.

I thought the hospital attitude was stupid too. I made two conditions before I could decide. First, they had to forget the argument on whether radiologists and pathologists were doctors or not.

They came to New Haven with their lawyers and met with me and John Tilson, who was the lawyer for the Connecticut Hospital Association and for my hospital. He is a very astute individual, who had had great influence in the development of the Attorney General's opinion in Connecticut. He was also in the House of Delegates for the AHA for a number of years later on. Iowa agreed to abandon the non-doctor argument.

I said, "My problem is that I am president-elect of the AHA. It might bring the AHA into a peculiarly embarrassing position. I'll have to go and talk with Crosby." So, I went to Chicago and talked with Ed.

Ed said, "No, you shouldn't do it. Stay away. Don't have anything to do with it. AHA can't afford it."

Don Cordes was a friend of mine. I believed in the hospital attitude in

Iowa and I had helped write the opinion of the Connecticut attorney general who had said the salaried practice of medicine was all right and was not illegal.

I don't think Ed Crosby ever quite forgave me: I went to Iowa and testified for about three days. It was futile. The judge ruled against the hospitals. However, nothing really changed at all. It was a lower court decision in the first place, and no physician apparently was on salary in any of the Iowa hospitals anyway. The legal battle had been on principle. The state medical society, the hospital association, and the Board of Medical Examiners then drew up a report, which was written into the law almost verbatim. All the purists in juris prudence said this was a terrible way to pass legislation. Nothing much happened after that, except the national radiological organizations still didn't like what was legislated, and gave their colleagues hell for what they had agreed to do. About two years ago, the Iowa legislature changed the law, and now it is legal to work on salary and have someone else collect the fees in Iowa. Progress is slow and laborious in some places.

One thing might be of interest. I was on the Joint Commission on Accreditation of Hospitals for about nine years. During that time you gradually move up in seniority. Usually by the time they are getting ready to get rid of you, you are senior enough so that when your turn comes you are the one who is selected as the chairman. I was the appropriate one. On the day of the meeting the AMA members said, "We met last night and we are going to have to oppose you, Al, as being chairman of the Joint Commission."

I said, "Do you want to tell me why?"

"Yes, your action at the Iowa trial."

I said, "I expected that." "I know I am not popular with the AMA. However, in this situation I would vote against myself as chairman. I think the Joint Commission is too important to give any more ammunition to emasculate it by having A. Snoke be a lightning rod as the chairman. You will get no argument out of me at all. Besides that, the chairman has to sit quietly and preside and let other people do the talking. And I don't like to do that."

So, I have the distinct honor of being the only individual, I think, who theoretically should have been chairman of the Commission, who never was.

When Ed Crosby died in 1972, I did not know anything about the mechanics of choosing a successor because they appointed a committee. They brought in the name of Walter McNerney.

WEEKS:

That was the regular search committee.

SNOKE:

Correct. How this came about, or if there was anyone else involved, I don't know. I have heard rumors that some of the past presidents and officers of the AHA were also interested in the job themselves, but the search committee recommended Walter McNerney, and this recommendation was turned down. This caused very, very bitter feelings among a lot of people. At this time I was in Chicago working with the governor. So all I did was to write to all the past presidents and to the board saying, "We have got to make sense and have a good person. It must not be political."

Subsequently, at the meeting of the AHA, one after another of the board people would come around -- they were as secretive as hell -- and say, "That was a very good letter you sent. You are going to be pleased when you see the

results." They chose Alex McMahon, whom I did not know at that time, but I thought he was a delightful and able person after I got to know him.

That night we had the customary formal dinner of the past presidents and chairmen and their wives. Alex was there for the first time, and my wife, Parnie, sat next to him at a corner of the front and side of the U-shaped table.

It was rather a tense affair, because on the committee that had been turned down were a number of past presidents, who were present at that meeting and who had recommended Walt. Parnie was busy drawing up a map of the people sitting around the table and indicating their names so Alex would be able to identify them. As she and Alex were talking, I watched the people around the room. You could almost cut the tension with a knife.

At an appropriate time I asked if I might make some comments. What could they say? So, I got up and I said that I had been very interested in the problems in the procedures we had gone through to select a successor to Ed Crosby. The thing that puzzled the blazes out of me was that they didn't pick the obvious individual who had all the qualities and experience and who would have made an ideal president of the American Hospital Association and yet he was completely disregarded. There was dead silence. I then said, "After a while I decided that if you don't want to have me as the next president of the AHA, I think you have done a remarkable job in getting the next best person. Alex, I am so glad you are here."

During my speech everybody was trying to understand what I was doing and saying. When I came out and said I was upset that I had not been selected, I haven't the slightest idea whether it was helpful, but I think it broke the ice. I know that Parnie and I afterwards talked about how we enjoyed the

looks on the faces of the people during the time I was giving the speech about how sad I was that I hadn't been chosen.

Alex took over and did a wonderful job. I believe that there is only one thing that makes me uncomfortable, and that is that the AHA hierarchy and staff has not had a doctor as part of the staff -- or as an officer for a number of years. The men and women, who have been chairmen of the AHA, and who have functioned in the senior levels of the AHA, have been superb as health professionals, and that is the most important aspect. However, I have felt that the AHA has deferred or depended too much upon the AMA — and while I think Dr. Sammons is smarter than hell and he has worked delightfully and constructively with Alex McMahon, I am uncomfortable that the medical input to the AHA seems to have been primarily from organized medicine, which I think is pretty conservative and defensive.

Russ Nelson and I talked with Alex. Alex said, "I would like to have a senior medical person in the AHA. You find him for me. I think this is the proper time to do so." We couldn't.

As far as AHA, I think I have talked enough. If you have any further questions, I'll try to answer them.

WEEKS:

I was wondering if there was anything you wanted to say about your work on the AHA committee on Medicare or on the AHA's committee on university teaching hospitals?

SNOKE:

Yes. I discussed Medicare in detail in my chapter on "Government and Health" in my 1987 book. Medicare was one of the first outwardly clear divisions in opinion or philosophy between the AHA and the AMA. Over the

years, there had been developed the various Wagner-Murray-Dingell bills, the Forand bill, the Kerr-Mills bill, the King-Anderson bill, etc. I didn't realize, however, until I read some of your oral histories, of the degree of politics that went on in Washington for so many years. There is reference to the worst speech Kennedy ever gave, when he spoke at the Madison Square Garden on the problem of the aged. I don't remember anything about his speech. All I remember were the cheers and flag-waving, and how Dr. Annis responded for the AMA at the same hall the next night -- with all the banners on the floor and no audience.

I was in on the problem of the care of the aged very much from the beginning, because Parnie and I had spent much time studying and writing about the Kerr-Mills bill. The thing that fascinated me was that when the bill was passed and put into effect, Massachusetts, Connecticut, New York, and one or two other states had some smart welfare workers who arranged to have all of their Old Age Assistance clients transferred over to the Kerr-Mills program, to get them off of the state funding and into federal funding. Why other states didn't do this, I haven't the slightest idea. Those few states saved millions of dollars by doing it.

The other thing was that the state medical societies, in Connecticut for example, fought like hell to get payment for professional fees and then to increase the professional fees available from Kerr-Mills. Here the AMA was going nationally against governmental medicine, but presumably because it had something to do with the state, they thought it was pure. They certainly were fighting for their professional fees for the aged from governmental funds.

Kenny Williamson and I were pushing to get something that the AMA and the AHA could get together on and support. This was around 1962. I was a past

president and some way or another I was on a joint committee of AMA and AHA. I'll never forget our having a meeting in Chicago in which AMA and AHA trustees and representatives could not come to any agreement. So, Kenny and I just disappeared from the room and wrote out what we thought would be a reasonable position. We brought it back in. The AMA threw it out.

That was essentially the end of any effort towards collaboration or cooperation between the two organizations. As a result, one of only two special meetings of the AHA House of Delegates was called in January 1962. This meeting also included the Blue Cross Plans.

The minutes are fascinating, because it was very clear that they wanted something done, because the aged needed help. There were arguments about King-Anderson versus Kerr-Mills, but the most fascinating part of that meeting was that Bing Blasingame of the AMA gave a speech to the delegates. The speech that he gave blasted the AHA resolution that was saying essentially that the aged needed financial help to obtain needed health care; they did not have the funds themselves; and assistance was needed from the government. he then went on to say that he knew that there was going to be a roll-call vote, and the AMA would see that how the delegates voted would get back to their own specific hospitals -- both the boards and the medical staffs. The discussion by the House of Delegates went on throughout the day.

I recall sitting next to Joe Stetler, who at that time was the general counsel for the AMA, and Alanson Willcox, who had been counsel for the AHA, but was now counsel for HEW. I can remember sitting with them and listening to the various comments and hearing the enthusiasm of Joe for one thing and the roars of Alanson for something else. Of course, they had completely opposite points of view.

I looked over the minutes about a year ago. There wasn't a mention about Bing Blasingame in the minutes. I couldn't figure out why. I checked with Norby. Norby said, "I wasn't even around. I had to do something else."

I talked with Hague. Nobody seemed to know why. Later, in talking with Stewart Hamilton, he told me, "I know why. He spoke at the luncheon, and didn't talk at the meeting. Therefore, there was no record of it."

I called Bing. Bing said, "I wouldn't ever say anything like that."

I know damn well he did. Stewart Hamilton even told me of one of Bing's jokes during his speech, that I remembered for years -- but have now forgotten the point.

WEEKS:

What was his job at the AMA at that time?

SNOKE:

I believe the same status as that of Dr. Sammons.

WEEKS:

The same as Sammons is now, executive vice president of AMA?

SNOKE:

Yes.

WEEKS:

He was before Howard?

SNOKE:

I think so. Blasingame was a big hero until somebody cut his throat and kicked him out. I liked Bing very much and respected him. We didn't agree all the time but I thought he was a high class guy. I didn't know Bert Howard very well. He was tough and the AMA needed such.

WEEKS:

What happened at the Delegates' meeting?

SNOKE:

I was very proud of the House of Delegates of the AHA, because after thorough discussion they passed the resolution with a substantial majority.

WEEKS:

What happened next?

SNOKE:

It took a number of years, but eventually the Medicare legislation was passed. I was having one of my weekly seminars with the students in my conference room when I got a telephone call from Kenny Williamson.

"Have you heard what Wilbur Mills has done?"

"No, what?"

"He has shifted the hospital-based specialties from Part A to Part B."

My students were listening to this conversation back and forth. My students knew everything that I knew. No secrets, but that it was to be confidential. That afternoon Martin Cherkasky came up from Montefiore Hospital to talk to the whole public health student body about Medicare. My students didn't say a word about the telephone call that I had received, but it was not secret to my wife, Parnie, inasmuch as she had heard about Kenny's call when we had lunch together at noon. She was, at that time, a public health graduate student, and so was at the meeting. As far as she was concerned, and I was concerned, her knowledge was not confidential such as obtained with my students in the seminar.

Parnie said, "Dr. Cherkasky, what do you think would happen if they would transfer hospital-based specialties from A to B?"

"My God," said Cherkasky, "that would be terrible. Is there any chance of that?"

Parnie said, "That's what Al tells me."

That night when we got home I got a call from Martin Cherkasky. He asked me, "Is it true?"

To make a long story short, it was transferred. The Senate got into the act. Senator Douglas and Jay Constantine got in touch with me and I helped them write the Douglas amendment. Maurine Neuberger of Oregon -- she was one of the few women in the Senate at the time -- Talmadge, Ribicoff, Byrd -- they were all of this Senate committee. The Douglas amendment was passed by the Senate Finance Committee. It was passed by the Senate. The amendment would put the specialists back on Part A of Medicare. The House bill was different, of course. When it came to the conference committee of the House and Senate, Wilbur Mills won. The hospital-based specialists remained in Part B.

WEEKS:

We know that Wilbur Mills was pacifying the doctors. He was doing this because he thought he would be able to pass Medicare without too much opposition if he satisfied the doctors.

SNOKE:

Medicare originally was going to be just the hospitals. Then they put in the Part B for the doctors, then they transferred the hospital-based specialists to Part B. Late in 1967, there was so much confusion and dissatisfaction that Congress amended the act to provide that radiologists and pathologists be paid 100% of their total charges when these were included on the hospital bill. The professional components of radiological and pathological in-hospital services were thus to be reimbursed as if they were

hospital services under Part A, and not according to the co-payment provision of Part B. This amendment brought Medicare in line with traditional practice. No other physician specialists were subject to this change.

WEEKS:

Earlier you discussed the informal organization of the University Hospital Executives' Council (UHEC) that you felt was so valuable when you were in Rochester. Would you comment on the other groups that you have been associated with that have also been helpful?

SNOKE:

There were three other groups, the Council of Teaching Hospitals (COTH), the Society of Medical Administrators (SMA), and the Medical Administrators' Conference (MAC). I think that I am personally prouder of the COTH and the MAC, because I had something to do with their formation.

I started the original COTH about a year after I came to New Haven. I had found the UHEC in Rochester very helpful, and it seemed so easy to get ideas or advice from others who faced the same problems. When I went down to New Haven, I felt very much alone. The only other hospital of a similar size was the Hartford Hospital, whose director was Dr. Wilmar Allen. Wilmar Allen didn't believe too much in cooperation with a younger man -- particularly as he considered New Haven as a competitor. I needed somebody to think out loud with, and when Jim Hamilton left, most of his senior staff went too. The only people I had left of the entire administrative staff who were there before I came were Paul Fleming, who was perhaps #3 in the administrative hierarchy, and an administrative resident, Charles Wynne. That was all.

I thought of developing a group similar to the UHEC -- only from the East. Because I had been working so closely with George Darling as Director

of Medical Affairs at Yale, and Hugh Long as Dean of the Medical School, I suggested that this Council of Teaching Hospitals, which we called ourselves at that time, should be made up of the hospital administrator, the director of medical affairs, if such existed, and/or the dean. For example, from Harvard came George Berry, the dean, and Dean Clark, the administrator of MGH. I think that Bayne-Jones came up from New York Hospital, with whoever was running New York Hospital at that time. Al Brinkert came with Dr. Rappleye from Presbyterian and Columbia, and Bob Buerki, who was then direcor of the University of Pennsylvania Hospital, brought a physiologist by the name of A.N. Richards from the medical school. Ed Crosby came from Hopkins, along with Lowell Reed.

I was most intrigued and flattered, when I told MacLean of this meeting, and he said, "Damn you, why don't you invite me?"

I said, "You are in the UHEC. I didn't think you would be interested."

He said, "The UHEC has five state hospitals and three others. I want to continue it, but I want to come down to your outfit." So, he came. I received the same reaction from Dr. Bishop at Lakeside in Cleveland, who also was in the UHEC.

That first meeting was in New Haven. It was an exciting thing because here I was the host along with George Darling, Dean Long, and President Seymour of Yale, and was meeting with people for whom I had great admiration. There was MacLean, who was number one as far as I was concerned, the Hopkins people, and Bob Buerki, whom I had known before and liked so much. And then to my amazement, I was introduced to Dr. A.N. Richards. All I could do was sort of gasp. I asked him, "Are you <u>the</u> Doctor Richards, the man who first put a pipette or a cannula into a glomerulus to drain the fluid of the

kidney?"

"Yes," he said.

When I had been a medical student years earlier, I had read in a prominent text book of this great research work of Wearn and Richards. And here I was meeting him in the flesh.

I will have to admit that this was an exciting part of coming east in the thirties and forties. When I came to Rochester, I met Dr. Bloor, whom I had read about as the epitome of knowledge on fat metabolism. And when I came to New Haven, there was John Peters of the text of Peters and VanSlyke that I had studied in medical school. There was also Dr. Arnold Gesell, who was the Dr. Spock of the forties. They had all been just names to me before -- but through Basil MacLean and my positions in the hospitals, I was meeting them personally. It is one of the reasons why I have enjoyed my life.

Within a relatively short time, the Council of Teaching Hospitals became fairly well known in the East, and our friends christened us the "Poison Ivy League." It was later that the formal Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges (AAMC) was organized and took that name. I have always enjoyed needling John Cooper and Dick Knapp that they stole our name.

WEEKS:

I was trying to remember when that took place. That was in the middle sixties, wasn't it?

SNOKE:

The basic organization was started before that. Gary Hartman of Iowa and Donald Caseley of Illinois were the first organizers. At that time the AAMC was located in Evanston. These two were the ones who got the idea that there

ought to be a section in the AAMC for teaching hospitals.

WEEKS:

Was this before Cooper came into the picture?

SNOKE:

Yes.

WEEKS:

When Darley was there?

SNOKE:

Yes.

As I said, Hartman and Caseley got the idea that there ought to be a special section in the AAMC for teaching hospitals. Their idea originally was to develop a section for just the primary university teaching hospitals. They met in Philadelphia. I think they elected one of the two as chairman, the other as chairman-elect.

While they were there, I got a telephone call, because I hadn't gone to the meeting. I didn't think much of the AAMC. It seemed to be just a dean's club. They would meet and introduce new members -- usually about 20% of the group -- for their tenure seemed to average about five years. Frankly, I was suspicious of an awful lot of the deans and so when Caseley and Hartman asked me if I would be the next chairman, I stalled. "I don't think this is such a good outfit. Why me?"

"Because we need somebody who will talk back to the deans." I was intrigued.

At the next meeting, which I think was in Cleveland, I was asked to give a talk at one of the planning sessions of the deans and hospital administrators. This is when I gave my speech on the three-legged stool. I

was talking about the responsibilities of the teaching hospitals: teaching, research, and patient care, and that they damned well ought to be committed to all three. I took pleasure in needling virtually all of my friends. George Berry, dean at Harvard, had told me in Rochester that, "of course the hospital is important, but we consider it in the group of the medical center like the animal house." He kept denying saying it but he did say it and I always enjoyed reminding him.

The chairman of the Department of Pediatrics at Hopkins had written an article stating that their primary object was research and that taking care of patients, and teaching students to do that -- I don't remember the exact words now, but it was very clear that he did not think that caring for patients was as important as doing research.

I goosed my various colleagues, and afterwards, was appalled. I suddenly realized that my son was a senior at Stanford and was applying for medical school at Stanford, Yale, Harvard, Cornell, Rochester and Hopkins -- all the places I had been needling.

I was also intrigued that for a number of years there would be references to the three-legged milkmaid stool. However, it never seemed to be the milk maid's stool alone. It was Snoke's goddamned milkmaid's stool. That connection eventually passed, but I still see reference to the three responsibilities of the teaching hospital in the literature.

The thing that really tickled me was that when John Cooper retired, they had a number of meetings of tribute, etc. The COTH gave him a present in a great big box. He unwrapped it in front of everybody, and you can guess what it was -- a beautiful three-legged milkmaid's stool. For a number of years they used to give the past chairmen a small three-legged stool, suitably

inscribed. Now they give them a gavel.

WEEKS:

Has Dr. Cooper's successor been chosen?

SNOKE:

Yes. Robert Petersdorp.

WEEKS:

I don't know him.

SNOKE:

He's quite a man. He was a resident in medicine at Yale. It was Grace-New Haven at that time. He is the only person I know that went from being a resident to an assistant professor down at Hopkins. From there he went out to Washington as chairman of the Department of medicine and has had a distinguished career.

WEEKS:

The AAMC has gotten to be quite an umbrella organization and the COTH is an important part.

SNOKE:

Yes, it has. Originally the hospital division was a relatively small teaching hospital section. However, after they started the reorganization of the AAMC based on the Coggeshall report, they followed his recommendation that there be a formal major division of teaching hospitals, the Council of Teaching Hospitals. There were perhaps a half a dozen of us who met, I think in New York, to plan for this. Russ Nelson and I were two of them. He has a little bit different recollection than I have. He recalls that he came up with an approximate number of a little over 400 hospitals. Those should make up the council of the teaching hospitals. All I can recall is that I raised

the question of whether a teaching hospital should be necessarily limited to those who were primary university teaching hospitals like Yale-New Haven Hospital or Strong Memorial. I felt there were other good teaching hospitals and I used three examples: Hartford, Mary Hitchcock at Hanover, and the Rhode Island General at Providence. All three at that time had no medical school, but all three were good teaching hospitals. I said that they all ought to be in this too. At any rate, the numbers grew, certain criteria were developed, and a strong and important hospital group came into existence.

It is interesting that even when we were just a hospital section, it seemed only a short time before the section programs were considered of such quality that the deans were coming more and more to our meetings.

There was another aspect about the formation of the teaching hospital section that Russ and I talked about, and just dismissed. This was the possibility that the COTH of the AAMC might be in competition with that of the AHA. As far as we were concerned, we were part of the AHA. We were part of the COTH. They were both the same. He and I have talked about it since, and I know that some of the directors of the major teaching hospitals have said, "The AHA is sort of Mickey Mouse. The COTH is much more important." I don't agree -- for I believe that the strength of our voluntary hospital system must depend upon a cooperative relationship of all sizes and types of institutions.

WEEKS:

You also mentioned the Society of Medical Administrators. What were they?

SNOKE:

This is the oldest and probably one of the most prestigious of the informal groups of medical hospital and health administrators in the country.

There have been three small books written about their history — the first two by Dr. Nathaniel Faxon of the Massachusetts General Hospital, and the third by Dr. Madison B. Brown. The last one was published in 1984.

Madison has summarized the history and the membership, along with the various activities and philosophy of this group, very well in his 1984 "Foreword," and in his comment, "In Retrospect." As Madison describes it, the first two volumes written by Dr. Faxon recall the Society's origin in 1909, when a group of 12 hospital superintendents met in New York to discuss hospital affairs and enjoy friendship. They met annually until interrupted by pressures of World War I. Meeting were resumed in 1919.

The original twelve members and ten new ones met February 28, 1920 at the Hotel Pennsylvania in New York City, and organized the new Medical Superintendents' Club. It was first limited to 25, and then enlarged to 50 by 1942. In 1951, the name was amended to The Society of Medical Administrators.

There is no question but that it was prestigious, but it was also somewhat stuffy at times. They would allow only men to belong, and they had to be physicians. For many years, no new individual would be admitted unless there was a unanimous vote. Apparently they became embarrassed in the early forties, because they had taken in so few for a number of years, and so changed the rules so that a two-third's vote would admit a new member.

Basil MacLean was a very prominent member of this group, and wanted to get me to belong. However, I could not, because I was his assistant. As soon as I became Director of the Grace-New Haven Community Hospital, Basil started pushing. I became a member in 1947, along with Ed Crosby, when the Society met at Dearborn, Michigan.

I apparently promptly got myself famous at the first meeting, inasmuch as

when I had made my hotel reservations for Parnie and myself, I had requested a double bed. It turned out that most of the other members did not request double beds, and the reservations at the hotel were such that they were only reserved for honeymooners. This seemed to me somewhat naive -- but Parnie and I didn't argue.

I think I also was a disturbing influence in this august group at the beginning, inasmuch as when I would attend the meetings, Parnie -- as did all the other wives -- came along too, but Parnie was interested in the program and the discussion. But women were not supposed to be interested in the meetings themselves. They were just part of the social atmosphere. Parnie, however, was just as interested as I, and knew as much about most of the things that were happening as did I, and so while the rest of the wives would go out socializing, Parnie would come in and sit next to me. Ed Crosby wasn't sure that this was such a good idea. I remember arguing with him, and then saying to Parnie, "Parnie, if you want to come, you come. I'll tell Ed to go to hell." So Parnie came but sat in the background on the meetings. Some of the other wives did too, and eventually, the Society actually became smart and admitted a woman as a member. The first woman was Dr. Mary C. McLaughlin in 1976, and she and others since have, of course, been of value.

I have always been impressed with this group, because they grew and expanded in their horizons from just concentrating on the operation of the hospital as an institution, to bringing in all types of individuals associated with health education, health financing, and many other aspects of health that did not have to do with just hospitals themselves.

It was from this organization, and through the influence particularly of Basil MacLean and Anthony J.J. Rourke, that the other group of hospital and

health administrators then was started.

WEEKS:

This was the Medical Administrators' Conference?

SNOKE:

Yes, and I was very fortunate to be part of the beginning of that organization.

WEEKS:

Would you tell me how it came about?

SNOKE:

I look back at almost 50 years of association with the Medical Administrators Conference, with a peculiar combination of pride, nostalgia, and a tremendous amount of personal pleasure. It started as a small group of nine young physicians -- all assistants to physician superintendent who were operating some of the great hospitals of this country at that time.

All of us had heard of the Medical Superintendents' Club, which was the term used in those days, and all of our chiefs were members of it. Anthony J.J. Rourke, who seemed to get more new ideas than anyone I have ever known, and Jack Masur were the instigators of this informal group, and Basil MacLean was its sponsor and host.

There were nine of us who met at Strong Memorial Hospital in Rochester, New York on December 8 and 9, 1939. The nine original members were Guy Brugler, University Hospitals, Cleveland; Roger DeBusk, St. Luke's Hospital, New York City; Gerald Houser, Massachusetts General Hospital; Jack Masur, Montefiore Hospital, New York City; Gordon Meade and A. Snoke from Strong Memorial Hospital, Rochester; Herbert Wagner, Roosevelt Hospital, New York City; Leverett Woodworth, Harper Hospital, Detroit; and Anthony J.J. Rourke,

University Hospital, Ann Arbor, Michigan.

We didn't have a name at first, but considered ourselves "Young Turks," and eventually settled on a formal name, The Medical Administrators Conference, because it would seem more appropriate when we wanted to list our expenses for our income tax returns.

The organization was really the brainchild of Tony Rourke, with the assistance of Jack Masur. The rest of us were delighted to become part of the original group, and we slowly grew in numbers. Tony was always pushing for enlarging the group -- for some reason. Jack Masur and I would drag our feet and try to keep the number small. It eventually has grown into a very major, important group that meets once a year, and I think that its limit is around 50 physician administrators.

It was just as stuffy as the original Medical Superintendents' Group in that it would not admit anyone who was not a physician and a male. And, like the older group, at first it met at the site of the hospital of one or another member, to spend two days on a prepared agenda that was never covered in full.

It was extremely valuable to me, because it gave me an opportunity to meet and learn from my colleagues, and it certainly broadened my horizons in the role of the hospital and health care in this country. I wrote the history of the first 40 years of the MAC, which Parnie and I delivered to the group when we met in 1980. I look back at that meeting with very mixed emotions, inasmuch as this was the last time that I was able to go to such a meeting with my girl -- she having died of a coronary the following year.

Our first meeting in Rochester was memorable, in that our minutes indicate how much we were concerned about personnel practices and people working in the hospital in those days. In 1939, for example, the minutes

indicate that a personnel department or its director was considered of very minimal importance. Although there were some stirrings. Strong Memorial had its personnel functions carried out by the purchasing agent with a part-time clerk. MGH questioned the value of the investment in a personnel department, as did Harper. St. Luke's had just started a personnel department six weeks earlier, and both Michigan and Montefiore were thinking about starting. How things have changed.

Tony Rourke and Jack Masur came to be two of my closest friends. They each had one son, Tony's son John going to MIT and then to medical school, and taking over his father's consulting practice after Tony died. Jack Masur's son is also a physician, and is currently working at the Bethesda Clinical Center that his father planned and built. He is chairman of the committee that decides which drugs will be tested in federally funded programs around the country for AIDS. My oldest son, Tom, also went into medicine, and rather ideally decided early in his career that he wanted to be a Public Health Service Officer and work with the Indian Health Service. However, my primary recollection of my son and the MAC was the hot buttered rum party that Parnie threw for our attending notables, and we found that nobody could do anything but hold his glass on high, because the small, one and one-half year old pride of the Snoke family would helpfully come around and take it from them to the kitchen, whenever it was within his reach.

The MAC gives me an opportunity to just make a comment on Tony Rourke and Jack Masur, who unfortunately died before the Oral History Program was started. They were both distinguished leaders of the American Hospital Association, and it is unfortunate that their contributions and memories have not been recorded.

Tony Rourke seemed to be in the forefront of everything. He started the idea of the "Young Turks," and pushed each year for an agenda that would be stimulating, and for guests who could contribute to our individual education. One of the most memorable meetings was in Evanston in 1944, where I first had the opportunity of meeting Isidore Falk, who at that time was Director of the Bureau of Research and Statistics of the Social Security Board of the Federal Security Agency, and Sidney Garfield, who had just been described by Paul DeKruif as the "White Knight in Shining Armor," who had started the Kaiser Health Plan.

Tony Rourke was the one who started the Hospital Administrators' Correspondence Club, which was so valuable for so many years, and helped stimulate the consulting group to have a formal organization and set up standards. Tony was President of the American Hospital Association in 1951-52, and I will never forget his arranging to have President Truman come and speak at the AHA convention, and also reacting to my needles about his being soft in his negotiations with the AMA. He immediately appointed me to a liaison committee with the staff and board of the AMA, so that I could learn firsthand the problems of diplomacy as well as confrontation. Tony Rourke died in 1973, and I still miss him.

Jack Masur was another giant of that original group. I have always regarded him as one of my best friends, and one of three individuals with whom I would have been perfectly willing to have worked as an assistant -- he was a wise and intelligent man.

I am not sure, but I believe that as he was maturing there was considerable question as to whether he would become a rabbi or go into medicine. He was learned in both fields. He did go through Cornell Medical

School, and then was an assistant to Dr. E.M. Bluestone at Montefiore Hospital in New York City when we started the "Young Turks" in 1939.

Jack went into the armed services during World War II, and decided to make the Public Health Service his career. I was honored to be able to work with him in planning the Clinical Center at Bethesda, and tnrough him I learned more about governmental medicine, the advantages and disadvantages of the Commissioned Officer Corps of the Public Health Service, and the problems of politics and bureaucracy than I could ever have learned otherwise, except during my experience in Illinois with Governor Ogilvie.

I was proud to be the Chairman of the Nominating Committee of the AHA when Jack was nominated as president-elect of that organization, and he served the AHA with distinction.

Jack Masur died March 8, 1969, and Ed Crosby and I were not so sure we were honored to have the privilege of helping carry his casket to the grave following the funeral ceremonies. Jack was a very big man in every sense of the word. The Jack Masur Auditorium at the Clinical Center was dedicated July 2, 1969, and some of Dr. Russell Nelson's comments at the dedication of the auditorium reflect our memory of Jack Masur:

> Jack was a big, indeed, a huge man -- big in body, big in stature, big in heart, and big in the marks he left during his professional and personal life. He was kind and loyal to his friends, at times even in excess. But Jack Masur was a great leader and a great physician, a physician of the highest order in his extreme sensitivity to the rights and dignity of the individual, especially the individual who, as a patient, lay considerably unprotected. I am sure he inherited this sensitivity in his genetic pattern, and had it sharpened in his early training as a student in medicine and administration.

I can only add to Russ Nelson's words my personal comments on Jack Masur -- for he left a lasting impression on his associates. They can be best

summarized in my "Introduction" to my 1987 book Hospitals, Health and People. In this introduction I tell of the picture of the little statue "Discharged Cured" that he gave to me over forty years ago. This part of the "Introduction" and the picture are reproduced in this history.

> In recalling years of changing responsibilities and relationships, I find that I have produced a chronicle of my "post-graduate" education in the care of people -- an account that seems to fall naturally into the distinct phases to which I have referred in the text. I believe, however, that the final stage of my evolving view of people care can be be typified by the picture of the small statuette "Discharged Cured" that Dr. Jack Masur gave me in the late 1940s. I hung it on the wall of my office at the Yale-New Haven Hospital and again in my office when I was an adviser to the governor of Illinois. It is now in my study at home. Each year I took this picture to my seminar in the course on hospital administration at Yale and spent the entire period discussing what the picture implies about our responsibilities in caring for people. I was most flattered recently to see a copy of this picture on the office wall of one of my former students, who now heads a major university teaching hospital.
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> I can do no better in explaining what this picture means to me than to quote from an article by Dr. Masur, "Some Challenges in Hospital Administration," that appeared in the Journal of Medical Education (October 1955), pages 567-72.
>
> > The whole question of the responsibility of the physician, of the hospital, of the health agency, brings vividly to my mind a small statue which I saw a great many years ago on the mantle in the late Dr. Corwin's office at the New York Academy of Medicine — a statue of a patient discharged from the hospital:
> >
> > It is a pathetic little figure of a man, coat collar turned up and shoulders hunched against the chill winds, clutching his belongings in a paper bag -- shaking, tremulous, discouraged. He's clearly unfit for work -- no employer would dare to take a chance on hiring him. You know that he will need much more help before he can face the world with shoulders back and confidence in himself. You suspect that he may never be able to go back to the work he has done before his illness. Past the age of 50, he will have to learn how to do a different kind of work if he is to be self-supporting. You think that he was probably once the responsible breadwinner of a family, husband and father, proud of his ability to earn enough to feed, clothe and educate his children. Now his present weakness is shaking him; his self-respect is deeply damaged. He is discouraged and frightened. This is the man who has been discharged with the cryptic notation on his medical chart: Discharged — Cured.
> >
> > The statuette epitomizes the task of medical rehabilitation: to bridge the gap between the sick and a job. Those of us who work in hospitals must join with education, social work, employment placement, vocational guidance and any number of related services to provide patients with the help they need to restore them to their maximum functioning. It means that, more than ever, physicians in hospitals must realize that their job is not ended when the fever is down, or the sutures out or "clinical cure" has been achieved. It means that rehabilitation does not limit itself to amputees or paraplegics, but that we need to think in terms of the bookkeeper with glaucoma, the welder with diabetes, the furrier with asthma and the truck driver with diminishing hearing. It means that we shall have to concentrate on the ends as well as the means in the management of patients.

A final comment about the MAC is the tribute that was given to Basil MacLean in May 1962 at Ann Arbor, Michigan. Basil, by this time, had had his eye problem, and had to retire from his Blue Cross Association responsibilities. It was another one of Tony Rourke's ideas, for he recalled how his boss, Dr. Harley Haynes, had helped stimulate him to get the MAC going, and that Basil MacLean had been the first host. Tony suggested that inasmuch as the meeting would be in Ann Arbor, the MAC invite Dr. Haynes and Dr. and Mrs. MacLean to attend. Dr. Haynes could not attend, but Basil and Carrie MacLean were there, and a specially lettered testimonial was presented to him at the banquet. I am proud of this for two reasons. The first is selfish. I wrote the original draft, and then Parnie rewrote it and polished it so as to make it grammatical and not too wordy. The other reason is that I believe it expresses, in our comments to Basil MacLean, the sentiment and thanks that so many members of the MAC had to their own early preceptors or associates who had helped them start in the field of hospital and health administration. I also hope that many of us will find that our younger associates have the same feelings towards us that we have had toward our earlier bosses. The testimonial is as follows, and is the best substitute I can offer for the AHA not being able to have an Oral History of Basil Clarendon MacLean, M.D.

> **BASIL C. MacLEAN** You have received widespread recognition as a physician, an administrator, a consultant, a teacher and a medical statesman. The Medical Administrators' Conference shares with Carrie our pride in your honors. They are richly deserved.
>
> Important as have been your contributions to the profession of hospital and medical administration, to Blue Cross and to your two countries of Canada and the United States, we regard them as secondary in importance to a more fundamental and productive contribution you have made to the health care of this world and its people. We refer to your stimulation, encouragement, support and development of young men and women in your own field of

hospital and medical administration.

Your rare ability to delegate authority, your even rarer willingness to recognize -- and see that others also recognize -- the work of junior associates, your consistent impatience with stuffed shirts and your equally consistent fierce loyalty to your friends -- all these have made working with you an exciting, stimulating, maturing experience.

The MAC owes much to this same interest in younger administrators. When we were, nearly a quarter century ago, eager "Young Turks," you encouraged the organization of this group in ways both theoretical and practical. Now we, somewhat greyed or balding and more than a little paunchy, find ourselves becoming today's mentors to tomorrow's leaders. We acknowledge with affection not only our twenty-three-year-old debt to you for our beginnings, but also our gratitude for your continuing influence, example and inspiration.

May you always be as proud of us as we are of you!

Ann Arbor, Michigan, Tuesday, May 22, 1962

WEEKS:

What about your work at the State of Illinois?

SNOKE:

This could be an afternoon's discussion in itself. I have dealt with it in fairly great detail in my chapter "Government and Health" in my book of 1987. I became involved in the state health program of Illinois purely by accident. I was at a meeting of hospital administrators in the South with John Porterfield, head of the Joint Commission on Accreditation, and Ed Crosby in the Spring of 1968. The two of them were talking about the problem of accreditation of the Cook County Hospital in Chicago, for they were worried. Cook County Hospital had previously received two single years of accreditation from the Joint Commission, and was coming up for a third review that spring. If the hospital could not get a regular three-year accreditation this time, they were unaccredited. This would be a very serious situation, for the

residency approvals for this great hospital would disappear -- and the house staff took care of the vast percentage of the indigent in Chicago and Cook County in this great institution.

Porterfield had decided what he was going to do. He was going to send in a team of specialists, rather than the regular small commission survey group. This would include an administrator, a radiologist, a surgeon, a pediatrician, and several other specialists. Porterfield was truly worried.

As he and Ed Crosby were discussing the situation, I happened to be nearby. Porterfield turned to me and asked, "Al, how would you like to be the Joint Commission representative for administration?" This was just after I had left Yale-New Haven Hospital. I agreed and spent perhaps a week in Chicago in February or March, being oriented on the Commission's survey methods, and reviewing the Cook County Hospital. I was very frank about the good points and the bad points of the institution, and I believe that all the surveyors felt that the hospital had really made major efforts to improve their operation and care of patients.

We pulled no punches in our criticism, but we felt then that the hospital should get full accreditation. The JCAH received the report, and to our pleasure -- and I am sure that of Cook County -- they were given full accreditation.

Later that spring, I received a telephone call. I think it was from Howard Cook, who was head of the Chicago Hospital Council, and a confidante of Mr. Richard Ogilvie, the President of the Cook County Board of Supervisors. I was asked if I could come visit Mr. Ogilvie. Parnie and I had been out consulting with the Pacific Medical Center in San Francisco. We came back by way of Saskatchewan, where we were consulting with the Commissioner of Public

Health on the wisdom of constructing a new teaching hospital and perhaps a second medical school for Saskatchewan in Regina.

So we dropped down to Chicago on our way home, and met Mr. Ogilvie, who said, "I read your report to the Joint Commission on Accreditation on the administration of the Cook County Hospital. You don't think much of it, do you?"

"Oh," I said, "it's not very good."

"How would you like to be the administrator of the Cook County Hospital?"

My answer was easy. "Mr. Ogilvie, you would have to be awfully hungry to be the director of the Cook County Hospital. I am not that hungry."

He grinned. "How would you like to come and review the Cook County Hospital and give me advice so that perhaps we could change things so that we might be able to entice someone who was unhungry to be the director?"

I still recall this, because it was a fascinating invitation, and I wanted very much to do it. I said, "Mr. Ogilvie, I would love to do it, but I don't think I will be that unhungry."

Mr. Ogilvie said, "I am just asking you to review the administration of the hospital."

Parnie and I spent August 1968 in Chicago. We lived in a very fancy apartment near the Northwestern Medical Center, and drove our car out every morning to the Cook County Hospital, where there would be an armed guard who would let us in the gates. We would be parked in a garage where Karl Meyer had his car. He was still alive -- but retired. We felt very important in our preferred parking place. We virtually lived in the Cook County Hospital, day and night, for a month.

At the end of the time, I wrote out a frank evaluation of the various

strengths and weaknesses of the Cook County Hospital, and what I thought should be taken out from under the political influence, and what should be given to a non-partisan, independent board. I did not refer to personalities in the report -- I don't believe in this -- but I was frank in my conversation with Mr. Ogilvie that one of his problems was his administrator. There were certainly plenty of other problems -- one of them being that his office of the Cook County Board of Supervisors interfered too damn much with the internal operation of the management of the hospital. I told Mr. Ogilvie that I could understand why there was interference with the present administration, but that even if he had a good person as administrator, as long as the county supervisors interfered as they did, it was not good.

Mr. Ogilvie said, "I hear you. I agree. Do you want the job if we do these things?"

All I did was laugh, because I had had contact with the Democrats, who were so politically involved in the whole Chicago and Cook County area, and I knew that Mr. Ogilvie was, by this time, running for governor. I asked him, "How long do you think I would last as the Director of Cook County Hospital if you were elected governor?"

"I hear you," he said. "Would you and your wife like to come with us to the political rally that we are having this evening at the Sherman Hotel?" This was our first introduction to political hoopla!

I had to make a public appearance before the County Board of Supervisors. This was a surprise and embarrassment to me. Mr. Ogilvie made a very definite point of not being there. George Dunne ran the meeting. They were pretty mad at many of my comments, particularly about political influence. There was one place where I said that an individual who did not obey the wishes of the guy

who got him the job could be viced.

"What do you mean, Dr. Snoke? Viced."

"You know what I am talking about, Mr. Dunne. The persons in maintenance, housekeeping, and dietary, and laundry and so forth are all individuals that are sponsored by some ward boss or somebody in the political hierarchy of Cook County or Chicago. If they don't play ball with the guy who gets them the job, they are fired. They call it "viced." On election day, and the day before, the hospital is virtually deserted by all these people.

"Viced? I never heard of it."

"All I know," I said, "is that it is a term I hear from the staff. I look at the personnel records and I see 'reason for discharge, viced.' That's all I know about it. I don't live here. I am not a part of it. This is what I have seen and heard."

No other questions.

Do you remember in 1968 when the Democratic convention was in Chicago? They had motion pictures of Mayor Daley in the audience shaking his fist or gesticulating about something while they were having the riots outside? Sitting next to him was this very handsome man. That was George Dunne and he still impressed me.

Parnie and I were home by this time. Before we had driven back, we had seen the various groups of young people collecting in Chicago for the convention. We had watched them coming down the street and when the light would turn red, they would stop. The whole mass of them would wait on the corner until the light turned green. Then they would walk on across the street. This is the mob that all the hell was raised about in the park a few days later.

WEEKS:

I gather you liked Mr. Ogilvie.

SNOKE:

Yes -- I both liked and respected him and his wife. I never paid much attention to his past political record, but he lived in one of the suburbs of Chicago that was Republican. As you know, the Democrats dominate the political world of Cook County, but each division of the county has an opportunity to elect their own supervisor to the Cook County Board of Supervisors.

For some reason, Richard ogilvie ran for an elected office in Cook County -- sheriff, I think -- and won. He did such a good job that after one or two years, he ran for a member of the Board of Supervisors of Cook County.

They had a custom in Cook County that you not only ran to be elected the supervisor from your town or district, but you could also run for the specific office of chairman or president of the Board of Supervisors. Mr. ogilvie did both. He had done such a damn good job as sheriff; he was well known; and the Democratic nominee put up by the opposition was not a particularly highly regarded individual. As a result, Richard Ogilvie became President of the Cook County Board of Supervisors, with five or six other Republicans in a group in which the vast majority were Democrats. However, they adhered so strictly to protocol, that the president, even if he was not of the majority party, was the boss. And Mr. Ogilvie, therefore, was the boss. This is why he was particularly interested in Cook County Hospital. He had met me a year earlier when Hiram Sibley of the Chicago Metropolitan Hospital Council had invited him to a meeting of the AAMC, at which I had been speaking, and then I had been on the joint JCAH Task Force that we got together for the survey of

Cook County -- this is how I became acquainted with him.

WEEKS:

After Mr. Ogilvie became Governor, he did give you a job, didn't he?

SNOKE:

Yes. After he became Governor, he invited me to come and be his Coordinator of Health Services, which was the first job of that sort any governor had created. Neither he nor I were exactly sure what the job was, except that he wanted professionals of various categories in his own office; individuals who were not politically oriented; and who would be responsible to nobody but him. He asked me to give him a list of what I wanted in the way of staff and accommodations.

My answer was, "This is a fascinating job, but I haven't the slightest idea of what it is, or what I will need. How about you letting me have a part-time assistant and a secretary? After I get to know more about Illinois and your political and health world, I'll come back and talk with you."

"Who will be the part-time assistant?"

"Parnie Storey Snoke."

He said, "Okay, it's a deal." Later, I was told that the State Comprehensive Health Planning Staff (there must have been eight or ten or more employees) would also be available to me if I wanted them.

I came, and Parnie and I got an apartment in Chicago, because so many of the health problems of the state seemed to be concentrated in that area, and most of the health organizations with whom we would be dealing had their headquarters there.

I enlisted an ex-bureaucrat of 25 years in Public Health and Hill-Burton for Illinois, and who was currently working at the Illinois Hospital

Association at the time, by the name of George Lindsley. I could not have obtained a more valuable person, because he knew the state bureaucracy, and he educated me in the valuable contributions that the intelligent bureaucrats could make if they were allowed to give their experience as professionals -- not as politicians.

I was also lucky to employ a black nurse, living on the south side -- a public health nurse who, as far as I am concerned, was one of the best staff people I have ever had. In fact, I am very proud of her. I keep referring to her as my black Mormon daughter. She has a daughter who is now graduating from college. Parnie and I thought she was a honey. She came because I kept needling the nursing association for a black nurse who had a baccalaureate degree; who had had experience and training in public health nursing; who lived in the black area of Chicago; and who had, if it were also possible, pretty legs and a mini-skirt. They thought I was crazy. Anyway those were the qualifications. Finally after about six months and nobody had come, I raised hell with Anne Zimmerman who was the head of the Illinois Nursing Association. And Mrs. Stokes was sent over. This was Cathy. I got Parnie to sit down with me and talk with her. In about a half an hour Cathy went out. Parnie and I looked at each other -- there was no argument. "She would be wonderful, let's get her." So Cathy came back in. I offered her the job. Cathy told me her reaction many years later. She had not come over to get the job. She had been sent over to find out what the job was all about.

Cathy said, "Do you know, Dr. Snoke, I worked for a doctor and his wife once, and I found that I was having two bosses. How many bosses am I going to have if I come here?"

We both turned to look at Parnie. She had disappeared. She had heard

the start of the question and she had gone out of the room.

I said, "Mrs. Stokes, I think you have the answer."

She went back and told her people about this. They said, "Stay away. This could be a terrible job." But, thank God, she came.

She helped introduce me to a life style of a group of people I didn't know a thing about. There were more than a million blacks in Chicago alone and many needed help. I will always be grateful to Mrs. Stokes for educating me and Illinois is lucky that she stayed on in public health in that state.

One of my most memorable consulting experiences later was when the governor of Kentucky had about 28-plus million dollars that he wanted to use for health. It was a windfall from federal funds or something. He couldn't figure out what in blazes to do -- for he had the medical school of the University of Kentucky at Lexington; the University of Louisville Medical School and hospital; and a batch of nursing schools. He wanted a one-shot deal with no continuing commitments.

I said, "I can be mildly intelligent as far as the medical schools are concerned, but I am not so sure about the nursing schools. I have an individual in whom I have great respect. I would like to bring her in on this. However, this is Kentucky and she is black. What are you guys going to do if I bring her down from Chicago?"

I don't remember who the governor was, but I was profoundly impressed. He said, "Dr. Snoke, if she is good, if she makes sense to you, as far as we are concerned, I don't care what color she is."

WEEKS:

What did you do with the situation in Chicago and Illinois? What did you do with the million or more indigents? What did you do to coordinate health

services?

SNOKE:

I cannot say that in the four years I was there I accomplished a tremendous amount. But I learned a lot. Probably the most important thing I did learn was that health was not just health alone. After I was there for a few months, I thought that this was a fine job and they needed it at this time, but this is not the way a state should be organized. They shouldn't have a political appointee being a sort of Vice Governor for Health. I decided, "I think we ought to have a Commissioner responsible for all health affairs."

Then I started talking with the various directors in the state. Every one of them said, "That sounds fine." The Mental Health Director said, however, "I obviously have the problem as far as the health care of the mentally ill is concerned. However, I have also the responsibility of feeding them, financing and operating the mental institutions, getting the patients back into the communities, but much of this has nothing to do with health per se, it is social."

I talked with the Director of the Children's and Family Services. he was sympathetic to my idea of concentrating health affairs, but responded, "The health of children is important, but I also have to be concerned with their education, their nutrition, foster homes, housing, and all aspects of this sort -- this is social services."

I talked with Welfare and those concerned with the aged. Every agency told me that they just couldn't separate health from social services.

This was fascinating. I am amazed how my personal point of view turned 180 degrees from that of being concerned with the health of people to the

welfare of people, the whole gamut of health and welfare, people services, human services, human resources. So, Parnie and I spent all of our spare time during our four years, going around the country to see what other states were doing.

I was particularly impressed with Washington State, where Governor Evans, now Senator Daniel J. Evans, had got the Dean of the School of Social Service at the University of Washington to head up a committee to look at the overall state organization for people care. Washington State was one of the first that had come up with the philosophy of a state being concerned with human services as contrasted to the fragmentation that existed in most states in the country.

I was also particularly interested in the experience in Washington, when they told me that they thought that what they were doing was an advance, but that these changes cannot be made in six months or even four years. It must be a long, continuing, educational process, because of the hesitancy of people to change, the suspicion of change, and the protection of "turf" or of jobs.

I was also interested that while I was being the Coordinator of Health Services in Illinois, and was going around trying to figure out how we could do a better job, that a number of states were most intrigued with what Illinois was doing, as far as having a Coordinator of Health Services. Governor Lucey of Wisconsin checked on what I was doing, and the state actually had a Coordinator of Health Services for a while. The same thing occurred in Michigan with Governor Milliken. My wife and I spent several days in Harrisburg with Governor Shafer and his staff. I think probably I enjoyed arguing with Herbert Dennenberg as much as I did talking about health services. The State of Pennsylvania tried it for a while. I am told that

Virginia did too.

I am convinced that I learned more than I gave during my four years in Illinois. It was my first opportunity to work as a consistent partner with my wife on a professional basis -- even though we had been doing many consultations together -- and I feel very lucky to have had that experience.

It gave me a completely different viewpoint about politics, bureaucracy and the role of government in our health and social affairs, and I am convinced that the government at the local, state and federal level, the voluntary sector, and the various parties responsible for payment for health and social care have to work together in partnership in the planning and delivery of "people care" to our population.

I realized how hard it is to change things, and how evanescent is our political world. I don't mind one set of "rascals" being thrown out and another set brought in, except that there seems to be a tendency to throw away anything that was done by your predecessor and to start all over again. Although my wife and I had agreed to stay only four years with Governor Ogilvie, I feel that we had developed certain pathways, and he had developed certain philosophies that would have been good for the state, if he had been able to remain in office. But the Democrats came in, and most of what he had learned and planned for the future of Illinois was ignored.

From a purely selfish point of view, I feel I was very fortunate to have the four year experience in Illinois, because it gave me an entirely different viewpoint on the care of people, that I would never have obtained if I had continued on in my position in New Haven. Of course, this can be considered rationalization -- but as I look at the present problems faced by the providers of service, the financiers of service, and the people themselves --

I am personally convinced that my experience in Illinois taught me the importance of a true partnership between government, the private health and social service sector, and the people, and that this is an objective that deserves the best attention that all of us can devote to the subject.

WEEKS:

I get the impression that you have respect for many bureaucrats.

SNOKE:

I do. My experience with the Public Health Service, the Indian Health Service, and my experience in Illinois, gave me high regard for so many individuals in the governmental or bureaucratic field. Lindsley and so many of the deputies in the various federal and state departments were high class. It was the system of bureaucracy, however, that truly bothered me. The system put so many barriers in the way of good people doing their proper job. Let me give you two examples that my wife and I encountered, when we were doing the original survey on the Cook County Hospital.

The first occurred when we were visiting the Oak Forest Hospital, the long-term unit for the Cook County Hospital system. The administration and the business office were financially strapped. The cash flow was in trouble. As we talked with them, they mentioned that they had several millions of dollars coming from Medicare or Medicaid for patients to whom they had given care, but had not been able to collect for this from the governmental agencies.

I said, "Why don't you bill them? All you need to do is to bill and you will get your funds."

They said, "We know. Our staff is working as hard as they can, but there aren't enough clerks in the business office. They can't get the bills out."

"Why don't you order more staff?"

"The budget says five positions. We have them filled, and we can't get more until the next budget comes out."

We spent that day roaming around the institution talking to people. Somebody remarked that they were so fortunate that they had been able to change their method of groundskeeping so that three groundskeepers were not needed. As a result, those jobs weren't filled. But the budgeted positions were still there.

"Oh," I said, "They need them in Medicare."

So I went back and told the head of the business office, "I found three positions in your hospital you can use for your billing staff."

"No, not until the county board meets again for next year's budget."

I said, "What do you mean? You have three jobs. you have the money in your budget that is not being spent. You need them in your business office. you can make millions by bringing these three extra people in."

"But the jobs we have are for gardeners. These jobs that you are talking about are for billing clerks. You don't hire billing clerks out of a budget for gardeners."

I retired.

I discussed the second incident in my 1987 book in the chapter on Government and Health. Our experience with the budgeting problems in the Nursing Department of the Cook County Hospital in 1968 was very revealing.

Although the Departments of Nursing and of Social Service were under a separate board, and supposedly immune from political pressure on their

> staffs, their budgets were controlled by the Cook County Board of Supervisors. I learned at first hand how this absolute control of the purse strings could alter the actions and even the very thought processes of otherwise independent professionals.

> Part of my concern was obviously the budget: how it was prepared and whether it provided for sufficient personnel. As I went over the nursing budget and staffing patterns, I was appalled by the unusually low number of graduate nurses and by the poor staffing during the evening and night shifts. I wanted to make a point of this in my report, so I tried to compare the actual number and type of nursing personnel budgeted and available with the minimum number that the associate director of nursing believed appropriate. It took me more than three days of review and discussion with this associate director before I could get her to outline for me (1) the many individual divisions of the hospital in which patients were cared for; (2) the approximate census that one might expect to budget or staff for; and (3) the minimal number of personnel who should be present for each shift. Whenever the director of nursing made up figures for each division and then extended it to the total number of nursing personnel that were required, we ran into a stone wall. She acknowledged that the figures were appropriate, but she would insist upon budgeting for far fewer personnel.
>
> I finally understood the barrier regarding her formal budget request. The Cook County Board of Supervisors always refused to accept the number of personnel she thought proper because it would cost too much. Instead, they arbitrarily reduced the number of personnel. This had apparently happened so many times in the past that she had given up fighting for what she really believed was needed, and she just presented figures that she believed might be accepted. Ordinarily, my wife and I would have been critical of such an attitude, but it was clear that she knew what was needed and that she wasn't even aware of the mindset she had developed.*

* from Hospitals, Health and People by Albert W. Snoke, M.D., Yale University Press, 1987.

As I look back on my experience in Illinois, I appreciate even more the relationship between Governor Ogilvie and myself. He was a professional in the political world, and I was his health professional. We respected each other, and I felt that I could depend upon him to be concerned with the welfare of the people as well as the rigidity of bureaucracy and the strictures of politics. Maybe he did not pay enough attention to the latter and that is why the Democrat, Daniel Walker, defeated him after four years -- but the regard the people in Chicago and Illinois have for Richard Ogilvie today speaks for itself.

WEEKS:

Dr. Snoke -- you have had an unusual experience of over more than 50 years in living and participating in the developments in the care of people of this country. What is your reaction to our present situation, and where can we expect to go from here?

SNOKE:

I wish that I could respond authoritatively and succinctly. Unfortunately, I find it difficult to phrase the pertinent questions -- let alone answer them accurately and concisely. I believe that my whole professional career -- particularly after I became involved in hospital and health administration -- has been that of trying to understand the problems of the present; to figure out how we could solve them; what could we expect to happen in the future; and how should we plan to meet these future problems constructively. Frankly, I don't think that it is possible for any one person to give all the answers -- even though there appears to be a number of individuals, who are sure they have the solutions. I can only give you my thoughts and suggestions.

I have been very lucky in my friends and colleagues -- for it was through them that so many of the issues were pinpointed -- and together, we worked towards solutions. In recent years, Edward Tripp, Editor-in-Chief of the Yale University Press, provided a stimulus to me that has proven invaluable in making me review the past in hospital and health administration, and as a result, to look at the present and try to guess the future.

It started out innocently enough, when my wife and I invited Ed Tripp to a two day conference, supported by a grant from the Commonwealth Fund to the Yale University School of Medicine, Department of Epidemiology and Public

Health. Its objective was summarized as "the presentation of the necessary, interrelated, administrative components of a comprehensive, national health insurance program that should be taken into consideration as the decision-makers consider the various options. This is necessary so that there will be reasonable assurance that the programs or the steps of the program finally developed will have the optimum opportunity for flexibility and for success."

Unfortunately, the conference itself was not particularly successful, for most of my academic friends were not at all interested in the organization or administration of health care in this nation. They were far more interested in some particular national health program, which could serve as a basis for their participation in a full-scale national conference.

My wife, Ed Tripp, and I were disappointed, for we had not come to grips with the fundamental administrative and organizational problems that this nation faces in this most complex problem. Some time later, after I had lost my Parnie, Ed Tripp raised the question as to whether I would be interested in writing a book on hospital administration. I am afraid I just laughed -- for it seemed about as logical for me to be writing about present day hospital administration as for anyone to be asking Henry Ford, Sr. to write about the developments of the B-1 bomber.

However, I did write several chapters, which I gave to him. I still treasure his hand-typed response. It was brutally frank. He had read the first few chapters, and as a result, had searched for ways of gently suggesting to me that I forget the whole affair. However, he had then read some of the subsequent chapters, and had concluded that if I could redo the first ones in the form of the later ones, the result could be of value.

He then added another comment that I will always prize. "The message

emerged clearly through the recollections. The writing was still pretty dreadful (I marvel at how you have maintained total innocence of acquaintance with your native language all these years), but the ideas came across, and they did so right to the end."

My answer to myself was very simple. I had lost my editor, Parnie, the year before. But I tried to follow his advice, and with his assistance and that of James Hague, former Editor-in-Chief and Corporate Secretary of the American Hospital Association, the book, Hospital, Health, and People, was published by the Yale University Press in May, 1987.

The book covers the approximately 60 years that I have been privileged to be involved in the health care of people. Starting as an inexperienced junior, fortunate enough to be closely associated with the giants of the health world, I eventually assumed major responsibilities of my own. The chronicle that I have written of a long career in hospital and health administration recounts how a cocky young doctor slowly grew to realize what many doctors are discovering today, and some have known all along: patients are not just collections of symptoms that offer intellectual challenges to doctors; they are persons who happen to be sick. In telling this story not year by year, but issue by issue, I have repeatedly been struck by the fact that many of these issues are as alive today as they were a half century ago, and some are more urgent than ever.

The intervening years have brought striking developments in our therapeutic armamentarium and in our ways of treating patients. Until recently, changes came about gradually, but during the last decade the transformation has been occurring with almost explosive speed. Techniques, administration, organization, and, most particularly, costs are changing at an

exponential rate. As a result, the chief preoccupation of health professionals and health institutions today often seems to be more with the business of medicine than with its presumed purpose, the care of patients. This fundamental shift in philosophy bodes ill for the recognition that patients are, first of all, people -- and that we, as well as they, will be poorer if we ever forget it.

As every new epidemic should remind us, the health of one segment of our society cannot be separated from that of other segments. The population as a whole therefore has a stake in the well-being of every part. If that well-being is to be ensured, neither poverty, color, age, nor any other condition can be permitted to deprive any group or individual of access to health care of good quality. Moreover, health and illness cannot be separated from other conditions of existence. Many of my associates advocate that the President's cabinet include a Secretary of Health, but if health services are to be effectual, they must be considered an integral part of social services. Their intimate relationship is particularly clear in the care of children and the aged. The needs of these two groups emphasize the importance of close cooperation between government -- federal, state, and local -- and the private sector in providing necessary services and in guaranteeing their quality. This ideal state will be achieved only when we are ready to regard such care as a right, not a privilege.

This is a tall order. It is made even more difficult by the fact that our present system is inefficient and costly. Its costs, now near $450 billion a year, is approaching 11% of our gross national product. Although the Consumer Price Index in 1986 increased only 1.1%, the cost of medical care alone rose 7.7% in the same period. Efforts to curb this trend have relied on

traditional business methods: limits on payment, deductibles, co-insurance, marketing and advertising ploys, competition, and the creation of multitiered, multibillion-dollar corporations which may be non-profit, profit-making, or some combination of the two. The picture of these giant businesses competing for the privilege of caring for 35 or 40 million indigent people in this country is not easy to imagine. I share the concern of Arnold Relman, editor of the New England Journal of Medicine, over the growing "medical-industrial complex" and the doubts of Eli Ginsberg that a competitive market will ever reduce the costs of health care.

Unfortunately, attempts to stem inflation have never examined the validity of the system itself. The fact is that an appreciable part of its cost is due to inefficiency. The system's components are fragmented, often uncoordinated or duplicated, insufficiently planned, and at times poorly administered. They need to be thoroughly reassessed, recognizing that if health care is to be effective, it must be a part of a continuum that includes both prevention and post-illness care. this continuum cannot be efficiently provided by corporations vying with one another to offer treatment mainly for acute illness. It will require several kinds of institutions working together to provide care at whatever level it is needed by each individual. The key to success is cooperation, not competition.

This cooperation can be ensured only by comprehensive national policy for health and welfare. I politely challenge my colleagues to define this today. The states will need to be intimately involved in developing this policy, and particularly in implementing it. One of their major responsibilities will be to provide the authority necessary to ensure true coordination of health and social services. Appropriate exercise of this authority will depend largely

on the efficiency of a state's political and administrative organization, which I submit exists in very few states today, and upon the dedicated leadership of true professionals, not politicized bureaucrats.

The participation of the private sector -- especially of professionals and organizations in health and social services -- and of informed members of the public will also be needed. It is at this point that I become uncomfortable for the future, for I sense a growing disenchantment of many of the public with the medical profession and the hospitals of today. Part of this may be an erosion of the "M-Deity Syndrome" of the past -- but some is due to the costs of health care, charges that seem hard to justify, and an impression of commercialism that is certainly fostered by the increasing marketing, advertising, tales of malpractice, profit-making, and "dumping." I am, however, pleased to continue to hear of the high regard in which most people hold their own physician or hospital. I am convinced that the vast majority of those in my profession are truly concerned with the welfare of their patients.

However, our deficiencies -- whether actual or perceived -- may result in our system for the care of patients being subject to radical change within the next decade. This may be for the better, or the worse. It will be dependent upon the leadership of the professionals in health and welfare, the political leadership throughout the country, and the wishes -- and the understanding -- of the people themselves.

Ultimately, however, the most important locus for planning and delivering comprehensive care will be the local community or region. That is where the needs of individuals can most sensitively be assessed, and where collaborative measures to provide them can most effectively be developed. It is also where

competition and duplication -- or lack -- of services are centered, and where willing collaboration among both providers and payers is most needed. If a spirit of cooperation can be engendered, with the state's help where needed, local organization can best find the most efficient and direct means of providing maximum care with a minimum of expense and red tape.

I am well aware that each organization, special interest group, and bureaucratic entity wishes to protect its "turf," its independence, and its financial status. If changes are to be made, they should be made reasonable and with fairness to all interested parties. But it must be kept clearly in mind that the parties with the most crucial interests at stake are the people. For this reason I urge that ways of developing cooperative health systems at the levels of community, region, or state be fully and promptly explored. A first step might be to study health care systems that have been considered in states such as Connecticut, or in regions that have already developed local, vertically integrated systems of caring for people. Our major Foundations should feel challenged to support such studies before soaring costs and public dissatisfaction stimulate demand for a national health service, with its inevitable component of bureaucratic or partisan politics. I think that I have always felt that partnership for health was basic for the development of any program for the care of people -- but political myopia or prejudice could be devastating. I can recall telling a crowded town meeting in North Haven, CT, over 40 years ago, as we were discussing the construction of its first high school, "I have never been able to figure out how to determine whether a child is a Democrat or a Republican." Every time I consider a governmental health system alone, I recall two things: the first was my early experience in Cook County in Illinois and the problems of the Cook County Hospital. The

second was my experience with the New York Academy of Medicine, and its Committee on Medicine in Society. It was during this period that my wife and I met Dr. George Himler, who at that time was President of the Medical Society of the State of New York. It was then I read of his delightful phrase, when he was delivering his report as President to the House of Delegates, "The current over-enthusiasm for public regulation is a real and imminent threat because, if it gets out of control, and the ant armies of bureaucracy are released on our profession, they will destroy everything in their path."

I can only end with re-emphasizing my conviction that we have all the resources, the funds, the personnel, and a reservoir of knowledge to care adequately for the people of this nation. I urge that care of people be given high priority and that politics, bureaucracy, individual ego, the personal and institutional pocketbook, "turf," the latest epidemic of multicorporate giants, and the reverence for marketing, advertising, and competition not distort our primary objective -- a true partnership for the health and welfare of the people of this nation.

Interview in Ann Arbor

November 11, 1986