HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Cecil G. Sheps

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

CECIL G. SHEPS

In First Person: An Oral History

Interviewed by John Lowe
August 20, 1991

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

Coordinated by
Center for Hospital and Healthcare Administration History
AHA Resource Center
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611
312/280-6263

Cecil G. Sheps

CHRONOLOGY

1913 Born July 24, Winnipeg, Manitoba, Canada

1936 University of Manitoba, M.D.

1936-37 Municipality of Lac du Bonnet, Manitoba, Canada
Health Officer and General Practitioner

1940-41 Manitoba Department of Health and Welfare
Associate Director, Youth Health Services

1940-43 School Health Physician and General Practitioner, Winnipeg

1943-46 Royal Canadian Army Medical Corps
Captain

1944-46 Department of Public Health, Province of Saskatchewan, Canada
Assistant Deputy Minister and Acting Chairman, Health Services Planning Commission and Director, Division of V.D. Control

1947 Yale University, New Haven, M.P.H.

1947-50 University of North Carolina, Chapel Hill
Associate Professor, Public Health Administration

1948-52 North Carolina College, Durham
Visiting Professor of Public Health

1949-52 Duke University, Durham
Visiting Lecturer in Preventive Medicine and Public Health

1950 American Board of Preventive Medicine and Public Health
Diplomate

1950-53 University of North Carolina, Chapel Hill
Director, Program Planning, Division of Health Affairs
Research Professor of Health Planning, Division of Health Affairs
Research Professor, Institute for Research in Social Science

CHRONOLOGY (continued)

1953-60 Beth Israel Hospital, Boston
General Director

1953-60 Harvard Medical School, Boston
Clinical Professor of Preventive Medicine

1960-65 University of Pittsburgh, Pittsburgh, Graduate School of Public Health
Director, Medical and Hospital Administration Department
Professor, Medical and Hospital Administration

1963 Stanford University Medical School, Stanford, CA
Visiting Professor of Preventive Medicine

1965-68 Beth Israel Medical Center, New York City
General Director

1965-68 Mount Sinai School of Medicine, New York City
Professor of Community Health

1968- University of North Carolina, Chapel Hill
Director, Health Services Research Center, 1968-72
Professor of Social Medicine, 1968-79
Vice Chancellor, Health Services, 1971-76
Taylor Grandy Distinguished Professor of Social Medicine, School of Medicine, 1980, and Professor of Epidemiology, School of Public Health, 1980-85, Emeritus, 1986-

MEMBERSHIPS AND AFFILIATIONS

Ad Hoc Advisory Committee on Current Status and Potential Role of the Public Health Service Hospitals, U.S.P.H.S.
Member, 1977-78

American Arbitration Association
National Panel of Arbitrators, Member

American Heart Association
Member

American Medical Student Association/Foundation
Board of Directors, Member, 1986-90

American Nurses' Foundation
Board, Member
Secretary-Treasurer

American Public Health Association
Fellow
Program Area Committee on Medical Care Administration, Chairman, 1961-68
Technical Development Board, Vice Chairman, 1968-70
Program Development Board, Vice Chairman, 1970-74
Executive Board, Member, 1980-89
Program Development Board, Member, 1983-89
Publications Board, Member, 1990-

Association of American Medical Colleges
Council on Teaching Hospitals
Committee for the Teaching Hospital Information Center
Advisory Committee, Member, 1969-71

Boston University School of Medicine
Board of Visitors, Member, 1977-

Canadian Health Association
Member

Council on Social Work Education
Board of Directors, Member, 1973-75
House of Delegates, Member, 1975-81

Friends of the National Library of Medicine
Board of Directors, Member, 1986-

Georgetown University Health Policy Center
Advisory Board, Member, 1974-76

Home Medical Program for Indigents
Consultant

Housing and Home Finance Agency
Advisory Committee on Housing for Senior Citizens, Member

Institute of Medicine
Member, 1974-
Program Committee, Member, 1976-79
Membership Committee, Member, 1981-85

Journal of Community Health
Editorial Board, Member, 1983-84

Journal of Health Politics, Policy and Law
Editorial Board, Member, 1975-90

Journal of Public Health Policy
Editorial Consultant, 1978-

Journal of Rural Health
Editorial Board, Member, 1987-90
Maurice Falk Medical Fund
Technical Advisory Board, Member, 1964-

Milbank Memorial Fund Commission for the Study of Higher Education for Public Health
Chairman, 1972-75

National Academy of Sciences, Institute of Medicine
Member, 1973-

National Academy of Social Insurance
Founding Member, 1991-

National Advisory Committee to the White House Conference on Aging
Member, 1960-61

National Association for Public Health Policy
Director-at-Large, 1990-

National Association of State Universities and Land-Grant Colleges
Health Policy Committee, Member, 1975-78

National Council on Aging
Board of Directors, Member
Vice President, 1965-68

National Health Law Program
Member
National Advisory Committee, Member

National HomeCaring Council
Board, Member, 1983-86

National Library of Medicine
Board of Regents, Member, 1978-80

National Research Council
Division of Medical Sciences, Member, 1969-75
Committee on National Needs for Biomedical and Behavioral Research Personnel, Member
Panel on Health Services Research, Member, 1982-84
Committee on the Problem of Drug Dependence, Member, 1970-77

National Science Foundation
Special Commission on the Social Sciences, Chairman, 1968-69

New York Academy of Medicine
Committee on Special Studies, Member, 1968-69
Subcommittee on Social Policy for Health Care, Member, 1968-69

New York State Department of Health
Technical Advisory Committee on Quality Care and Utilization Review, Member, 1966-68

North Carolina Blue Cross/Blue Shield
Consultant, 1977-87

Office of Economic Opportunity, Washington, DC
Consultant

Pan-American Health Organization
Advisory Group on National Health Planning, Member
Special Consultant to the Dominican Republic

Physicians for Human Rights
National Advisory Committee, Member, 1986-

Physicians for Social Responsibility
Board of Sponsors, Member, 1983-

Podiatric Medicine in the South
Southern Regional Education Board, Study Team, Member, 1976-77

Rockefeller Foundation
Division of Medical Sciences, Fellow, 1946-47

Round Table Conference on Health Manpower and Medical Education in Latin America
Participant, September 30-October 4, 1963

Sigma Xi
Member

Social Work in Health Care
Editorial Board, Member, 1975-90

U.S. Department of Health, Education, and Welfare
Food and Drug Administration, Bureau of Medicine Advisory Panel System, Consultant
Health Services and Mental Health Administration, Consultant
National Advisory Committee on Chronic Disease and Health of the Aged, Member
National Cancer Institute, Consultant
National Center for Health Services Research and Development, Consultant
Social and Rehabilitation Service, Consultant

U.S. Public Health Service
- Bureau of Health Services, Consultant
- Communicable Disease Center, Training Division, Special Consultant
- National Institutes of Health
  - Health Services Research Study Section, Member, 1955-58
  - Health Services Research Study Section, Chairman, 1958-62
  - Program Advisory Committee, Stroke and Trauma Program, NINCDS, Member, 1976-
  - National Advisory Health Services Council, Member, 1963-67

World Health Organization
- Medical Society, Member

Wright State School of Medicine
- Advisory Committee, Member, 1990-

AWARDS AND HONORS

American Men and Women of Science
Listing, 1992

American Public Health Association
Sedgwick Memorial Medal for Distinguished Service in Public Health, 1990

Association for Health Services Research
Distinguished Investigator Award, 1988

Association of Teachers of Preventive Medicine
Duncan Clark Award for Distinguished Service to the Field of Preventive Medicine, 1988

Association of Yale Alumni in Public Health
Distinguished Alumnus Award, 1989

Ben Gurion University of the Negev, Israel
Doctor of Philosophy (honorary), 1983

Canadian Public Health Association
Mile Award for Scientific Achievement, 1970

Chicago Medical School
Doctor of Science (honorary), 1970

International Who's Who
Listing, 1991-92

National Rural Health Association
Louis Gorin Award for Outstanding Achievement in Rural Health, 1985

University of Manitoba, Canada
Doctor of Science (honorary), 1985

University of North Carolina
Order of the Golden Fleece, 1977

University of North Carolina
Thomas Jefferson Award, 1983

World Health Organization, Western Europe
Traveling Fellow, 1951

Yale University
Rockefeller Fellow, 1946-47

PUBLISHED WORKS

Sheps, C. G. The municipal doctor system. Canadian Advance. 1939 Apr.

Sheps, C. G. A health survey of rural Manitoba youth. Canadian Journal of Public Health. 1941 Jul. 32:350-356.

Sheps, C. G. Venereal disease and the school. Bulletin of the Saskatchewan Teachers Federation. 1945 Oct.

Sheps, C. G. Venereal disease control in Saskatchewan. Saskatchewan Medical Quarterly. 1946 Mar.

Sheps, C. G. Health regions - essential first step in Saskatchewan health program. Canadian Hospital. 1946 Sep. 23(9):49,92.

Sheps, C. G., and Watkins, J. H. Mortality in socio-economic districts of New Haven. Yale Journal of Biology and Medicine. 1947 Oct. 20:51-80.

Wright, J. J., and Sheps, C. G. Reports of North Carolina syphilis studies; evaluation of case-finding measures in syphilis control. Journal of Venereal Disease Information. 1949 Feb. 30(2):35-52.

Wright, J. J., and Sheps, C. G. Reports of North Carolina syphilis studies; evaluation of case-finding measures in multiple episodes of infectious syphilis. Journal of Venereal Disease Information. 1949 Jul. 30(7):187-194.

Wright, J. J., and Sheps, C. G. Reports of North Carolina syphilis studies; evaluation of case-finding measures in the control of gonorrhea. Journal of Venereal Disease Information. 1949 Aug. 30(8):211-217.

Sheps, C. G. The necessity for further intensification of venereal disease case-finding activities in the immediate future. Venereal Disease Control Seminar. Raleigh, NC: Health Publications Institute, Inc., 1950.

Wright, J. J., Sheps, C. G., and Gifford, A. E. Reports of North Carolina syphilis studies; some problems in the evaluation of venereal disease education. Journal of Venereal Disease Information. 1950 May. 31(5):125-133.

Wright, J. J., and Sheps, C. G. Role of case-finding in syphilis control today. American Journal of Public Health. 1950 Jul. 40(7):844-849.

Sheps, C. G. The changing emphasis in communicable disease control. North Carolina Medical Journal. 1950 Jul. 11(7):318-322.

Greenberg, B. C., Wright, J. J., and Sheps, C. G. A technique for analyzing some factors affecting the incidence of syphilis. Journal of the American Statistical Association. 1950 Sep. 45(251).

Sheps, C. G. The concept of multiphasic screening for chronic diseases. North Carolina Medical Journal. 1950 Nov. 11(11):626-630.

Wright, J. J., Sheps, C. G., and Gifford, A. E. Reports of North Carolina syphilis studies; indices in measurement of congenital syphilis. American Journal of Syphilis, Gonorrhea and Venereal Disease. 1951 May. 35(3):225-233.

Sheps, C. G. Commentary on a project for community health care. Progressive Architecture. 1951 Jul. 32:89-90.

Wright, J. J., Sheps, C. G., Taylor, E. E., and Gifford, A. E. A Study of Missed Opportunities for the Control of Congenital Syphilis. Chapel Hill, NC: University of North Carolina Press, 1951.

Sheps, C. G., Newton, G., and Connor, R. Hospitalization arrangements for the indigent of North Carolina. Public Welfare News. 1951 Sep. 15(3).

Wright, J. J., Sheps, C. G., and Taylor, E. E. Reports of North Carolina syphilis studies; study of the extent of prenatal blood testing for syphilis in a southern rural area. Southern Medical Journal. 1952 Dec. 45(12):1185-1192.

Wright, J. J., Sheps, C. G., Taylor, E. E., and Gifford, A. E. Obstacles to eradicating congenital syphilis. Public Health Reports. 1952 Dec. 67(12):1179-1184.

Gifford, A. E., Wright J. J., Sheps, C. G., and Taylor, E. E. Congenital syphilis can be eradicated. Nursing Outlook. 1953 Jan. 53.

Sheps, C. G. The city planner and the public health. In: Planning. Washington, DC: American Society of Planning Officials, 1952.

Sheps, C. G., and Fleming, W. L. Extramural facilities in medical education; student participation and supervision. Journal of Medical Education. 1953 Jul. 28(7):44-48.

Sheps, C. G. New approach to planning for public health care in North Carolina. North Carolina Medical Journal. 1953 Sep. 14(9):409-413.

Sheps, C. G., and Taylor, E. E. Needed Research in Health and Medical Care - A Biosocial Approach. Chapel Hill, NC: University of North Carolina Press, 1954.

Sheps, C. G. Cooperation between hospital administration and social service - in planning services for the patient in the community. In: Commemoration of the Fiftieth Anniversary of the Founding of Medical Service at the Massachusetts General Hospital. Boston: Massachusetts General Hospital, 1955.

Sheps, C. G. Health, hospitals and medical care. The Jewish Community. 1955 Nov. 10(4).

Sheps, C. G. We must use hospitals more effectively. Modern Hospital. 1956 Feb. 86(2):90-91.

Hunter, F., Shaffer, R. C., Sheps, C. G., and others. Community Organization - Action and Inaction. Chapel Hill, NC: University of North Carolina Press, 1956.

Sheps, C. G. Community hospital - the future health center. In: Health Horizons. Birmingham, AL: University of Alabama in Birmingham, 1956.

Sheps, C. G., and Feaks, M. E. Hospitals and health education. Health Educators at Work. 1957 May. 8.

Sheps, C. G. Health in the middle and later years. In: The New Frontiers in Aging. Ann Arbor, MI: University of Michigan Press, 1957.

Solon, J., Sheps, C. G., Lee S. S., and Jerkowitz, M. Staff perceptions of patients' use of a hospital outpatient department. Journal of Medical Education. 1958 Jan. 33(1):10-21.

Axelrod, S. J., Goldmann, F., Muller, J. N., Sheps, C. G., and Terris, M. Readings in Medical Care. Chapel Hill, NC: University of North Carolina Press, 1958.

Sheps, C. G. Hospitals and clinical teaching. Journal of Medical Education. 1959 Oct. 34(10):56-66.

Sheps, C. G. Home care programs - progress and potential. In: Proceedings of Workshop on Home Care Services. Chicago: American Hospital Association, 1960.

Lee, S. S., Solon, J., and Sheps, C. G. How new concepts of medical care affect the emergency unit. Modern Hospital. 1960 May. 94(5):97-101.

Solon, J., Sheps, C. G., and Lee, S. S. Delineating patterns of medical care. American Journal of Public Health. 1960 Aug. 50(8):1105-1113.

Solon, J., Sheps, C. G., and Lee, S. S. Patterns of medical care: a hospital's outpatients. American Journal of Public Health. 1960 Dec. 50(12):1905-1913.

Sheps, C. G., and Drosness, D. L. Prepayment for medical care. New England Journal of Medicine. 1961 Feb. 23. 264:390-396.

Sheps, C. G., and Drosness, D. L. Prepayment for medical care (continued). New England Journal of Medicine. 1961 Mar. 2. 264:444-448.

Sheps, C. G., and Drosness, D. L. Prepayment for medical care (conclusion). New England Journal of Medicine. 1961 Mar. 9. 264:494-499.

Sheps, C. G. Problems, pressures and prospects. Journal of Medical Education. 1961 Dec. 36(12):3-20.

Sheps, C. G., and Lamson, Jr., G. G. Medical schools and research in medical care. Journal of Medical Education. 1961 Dec. 36(12):234-240.

Sheps, C. G., Wolf, Jr., G. A., and Jacobson, C. Medical Education and Medical Care - Interactions and Prospects. Evanston, IL: Association of American Medical Colleges, 1961.

Solon, J. A., Sheps, C. G., Lee, S. S., and Barbano, J. P. Patterns of medical care: validity of interview information on use of hospital clinics. Journal of Health and Human Behavior. 1962 Spring. III(1):21-29.

Sheps, C. G., and Kastern, J. Home care programs. Rehabilitation Literature. 1962 May. XXIII(5):130-135.

Clark, D. A., Gerdes, J. W., Halpern, E., Hershey, N., Horty, J. F., and Sheps, C. G. Study of Affiliations Between Medical Schools and Teaching Hospitals. Evanston, IL: Association of American Medical Colleges, 1962.

Freeman, R., Sheps, C. G., Tibbitts, H. G., and Lamson, Jr., C. G. Patient care research: report of a symposium. American Journal of Public Health. 1963 Jun. 53(6):965-969.

Sheps, C. G., and Clark, D. A. Expenditures for health and medical care in the United States. New England Journal of Medicine. 1963 Dec. 26. 269:1411-1417.

Sheps, C. G. Agenda for the future. In: Past, Present and Future of Schools of Public Health. Chapel Hill, NC: University of North Carolina, 1963.

Sheps, C. G. Discussion of trends and needs for leadership in public health. In: Program Planning in Public Health Nutrition. Pittsburgh: University of Pittsburgh Graduate School of Public Health, 1964.

Solon, J. A., Sheps, C. G., Lee, S. S., Keppel, B. A. R., and Jones, S. H. Hospital outpatient services. In: Guide to Surveying Clinic Procedures. Washington, DC: Public Health Service, U.S. Department of Health, Education and Welfare, 1964.

Sheps, C. G., Clark, D. A., and Gerdes, J. W. Hospital and health resources in Idaho, Montana, Nevada and Wyoming. In: The Mountain States Medical Education Study. Boulder, CO: Western Interstate Commission for Higher Education, 1964.

Clark, D. A., and Sheps, C. G. On the administration of university teaching hospitals. Journal of Medical Education. 1964 Jun. 39(6):527-530.

Sheps, C. G. Research in Community Health. Report of Special Subcommittee of the National Advisory Community Health Committee. Washington, DC: Public Health Service, U.S. Department of Health, Education and Welfare, 1964.

Sheps, C. G, and Bachar, M. E. Nursing and medicine--emerging patterns of practice. American Journal of Nursing. 1964 Sep. 64(9):107-109.

Sheps, C. G., Sloss, J. H., and Cahil, E. Medical care in Aluminum City: I. families and their regular doctors. Journal of Chronic Diseases. 1964 Sep. 17(9):815-826.

Sheps, C. G, and Bacher, M. E. Changing patterns of practice - nursing and medical. North Carolina Medical Journal. 1964 Oct. 25(10):435-438.

Shapiro, M. A., and Sheps, C. G. Las funciones de los servicios y organismos de salud en relacion con la vivienda. Boletin de la Oficina Sanitaria Panamerican. 1964 Oct. 57(4):342-364.

Sheps, C. G. Organization and economics of outpatient and home care--realities and prospects. In: The Physician and the Community. New York City: Hartford Donation Conference on Ambulatory Care and Rehabilitation, 1964.

Sheps, C. G. Hospitals, health services, and patients. Journal of Medical Education. 1965 Jan. 40(1):50-61.

Sheps, C. G. Conference summary and the road ahead. In the Twenty-fourth Eastern States Conference, The Expanding Role of Ambulatory Services in Hospitals and Health Departments. Bulletin of the New York Academy of Medicine. 1965 Jan. 41(1):146-156.

Sheps, C. G. Interface between health facilities planning and total city planning. In: Areawide Planning: Report of the First National Conference on Areawide Health Facilities Planning. Chicago: American Medical Association, 1965.

Sheps, C. G. Emergency medical care in Allegheny County. In: Report of Committee on Emergency Medical Care in Allegheny County. 1965 May.

Kroeger, H. H., Altman, I., Clark, D. A., Johnson, A. C., and Sheps, C. G. The office practice of internists: I. the feasibility of evaluating the quality of care. JAMA: Journal of the American Medical Association. 1965 Aug. 2. 193:371-376.

Altman, I., Kroeger, H. H., Clark, D. A., Johnson, A. C., and Sheps, C. G. The office practice of internists: II. patient load. JAMA: Journal of the American Medical Association. 1965 Aug. 23. 193:667-672.

Johnson, A. C., Kroeger, H. H., Altman, I., Clark, D. A., and Sheps, C. G. The office practice of internists: III. characteristics of patients. JAMA: Journal of the American Medical Association. 1965 Sep. 13. 193:916-922.

Sheps, C. G., Clark, D. A., Gerdes, J. W., Halpern, E., and Hershey, N. Medical Schools and Hospitals: Interdependence for Education and Service. Evanston, IL: Association of American Medical Colleges, 1965.

Sheps, C. G., Clark, D. A., Gerdes, J. W., Halpern, E., and Hershey, N. Medical schools and hospitals: interdependence for education and service. Journal of Medical Education. 1965 Sep. 40(9):1-69.

Clark, D. A., Kroeger, H. H., Altman, I., Johnson, A. C., and Sheps, C. G. The office practice of internists: IV. professional activities other than care of private patients. JAMA: Journal of the American Medical Association. 1965 Oct. 11. 194:177-181.

Sheps, C. G. Ambulatory care: the need for a new focus. In: Nursing Care for the Ambulatory Patient. New York City: John A. Hartford Foundation, 1965.

Sheps, C. G. Crucial issues facing preventive medicine and public health. Journal of Medical Education. 1965 Oct. 40(10):112-122.

Kroeger, H. H., Altman, I., Clark, D. A., Johnson, A. C., and Sheps, C. G. The office practice of internists. V. background and form of practice of 500 internists in New York State. JAMA: Journal of the American Medical Association. 1965 Nov. 1. 194:533-538.

Sheps, C. G. A perspective for today's realities. Report of the Second Administrative Institute, Medical School-Teaching Hospital Relations. Journal of Medical Education. 1965 Nov. 40(11):76-80.

Hunter, F., Schaffer, R. C., and Sheps, C. G. Working hypotheses regarding community health action. In: Perspective on the American Community. Chicago: Rand McNally and Company, 1966.

Sloss, J. H., Cahill, E., and Sheps, C. G. Medical care in Aluminum City: II. the selection and use of specialist. Archives of Environmental Health. 1966 Jan. 12(1):6-62.

Sheps, C. G. Clinical care and its provisions. In: Community Health; Its Needs and Resources. New York City: Basic Books, 1966.

Sheps, C. G. The impact of federal legislation on the practice of medicine. Cornell University Medical College Alumni Bulletin. 1966 Fall. 30(1):12-13.

Sheps, C. G. Extending patient care. In: Report of Tenth Joint Annual Auxiliary Conference. New York City: United Hospital Fund of New York and Hospital Association of New York State, 1967.

Solon, J. A., Feeney, J. J., Jones, S. H., Rigg, R. D., and Sheps, C. G. Delineating episodes of medical care. American Journal of Public Health. 1967 Mar. 57(3):401-408.

Sheps, C. G. The medical school--community expectations. Journal of Mount Sinai Hospital. 1967 May-Jun. 34(3):216-221.

Sheps, C. G., and Madison, D. L. Evaluation of Neighborhood Health Centers; A Plan for Implementation. New York City: Mount Sinai School of Medicine, 1967.

Van Houten, D. R, and Sheps, C. G. The role of the president of the medical staff: the administrator's view. Hospital Administration. 1967 Summer. 12(3):21-39.

Sheps, C. G. Group practice. New York Medicine. 1968 Jun. 24(6):323-327.

Dana, B., and Sheps, C. G. Trends and issues in interprofessional education: pride, prejudice and progress. Journal of Education for Social Work. 1968 Fall. 4(2):35-41.

Barry, M. C., and Sheps, C. G. A new model for community health planning. American Journal of Public Health. 1969 Feb. 59(2):226-236.

Kovner, A. R., Katz, G., Kahane, S. B., and Sheps, C. G. Relating a neighborhood health center to a general hospital: a case history. Medical Care. 1969 Mar.-Apr. 7(2):118-123.

Sheps, C. G. The new imperative. The Johns Hopkins Medical Journal. 1969 May. 124(5):283-290.

Solon, J. A., Rigg, R. D., Jones, S. H., Feeney, J. J., Lingner, J. W., and Sheps, C. G. Episodes of medical care: nursing students' use of medical services. American Journal of Public Health. 1969 Jun. 59(6):936-946.

McNulty, Jr., M. F., Sheps, C. G., and Knapp, R. M. The role of the teaching hospital in community service. Journal of Medical Education. 1970 Jun. 45(6):403-410.

Sheps, C. G. The medical student, the public and medical care. Illinois Medical Journal. 1970 Dec. 138(2):598-601.

Sheps, C. G. Trends in hospital care. Inquiry. 1971 Mar. 8(1):27-31.

Sheps, C. G., and Seipp, C. The medical school, its products and its problems. The Annals of the American Academy of Political and Social Science. 1972 Jan. 399(1):38-49.

Sheps, C. G. The influence of consumer sponsorship on medical services. The Milbank Memorial Fund Quarterly. 1972 Oct. 50(4):41-69.

Sheps, C. G. What gives meaning to the interdependence of hospitals. Bulletin of The New York Academy of Medicine. 1972 Dec. 48(11):1481-1485.

Sheps, C. G. Faculty tradition and the HMO. Journal of Medical Education. 1973 Apr. 48(4):34-40.

Sheps, C. G. An overview of the area health education centers. In: Proceedings of the Area Health Education Center National Conference. St. Louis: Area Health Education Center, 1973.

Sheps, C. G. Integration of hospitals and community medicine. In: Proceedings: Batsheva Seminar on Health Administration and Health Economics. Beersheba, Israel, 1973.

Sheps, C. G. Trends in hospital care. In: Health Care Administration; A Managerial Perspective. Philadelphia: J. B. Lippincott Company, 1973.

Sheps, C. G. Schools of public health in transition. Milbank Memorial Fund Quarterly - Health and Society. 1973 Fall. 51(4):462-468.

Sheps, C. G. The influence of consumer sponsorship on medical services. In: The Citizenry and the Hospital. Durham, NC: Department of Health Administration, Duke University, 1974.

Alcott, J., Madison, D. L., and Sheps, C. G. Primary medical care and group practice in North Carolina. North Carolina Medical Journal. 1974 Jan. 35(1):33-37.

Sheps, C. G. Integration of hospitals and community medicine. Israeli Journal of Medical Sciences. 1974 Jan.-Feb. 10(102):5-8.

Kovner, A. R., Katz, G., Kahane, S. B., and Sheps, C. G. Relating a neighborhood health center to a general hospital: a case history. In: Neighborhood Health Centers. Lexington, MA: D.C. Heath and Co., 1974.

Sheps, C. G. Trends in schools of public health in the United States since World War II. In: Schools of Public Health; Present and Future. New York City: Josiah Macy, Jr. Foundation, 1974.

Sheps, C. G. The future of schools of public health: The University of North Carolina School of Public Health. In: Schools of Public Health; Present and Future. New York City: Josiah Macy, Jr. Foundation, 1974.

Sheps, C. G. Developmental perspectives on interprofessional education. Medicine and Social Work. New York City: PRODIST, 1974.

Sheps, C. G. The influence of consumer sponsorship on medical services. In: Organizational Issues in the Delivery of Health Services: A Selection of Articles from the Milbank Memorial Fund Quarterly. New York City: PRODIST, 1974.

Sheps, C. G. Issues in higher education for public health. The Role of Black Colleges in Education and Training Health Services Administrators. Washington, DC: Howard University, Health Services Administration Department, School of Business and Public Administration, 1975.

Sheps, C. G. The houses of health. Moment. 1975 Dec. 1(5):54-58.

Sheps, C. G. The university and the governance of area health education centers. In: Proceedings of the Area Health Education Center National Conference. Asheville, NC: U.S. Department of Health, Education and Welfare, 1975.

Sheps, C. G. Higher Education for Public Health. New York City: PRODIST, 1976.

Mechanic, D. E., Elinson, J., Fein, R., Haggerty, R., Hess, A., Lewis, C., and Sheps, C. G. Report on the development of a universal health system, Puerto Rico. In: Research and Analytic Series. Madison, WI: University of Wisconsin, 1976.

Sheps, C. G. Academe and state health action: the case of mutual advantage. In: Academe and State Legislative Policies for Health. Washington, DC: Georgetown University, 1976.

Sheps, C. G. Public policy and the prospects for preventive medicine. In: Preventive Medicine, USA. New York City: PRODIST, 1976.

Sheps, C. G. Reply to Sagar Jain. Journal of Health Politics, Policy and Law. 1977 Spring. 2(1):146-152.

Sheps, C. G. The university and dental education. North Carolina Dental Journal. 1977 Spring. 60(2):10-15.

Sheps, C. G. Education for what? A decalogue for change. JAMA: Journal of the American Medical Association. 1977 Jul. 18. 238(3):232-235.

Sheps, C. G., and Madison, D. L. The medical perspective. Regionalization and Health Policy. Washington, DC: Health Resources Administration, Public Health Service, U.S. Department of Health, Education and Welfare, 1977.

Sheps, C. G. New forms of health science education. In: Health Sciences Education in the Twenty-First Century. Newport Beach, CA: Strategic Planning Team - Health Sciences, University of California Academic Planning Program Review Board, University of California, 1977.

Burrell, C. D., and Sheps, C. G. Primary Health Care in Industrialized Nations. New York City: The New York Academy of Sciences, 1978.

Sheps, C. G. Primary care - the problems and the prospect. Primary Health Care in Industrialized Nations. New York City: The New York Academy of Sciences, 1978.

Sheps, C. G. Mary E. Switzer Memorial Lecture: health services and professional eduction--vested interests versus public need. Journal of Allied Health. 1979 Feb. 8(1):15-23.

Sheps, C. G. Preventive medicine. JAMA: Journal of the American Medical Association. 1979 Mar. 30. 241(13):1984-1985.

Sheps, C. G. Identifying the relationship between higher education for public health and the field of practice. American Journal of Public Health. 1980 Jan. 70(1):1,7-9.

Sheps, C. G. A developmental approach to meeting human needs. The Social Welfare Forum 1979. Philadelphia: Columbia University Press, 1980.

Sheps, C. G. Problems and prospects for management development in health care. Conference Summary: National Conference on Management Development in Health Care. Philadelphia: The Wharton School, University of Pennsylvania, 1980.

Sheps, C. G. Trends in hospital care. In: Multihospital Systems: Strategies for Organization and Management. Germantown, MD: Aspen Systems Corporation, 1980.

David, J. E., Greene, S. B., and Sheps, C. G. Ambulatory surgery in North Carolina, 1980--the need for greater utilization. North Carolina Medical Journal. 1980 Dec. 41(12):815-817.

Sheps, C. G., and Bachar, M. Rural areas and personal health services; current strategies. American Journal of Public Health. 1981 Jan. 71(1):71-82.

Sheps, C. G. The modern crisis in health services - professional concerns and the public interest. Israeli Journal of Medical Sciences. 1981 Jan. 17(2-3):71-79.

Sheps, C. G. The role of health services research in the Veterans Administration--and beyond. Journal of Medical Systems. 1981. 5(1-2):147-155.

Sheps, C. G. Geriatrics as a subversive force in medical education. In: Proceedings of Seminars, 1976-80, Duke Council on Aging and Human Development. Durham, NC: Center for the Study of Aging and Human Development, Duke University Medical Center, 1981.

Sheps, C. G., and Richie, N. D. The U.S. health care system today, part A. In: The Health Professions. Philadelphia: W. B. Saunders Company, 1982.

Sheps, C. G., Lewis, I. J., and Lukashok, H. The Academic Medical Center in New York City. New York City: United Hospital Fund, 1982.

Wilson, G., Sheps, C. G, and Oliver, T. R. Effects of hospital revenue bonds on hospital planning and operations. New England Journal of Medicine. 1982 Dec. 2. 307(23):1426-1429.

Sheps, C. G., Wagner, E. H., and Schofeld, W. H. An evaluation of subsidized rural primary care programs: I. a typology of practice organizations. American Journal of Public Health. 1983 Jan. 73(1):38-49.

Lewis, I. J., and Sheps, C. G. The Sick Citadel: The American Academic Medical Center and the Public Interest. Cambridge, MA: Oelgeschlager, Gunn, and Hain, Inc., 1983.

Sheps, C. G. Public health. In: Handbook of Health Professions Education. San Francisco: Jossey-Bass Publishers, 1983.

Sheps, C. G. Dean Alexander Clark, General Director, 1949-1961. In: The Massachusetts General Hospital 1955-1980. Boston: Little, Brown and Company, 1983.

Ricketts, T. C., Guild, P. A., Sheps, C. G., and Wagner, E. H. An evaluation of subsidized rural primary care programs: III. stress and survival, 1981-1982. American Journal of Public Health. 1984 Aug. 74(8):816-819.

Menken, M., and Sheps, C. G. Undergraduate education in the medical specialties: the case of neurology. New England Journal of Medicine. 1984 Oct. 18. 311(16):1045-1048.

Menken, M., and Sheps, C. G. Consequences of an oversupply of specialists for primary care: the case of neurology. Public Health Reviews. 1984. 12(3-4):253-257.

Sheps, C. G. Congress review - what have we learned? Public Health Reviews. 1984. 12(3-4):393-402.

Sheps, C. G. Implementing change within the academic medical center. Bulletin of the New York Academy of Medicine. 1985 Mar. 61(2):175-183.

Menken, M., and Sheps, C. G. Consequences of an oversupply of specialists. JAMA: Journal of the American Medical Association. 1985 Apr. 5. 253(13):1926-1928.

Sheps, C. G. Private investment in perinatal services. Birth. 1985 Spring. 12(1):37-39.

McLaughlin, C. P., Ricketts, T. C., Freund, D. A., and Sheps, C. G. An evaluation of subsidized rural primary care programs: IV. impact of the rural hospital on clinic self-sufficiency. American Journal of Public Health. 1985 Jul. 75(7):749.

Sheps, C. G. Orchestrating the delivery of health care for individuals with musculoskeletal disorders. In: Arthritis and Society - The Impact of Musculoskeletal Diseases. London, England: Butterworths & Co., 1985.

Sheps, C. G. Convocation address. University of Manitoba Medical Journal. 1985. 55(2):47-48.

Sheps, C. G. Review of the national preventive dentistry demonstration program. American Journal of Public Health. 1986 Apr. 76(4):434-447.

Green, S. B., Hoffner, J. C., and Sheps, C. G. A statewide program for increasing the use of ambulatory surgery. In: Major Ambulatory Surgery. Baltimore, MD: Williams & Wilkins, 1986.

Sheps, C. G. Coda: patient and community involvement. In: Primary Care: From Principle to Practice. Washington, DC: U.S. Department of Health and Human Services, 1987.

Maglacas, A. M., Ulin, P. R., and Sheps, C. G. Health Manpower for Primary Care: The Experience of the Nurse Practitioner. Chapel Hill, NC: University of North Carolina. 1987.

Sheps, C. G. The changing health care system: AHEC and education in the ambulatory setting. The National AHEC Bulletin. 1989 Spring. VII(1):3.

Sheps, C. G. The context of the paradigm shift. Journal of General Internal Medicine. 1989 Jul.-Aug. 4(4):356-357.

Friedman, C. P., de Bliek, R., Greer, D. S., Mennin, S. P., Sheps, C. G., Swanson, D. B., and Woodward, C. A. Charting the winds of change: evaluating innovative medical curricula. Academic Medicine. 1990 Jan. 65(1):8-14.

Sheps, C. G. Public policy: national health insurance and the United States. Journal of Professional Nursing. 1990 Jul.-Aug. 6(4):196.

Sheps, C. G. Prevention and promotion. Bulletin of the New York Academy of Medicine. 1992 Mar.-Apr. 68(2):236-238.

LOWE:

What are your most fond remembrances of growing up?

SHEPS:

I was born in Winnipeg, Canada. My parents were both immigrants from Southern Russia--the Odessa area. They were socialists, and that combination had a tremendous amount of influence on my beginnings and my general orientation. I was brought up to understand that there are a lot of people in this world who don't have enough to eat and don't have a decent place to live and no jobs and so on and that I had some responsibility to try, at least in my own small way, to do something about that. So, when I was a small boy, my notion was that I would go to law school, become a lawyer, and go into politics, not necessarily run for office but be deeply involved in politics because that is the language of social change.

What happened to me was that in my last year of high school in Winnipeg, I went to a university extension lecture. The University of Manitoba arranged for its faculty to give a public lecture every two or three months. I went to a lecture given by Professor William Boyd called "The Triumphs of Medicine." William Boyd was a famous man in medicine. He was the author of what was the standard textbook of pathology in the English language and used all over the world. He was a very articulate Scot, a very interesting man, and he gave a wonderful talk. In 1930, the

triumphs of medicine were also in public health. The big developments of clinical medicine didn't start until after World War II, so what he talked about was public health. I came away from that lecture resolved that I could deal with my social conscience by studying medicine and then going into public health, and so that is what I did.

Now, I quite deliberately spent a little time in rural medical practice and also in urban medical practice knowing that I wasn't going to stay in it but wanting that experience as part of my background. I believed that I couldn't be very effective in public health if I didn't understand what clinicians do and how they feel about it. I had about a year's experience in rural practice by looking after doctors' practices who went on vacation. Then I opened an office for the practice of medicine in the city of Winnipeg. The war began, and I joined the Army. And I was simply acting as a clinician in an Army camp hospital when Dr. Brock Chisholm, who was the director-general of medical services in the Canadian Army, came to our camp. He gave a talk about the Royal Canadian Army Medical Corps and what it was doing and so on. I asked some questions and apparently those questions impressed him because, about two weeks afterward, I was given orders to go to Ottawa where I spent a couple of months in the central office of the director-general of medical services. Then he said to me, "You know you really ought to go into some form of public health. I'm

going to make you the venereal disease control officer for military district 10, which is coterminous with the boundaries of the Province of Alberta."

LOWE:

This was World War II?

SHEPS:

Yes. I was also civilian venereal disease control officer for the Province as a whole. This was a very good combination because we used the concept of the facilitation process. That meant where is the spread of venereal disease facilitated? It's facilitated in the bars, the beer parlors: places where soldiers pick up girls. We had a very effective program by which, when we made a diagnosis of syphilis or gonorrhea in a soldier, we would question him about his sexual contacts. We didn't follow up the contacts, but what we did was to follow up the places where they made these contacts. And we would say to a beer parlor owner, for example, "Look. This is what's happening in your place, and this is what we want you to do," and so on.

LOWE:

Was that standard practice for venereal disease control?

SHEPS:

Yes, it was, and it was very good, you know, because it was a total program. There was a man called D. H. Williams, a physician, a very brilliant guy who developed this whole idea, and

it was ultimately picked up by the British Army and the American Army because it worked very well. Anyway, I did that and then what happened was that in the Province of Saskatchewan, there was an election in 1944 and, for the first time, the Canadian Cooperative Federation, which is now called the New Democratic Party--that's the third political party in Canada, which is a socialist-farmer-labor party, which I belonged to Manitoba--was elected to office. The leader of the party, Tommy Douglas, called me and invited me to come to Saskatchewan to develop their health insurance program. And I did that. I was seconded to Saskatchewan to be the venereal disease control officer for the Army in the morning and in the afternoon I developed the first legislation on the North American continent for universal and compulsory hospitalization insurance. It was adopted in 1946. It wasn't until the early '60s that Saskatchewan again led the field by developing insurance for physician services, and then by 1970 all the provinces had followed suit as they had previously done for hospital insurance.

LOWE:

There was the election of this socialist government who paved the way for that.

SHEPS:

That's right.

LOWE:

How long was that government in power? Were they able to see it through?

SHEPS:

Oh yes, they were in power uninterrupted for about 20 years, and it's been in and out since then. What they did was very popular. Hospitalization insurance made them very popular and other things too. They tried to reorganize the economy, that was much more difficult to do, in one province. Anyway, I was doing that and then what happened was that my wife was also a physician and we worked together, but during that time we adopted a child so she wasn't doing work for a little while.

In 1946, Dr. John B. Grant, who was a staff member of the Rockefeller Foundation, came out to Saskatchewan to look at the program, but he had another item on his agenda, and that was to see whether I would be a suitable person for the Rockefeller Foundation to give a fellowship to. They had decided at the foundation, after the war, that medical care administration should become a subject for academic study. Having made that decision they then decided they had to find some people whom they could invest in in order to do that, and that's the main reason he came out. He interviewed me, grilled me. I didn't know that this was the reason, and then he offered me a fellowship and I accepted it. I went to Yale to study with Franz Goldmann, who was one of the pioneers in this

field. The first pioneer was Nathan Sinai of the University of Michigan, who started in the '30s, and the next person was Goldmann. Goldmann came from Germany. He was partly Jewish, and he left Germany and was a refugee in Peking, China, for a while.

LOWE:

So this was long before the government decided to get involved in funding medical care studies, and Rockefeller was unique at that time among philanthropies also.

SHEPS:

Yes, they made the decision that this was timely, and they looked for suitable people. There was a man called Wing who was at Hopkins whom they supported. They supported me, they supported Dr. Leonard Rosenfeld, who ended up here and died not quite a year ago, and a few other people.

LOWE:

Did they bring this group of people together?

SHEPS:

No, they never did that. But, in my case, for example, they provided a tremendous amount of support. I don't mean money, they provided money, but, you know, you were a goddamn Communist if you went into this field at that time. The AMA had a file on me, not only because of this but because of the work I had done in Saskatchewan.

LOWE:

And your revolutionary background.

SHEPS:

That's right.

LOWE:

Those were tough days for a Communist.

SHEPS:

Oh yes, and I wasn't a Communist. I was a Socialist. I was brought up by my parents who had a tremendous animosity toward the Soviet Union because of the split between the Socialists and the Communists.

LOWE:

What was your parents' reaction to this career track that you had adopted, this change from law to medicine and then going to medical school?

SHEPS:

They were very supportive. They thought it was a bit risky to go into the public side of this. It wasn't secure, but they were proud of it because of the fact that they had this conviction that good people ought to be working in the public sector. So there was support from them.

LOWE:

Looking back, your early Canadian days obviously had a lot of influence on your thinking and your future directions. You

mentioned a number of people. Were there people, clinicians in particular, in your early days in practice or faculty from the medical school, that were particularly impressive to you?

SHEPS:

There was a faculty member at the medical school called Fred Jackson, M.D., who was the deputy minister of health in the Province of Manitoba. I'm glad you asked me that question. I haven't thought about it for a long time. He wrote a paper in the early '30s when I was a medical student in which he talked about medicine as a public function. I read that paper, and I just thought it was great. I went to see him, and he gave me a job after I graduated. I worked in his department for a year half-time, and the other half-time I was trying to go into private practice. That gave me a lot of encouragement.

LOWE:

Did you detect the tensions between private practice and public-supported health care in those days? Was that something that was fairly evident?

SHEPS:

Oh, yes, that was very clear, and even epidemiological studies were frowned upon. I remember one time when my wife was the physician for the Planned Parenthood organization of the city of Winnipeg, and after several years she analyzed all her cases. There were over 300 of them to whom she had given birth-control

advice, and she did a paper on this, which she presented to the Winnipeg Medical Society. I remember sitting in the audience before the meeting started with the doctors slapping their thighs and chuckling because they figured that this would be lascivious stuff, and they were flabbergasted when they saw that most of these patients had had three or four children. I remember that scene very well. That kind of work didn't get very much recognition then.

Nevertheless, when I was working, for example, for Dr. Fred Jackson in the Provincial Health Department, and afterward I had a part-time job in the City Health Department doing physical examinations in the school system that, too, people thought was a waste of time. That's the attitude that existed with regard to medicine. The epidemiologic approach to health problems wasn't very strong at that time. It was just beginning to develop.

LOWE:

Well, the technology of it was not well developed and that took people doing it, doing the surveys, doing the analysis, and coming back.

SHEPS:

That's right.

LOWE:

You and your wife made a very formidable-looking team of two capable physicians. Was that unusual in those days, professional couples?

SHEPS:

Yes, it was unusual. But our families were friends, and we had known each other since we were children. I talked her into going into medicine. She was going to do mathematics. She was very talented mathematically, and, of course, went on later to became an internationally known biostatistician and then began to work on demographic problems and helped to develop the field of mathematical demography.

LOWE:

So she continued that work when you left for Yale and the family went. Did she continue working in that field?

SHEPS:

Yes, she was developing, but when we were at Chapel Hill the first time, she worked as a clinician in the rapid treatment center for syphilis in Durham. But, at the same time, she took courses in biostatistics and in mathematical statistics at the University of North Carolina (UNC) so that she equipped herself to become what she eventually became, which was a biostatistician. Much later she began to apply that knowledge and those skills to the field of

demography. Very quickly, in a couple of years, she became very well known in the field of mathematical demography.

LOWE:

You began to talk about your time at Yale and some of the influential people, and there came a point where a decision needed to be made about returning home, taking an academic position. Talk a little bit about the dynamics of that.

SHEPS:

Before I do that, let me just mention Yale again because in addition to Goldmann, a tremendous influence on me was C. E. A. Winslow. He had been the first chairman of preventive medicine at Yale, and then he set up its school of public health. He was a sanitary engineer by training. He was a brilliant guy, just brilliant, very articulate, a wonderful man. He was also very inspiring. Being near him was very important so that I had two father figures, and that's unusual. Two figures who really represented what I was deeply interested in, and they had a lot of influence on me. Now let's go back to what you were asking.

LOWE:

From your time at Yale, your next move, because your fellowship was concluding for your master's work.

SHEPS:

I was on leave from the Province of Saskatchewan. The health services planning commission that my wife and I set up was to

continue to develop new program elements. When we were still there, before we went to New Haven, we developed the legislation for compulsory hospitalization insurance. They hired two people, Dr. Fred Mott and Dr. Leonard Rosenfeld, who was Mott's assistant, to implement the legislation. Rosenfeld went all over the province to help make that legislation work.

I went off to get an MPH in medical care administration, expecting to come back to Saskatchewan. In the early spring toward the end of the academic year, I received a letter from Dr. Mott telling me that it would be best if I didn't come back, because I had succeeded in alienating the medical profession, and it really wouldn't be good for the program or for me if I came back. I was very hurt by that, personally very hurt, as you can understand. You could also understand that for the College of Physicians and Surgeons, which is what the medical society was called in that province, I was, of course, the devil incarnate. But anybody who did what I did would have earned that reputation from them. It may be that I wasn't as diplomatic as one might be, but basically I represented the disaster from their point of view.

LOWE:

Like shooting the messenger almost.

SHEPS:

Yes, that's right. I was very hurt by that, and I had to look for a job.

LOWE:

But they made it clear it was a political issue.

SHEPS:

Oh, yes, they made it very clear.

LOWE:

It didn't make it any easier.

SHEPS:

No, it didn't, and, of course, I think that it was unnecessary, because Mott at that time was the head of the program. He was older, had a lot of prestige. He had studied medicine at McGill in Montreal, and his father had been the international secretary of the YMCA, and so on. But still that is what they did, and so I had to look for a job. There was an opening in Chapel Hill at UNC to teach in the summer school of the school of public health. At that time, summer school was very important, because it provided opportunities for people in health departments, primarily public health nurses, to beef up their background, and you could do it in the summertime.

LOWE:

So it was very much a continuing education opportunity.

SHEPS:

Exactly. I was appointed for the summer to teach biostatistics and epidemiology. Well, I had just taken these courses; I was hardly qualified to teach. However, I came down

here. I lived at the Carolina Inn, and my family went to Winnipeg. It was hotter than hell. There was no air conditioning then, and in the morning I would give a lecture in epidemiology and a lecture in biostatistics, and in the afternoon, I would prepare the next day's lectures while sweating bullets. I was just a little bit ahead of the students, having just taken these courses myself. But it was a marvelous experience because it necessitated my really understanding what those fields meant.

LOWE:

There is nothing like convincing people that you have enough mastery over a subject to keep ahead of them.

SHEPS:

That's right, and getting that mastery was a continual task, but it was something that was very good for me. I realized it even then, once I saw that it was going well.

LOWE:

But that appointment was just for the summer. Was that right?

SHEPS:

Just for summer. But after I was here four or five weeks, they offered me an appointment on the faculty as an associate professor. So I accepted it, and I developed a course called "Health and Sickness in Modern Society," which I gave in the school of public health and in the medical school. It was what is called today social medicine--social factors in health and disease and

social and political aspects of health and human development. I had a lecture on housing and health, nutrition and health, job security and health, and so on. I also had one on religion and health. I talked about various religions and their attitudes toward health and the dietary proscriptions of the Jewish religion.

Without fail--I gave this course for six years--a week or 10 days after I gave the lecture on religion and health, there would be a priest who would want to see me, a Catholic priest, and he would say, "I understand that in the course you talked about religion and you were critical of the Catholic religion." I said, "I'm not critical of the Catholic religion. What I say in my course is that people are entitled to any religious beliefs that they want to adhere to, but that doesn't entitle them to expect that everybody else is going to adhere to it and that my criticism of the Catholic Church is that it's not satisfied with its own adherence and tries to produce a situation in which other people would have to adhere also." Anyway, that happened every year. It was a very stimulating time for me.

LOWE:

Were you into your diplomate in the Board of Preventive Medicine at that time?

SHEPS:

Yes. I think it was 1950 or 1951. It was the third year after it was formed, and I was very proud of the fact that they

told me that I had achieved the highest grade that anybody had so far. Well, you know it meant a great deal to me. It was not just a job. It was an expression of what I stood for. I was happy here as a faculty member.

LOWE:

You were quite productive in terms of publishing then with Wright in venereal disease.

SHEPS:

That paid my salary for the first few years. It was for me wonderful stuff because it was evaluation work, and I was among one of the first people to ever do an evaluation of health programs. We were evaluating programs that were delivering care, and it was a wonderful experience. I wrote a paper, which I'm very proud of, on the evaluation of health education activities. I was the first person to say, "We can evaluate these programs, and here are some of the ways of doing it." I remember in my last sentence, which the colleague with whom I wrote this was critical of and I insisted that it should stay in, was the fact that this is a difficult task doesn't make it one whit less important. And she thought that this was too colloquial. It wasn't a scientific expression. And I said, "That's right, but it's going to hit people between the eyes." That got me started on this whole evaluation thing, which I worked on in other ways afterward.

LOWE:

Well, evaluating health education has long been roundly criticized or viewed as impossible or not informative, and the technology of evaluation has evolved over time as well.

SHEPS:

When was the book that we put together on readings in medical care?

LOWE:

It was about the mid-'50s.

SHEPS:

It was after that. Yes, I was in Boston at that time. Well, in 1953, much to my surprise, I was invited to Boston to be the general director of the Beth Israel Hospital in Boston. It's a very prestigious place. They had a director who had been there for 25 years who was retiring because of age, Charles Wilinsky, who was a very interesting guy, very political. He was also a part-time health officer for the city health department. He was a confidant of the Catholic bishop whom he was very close to, and he was a very political guy. They invited me to take the position as well as a faculty appointment in the Harvard Medical School.

LOWE:

Was that as the result of a search, or did they come after you?

SHEPS:

Yes, they came after me. It never occurred to me that I would do something like that.

LOWE:

How do you think that they were made aware of your capacity for this job? What were some of the dynamics?

SHEPS:

There was a meeting that the Rockefeller Foundation had arranged in the Rocky Mountains somewhere, and there was somebody there from the Rockefeller Foundation, a very brilliant guy. And, in any case, they arranged this meeting to talk about the future of preventive medicine. The question of the role of medical care administration was discussed, and I was involved in that discussion. I guess that gave me a boost. I am quite articulate. Anyway, I got this invitation, and the dean of the Harvard Medical School at that time was a man called George Packer Berry, who was a very broad-gauged person. He was a bacteriologist from Rochester, NY. He was the key figure that urged the hospital to take me on, and he was very helpful to me.

I have a wonderful story about him. One day we were working on something, and he said, "Come. I have to speak to the medical students about something. It won't take long." He met with one of the classes I taught earlier in the year, and he made a little talk. As we were walking back together, I said, "George, that

tradition that you were talking about at Harvard. When did that start?" And he said, "Today." It's something that I've used since then a couple of times in a situation where I've said, "It's a tradition of this institution." Everybody accepts it when you put it that way.

LOWE:

How did you feel about going to an institution as prestigious as the Beth Israel not having really much management experience and now the kind of supervisor of a far-flung empire? How did you deal with that?

SHEPS:

Well, it was a concern to me. I read a few things that were helpful, and I realized that I had two jobs. One of them was to manage the place, to worry about the bottom line, to make sure the labs opened on time and all that kind of thing. But the other job was to help lead the medical staff toward greater academic achievement, and I saw a distinction between those two things.

The board of trustees was not so clear about that, and I had a big job of educating them, and it's best illustrated, I think, by the following incident. We had somebody in rehabilitation, a field that was just beginning then. We had a part-time physician who was a rehabilitation expert, and he came to me and he said, "I'm working at three hospitals, and I really don't like that. The biggest job I have is to educate the medical staff to what the

possibilities are because they have to make the referrals to us. So I've decided I want to work in one place, and I would like to be here." I said, "That's a great idea. I agree with you, but I'm going to have to go to the board and get the money." So I proposed this to the board. Now the board had a member who was an older man, a bachelor, a lawyer, a very tough, testy guy who prided himself on knowing more than anybody else on the board and more than the director about how to run the place and what the issues were. He began to quiz me in a very unfriendly way about this. "Will it pay for itself?" I said, "I don't know." "How long will that take?" "I don't know." "Well," he said, "I don't think we should do anything like this unless we know it's going to pay for itself." I said, "Mr. Watchmaker, you're proud of this place, aren't you?" He said, "I sure am." I said, "How would you feel if a member of your family was treated here and was discharged with a disability that he really didn't have to have and that happened because we didn't have a rehabilitation consultant?" Well, that devastated him. He never forgave me. That kind of thing didn't happen very often. That was the most striking illustration.

But it was great fun because I was moving the institution. Then I began to realize how important ambulatory care was, and I had a friend, Dean Clark, who was a physician a bit older than I was, and I'd known him for a long time, and he was very progressive. He was the general director of the Massachusetts

General Hospital at that time. He and I came to the conclusion that the future really lay in ambulatory care. We were way ahead of the current thinking in this regard.

LOWE:

Yes, the '50s.

SHEPS:

Each of us began to work on our Outpatient Department and produce changes. I hired Sidney S. Lee, whom I'd known as a medical student. When I was getting my MPH at Yale, he was an undergraduate student. I got to know him because you could at Yale get your MD and MPH together if you were a student there, and he was doing that. I hired him to be the director of ambulatory care, and I think that was the first appointment of a full-time person in the country for that kind of task. All patients got appointments at that time, either 8:00 in the morning or 1:00 in the afternoon, and then of course they would wait. They were taken in the order in which they registered so that some people would turn up at 6:00 in the morning.

We were the first in the country to develop an honest-to-God appointment system for ambulatory patients. The physicians, most of them, were opposed to this. They would say, "What do you mean you're giving them appointments just like I do in my private office?" But that changed. After it was in operation a year or so, I got a call one day from a physician who said, "I just want

to tell you it took me 20 minutes to find a parking space this morning, and there are patients waiting for me in the Outpatient Department!" For years before that, it never would have occurred to him that that was a problem. It's an interesting story.

LOWE:

Boston is a very important and interesting health care city in medical care. Were there unique aspects of that environment that made it possible to do some of these things? You had so many brilliant people in many disciplines.

SHEPS:

There was a tradition, a Boston tradition, which you had to be part of. If you didn't recognize it and do something about it, you were left far behind. It's an interesting reflection of that, and that started in the early part of the century. The Beth Israel Hospital was originally started by another name, and then it took its current name at the turn of the century. It was a place for Jewish doctors, because they were discriminated against for the staff appointments in other hospitals, and for Jews who were religious, most of them were at that time, there was the problem of the dietary laws and so on.

So they started a little Jewish hospital in the Jewish district of Boston. I have forgotten the name of it. There was a man who was the king of the Jews in Boston, Mr. Kirstein. He was the manager of the big department store, Filene's. He got the idea

that this hospital wasn't going to get anywhere. It wasn't going to achieve its objectives of high-level medical care and provide real opportunities for the Jewish physician if it didn't affiliate with Harvard. So he was powerful enough in the community that he got them to move to the Harvard Medical School campus area.

LOWE:

Move the entire facility?

SHEPS:

Yes, and they moved to an area right next to the Harvard Medical School, and they built Beth Israel Hospital and that was the objective. Dr. Wilinsky, who was also a part-time health officer, was the director for some 25 years, and then they asked me. It was a very stimulating place to be. It was a place where you could experiment with new services and so on. The standards were very high.

LOWE:

We were in the middle of discussing what an interesting place Boston was and the neat kind of things and health programs that were possible there.

SHEPS:

People had this self-expectation. It was a forerunner. It was a pioneering place and, since the standards were very high, it was taken for granted that these things were expected, and it made it possible to do things that you couldn't do in other places.

LOWE:

You mentioned Dean Clark as an influential person. Was there a cadre of administrators? Were there administrators in those days or superintendents and general directors or directors, I guess, is the term?

SHEPS:

Yes, that's the term. And that's significant because prior to that, people were called superintendents. The change in terminology is very significant because a superintendent kind of keeps things going, whereas a general director is supposed to lead, and that is what was meant by this change. You have to remember it was also a time that there were big changes in medical knowledge going on all the time so it was important to incorporate them effectively and so on.

LOWE:

One of the areas that you wrote in during those years with Jerry Solon, the Patterns of Care pieces. There were a number of them. Were those based on studies at Beth Israel?

SHEPS:

Oh, yes, and he still is going strong. He's retired, but he was a very effective guy. I don't remember how I ran across him, but I appointed him and then he came with me to Pittsburgh. We did a lot of work in both places that I'm very proud of.

LOWE:

That was, then, the time where the *Readings in Medical Care* book was published.

SHEPS:

Yes, and I'm very proud of that too. I had a lot to do with that. There was an informal group that used to meet at the time of the American Public Health Association meetings called the Section on Medical Care Teaching. We'd get together every year at the APHA meeting, and out of that grew this idea. We realized that the most important publications dealing with the development of the idea of medical care administration as a discipline were in what the librarians call *fugitive literature*. Have you heard that term? It's a wonderful term. It means that it was in serial publications, in journals, and it disappears unless you know that it's there. This was before the days of computers and so on, so looking things up was much more difficult. It was elusive. We were all medical care teachers and decided to put together these readings in medical care so that medical students would have this readily available. And it was published by the UNC Press, and it was revised at least once.

While that was going on, I moved to Boston. When we finished putting it together, the question was who should write the preface? We wanted somebody to write the preface who was very prestigious to draw attention to the book. And I said, "You know, George

Berry, Dean George Berry of the Harvard Medical School, has always had a very progressive attitude toward these matters. Let's try him." So I was selected to try to get him to do it, because I was on the Harvard faculty then. I went to see him, and he said, "Oh, no. I'm no good at writing." But it was very important as he went to talk about it. I said, "You just write the preface." He said, "All right. You write it, and I'll sign it." He said there was only one condition though, and I said, "What's that?" He said, "You must include in the preface the number and proportion of authors of the papers who have a Harvard connection." I said, "What's a Harvard connection?" He said, "Anything. Anything--a medical student, a resident, a faculty member." So in the preface there is this estimate, and it's quite high.

LOWE:

So he was into marketing even then?

SHEPS:

Yes, he was. Now here are the selected papers of John Grant. I would give you a copy, but this is the last copy there is. But here is the preface that I wrote. I should tell you something about him. He, Isidore Falk, Nathan Sinai, and Franz Goldmann were the key figures who developed this field in the United States. John didn't do very much writing, he did some, but he helped a great deal by providing Rockfeller Foundation support to younger people like myself.

LOWE:

That's a very important role, especially in an emerging field where people are kind of groping and feeling their way anyway and they are early in their professional careers, and so they have a lot of that to worry about.

SHEPS:

That's exactly right. As you said, it's a kind of validation that's very helpful if you're going into something that most people have never heard of or think is flimsy and risky and so on. I think it's fair to say that for the people who went into this then, a handful of people like Cy Axelrod, Roemer, Rosenfeld, and I, it was an expression of our social conscience. It was more than a job. It was more than a field in which you could earn a living and maybe some prestige, though prestige wasn't there at that time. It represented a social attitude that was very important to us.

LOWE:

Your work on the *Readings in Medical Care* and those kinds of works were really geared for physician and medical student audiences, but their relevance to administration programs and management types was relatively quickly apparent.

SHEPS:

I guess that's right, but certainly it's true that we were aiming toward physicians. We felt, particularly at that time, before the idea of health administration as a field in which people

could go into without being physicians or nurses was developed. By the same token, I would say that I have serious reservations about the health administrators who are trained in programs outside of schools of public health and who don't have a background in nursing or in medicine. They are managers. If you're only a manager in medical care and health services, and you don't know what it smells like, you don't know what it feels like, you've never seen a patient cry in the middle of the night, that kind of thing, that's missing, and it's a very important ingredient that is missing. There are very few such places that maintain a requirement that the students have to learn something about the human body, health, and disease. The health administration program at Hopkins continues to have this requirement. Ours doesn't at all, and ours is the typical kind.

LOWE:

I think that has long been a criticism of the field. They separated the manager from the product. In most of the successful corporations and companies, the executives in the company have an intimate working knowledge of the product that they are producing and the business that they are in, but there seems to be a separation in health administration.

SHEPS:

That's right. I don't know how many people are concerned about that. Do you run across much concern about that?

LOWE:

There is a lot of hair pulling and lip service. I think you find in the leadership of the American College of Healthcare Executives, Stuart Wesbury, I think, was quite articulate about the need for this and the concern that one of the upshots of this separation, if you will, is a separation of the institution from its community. You have managers who are bottom-line oriented and concerned about new product and service delivery and don't have that innate feel for what's going on in their community in terms of health. And you see the institutions drawing away, you find patient dumping, and you find these things that are just outside of what should be acceptable. And there is some concern about it, but it's easier said than done, I think.

SHEPS:

I had a joint appointment in epidemiology. We had a well-recognized Department of Epidemiology at our School of Public Health, and what I saw happening over the course of time was an overweaning and domineering interest in methodology to the extent that they would admit students in master's and doctorate programs who didn't have an iota of health background.

LOWE:

They will be working in a vacuum.

SHEPS:

How will they know what kind of questions to ask? Well, I didn't get anywhere. There are a couple of exceptions, and one of them is at Johns Hopkins. At Hopkins today, you can't get a degree in epidemiology or in administration without taking some of the same courses that medical students do. They go a bit further than they need to, I believe.

LOWE:

To develop a context to ask questions?

SHEPS:

That's right.

LOWE:

One of the things I wanted to spend some time on in our discussion, and this kind of leads naturally into that, is the emergence of the science of health services and health services research and your involvement in that, I guess beginning while you were in Boston and the initial study sections in Washington. It was beginning about that time.

SHEPS:

Yes. I was a member of the first study section in this field. After the Hill-Burton Act was in operation for a number of years, some people in Washington became aware of the fact that there was a clause in that act that provided that you could use some of the money for research in hospital care. After three or four years on

the study section, I was made chairman so I had another four years, and then I was put on the council, so there was about a dozen years in which I had a lot to do with the development of this field. I wasn't alone, but I had a lot to do with it. I was the one who lead the struggle, and it wasn't too much of a struggle, to change its name to medical care administration, which would include care wherever it took place.

This next is something you might want to look up. We got together with the nursing section, at least the nursing section, maybe some others, but at least the nursing section, and we put together a report called *Patient Care Research* or the *Field of Patient Care Research*. That would have been in the early '60s. We published a very good statement of what patient care is and the kind of research in it that could be done. It was the first time we were turning people's attention to this as more than a series of clinical activities but rather how you put it together, how they fit with each other, and all that kind of thing that needs attention on the part of research.

LOWE:

So the organization of service became an important area of inquiry.

SHEPS:

That's right. There was a man in the Public Health Service, Dr. Jack Masur, who had been a hospital administrator in New York.

He joined the Public Health Service and ended up as director of the Public Health Service Hospital in Washington, a big teaching and research hospital. He was a very articulate man. He and I, Cy Axelrod, and Nathan Sinai, we had a lot to do in developing interest in this and getting appropriate recognition for it and that sort of thing.

LOWE:

So the initial moneys to support research came out of the Hill-Burton Act.

SHEPS:

That's right. And it took a while before medical care research as such got its own recognition.

LOWE:

It was largely, even in those early days, primarily supported out of public funding, where the foundations were not. They were doing programs, but not so much evaluation or studies.

SHEPS:

Yes. The Rockefeller Foundation and the Commonwealth Fund were most helpful. The Rockefeller Foundation was crucial in selecting people and supporting them, but they weren't supporting studies. Studies were supported by the Public Health Service. Then, when Thomas Parran was the Surgeon General of the Public Health Service, he was very progressive. He was the person, for example, when he was Surgeon General of the Public Health Service,

he went on the radio in the '30s and talked about syphilis and gonorrhea, and that was a very courageous thing to do at that time. But he opened up that whole area. He was in fact the person who was responsible for my leaving here and going to the Pittsburgh School of Public Health.

LOWE:

Leaving Boston you mean?

SHEPS:

Yes, leaving Boston.

LOWE:

How did that dynamic happen?

SHEPS:

The fact of the matter was that after six years or so in Boston, I was bored. I had done as much as I could. I knew that the next logical steps couldn't be taken for a long time. The next step was to have full-time doctors in the Outpatient Department and not rely on those who gave up time, in return for which they had admitting privileges. But there was no money for this at that time.

LOWE:

The incentive connection wasn't as clear and as crisp as a manager would like to pay the guys to do the work.

SHEPS:

That is exactly right. I couldn't make some necessary changes. It was difficult. Now Sidney Lee had the job of running the ambulatory services, and it was a tough job for that reason. So I felt that I had done as much as I could. One the things that I was very proud of was the recognition of the importance of ambulatory care.

Another thing that I was proud of is that I had brought psychiatry to the level of a full-fledged clinical department. The head of that activity, Dr. Greta Bibring, was a very fascinating woman. She had been analyzed by Freud and was a refugee from Vienna. She really applied herself to how to use the psychiatric insight in the hospital, not just to treat patients, but how to use the psychiatric insight inside the hospital as a whole. She wrote a paper about that, which is a wonderful paper and which was really quite surprising because all the other analysts cared about was analyzing patients and that's all. She did that but, in addition, she used her psychoanalytic insight and experience as a way of understanding what one should do with patients who didn't present clear-cut psychiatric problems. Working with her was a very stimulating experience.

The director of surgery, the chief of the Department of Surgery, Jacob Fine, was a very interesting man, a very colorful

guy, difficult guy, who couldn't suffer fools gladly and always spoke his mind bluntly.

LOWE:

A typical surgeon.

SHEPS:

I have a great story about him. One time I heard he was about to do something that I knew was dead wrong, so I went to see him, and he said, "You're coming to see me instead of asking me to come to your office. It must be important." I said, "It is." I told him what was on my mind. He said, "No, you can't change my mind. I'm going to do it." So I tried again. He says, "You're not going to change my mind. I'm going to do it." I tried a third time. "No, I'm going to do it," he said. So, I said, "Jack, I see that I can't convince you, so I'm going to ask you not to do it as a personal favor to me." "Oh," he said, "that's different. I won't do it." You can't do that very often.

LOWE:

That's for sure.

SHEPS:

It just came to me in a flash at the time, but it's a great technique.

LOWE:

Of course. When you have mutual professional respect, that's something that you can do.

SHEPS:

His son is a physician, and he's the founder and executive director of an organization called Physicians for Human Rights. He is really a chip off the old block.

LOWE:

That's an interesting group.

SHEPS:

What they do is work for the release of physicians who are in prison for political reasons and that kind of thing.

LOWE:

So you were enticed to go to Pittsburgh. You looked them over, and how did that come about?

SHEPS:

There was a man called Bob Sigmond. You know his name, right?

LOWE:

I know Bob quite well.

SHEPS:

He's a great character. He is one of the brightest people I've ever met. Anyway, he and I knew each other. We met somewhere. I don't know. He was in Pittsburgh working with Dr. Rufus Rorem at the Hospital Planning Council.

LOWE:

Yes, he is.

SHEPS:

He is a wonderful guy. Anyway, he arranged for me to be invited to visit and so on, and that's how that happened. I was ready for it, because I became bored and I knew the next steps could not be taken for some time. The next steps weren't taken for a good many years until money became available with the Medicare and Medicaid programs. That is how I got to Pittsburgh. The department had been started by my predecessor, whose name I forget now, who was somebody who had been in the Public Health Service. And he was okay, but he wasn't a very imaginative person. So I developed the activities, developed the research program, got a seven-year grant to do research, and so on. That's when I recruited Jerry Solon and, as you know, we did a lot of work emphasizing again the ambulatory framework.

LOWE:

One of the pieces that was written during that time was a series in *JAMA* on the practice of internists. You worked with some very interesting people on that, and that was a very important series.

SHEPS:

I wish I could remember how I got connected with it. I can't remember it now, sorry. But the connection was wonderful for me and for them. They trusted me. They were a bit scared. It was the Association of Internal Medicine, something like that, and it

was the branch in upstate New York, but we quickly developed mutual trust. We were the first people to go into doctors' offices and look at records and all that kind of thing. I'm glad that you reminded me about that. That was great fun. They were an interesting group, and it didn't take long until we had faith in each other.

LOWE:

That was pretty unusual field work, really.

SHEPS:

Yes.

LOWE:

Then writing it up for the prestigious clinical journal at that time on a nonclinical subject, really--how doctors' offices were organized and how they functioned.

SHEPS:

The *Journal of the American Medical Association* (*JAMA*).

LOWE:

That's right.

SHEPS:

And *JAMA* didn't publish much of that stuff at that time. You're quite right. But they were happy to have it because it dealt with clinicians and clinical activity, and it did it in a systematic, scientific way.

LOWE:

One of the things I guess you became concerned about as a hospital administrator in Boston, but then coming to Pittsburgh to give some more academic thought to it, if you will, was the role of the hospital in education for health care providers, for clinicians of all stripes. The academic medical center and education as its central role. You began to write about it then in the *Journal of Medical Education* and some other places. What was it like then in terms that it was really the physicians' workshop and the education role was quite peripheral?

SHEPS:

George Berry was very helpful in this. He saw this, and he opened a lot of doors for me, and he gave me credibility with the AAMC, for example, and that is where I presented this approach the first time that anybody ever presented it to them. But he was crucial. He opened those doors. I edited a number of publications that were summaries of presentations that were made at AAMC conferences, and that was very helpful to me in an informative kind of way. But Berry was very helpful in doing that.

The thing is, you see, that Nathan Sinai, who was the first academic to really work in this area, was unjustifiably a very much criticized person. The AMA saw him as a threat, and they published critiques about him pointing out that he was not a physician, that he was a veterinarian, stuff like that that was totally irrelevant.

They were attacking him over a period of years, and so one had to overcome that if you went into this field.

That wasn't hard to do, because the other thing that was happening, you see, was that the public was beginning to pay for care in an organized way, either private insurance or Medicare or Medicaid. And so this moved the issues into the public arena, where it wasn't there before at all. When the payment issues were entirely between the patient and the physician, it was very different. Once you get organized programs, then they have an interest in what goes on. So you get involved in doing more than just paying for services.

LOWE:

Education started to become more heavily subsidized.

SHEPS:

That's right. I remember in Saskatchewan, for example, when we started the hospitalization insurance, soon after we put it into effect, we began to say to ourselves we better work with these hospitals and improve them and make them more efficient. Well, under the latter category, one of the things that we undertook was to regionalize laboratory services. In other words, we said every hospital needs to have lab work done, but the smaller hospitals should not be doing complicated lab work. It should be done on a regional basis. Well, there was hell to pay.

LOWE:

Everybody had to have the full range of services.

SHEPS:

That's right, and it was nonsense. Because even if they had it, they couldn't do it well because some of it wasn't used frequently enough. But it was a revolutionary thing to do to operate on the assumption that hospitals are not all the same.

LOWE:

That was really one of the premises of health planning in the early days.

SHEPS:

Exactly.

LOWE:

The beginnings of regionalization. Pittsburgh was a place where that was probably further along than a lot of other places.

SHEPS:

That's right. That was Rufus Rorem, who had this quiet manner that was simply wonderful. But, as you know, that failed. And the reason it failed was it was given to the hospitals by themselves to do.

LOWE:

The fox guarding the chicken coop.

SHEPS:

That's right. That was a terrible mistake. I don't remember the details of why that happened, but it was given to the hospitals to do. My guess is that, and I'm not sure about this, my guess is that they saw the threat and therefore undertook to do it. But, as you say, it's like the fox guarding the chicken coop. It just doesn't make any sense at all.

LOWE:

It seems like even then, well, the tradition, I guess, goes back a long way. The health care community, the providers, the physicians, and the hospitals have traditionally been very strong, and third-party imposed controls and regulations have been not only resisted but successfully resisted, and planning is one of those things.

SHEPS:

You know when you think about it, as I've done for obvious reasons lots of times, the difference between Canada and the United States, for the United States to move into national health insurance, moving from 1,500 insurance companies to a single payer would, I suspect, be politically impossible because you have these tremendous vested interests. Well, in Canada we didn't have these companies. They didn't exist at that time.

LOWE:

You didn't have those barriers to overcome. There were other barriers.

SHEPS:

There were other barriers, but we didn't have a vested interest in private insurance, and that made a big difference. I don't think we could have succeeded with a single payer if we had all these insurance companies to work with because insurance companies are politically pretty powerful.

LOWE:

That is going to be a tremendous barrier in this country.

SHEPS:

Indeed. A tremendous barrier.

LOWE:

Even if you cut them in for a part of the action, you can't cut all of them in.

SHEPS:

The truth of the matter, as I understand it, is that most insurance companies don't make money out of this. It's a loss leader. They want to be in it in order to sell other kinds of insurance, but they are a powerful political force.

LOWE:

Well, and as fiscal intermediaries, they've made tremendous amounts of money, a lot of the Blue Cross plans.

SHEPS:

That's right. But, you see, administration represents 15 to 20 percent of the cost, whereas in Canada, the administrative cost is 1 percent. That is a lot of money. That's billions of dollars. Rashi Fein figured that out once, and he said it's enough money to pay for the people who don't have care now. It would pay for those 37 million. That's what he said, and he's a pretty careful guy.

LOWE:

Yes, he is.

SHEPS:

I'm very proud of him. Have you met him?

LOWE:

I know who he is. I've not had the opportunity.

SHEPS:

Well, I got him into this field. His father was the principal of a Yiddish school in Winnipeg that I went to every evening after public school. We would go from 5:00 to 6:30 to learn the Yiddish language and the history of the Jews in the last couple of centuries plus socialism.

LOWE:

Had to work that in.

SHEPS:

Yes. Rashi's father was the principal of this school for a number of years. Then, years later, his father was on the faculty

of a Jewish college of some kind in Baltimore. Anyway, I was visiting there and here was Rashi Fein, who was starting his postgraduate program in economics, and I got him interested in medical care. I brought him here, gave him a part-time job, and he got his PhD here. And he has done extremely well since then. You should put him on your list. He has lived through a lot of this stuff. He is a very articulate and thoughtful person.

LOWE:

He has made a lot of contributions to the literature.

SHEPS:

Yes. You would enjoy talking with him, and I think he has a contribution to make.

LOWE:

We are in the Pittsburgh era right now, so I'm going to throw this in--the health administration crowd. At some point, there was a fork in the road between medical care organization and medical care administration, and I mean the organizing and the delivery of medical services as opposed to the administering of hospitals. And somehow that distinction, that separation, didn't happen at Pittsburgh. I mean you were able to keep that integrated and maybe in terms of the effect that has had on future generations of administrators, this separation. Was the curriculum at Pitt as you helped develop it, was it unique in that respect?

SHEPS:

It became unique after I came to head it up. It was really after that that dozens and dozens of programs in health administration were set up in schools of public and business administration.

LOWE:

Business schools.

SHEPS:

But what you were ultimately dealing with was what happens to patients on an hour-to-hour basis in what has become a predominant development, particularly when programs, as most of them are in schools of business. They don't pay any attention to that.

LOWE:

Do you think the trend toward more clinicians going back into management--the number of physicians that are becoming reinvolved, if you will--in administration is a backlash against that? Are we overproducing too many clinicians, and so they need to do this as a cover-up?

SHEPS:

No, I don't think it's that at all. The person who has worked on this a lot is David Kindig at Wisconsin. He has a summer program in administration for physicians, which is very good. I used to be involved in it a lot. There are these people in Philadelphia at the Wharton School. I think that there is a real

place for it. I think it's recognition that if you want to be certain that the full range of medical care is available and that it's provided efficiently and effectively, you really have to learn how to manage this. It doesn't happen naturally by itself, but you have to know how to think about these problems and how to use resources, not only money but the people and facilities.

If you and I were to start a program today, we would think very seriously, I believe, of linking it primarily from a clinical point of view with ambulatory activities and not necessarily with hospitals. We would link it with a prepaid group practice. And, in fact, the prepaid group practice, in my view, provides the most effective framework, because it's an organized activity. And you can therefore examine it and make recommendations to the managers and to the staff about how to be more effective, which they would recognize as being relevant, because they examine their organization and the tasks that the organization undertakes, and they think in those terms. In that kind of framework, for example, it's easier than in other contexts to use people like family nurse practitioners and so on because you say, "What are the tasks?"

There is a principle in this field that has been observed predominately, which I think is wrong. That principle is that for every task, you use people who are the most qualified to do it. I think that's the wrong principle. I think the principle ought to be that for each task, you use the person who is able to do it

satisfactorily with the least training. That's the way to do it. Then you don't waste training.

LOWE:

And the organized plans, the organized practices are the best venue to do that because then everything is so compartmentalized and segmented.

SHEPS:

In my experience, when I enunciate this principle, the first reaction is one of horror.

LOWE:

It reduces quality. You don't have the best person doing it; then it can't possibly be good.

SHEPS:

And that's nonsense.

LOWE:

That's part of what the issue of total quality management raises, because that has been introduced, if you will, from both perspectives: having only the best and most highly trained people doing the job, and then the Deming approach, if you will, which is to push it down as far as you can.

SHEPS:

What do you mean by the Deming approach?

LOWE:

The statistical analysis of the task and so forth and assigning it to the people that can get it done for the least and most effective. It has been so popular in hospitals. Everybody is doing total quality management and, of course, not everyone knows what they are talking about.

SHEPS:

When we were starting our family nurse practitioner training program, we had a meeting with the leaders of the North Carolina Medical Society at the governor's mansion. The governor was there. He had supported it. And I said to him, "The issue is not cheap medical care. The issue is how can you get good medical care for the least effort and the least amount? And this is the way to do it."

LOWE:

We are talking about the efficient and effective delivery of services and the introduction of nurse practitioners to the physicians of North Carolina.

SHEPS:

We had a test situation, which Jim Bernstein carried out for me in a little town. It became very clear that this was an effective way to go. He also had a nurse who was a nurse practitioner by her own training, self-trained, working in a mountain community that was quite isolated. We arranged to have

a meeting with the leaders of the state medical society at the governor's mansion, and we made sure that one of the people who was there was a physician in the mountains near Asheville who worked in a kind of supervisory way, informal with this nurse practitioner in the mountains, and he was, of course, very helpful in this meeting. I said to these people, "Look. No physician is going to go to these areas. How are we going to get care to these areas? Do you think a physician is going to go there? No." I said, "How are we going to get care to these areas?" And this is one way of doing it.

Let me go back a little bit before that. This is part of a campaign to get it done. I had given an interview to the press about this whole question, and we had had this demonstration going on. The Republican candidate for governor in North Carolina called me up and said, "I read what you said in the paper, and I want to use it in my campaign. Can I get together with you?" And so he did.

Then when he was elected, he said, "Now we have got to make it work." I got him Jim Bernstein, who was a young administrator working with me here and he went. And he's still there. And he has the best program in the country, and everybody knows it. That was the origin of it. We had this meeting with the leaders of the medical society, and the issue was what could you do, what are the alternatives? And that's what stopped them. Plus, this doctor in

Asheville, who was able to say, "I know that this young lady is doing first-class work. She knows what her limitations are, and it represents not only care, but access to the whole system."

LOWE:

So you not only had your own credibility in terms of being a physician and being able to relate to these physicians, but you had one of their own.

SHEPS:

That's right. He was more acceptable than I was. Because in a sense, I was almost the enemy. I was the organizer, the guy responsible for change.

LOWE:

You seem to do that a lot. Saskatchewan. New programs in Boston.

SHEPS:

That's why I went into this field. It's not an accident. It's something that I would do wherever I was. I think I was fortunate in that I ended up in places where there was a reasonable amount of acceptability so that I could do this without getting into too much trouble. I was seen as a troublemaker, you know.

I could give you an example that comes to mind. The first day that I went to my office at the School of Public Health in Pittsburgh, I got a call from the director of the Federation of Jewish Philanthropies, and he said, "I know your reputation and we

need your help because we are about to undertake to build a big addition to the Jewish Home for the Aged and we need help on what kind of medical facilities we need." Well, I talked him out of building it, because I said, "Let's take a look." I didn't know where this would lead, but I had a feeling I was onto something. I said, "Let's take at look at the waiting list." We examined the waiting list of 40 to 50 people, and I looked at the records, and it was clear that most of those people didn't need an institutional residence. They needed some medical care readily available. They needed a diet readily available, things like that, but they didn't need to be institutionalized.

So, what I suggested they should do (it wasn't original--there was already one like this in Philadelphia) was to build an apartment house on the grounds of the Home for the Aged for these people who could lead their own lives, but could arrange to see the doctor any day they wanted or could go and have one meal a day or have three meals a day or whatever. In other words, to make the adaptation to what they needed, rather than to say you're either going to be fully on your own or you're going to be institutionalized and to make arrangements so that they could get whatever range of this that they needed.

Well, it took a lot of doing, because the whole notion of philanthropy at that time was that you build something. You build institutions. I remember the superintendent of the Jewish Home for

the Aged who had been there for quite some time. I said, "You're talking about this new building. How is it going to be done?" He said, "Easily, two rooms and a toilet, two rooms and a toilet, two rooms and a toilet." That was his notion. I never forgot that. Two rooms and a toilet--that was his notion of what would solve the problem. And let me just add, because this is what life is really like, my task of talking the philanthropists out of building a building and instead developing a special kind of service, which is very difficult to do, was greatly assisted by the fact that the leader of this view died, so I didn't have to deal with him and there was enough discussion so that the next president was somebody who had some interest in a new approach.

LOWE:

I believe the series of White House Conferences on Aging began in 1960.

SHEPS:

Yes, that's my impression. I was at the first one.

LOWE:

A lot of these notions about care for the elderly, part of that tracked into what happened with Medicare and the finances and stuff.

SHEPS:

Let me interrupt you just to tell you a story about that. I was on the planning committee for the health area. The White House

was arranging this. One day I received a call from this official at the White House saying, "Dr. Sheps, I'm very sorry to tell you we've got to take you off this committee." I asked why. He said, "The AMA would not stand for you being on the committee. They will withdraw if you remain on the committee." I said, "Okay." That's the way they felt at that time. Now it's different. Now they don't take that attitude, but then you were a traitor if you had the views I represented.

LOWE:

They had very specific ideas about how things should be done. You comment about this particular care regime that was visualized for the care of the elderly, the two rooms and a toilet. A lot of those notions were beginning to be dispelled during the time of the beginning of the conference. A part of that led to different financing mechanisms, but the caring for the elderly started changing, I think, dramatically.

SHEPS:

They were very powerful meetings. They had a lot of effect, I believe. The woman who was the head of the North Carolina State Department of Welfare, Ellen Winston, was very powerful in this. She and I worked together a lot on North Carolina problems. Then she went to Washington and was in the department of whatever it was then called as the head of the whole social welfare side of things. I was her medical consultant, and I went to Washington at least

once a month for several years--a very interesting set of experiences.

There was one particularly interesting story. When Medicare and Medicaid were coming in, we were sitting one day working on regulations to qualify nursing homes to get paid. In the middle of this meeting, Ellen Winston got a call from the White House. LBJ wants to see her. She goes over. She's back in 30 minutes with tears in her eyes. I said, "What happened?" She said, "The president said to me, 'I understand that you are now working on regulations to qualify nursing homes to get reimbursement and want to tell you, girly,' he said--that's the way he talked--'let me just tell you, girly,' he said, 'those regulations are not going to be accepted unless every existing nursing home in Texas will immediately qualify.'" And that was it. Somebody in her office was in touch with the White House. It's a great story. It was exactly the way LBJ would behave.

LOWE:

Even though he had this great--I want say it's great--an alleged social vision and made a tremendous contribution to this.

SHEPS:

No, the legislation that was passed under his regime, equal rights, human services, all kinds of things were very, very effective in my opinion and very progressive. Have you read that stuff by Carow about his life in the *New Yorker* or something? He

was really such a mean bastard and a reactionary guy until he became president. He continued to be mean, but he wasn't reactionary any more. It's very interesting.

LOWE:

Almost 180 degrees. He was more able to let go of the constituency that pushed him in part in that direction, I think. He had a broader constituency but powerful.

SHEPS:

That stuff is fascinating.

LOWE:

Yes, very interesting. Well, about in the middle of all that, the mid-'60s, you were in the process of deciding to leave Pittsburgh and go to New York, and I want to pick that up. In a few minutes, we will pick up and talk about the decision to leave and the opportunity in New York.

SHEPS:

There were two factors that made my wife and me decide that we should leave Pittsburgh. One was a very powerful one and that is that she was very unhappy in the Department of Biostatistics, and justifiably so. Two things were happening. One was that her work, which was judged as being brilliant nationally and internationally, was really not appreciated in the department by the chair, who was a very difficult character by the name of Antonio Ciacco. I suspect there was some envy involved, but anyway

she was treated very shabbily, and we decided that we ought to leave.

It was easier than it ordinarily would have been for me to agree that we should leave, because what I found was that the framework in the School of Public Health that I was in and the Department of Health Administration was really not a stimulating one. I was deeply involved in policy issues that were going on in Washington. I was on various committees and so on. I would come back and report to the faculty, and they said they had no interest in such matters. What I mean by that is that they had no interest in national policy. The characters that sat around the table were satisfied. They had enough money to do what they wanted to do, and that was all they cared about. I felt that they really ought to show some interest in national policy.

LOWE:

They were missing the boat.

SHEPS:

I was ready to leave. My wife was very anxious to leave for the reason that I mentioned. By that time, we both had the kind of reputations that we knew we could get jobs without any trouble, and so we decided to make the decision on the basis of where we would like to live. And we decided we would like to live either in Boston, New York, or San Francisco. Boston because we knew it, and we liked it very much. It was a sophisticated city. New York

and San Francisco for comparable reasons, although we didn't know them the way we knew Boston. So we let it be known that we were interested in moving, and it didn't take very long before I was offered this job in New York at the Beth Israel Medical Center, and she said, "Let's go to New York. I know something will happen." And sure enough, she was offered a faculty position at the School of Public Health. So we moved to New York.

We thought this was our last move. But, when three years later, this university (UNC) was one of the institutions that got a seven-year award for a health services research center, which I had helped them develop, and my wife always had a standing invitation to join the Department of Biostatistics, which was one of the best in the world at that time, we decided to come back home to Chapel Hill, which we always liked. We came back. We built a house, and this is where we were, and then she died eight years later. But for each of us, it was a very salutary move. We came back at the end of '68.

In 1971, I was made vice chancellor for health services. And I was vice chancellor for six years. I was the one who decided it would be for a limited period. I enjoyed it very much. I had no illusions about what I could do. I knew some things would be possible. I didn't have a foolish notion of what you could do in that job. Having been a hospital administrator, I knew what the limitations were.

LOWE:

That must have been particularly true in New York. Going back to the New York experience, it was three years, but I was looking at your publication record and the things that you were interested in at that time. One was the whole issue of the neighborhood health centers. You were interested in ambulatory care and all that. The other topic that jumped out at me was the issue of how hospitals appropriately relate to this network and appropriately relate to ambulatory care. Going back to your interest in Boston, how did that play out in New York? You were there. It was a snapshot three years, but there was a lot happening.

SHEPS:

Oh, yes. There was a lot happening. I never would have left, except that Chapel Hill was too attractive. I had all this other experience. I knew just what I was doing, and there was already existing some kind of unspecified commitment to the special character of the area, and I put this to work. We were operating a clinic in the lower East side with a heterogeneous population. We put up Spanish signs and Chinese signs. I did all sorts of things to recognize the nature of the population. I enjoyed that work very much. I had at this one point this wonderful doctor running it, Leonard Rosenfeld.

LOWE:

Did you bring him from Canada?

SHEPS:

He was in New York, but at that time I brought him from New York and later I brought him here to Chapel Hill. I knew what I what I wanted to do. I had lots of power and lots of control and prestige. In the first place, I understood the population and I knew they could be helpful. I wasn't just tolerating the board like most administrators do. There were some very smart people on the board, and I got them involved so they would carry the ball for me without me having to do it all the time. It was a very good experience. I never would have left that. I don't regret leaving because coming back here was worthwhile.

LOWE:

The role of boards is interesting. It seems to me that the literature shows that, particularly if the institution has a strong community focus, the board can be a tremendous ally more than the bankers and the financiers who are worried about the bottom line. The people who can really help solidify the reputation of the program in the community.

SHEPS:

Oh, yes, and he had some board members like that. In fact, one of them, Herbert Singer, who is a lawyer in New York, later became interested in WHO and works a lot on international health, and it all came out of the way I introduced him to something beyond the cost. He wasn't the only one. There were a few others who

have since passed away, but he is still going strong. He is in touch with me every six to eight months about what he's doing and what his interests are. There was a genuine interest on the part of some of the board members in the hospital's contributions to the neighborhood and that whole idea, which I brought to them. We were a major resource for health care in this area over and above patients who come from all over the place--from Park Avenue and from Jewish areas, Brooklyn and so on. Some of the board members had to make an adjustment to it, but the leaders were very clear about this.

LOWE:

I think the issue of community service and not only the adoption of the community but also the taking of responsibility for a defined population almost like COPC, but applied at the hospital level, is an unusual commitment.

SHEPS:

Yes, and you know at the present time, there is a survey project that is being conducted by the Department of Health Administration at NYU with Bob Sigmond as a key figure in that, and I'm deeply involved in it too, in which we are surveying over 40 hospitals that have met the criteria of having a community-oriented program per se that goes beyond looking after the clinical problems of the patients who come to the hospital. These are programs that address a designated geographic area, and it's very

interesting. There are a lot of hospitals that are clear about this and feel they need to carry out this responsibility. Some of this interest is stimulated by the court judgment in Utah and in other places regarding community services in exchange for real estate tax-exemption.

LOWE:

The tax issue.

SHEPS:

That's right. The tax issue. They are being asked these very tough questions. As you know, in Utah and in one or two other places, but in Utah in particular, the courts have said that they can maintain their tax-exemption only if the free care that they give is at least equivalent to the tax.

LOWE:

That would stimulate some different behavior, particularly if it occurs in a number of jurisdictions. Your involvement in that project, are you advising them?

SHEPS:

I'm on the steering committee, so I have a lot of involvement in what they do, how they do it, and so on.

LOWE:

Were you surprised at the number of hospitals? Did they come forward to be identified?

SHEPS:

They mostly came forward. The project was publicized. It's going to lead to a kind of accreditation, not to compete with the standards of JCAHO. I guess some of them are very serious about it, and others simply want it as a decoration, which would be a feather in their cap.

LOWE:

Well, there are worse things that they could be doing.

SHEPS:

That's right.

LOWE:

It will be interesting to see how this anointing process is recognized by the government or the taxing authorities or whatever.

SHEPS:

My guess is that the taxing authorities will be influenced by this because it's going to be clearly designated.

LOWE:

You yourself are an example of where the leadership for this kind of commitment at an institution comes from--the executive director, the CEO. Is that where the leadership for this kind of thing is emerging? Is that where it has to be, and what is the role of the collective physician element and so forth? It seems to me that's a complex thing.

SHEPS:

It is, but I think you omitted what I think is the most powerful force, that is, the external forces, the community forces, the state forces that say, "Look you're in a special place. You want special recognition. You have to give us something that's clear." That's happening all the time now. I think that externality is very important, and I think by and large what we're getting in the way of initiative from the institutions is a reaction to that external pressure.

LOWE:

So it's a responsive type of development, rather than a proactive.

SHEPS:

That's right. Now you could say that that existed when I was at Beth Israel in Boston and when Dean Clark was at Massachusetts General. We brought it ourselves, but that's not common. That's unusual. Forgive me for saying that, but certainly at that time it was very unusual that we saw our hospitals as resources that needed to be turned in various directions and not simply as a workshop for physicians and a treatment place for the poor. We went beyond that.

LOWE:

Today there are 6,000 hospitals around the country or thereabouts, and I'm sure there are a fair number of visionary type

CEOs who now see this as a necessity, as, you know, let's do this before it's done to us kind of approach and who have this kind of social responsibility. Maybe it's from guys or gals who were trained 20 and 25 years ago who have matured into positions who have this kind of social approach, because it seems to me that the younger group is much more business-oriented and much more interested in maximizing reimbursement and so on.

SHEPS:

It's the nature of their of training. It's the nature of their preparation. In the programs of training in health administration, they are preparing people for jobs in the "industry." That's what they call it. It makes my skin crawl. I understand why they do it and why it can be described that way as an industry, but I think it's a hell of a way to train people for this field, to say that you're in an industry, and this is how you can make it work. They ought to be saying you're in a social institution and what is the nature of your responsibility for it.

LOWE:

That's what this kind of project is getting at though. This kind of effort is starting to uncover that and make it more obvious. This project that you're involved in.

SHEPS:

Yes.

LOWE:

The link between that and training the social responsibility is not something than can be overtly done now, but it's something that needs to happen, I would think.

SHEPS:

I'm not terribly hopeful about it. There is the true-sounding ethic that says, "Look, this is a business operation, and people need to know how to do that." The rest of it's nice, but it's not very important. If the business operation is no good, nothing works. Well, there is something to that. In Boston, I was very careful to have a controller who was a terrific guy. It was hard to get a good controller, but I finally got one. You need that sort of thing. It made it possible for me to deal with those various requirements and expectations--the bottom line on the one hand and the community responsibility on the other.

LOWE:

Have you been impressed with any particular executives that have kind of stood out in your mind in terms of being able to lead on issues like this?

SHEPS:

I could think of people in my day. As for such people now, I don't know. I'm not close enough to it. I don't go to their meetings, so I don't know. But in my day, there were some people like that, but, in addition to Dean Clark, there was Ernie

Shortliffe, who was very, very good from Pittsburgh. He was very good. There was a fellow, I can't remember his name now, who was at Columbia Presbyterian at that time who was also very good.

There was this great guy who did a lot of consulting but who was also a physician, Basil MacLean, who was also the director of the teaching hospital in Rochester, NY. He was the leader in this field. There was a man also at the School of Public Health in Minneapolis who did a lot of consulting and who was a leader. I can't remember his name. Those two did a great deal. McLean gave me a lot of encouragement. That encouragement was helpful. It didn't change my mind about anything, but it made me feel that I was right. He trained a handful of people who did a very good job wherever they worked. Henry Clark, who was the vice chancellor for health sciences here for a while, is one of them. This was long ago. It was before these external pressures, these insurance programs. You had no organized payment of activities to speak of. It was very nice to have someone with that kind of prestige express these progressive views.

Another good person of this type was Ray Trussel. He was the dean of the School of Public Health at Columbia. He followed me as the director of Beth Israel Medical Center in New York.

LOWE:

I'll note it. Let's come back to Chapel Hill, and we'll start on that and go for a few minutes. The university had applied for

and received a grant to start a research center, which you had helped them develop from afar, and so you were invited to come down and assume its leadership. How did that go in the first couple of years? Was that a rocky beginning?

SHEPS:

No, it wasn't rocky at all. The place was ready for it, and they trusted me. I wasn't an unknown quantity. They knew that I was a tough guy with high standards. They knew that I was energetic. They knew that I knew what I was doing. I was a known quantity. So you didn't have that period of what's this guy like and so on. I had the support of the university administration, so it wasn't difficult at all.

The problem was that some of the schools, particularly the dental school, that had been involved in preparing this proposal, came to me and said, "I want my money." I said, "Well, we are developing a program, and you fit into it probably, but we have to wait and see where you fit and where the emphasis should be in the beginning, later, and so on. For example, we had said in the proposal that there was a special interest in rural problems, because this is a rural state. Well, that means you work on some things and not on others. In the dental area, for example, we supported a demonstration, which was very carefully done and carefully evaluated, of the optimum role for the dental auxiliary, which was much more than what they then were being allowed to do.

We demonstrated that here in the dental school, and the quality of their work was more than acceptable.

We ran into great difficulties when we tried to apply this outside of the school, because it turns out that the dental society was by legislative mandate, in the last analysis, in control of the School of Dentistry. They had initiated the idea of having a dental school, and the legislation was set up in such a way that they had something to do with policy, and they refused to give us the authority to take this demonstration outside of the school. There was nothing we could do. We didn't want to accept this, and we argued about it as much as we could. And ultimately we wanted to make a presentation to the annual meeting of the state dental society. And I went, together with Bill Friday, who was the president at the time. He's a prestigious guy. They wouldn't let us speak. Okay, they could stop me, but the president of the university! Neither of us were allowed to speak. So it never got demonstrated outside of the school.

LOWE:

That's an unusual level of authority of the field of practice over an academic institution.

SHEPS:

They wrote the legislation for the school. It wasn't the other way around. We had a medical school here since the turn of the century. It was a two-year school for a long time, but it was

a school. The dental school was started after World War II. They started it so they were in control.

LOWE:

That is something.

SHEPS:

I'll never forget that evening at the meeting. It was just unbelievable.

LOWE:

Talk about academic freedom. Right.

SHEPS:

They didn't want to hear what we had to say. Their minds were made up, and they didn't want to waste any time on this.

LOWE:

How long were they ultimately able to keep it under wraps?

SHEPS:

So far as deliberate demonstrations organized by the School of Dentistry are concerned outside of this campus, I don't think there are any now. But I would expect that there are quite a few dentists who are doing this, because it's an economical way of organizing a practice, and it pays to do that. Since you have a fee-for-service arrangement, it doesn't matter who does the work.

LOWE:

You want to do it in the most efficient way as possible. Who were your key allies in getting the center started here? You had to have some important lieutenants and collaborators here.

SHEPS:

That's not the same as allies. Let me start with allies. A very strong ally was the university administration. Very strong. They knew me. They trusted me. I was the local boy who made good in the big world, big cities, that kind of thing. That help was tremendous. There was also support from some of the leaders of the state medical society. One man in particular by the name of Amos Johnson. He was a general practitioner in a small town, the only doctor in town. He had a black man who was his assistant whom he had trained to be a physician's assistant, and he had a genuine concern for the people of North Carolina. He was very close to the ordinary folk because of the town that he came from. Even though I had been obviously described to him as a dangerous guy, he listened very carefully and when relevant and convincing data were presented to him, that's all he needed. He was a tremendous ally, because the medical profession throughout the state trusted him. He already had experience with this black man. He was an important ally. My close relationship with the current Republican governor was very helpful. The kind of work that Jim Bernstein was doing was very helpful, because it was accepted everywhere. He does it

extremely well. He does it by identifying the local leaders, medical and lay, and works with them closely. It worked very well for those reasons.

LOWE:

Who were some of the key early researchers?

SHEPS:

There was a colleague that had joined me in Pittsburgh who was influenced by John Grant very much, Conrad Seipp, who was a political scientist by training. He was very helpful. Gordon DeFriese, who was here almost from the beginning, is a tremendous person, very hard working and imaginative. Bill Beery, who is now in the Group Health Cooperative in Seattle, very effective guy, very committed. There were a handful of people. Ed Wagner was very capable guy, also very committed.

I want to mention Don Madison. I brought him from New York, where I had been and where we had done some work together. We wrote one of the first papers on the neighborhood health center and its potential, which we enjoyed doing very much. We did a paper on evaluation, which we also enjoyed doing. He was an important figure. Shortly after, he came and he got a very large grant from the Robert Wood Johnson Foundation to examine rural programs and their leadership in those programs.

Miriam Settle was a student of mine in Pittsburgh, and I brought her here to Chapel Hill. She was a key figure in the

conduct of the rural evaluation project. She really ran that project on a day-to-day basis. I was responsible for it, but she's the one who really devoted all her time to its conduct. She is very good at that kind of thing.

LOWE:

Who were the key people at the foundation? I'm sure you had to work with them both prior to conceiving the project and then carrying it out.

SHEPS:

Howard Freedman was a major consultant, and he had a lot to do with evaluating our proposals and what we were doing. He was very important. Linda Aiken was very significant. This was before she married David Mechanic.

LOWE:

Your interest in rural health goes back to your very early days. This program, I think, was one of the first major initiatives in rural health research and demonstration purposes.

SHEPS:

Do you want to ask a question about that?

LOWE:

No, I just want you to talk about it.

SHEPS:

I always felt, and I think I'm right, that if you really understand the issues in rural health, that prepares you for

anything in other areas because the most fundamental elements that make it possible to have a program of medical care for a population are sharply etched in a rural area. You don't have the same kind of resources, and you have the problem of access, which is compounded not only by the relative shortage of resources but by geography alone.

LOWE:

This center has had its finger in that pot ever since its founding. That was one of the major initiatives. North Carolina is a rural state and so forth.

SHEPS:

But there's a lot of work. The kind of thing that Tom Rickets is doing, for example, just makes all kinds of sense.

LOWE:

Shortly after you were brought here and you got the center going and all of that, the university administration invited you to do something a little further up the hierarchy. How did that come about, not only in terms of circumstances and dynamics, but what is it that they recognized you could provide during this particular period?

SHEPS:

My office was in the South building, which is the administration building. This was because when I came here, there was no room anywhere else, so they put me in there. When I brought

staff, they were put in the basement of the nursing school. That simply meant that I was in day-to-day contact with the administration. When they needed to appoint a new vice chancellor, it was in some ways natural that they chose me, because I was right there. I took the job with, I think, a very balanced understanding of what one could do and what one couldn't do.

I realized that my week-to-week contacts, aside from those with the top administration of the university but also in the health field generally, would be useful to the deans of the schools. I also realized that the deans were limited in what they could do, because, in the health field, the schools are organized in such a way and the funding is such that the chairs of the departments and the individuals in the departments raised their own money, and so they'd say, "What do I need you for? You don't give me anything. All you can do is maybe get me a better parking space." Realizing that, I launched a very definite policy and a set of procedures, which was to try to anticipate an opportunity or a problem, but an opportunity mostly that was coming down the pipeline in terms of funding or in terms of an area that was beginning to get attention even if there wasn't readily available funding. I would then set up a committee, which I would appoint to advise me of what, if anything, we should do in that particular area. That worked extremely well.

LOWE:

Do you have some specific examples of how that turned out?

SHEPS:

I'll think about that in a minute, but I want to say something else. When I appointed these committees, I rarely consulted with the deans or the department chairs regarding who should be on these committees. I appointed people from assistant professors up and appointed people who could be helpful in tackling that particular question or whatever it was. That's the way we proceeded, and the effect that that had was to begin to alert not only the committee members but others to what might be done or what ought to be done and to what one ought to be sensitive.

LOWE:

Emerging opportunities.

SHEPS:

That's right. I would circulate my recommendations for these committees throughout the division of health affairs. One of the significant and most appreciated compliments, appreciated by me, that I got when I left the vice chancellorship was from a man who had been the chairman of economics, who wrote me a letter and said, "I never thought that I would see a vice chancellor for health sciences who would be just as interested in the arts and sciences as he was in health sciences." Well, I took that to be a real compliment, and it was true. At first, when I would, on occasion

in certain meetings, I would say something about the arts and sciences and what they were doing, people would look at me and say, "What is he doing? It's none of his business." But pretty soon, the arts and sciences people, not that this was terribly frequent but it was not uncommon, pretty soon the arts and sciences people began to appreciate that because it was helpful to them to have an outsider, so to speak, appreciate their role.

LOWE:

This provided opportunities for the social sciences to get funding for research via the health sciences program, which was usually much more generously funded than the social sciences, so they could participate if not lead in programs. It added a richness to the research that was going on, particularly if you look at organizational and social issues. Rural practice, for example, must have been really valuable collaboration in terms of that.

One of the things I also wanted to talk about was the Milbank Commission for the Study of Higher Education for Public Health. Similar discussion about interdisciplinary approaches to problems has a bearing on that. But what were the antecedents of that commission idea? By then you were vice chancellor. You were not a direct faculty member from a school of public health per se. How did that commission get started and how did you become involved?

SHEPS:

David Willis was a key figure in this. He was very imaginative, more so than Lee Burney. Lee Burney represented the establishment in public health, and he did that very well, but that was his entire experience. He had, for example, been health commissioner for the state of Indiana and so on, whereas David Willis didn't have that background, which, in a sense, was helpful because he could be more open-minded, and he's got a very fertile imagination, as you know. They developed some interest in this, and they knew that I was interested in it, because I had talked about it from time to time. In 1968, when the newest building at UNC was put up, they had a ceremony. I was one of the people they invited back to participate and speak.

LOWE:

This was for the new school of public health?

SHEPS:

The new building. Yes. I made a speech in which I talked about what the future of public health needs to deal with, and this was one of the things that I mentioned. Perhaps that had something to do with Lee Burney and David Willis deciding that they should ask me to set up that kind of commission. I enjoyed that work tremendously. It was so interesting.

One of the reasons it was interesting was that we appointed a very heterogeneous group of people to the commission. We had

some standard people in public health. Then we had a guy like George Silver, who's a controversial person full of ideas, and half the time he's wrong, but it doesn't matter. You need that kind of stimulus. Then I put on somebody who had been the head of social welfare in the state of California and was at this particular time the dean of the School of Social Work at Brandeis University. He came from the field of practice and knew something about academia. Then we had somebody from the field of environmental health, a chemist, he was very good, Norton Nelson. We had a mixture of experts in public health, but they couldn't control the situation, which I thought was very important, because what you get from them is generally more of the same, and I wanted to have a situation in which people could make a primitive recommendation, which could make a lot of difference. It worked out that way, and it was really very good. The interesting thing to me was that was 1974.

When that report was published, the schools of public health said, "With friends like you, we don't need any enemies." They wanted us to say they were doing fine and all that was needed was more money. We didn't say that, and we talked about what they ought to be like. Of course now, starting about a year and a half ago, the recommendations of that report are beginning to get attention and, in fact, most of the recommendations in the Institute of Medicine report on the future of public health came (without credit) from that report. There are three of them that

are word-for-word with no credit. The next time I see Karl Yordy, I'm going to give him hell. We made recommendations that they weren't ready for but are now getting attention.

The most outstanding recommendation in that category was the one that said that the faculty ought to have close intimate responsibility and relations with the field of practice. The way I find it convenient to put it is what the schools did is that they went in the direction of academia. In academia, the faculty members feel that their overriding objective as so far as teaching is concerned is to reproduce themselves. That's very different from professional education, whose overriding job is to train people for practice. Ask a law school what its job is, and the first thing they'll say is to train lawyers. Ask a medical school what its job is, and they'll say to train physicians.

Schools of public health didn't appreciate that, and so there was a period of maybe almost 20 years where all they cared about was the academic criteria and achievements rather than the professional ones. Those are not contradictory to each other, but it's a question of what comes first and what your purpose is, and the purpose here is to train people for practice. Now you can't do that well without a major component of academic integrity and performance. But academic integrity and performance are not enough if you've got a professional school, and the difference between these two things is inadequately appreciated by most people.

LOWE:

I think it's more appreciated in medical school where it's much clearer as you suggest, but in schools of public health, I guess it was equivocal.

SHEPS:

Yes, it was, and the reason it's more appreciated in medicine is you got the general public, which says, "I need you to look after me when I'm sick." Who's going to say that in a health department?

LOWE:

Was there a recognition at the time of the commission by Milbank and key leaders that this was a real crossroad? Was there a crisis in confidence, or was there a sense that this needed to be addressed and that this coming together was important at that time? Or is the evidence that the recommendations are now being paid attention to 15 years later, a testament to the fact that it was too far ahead of its time?

SHEPS:

It was too far ahead of its time to be accepted at the time. Whether something else could have been done that would have moved them ahead, I don't know. I can't think of what it would be. The problem was that the field of practice was not organized. There was no single body that represented the field of practice. There was an association of schools of public health. The field of

practice would be the state and territorial health officers, the association of county health officers, the APHA. The first two had other agendas. They had their own recognition to fight for and develop, and they had their own problems with adequate financing and so on, so this was secondary, and they didn't consider it an important thing for them to do.

Whereas, if you look at the history of developments in medicine, the medical schools saw the need for research as a very important thing and, in fact, allowed it to predominate, whereas, in the public health area, that kind of thing didn't happen because, for one thing, so much of public health was dependent upon organization and political structure that one didn't see these problems as requiring research, particularly social research, to improve the situation.

LOWE:

So the field of practice was less well-organized to respond and to demand that the schools change.

SHEPS:

That's right. Another reason was the field of practice as a whole doesn't look to the schools of public health as their progenitor, whereas the field of medical practice looks to the medical school as its progenitor. That's a big difference.

LOWE:

Absolutely.

SHEPS:

I never thought of it this way before, but I'm sure I'm right.

LOWE:

What about APHA as primarily a practitioner organization? You began your involvement with them early in your own career and served on commissions and committees until the cows came home.

SHEPS:

I was on the executive committee for four years as a member of the executive committee and then on the executive committee for another six years as the chair of the program development board. That's a lot of involvement. It is an organization of members who are practicing in the field of public health. It serves that big membership, and that's its overriding responsibility. In that way, it believes it's serving the cause of public health. It is, but that's an indirect way of doing it.

Just recently, I wrote to the upcoming president, Christine Gebbie, who is the secretary of health in Oregon, a marvelous, very bright woman with a nursing background. And I said to her, "Look, you're going to be the president, for God's sake, do something about taking on the responsibility of developing *public* understanding of what public health is all about." The public needs to know that the health department is its best friend. It doesn't know that now. It thinks of the health department as an organization that does sanitation, and that's all it thinks about

as a rule and maybe looks after people who can't afford to pay. You and I know that shouldn't be a public health responsibility. It's a responsibility that should be carried out in another way. As long as health departments do that, they are postponing the day when financing really comes the way it should.

I feel that way very strongly. I think that there is a very crucial need to get the American public to understand what a health department does and what they should expect from it. At the present time, as I say, they expect that department to look after nuisances, large and small, from the water supply to the dead horse, and that's really not good enough. I said to her in my letter that one way to begin this is, if there is an important public health issue that the APHA has taken a position on, to call a press conference so that the public should be informed.

The APHA carries out its public responsibilities almost totally in terms of its lobbying on the Hill. I tried unsuccessfully to get them to work in various states, not in every state, but if they knew there was an important issue in the state of Michigan that they should say to the public health association of the State of Michigan, "We'd be happy to come and help you give testimony." I have not been able to get them to do that.

LOWE:

Has the APHA been reluctant? Is one of the reasons why they are reluctant the intrusion on state prerogatives, or were the states reluctant to invite them in?

SHEPS:

State people never think of that. They have never represented themselves to the public in one way or another. APHA's public work is virtually entirely lobbying on the Hill. Now that's very important, but it's not enough. I've always felt that they should be doing that. Bill Keck, who is the president this year, agrees with that. He asked for some suggestions. I gave them to him and, as I say, I now am writing to the next president. I suppose it won't be long before they say, "Oh, there's Cecil again singing the same old song." But I think it's very important.

LOWE:

The field doesn't have really an identifiable central spokesman like that. Who were some of the key people involved in that commission? You mentioned a few and the report came out in 1976 or something like that. Who was the secretary to the commission?

SHEPS:

Florence Kavaler. She was very good in that job. She's on the faculty now at Downstate Medical Center. She was brought up

on the sidewalks of New York, so to speak. She was a very tough lady.

LOWE:

So in terms of the impact of that commission, it is mostly being felt, as is true with many of them, down the road in terms of timing.

SHEPS:

That commission report is getting attention now. Its recommendations are getting being discussed.

LOWE:

Even without attribution.

SHEPS:

Yes, sometimes there's attribution. The Institute of Medicine brought some people together five or six months ago to examine the question of whether they ought to take an interest in education for public health. The commission report was a major reference that they sent out in advance. They are now going to proceed to try to get some money to work on this. I hope they do because their reports get a lot of attention.

LOWE:

Is there a current crisis, if you will, in terms of this subject?

SHEPS:

In terms of education?

LOWE:

Right. Or are the schools doing a pretty good job?

SHEPS:

I don't think there is a crisis as they see it. The departments of health administration or health policy administration have a lot of students whom they're training, as I said, for the "industry." Very few of them, with the exception of Hopkins and maybe one or two others, probably UCLA because Milton Roemer is still there, are different. With those exceptions, and Hopkins is a strong exception, they get nothing about the health of the public. They are trained as managers. There is nothing about principles in public health. They get nothing about health issues from the biological point of view. I think that's unfortunate, and I think it's wrong. But the schools get a lot of students. They are competing with the schools of business. There are many more such programs outside of schools of public health than inside on the order of four or five times as many if not more. I don't know what is going to happen.

One of the recommendations we made that was very unpopular was that, given the fact that you have all these schools training people as administrators, the health administration departments of schools of public health should concentrate on training leaders, taking the graduates of the other schools and giving them another year or two that would help them understand what communities are

like, what public health is about, and so on. That was very unpopular with the schools of public health, because they took it as a limitation on their prerogatives and a limitation on their potential reservoir of students. Well, I think they were wrong. It's a losing battle to compete with those other schools. There are too many of them, and they are doing very well, thank you very much, and you might as well accept that they do something for which there is a need. There are now 21 or 22 schools of public health. If they were all to go out of business in health administration, the field wouldn't suffer in terms of what is going on now, but the field as a whole is suffering from the fact that most of the people in administration have no concept of a sense of community, a sense of public health, a sense of public health priorities.

LOWE:

Can leadership really be taught, not in an academic curriculum sense, but where do people like Cecil Sheps come from, because these are the kinds of people you think of as leaders?

SHEPS:

What the schools of public health did for me and for Roemer and for Rosenfeld and all sorts of people like that was they gave us the context. We started with the notion that there was a development and leadership issue and needs that weren't being met and that an appreciation of that needed to be developed. The managers who are being trained now have very little interest in

that. They look for a job, and they take it. Those jobs have already been established, and their objectives have been established, and they are usually of the limited kind. It's understandable that people who have not been given such orientation say, "Well, the health department is like the school of education. You train people to run the organization, but a health department, like a school of education, has to have a set of objectives. How are you going to get that? You can't get it from people who are just looking at the bottom line and keeping the place clean. You need more than that. I think that can be developed among students who don't come with it, but as important, if not more, is for the people who come with those general notions to give them the strength, the knowledge, and the skills they need in order to move ahead in this direction effectively.

LOWE:

You were entering the field at a time when there was great opportunity for change. There was no large system of payment for services, and that developed. And there were other important things like that. It seems that we tried the competition route and all that business in the '80s, and the jury is halfway back on that. One of the things, obviously, a set of experiences, that you have that have been very important--going back to your WHO fellowship when you were in Western Europe--has been your international experiences, both as a consultant and visiting

fireman, if you will, and involvement in health manpower issues. You bring your perspective to all the things that you do, but how do you think that was received, and how did those things come about?

SHEPS:

How it was received? I guess I would say that it varies a lot with each situation and with what you are expected to do. There are two kinds of situations that one sees most commonly. One is where they want very badly to have some help, and the other is where they don't want it at all. Somebody else has foisted it on them, and one could quickly determine which is which. It makes a big difference in how you go about it, how much effort you put into it.

LOWE:

And how well you appreciate which one it is going in.

SHEPS:

To give you an example, I was in the Dominican Republic for several visits over the course of a few months, a total of 10 or 12 weeks, to help them do some health planning 25 years ago. I was in the health department, and I asked them if they had population figures. And they said, "Oh yes. We did a census a couple of years ago." They brought out a printed table showing three or four provinces with the population of each province, and then on the extreme right of the printed table there were some figures in

pencil written in. I said, "What are these figures?" "Well," they said, "El Jefe wanted four million people, and we only had three and a half, so the printed table is what he wanted, and the figures written in are the real ones." It imprinted something in my mind that I have never forgotten. The truth of the matter was that, except for a small nucleus of dedicated professional people in the department of health in the Dominican Republic, nobody else was interested.

There was a problem with bovine tuberculosis at that time, which was responsible for a lot of tuberculosis in human beings because of tuberculosis bacteria in milk. I went to the agriculture department, because in order to deal with this you had to get their cooperation. I couldn't get any cooperation. It wasn't their field. They didn't care about disease. That kind of thing is a dose of realism that everybody needs, and it's not very encouraging when it happens.

Then there are situations where people want you very badly, because they decided they need some help, and they are very appreciative of it. Once I went to several academic medical centers that were interested in doing a better job of serving their community--deciding what their community was--and that went over very well, because it was my meat and drink and they really wanted it. There was a health planning activity in several countries where the situation was that 90 percent of the money was being

spent building hospitals in the capital city and the next biggest town, whereas 80 percent of the population was rural. That kind of thing, even though if it's obvious, one had to make it even more obvious and confront the government people with what they were doing. Those who wanted to do something about it had to learn that they couldn't do it by themselves. They had to build the strength up in rural areas and build leadership in rural areas, which could then confront the government and say, "Look at the difference." There was an issue that came up not uncommonly and that was, as far as the public was concerned, generally getting a doctor to look after you when you're sick--that's the important thing and the health department was something they didn't understand. We could only get them to understand it by teaching them in the context of some principles of bookkeeping with regard to health, just ordinary bookkeeping.

LOWE:

Were there situations where you went out purposefully to learn something, where the knowledge was flowing the other way or it was at least, I think your Israeli experience was along those lines, at least the way I understand it? You were brought in as a consultant, but the way they went about implementing things sounded to me like you were.

SHEPS:

Oh, yes. Professor Prywes and I, he was the Israeli, the two of us realized that we couldn't get anywhere to build the kind of school we wanted unless we got the people from the area to want us to be there and unless we involved them. The mayor of Beersheba was an important figure for us, and we made him part of the deal. He wanted of course to have a school, because of the prestige and more people and so on, but we were able without too much difficulty to point out to him how much more he could get from one kind of school as opposed to another. And he was converted, and it was extremely helpful.

LOWE:

What was the principal difference between the way that school was set up from the traditional medical school?

SHEPS:

The concept was to teach and learn within the context of the health problems of a designated population. It was easy to designate the population, because it was a desert area, and while they could travel north, not everybody did by any means. That was one part of it. We recruited faculty who had an interest in the concept. We recruited people who didn't just want to come and do orthopedics. They wanted to do orthopedics in this context, and the medical people in particular, those in internal medicine were of that kind. I mentioned orthopedics, because we had a very good

chief who was like that. That would be most unusual in the surgical specialties. But that gave the place a special cachet, because we always and regularly would bring up the evaluation of effectiveness in terms of the epidemiologic information from the field, which helped to supplement and didn't displace the natural tendency and historical tendency to say, "I'm doing very good orthopedics. I just did a fancy operation," etc. That was still there.

LOWE:

You went beyond the technical to the impact on the population.

SHEPS:

That's right. Everybody was aware of that. There were a few people who didn't care about it, but they had to pretend that they did, because otherwise they would be frowned upon. There was one guy in medicine particularly who wanted to be in a medical school and came under any circumstance but didn't buy into this. He wanted to keep quiet. I said to him, "I can't change your mind, but don't get in our way. You can get what you want out of this, but don't get in our way."

LOWE:

We were speaking about international experiences. One of the things that enters into the great debate in this country about how to deal with cost-containment issues and a national health program in particular is that we ought to learn from Canada and from other

countries that have national health programs. You're a Canadian. Do you flagwave the Canadian system in our country?

SHEPS:

At every opportunity. I don't think it's perfect. Certainly from the point of view of the public, it does an excellent job. There is no financial barrier that separates the patient from the physician. What's missing is what's missing in every country that has removed the economic barrier and that is, it's been such an important thing that when they get it done, they figure they've done everything. What they don't realize is that it solidifies the current system, and it's not good enough because the whole question of how you can make medical care more efficient and more effective doesn't get dealt with.

These questions are not asked. That's beginning to change. After a number of years of the cost going up every year at a rate twice that of inflation in some countries, and Canada is one of them, it's beginning to make commencement of a start at looking at this kind of thing, and those questions are going to be asked, I think, in this decade. It's very, very important that they be asked. But they are not going to be asked effectively until the public understands that it has a lot at stake, that the budget considerations are serious, and they need to open their minds to the fact that there may be a more efficient way of organizing care

and that this can be done without sacrificing quality or comprehensiveness.

LOWE:

What about the question of de facto rationing becoming de jure rationing?

SHEPS:

In this country, there is de facto rationing, and it means that the people who are rationed are the ones who can't afford to pay. When you have de jure rationing, you have national health insurance. Then everybody is treated the same way, and any denial affects the whole population and not just certain segments of the population. So that, for example, the rationing in Canada, the de facto rationing, for some complex procedures where there is a waiting period of six weeks or eight weeks or even longer, affects the less affluent than it does the affluent, because the affluent take their car and they cross the border and get it done in the United States. A significant proportion of these complex procedures for Canadians are done in the bordering towns and cities. It's unfair.

If I were in charge of the situation in Canada, I would say, "Let's spend the extra capital and have what we need, maybe a little bit less than we need. I think we should have a little bit less than we need because if we have what we need, it will all be used, and the demand will increase. If we have just a trifle less

than what we need, then you would have a set of priorities that would be different. But this is a fine point. I think it's wrong and foolish for Canada, for example, not to provide enough resources for such purposes. They don't have that problem in Britain. The waiting period is very short for seeing consultants, who are all in hospitals. For emergency conditions in both countries, there is no problem at all. It's not a serious problem in that it doesn't do very much, if anything, to reduce the standard of health maintained for the population, but it's a bothersome public relations problem in an area where there would otherwise be widespread satisfaction.

Widespread satisfaction is a very important thing. It means that you can always get enough money to keep the system going, because people feel they are getting value for the money. I think one of the problems with our education system in this country and one of the reasons that can't get as much money as they need is that there isn't faith in its effectiveness.

LOWE:

There is not enough perceived value.

SHEPS:

That's right. There is theoretically, but not in the system. I think that's a very important consideration.

LOWE:

Do you think the U.S. citizens are losing faith in the health care system to the extent of which some kind of national program is on the horizon?

SHEPS:

I think there are two relevant elements here. One is that the large employers are now saying publicly, as General Motors did and as a former secretary of HEW and head of General Motors said in a piece in the *New York Times*, that the cost of medical care for their workers and their families is too great for them to continue to be able to absorb it as a charge against the cost of production and that it ought to come out of taxes. That's very powerful, very important. Their feeling about this is very strong, and it's very much in their self-interest to have it come out of taxes as a charge against the cost of living. The second factor that I think is important and real is that there is a steadily increasing sense of shame that we have 37 million people who have a financial problem getting care. And their number is increasing. I think this combination will produce a situation in this decade by which, in this decade, we will get national health insurance. The comparison with Canada continues to get more and more odious.

LOWE:

Have you been involved in some of the work of groups that are looking in on these questions? I know that Glasser and the union folks have been looking at this. Tell a little bit about that.

SHEPS:

That was a very stimulating exercise. The Glasser committee is a powerful committee--the AFL-CIO, former secretary Fleming, and other people. Rashi Fein was asked to set up an expert committee on medical care and health insurance. He asked me to be on that committee, and we met every five or six weeks over the course of three years. We developed a report that Rashi wrote and that the AFL-CIO has not quite adopted, because it goes a bit too far for them.

LOWE:

They have to give up too much.

SHEPS:

Yes, of their own controls. It's an understandable but a disgusting business. But there are a couple of unions that have accepted it. Not the AFL-CIO. I was involved in that, and it was a wonderful exercise. We had very good people, and we had a very stimulating time, and I think we developed a report that was very good. Have you seen anything of it at all?

LOWE:

I have not read it personally, but I know of it. That's why I asked about it.

SHEPS:

I have a pamphlet that lists the criteria. Let me get it for you. Bert Seidman was on, and he brought the trade union point of view into the picture. He was the only one who had ongoing contact with them.

LOWE:

Your net conclusion, then, is that the forces of changes are positioned as such that in the next 10 years . . .

SHEPS:

I'm absolutely sure. I don't know what could stand in the way.

LOWE:

Well, 1,500 insurance companies.

SHEPS:

Well, that's right. But what will happen is that it will be a federal and state thing, we think, in which the federal government would pay a substantial chunk. The states would pay in some relation to their capacity, and there would be a federal set of guidelines and criteria and standards, and the states would be responsible for the conduct of the programs. I think most of the

states will say to the insurance companies, "Do you want to do this too?"

But, in the course of time, they won't make any money out of it, because if the state programs are any good, they are going to be efficient, and there is no profit for them. On the other hand, some of the insurance companies in this business are not able to make money out of this. They know they can't, but it's a sort of loss leader that gives them the connection with the public that enables them to sell their other stuff.

LOWE:

How will the hospitals and physicians fare under this change of the source of their payment?

SHEPS:

Well, remember that hospitals are no longer getting paid on the cost-reimbursement basis. They are getting paid on a package basis based on an estimate of what it should cost.

LOWE:

So that won't change.

SHEPS:

So that won't change except that it will be an annual budget,a global budget. They will sit down like they do in Canada and say, "Let's talk about your budget for next year and reach an agreement that would include decisions, where necessary, about capital expenditures also."

LOWE:

This is an interim program that is paving the way for this.

SHEPS:

Yes, payments on the basis of the nature of the problem and so on and not a fee-for-service basis. So they're going to get used to that. I don't think by the time that national health insurance arrives that these are going to be important issues. There will be fussing about it, but there is enough going on, and that's going to increase, so that there will be other experiences that people can refer to. It won't be a guessing game. They'll say, "Well, in Oregon, they have done this for several years, and this is their experience." I don't think it's going to be as difficult as it would be now.

LOWE:

Are there sufficient leaders in medicine, hospital leadership, and so forth that are anticipating this with some foresight?

SHEPS:

I think one can say this more positively now, not strongly but more positively, than five years ago. You have, for example, the policy statement of the American College of Physicians. I don't know if you've read that. Well, it's a marvelous thing. It doesn't deal with financing, but it deals with everything else and with the need for people to get care, the need to organize care, and that kind of thing. With statements like that from a body like

the American College of Physicians, it's not all the physicians in the country, but it's the most prestigious group. It's the leadership group. And, on the other hand, as far as surgery is concerned with the changes that are taking place in the payment system through the Harvard plan, that is the resource use approach.

It was so shameful when I was in practice, which was a long time ago, an office visit was $3, but if a man came to get a shot for syphilis it was $10. I remember feeling badly and stupid for doing that, but yet I felt I could not charge less than the other guy. But that $10 charge was simply because he had a shameful disease. What kind of fee for service system is that? I think the resource use approach is a very good one until people are put on salaries. I think it's a very good way to go, because at least they pay some attention to what's involved in any particular procedure.

LOWE:

Will there be a larger role for planning, regional or otherwise?

SHEPS:

I think so. It's got to happen. They can't just sit there and see the costs go up. They can't just sit there and see a higher and higher proportion of care given on an ambulatory basis, and yet we've got these great big institutions sitting there. They can't just make an odious comparison between ambulatory care

outside the institution and ambulatory care organized in the institution, which is always more expensive if for no other reason than the fact that the overhead is high in a hospital. It's not as though you put up a building for ambulatory care with a lower overhead, but the overhead is still going to be on the basis of the whole hospital, and it's in the interest of the hospital to have it that way because it spreads it out more.

I think those situations will improve when they are seen in that light. The major thing is the public interest in having these things done on a basis that represents the public and the public being a force that needs to be reckoned with and a force that is involved in negotiations. I think that's very important.

LOWE:

That will make more fundamental the ambulatory care and primary care aspect of service delivery. I think I read somewhere you called it the primacy of primary care. I'm not sure where you wrote that, but I remember seeing it.

SHEPS:

Yes, I did write that.

LOWE:

It forces a refocusing of priority.

SHEPS:

In that paper, I'm sure I must have said that it means not only is primary care the primary access point, but it is in charge.

It doesn't provide everything, but it's responsible for seeing to it that what's needed is provided, not more and not less. That's the way I put it. I think it's a very important concept. I have found that when I say it that way, it helps people understand that there is more involved than paying the bills, that the very paying of the bill on a public basis raises the issue of being efficient and being effective. It's one and the same thing. That twin objective of efficiency and effectiveness is very important.

LOWE:

That's what really provides value to the society because health care is a societal issue, and it has to be perceived as valuable by the entire culture.

SHEPS:

The problems of providing it properly and the problems of regionalization are paralleled in my view by the problems in education. They are the same thing. There was a time when all the medical care could be delivered by a single physician just like there was a time when education could be provided by a one-room schoolhouse but not any more in either case, and the reasons are the same. There is more to be taught, there's more to be learned, there's more to be delivered.

LOWE:

More specialization, departmentalization of knowledge.

SHEPS:

I looked into the history of the development of these larger school districts, as were they called.

LOWE:

Unified school districts.

SHEPS:

And, in fact, Dick Weinerman wrote a paper on this parallel long ago. He was in medical care at Yale, and he was killed in an airplane accident in Europe. He wrote a paper long ago in which he made this comparison. It's a very valid comparison. What the people learned toward the end of the nineteenth century was that if you wanted your kid to know some physics and some chemistry, you couldn't do it in a one-room schoolhouse. It wasn't efficient. You have to do it in a place where the costs could be spread around, and this is the same kind of principle. The people, therefore, consolidated their school districts. The movement for consolidated school districts was a movement to see to it that all children could get the full range of what they needed.

Well, in medical care, you've got the same principle, the same objective. People realized at the end of the nineteenth century that that was needed in education. They like to do it because there was pride in the ownership of one's own school, but they realized they had to go beyond that if they wanted their children

to have the kind of education that they needed. In the field of medical care, the principle is the same.

LOWE:

But it has gone, in some people's view, too far. Every town doesn't need a hospital.

SHEPS:

That's right. Like every little town doesn't need a high school.

LOWE:

But there is a pride involved, and if you have a hospital you want it to be full service. And if you're a physician on the staff of that hospital, you want to have a full-service hospital.

SHEPS:

When I was in Saskatchewan, one of the programs that we developed was to attract doctors to rural towns by building several hospitals. I had a delegation one day from a little town, and I said, "Okay, I know that in your area, it makes sense. We'll try to get one for you. Two days later, a delegation came from the next town 10 miles away, the same kind of town of about 300 or 400 people, and said, "We need a doctor." And they decided to compete with other towns. And what they were competing for was the additional business that would come to that village if the doctor was located there, because you not only came to see the doctor, but you went shopping and so on. I said, "Look. We are not in that

business, and you fellows can decide together where it's going to be. I'm not going to decide. There is only going to be one doctor. You tell me where you want him to be located. Either town will do."

LOWE:

What happened?

SHEPS:

They couldn't agree, so then I made the decision. I made the decision where there was a larger population by about 100 or 200.

LOWE:

We had talked a little bit about what has happened with the role of the institution in education and how that might fare if a national health program comes in and financing of education and all that. One of the books that I know you're proud of is *The Sick Citadel*. The work and the analysis that went into that when it was published eight years ago or so a lot of that is as apt today and, in fact, even more so. It's one of those things where you're ahead of your time again.

SHEPS:

That's right. It's only now beginning to get attention. At the time it was published, it fell into the sea. Really, we were very disappointed, but we shouldn't have expected anything. But now I see reference to it more and more. My wife was talking to a young student, an undergraduate student who was interested in a

dramatic production with her, and he said to her, "Are you related to Dr. Cecil Sheps? She said, "Yes. I'm married to him." He said, "I just finished his book on *The Sick Citadel*. I got it out of the library. It's a wonderful book." He enjoyed it very much. It's now getting attention. That's nice. It was my idea to write the book. Irving J. Lewis's name comes first, because we tossed a coin. There was no other way to decide. I recruited him to work with me on this because of his Washington background in public policy.

LOWE:

He was from New York, is that right?

SHEPS:

Yes, he's back in New York now. He was, at that time, in the Department of Preventive Medicine and Public Health of the Einstein Medical School. But his main job for a long time was in the budget bureau, and he dealt with social and health problems, so he had a very interesting point of view. Then Martin Cherkasky got him to come to New York. I recruited him for this book, because I felt that I didn't know enough about how public policy was formed and so on at the government level, and that was his meat and drink. We were a very good combination. We had a wonderful time. It was such a gratifying experience to work with him. We would meet every month or so at Chapel Hill or in New York and assign portions to each other and then review them carefully and so on. But the

discussions we had and the arguments we had about what was to happen were a great experience and very productive. Ever since then we've been saying we ought to do something like that again, but we can't agree on the subject.

LOWE:

Like writing a book with your son. You can't agree.

SHEPS:

Lewis has really retired. I think he would stay involved, but the department took away his secretary after his official retirement date as most departments do. I'm very lucky because Gordon DeFriese and I have this kind of relationship, so he gives me a half-time secretary, and I appreciate it very much. But if I didn't have that, I would have been out a long time ago.

LOWE:

You've been involved in teaching one way or the other for 50 years or longer and have had a series of students, many of whom have had their own brilliant careers one way or the other. I wonder if you might talk about maybe three or four, not in a way to exclude people you don't mention, but just as a sample from different points in your career where you've had an influence on a certain person and you've been proud of what they've been able to achieve subsequently.

SHEPS:

I would say that effectiveness was less so with the formal students, because there I would give a series of lectures or a lecture and perhaps some students were turned on. I imagine that's true, and also other students began to see things in a different way. At that level, I cannot measure. On the other hand, on the level of, for example, in the last 10 years, the physicians that are attached to our center, either through the Robert Wood Johnson program or other programs (at all times, now there are some 30 physicians who are related to this center in one way or another in various programs) and out of that group, there are always four or five who gravitate toward me. I see them on an informal basis every two or three weeks, and we spend an hour or more together. I suggest the readings they should do, and then they come back and discuss them and so on. I enjoy that tremendously. These are very bright young people. They've reached a stage where they're really not just learning for the sake of accumulating data, but they are trying to learn how to be effective themselves and how to think about the material they're working on. I find that very stimulating. They are very bright, and they have a good social orientation and tell me that they find those discussions helpful. It's the most stimulating thing that I do now. Not a week goes by that I don't see one or two such students.

LOWE:

It must be very satisfying.

SHEPS:

Very satisfying, very stimulating, and it's the stimulus that makes it satisfying. Most of them, I think, find it interesting because I bring the perspective of a half a century to this. I remember once I was dealing with a small group of medical students, and they asked me a question, and I said, "Well, the best reference on this was written by so and so, and it was about 35 years ago. They said, "It has to be out of date." I said, "Listen, is the Bible out of date? This is a classic. You can't improve on it, and the changes that have taken place since then simply bear out their relevance."

LOWE:

Elaborate on it.

SHEPS:

There's a notion that for medical students must be recent and new because they are told, "Everything you learn now will be out of date 10 years from now." They can't make the distinction between amassing facts and understanding principles, and the latter is the kind of thing I do. But the ones I see are clear about the direction in which they want to go, and they are mature and the average age is close to 30, and they are taking off a year or two years in order to get this additional background to equip them

mostly for faculty positions. A few for administration but mostly for faculty. I feel very fortunate.

LOWE:

Is that relatively new? You have always had some physicians affiliated with the center.

SHEPS:

That has developed much more in the last 10 years.

LOWE:

That's a very important development.

SHEPS:

But, you see, the center has had training grants for over 20 years. That's a small number of people. The number has increased. But the center is also crucial to a series of other training grants that are located, say, in the Department of Medicine or in the Department of Preventive Medicine or in the Department of Pediatrics. And this is an element of their development and training of those young physicians, and it's very important. As it expands, the number becomes very significant. I think the students find me an interesting old character.

LOWE:

You have a good story or two.

SHEPS:

That's right.

LOWE:

That's how a lot of good learning takes place.

SHEPS:

And I enjoy re-telling the story. They can tell that I'm enjoying the interaction. They don't see much of that kind of thing. In clinical departments, the senior guys are very busy, and you don't see much of them. Teaching is given to the young people.

LOWE:

Not everyone has the same interest or capacity to teach.

SHEPS:

I'm sure that's true, but still I think there's a difference. The young person primarily tends to be concerned with transmitting the factual information. The older person tends to be concerned with transmitting some understanding. And there is a big difference.

LOWE:

Absolutely.

SHEPS:

What it does is help them understand how to think about certain kinds of problems. How to be systematic and organized about policy questions. In order to do that, you have to have a concept.

LOWE:

And having a research center that's a very systematic and organized outfit anyhow.

SHEPS:

Gordon has been very good, very effective in a number of ways, but the one I want to mention now is the close working relationship with other departments and schools on the campus. He has been able to achieve that.

LOWE:

The original concept of health service research back when you were doing the studies that you saw immediately that there would be benefit in mixing the hospital and the nursing study sections. It's the interdisciplinary aspect, and to run a good center, you have to have a good relationship with the major departments. The development of this center and your career was kind of, in no small measure, kind of capped in June when the center was renamed in your honor.

SHEPS:

That's the kind of thing that Gordon thinks of doing and can get done, and I'm deeply appreciative.

LOWE:

That must have been a very special.

SHEPS:

Yes, and he successfully kept me uninformed. I had no notion this was going on until it was achieved and he was able to tell me the date. He apparently had worked on it over the course of three years. It was very gratifying. It was very nice to have my son here, and my brothers came. It was very nice. It's the kind of thing you never expect. In my life, I've had various kinds of recognition. I have never, that I can remember, deliberately set out to get that kind of prize.

LOWE:

I think your son's remarks to me drove home the point that you started out with a kind of social philosophy about how things ought to be and devoted a career and a lifetime to pursuing both broad and focused activities that had to do that, and it was very principled. And when someone is both principled and effective in getting things done, then it seems like these kinds of accolades are to be expected.

SHEPS:

It's been very gratifying. When I look back on it now, when I was doing it, I was doing what made sense to me to do. That's all. I wasn't looking for some kind of special recognition but rather a social goal.

LOWE:

You were getting paid to do what you like to do.

SHEPS:

That's right, and I didn't seek any kind of special recognition, but it's nice to have it just the same. I can't deny that.

LOWE:

It's a validation of the fundamental premises and how important they are in our society.

SHEPS:

My mother had a lot to do with the way I behave and think. She came from a little village in Russia, and she finished high school, which is remarkable thing at that time for a woman in a village, and particularly a Jewish woman. She was a very intellectual kind of person. When I was three years old, she began to read me Charles Dickens, and every time, she would say, "When you grow up, I want you to write a book." I was never quite good enough. I would come home second in class, and she'd say, "Why didn't come first?" It is really surprising that I'm reasonably well balanced despite that kind of upbringing, because I was never quite where I ought to be. But it did stimulate me, I guess. And it didn't cripple me. I didn't feel inadequate.

LOWE:

That's a tribute to her and your father.

SHEPS:

They set objectives for us. My son is the same way. He is very principled and very down-to-earth at the same time.

LOWE:

Life and work kind of come together.

SHEPS:

Yes.

Index