HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Everett Johnson

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EVERETT JOHNSON

In First Person: An Oral History

Interviewed by Donald R. Newkirk
February 11, 1993

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Everett Johnson

CHRONOLOGY

1925	Born May 11, Chicago, Illinois
1943-1944	United States Army, Infantry Private First Class
1947-1952	United States Military Intelligence First Lieutenant
1948	Northwestern University, Chicago, Illinois, B.S.
1950-1951	Methodist Hospitals Northwest Indiana, Gary, Indiana Administrative Intern
1951	University of Chicago, Chicago, Illinois, M.B.A.
1951-1954	Chicago Memorial Hospital, Chicago, Illinois Superintendent
1954-1975	The Methodist Hospital of Gary, Gary, Indiana Chief Executive Officer
1962	University of Chicago, Chicago, Illinois, Ph.D.
1975	Bedford Health Associates, Inc., Katonah, New York President
1976-1979	Dunes Group, Michigan City, Indiana President and consultant
1976-1979	University of Chicago, Chicago, Illinois Associate Director, Graduate Program in Hospital Administration
1979-	The E. J. Group, Inc., Marietta, Georgia Director
1979-	Georgia State University, Atlanta, Georgia Director, Institute of Health Administration

MEMBERSHIPS AND AFFILIATIONS

American Association of Healthcare Consultants
Member

American College of Healthcare Executives
Fellow
President-elect
Regent for Indiana, 1964-1968
Governor, District 04, 1968-1970
Chairman Officer, 1971-1972

American Hospital Association
Member, Council of Administrative Practice
Member, House of Delegates
Member, Nominating Committee

Blue Cross/Blue Shield of Georgia
Member, Board of Directors
Member, Executive Committee

Blue Cross/Blue Shield of Indiana
Member, Board of Directors
Member, Executive Committee

Indiana Hospital Association
Chairman and president, 1960--1961
Committee member, 1965-1968
Delegate, 1965-1968

National Advisory Council on Nursing of H.E.W.
Member

National Council cf Com..i-r.tyni Hospitals
Member, Board of Directors
President

AWARDS AND HONORS

American College of Healthcare Executives
- Edgar C. Hayhow Award, 1973
- Edg r C. Hayhow Award, 1978
- Silver Medal Award, 1989

Beta Gamma Sigma
- Member, 1951

Phi Delta Kappa
- Member, 1962

Tri-State Hospital Association
- Award of Merit, 1968

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NEWKIRK:

Today is February 11, 1993. My name is Donald R. Newkirk. We're in the beautiful city of Atlanta, Georgia, at the downtown campus of Georgia State University in the Business Administration building. The subject of our interview this morning is Dr. Everett Johnson, a longtime personal friend and one of the most prolific contributors to the profession of health care management and policy. History will show that Dr. Everett Johnson is a true scholar, practitioner, and, in general, a fine contributor to the knowledge of health care policy and management. But let's hear his story from his own lips. Okay, let's start with 1925.

JOHNSON:

In 1925 I was born in the old Lutheran Deaconess Hospital in Chicago. When I finished high school in 1943, World War II was on. I then started at Northwestern University, got drafted into the army in November of 1943. I spent a little over a year in the army/ half of it in an army hospital with rheumatic fever. I was discharged at the end of 1944, came back to Chicago, and returned to Northwestern University.

NEWKIRK:

Let me ask you a question. In the ACHE directory it says military service, 1943-52.

JOHNSON:

Well, because once I graduated in '47, I then joined the Counterintelligence Reserve Corps. So I was in the reserves until '52 or '53, whenever that was. So I finished at Northwestern; in the process, we'd gone back to the days when I was laying around in an army hospital and I tried to figure out what I wanted to do-what kind of a career I wanted to have. I came up with the idea that when I got back to school in Chicago, I would start interviewing a lot of people about their jobs. That's exactly what I did. I probably interviewed, during my years at Northwestern, some 200 different men. I asked them what they did, how did they like it, how did they get into it, were they satisfied with it. I wanted to find out what different careers were all about. In the process I interviewed with Ed Hansen, who was then the superintendent of Lutheran Deaconess Hospital, who'd been there for years and years, and with Bill Bohman . . .

NEWKIRK:

Who? Hansen?

JOHNSON:

Ed Hansen.

JOHNSON:

Right. And I also interviewed with Bill Bohma.n, who then was at Norwegian American Hospital in Chicago. He used to be-you know him from Middletovm.

NEWKIRK:

Yep. Right.

JOHNSON:

So I decided that what I should do is go into hospital administration. At the same time, my brother used my information and applied to the University of Chicago program before I did. So he was accepted a year ahead of me. I had about a two-year break. What I did there was I first worked for U.S. Rubber Company helping them set up a plant-one of the early plastics plants in Chicago-and then I went and worked for Continental Insurance for about a year in their casualty underwriting. The reason I left U.S. Rubber was they had a lot of unprotected machinery. I almost cut a finger off working in the plant, and I decided that was not my cup of tea. So I worked at Continental Casualty until the fall of 1949 and entered the program at the University of Chicago for an MBA.

NEWKIRK:

You mentioned your brother.

JOHNSON:

Yes.

NEWKIRK:

We didn't get very far into this till your brother pops up.

JOHNSON:

Right.

NEWKIRK:

Better explain. First of all, give us his name.

JOHNSON:

It's Richard Johnson, who's a twin brother, who has also been in the health field since about 19.50. At one time, he was an assistant director of the liliA. He was the first administrator at the University of Missouri Medical Center. He also, now, for the last 24 years, has had his own health care consulting operation called Tribrook, Inc. So we've been very close. In fact, even to this day we talk on the telephone practically every day no matter where we are.

NEWKIRK:

And just compare notes.

JOHNSON:

He's been a partner and companion for the last 44 years. Well, he's more direct than I anL I tend to be more laid back. Well, so I went into the program at Chicago. It was a one-year program **with** a one-year residency. For my residency, I went to Methodist Hospital in Gary, Indiana, because of J. Milo Anderson, who was the administrator at that point. I stayed there for a year, developed their first fund-raising program for Milo, and watched an addition get built to the hospital. When I finished 1ny residency, Dr. Arthur Bachrneyer, who was then the program director of the Chicago program, recommended that I become the

superintendent, in those days, of Chicago Memorial Hospital。 It was a 103-bed hospital just south of Michael Reese Hospital on the Outer Drive o It was-its medical staff were all-practically all-previous faculty members of the medical school at the University of Chicago. So they decided that they did not want to stay on a salary in medical practice, and went into private practice. It was probably the best learning experience in medicine I ever hado There were internationally famous physicians on that medical staffo For example, in a 103-bed hospital, we had five neurosurgical residents. It was really a very special experienceo

When I took over that hospital, I will never forget ito They would not let me visit the hospital prior to accepting the jobo That was because they had a bookkeeper that had been running the hospital for about 20 years, and she was pretty upset about the way things were going. The hospital was about $800,000 in the red, but it had been a hospital that was supported by the wealthiest people in Chicago like the Wrigleys, the Armours, the Swifts, the old-name families of Chicago. The first day I walked into the hospital, I was on the job. They had removed the previous superintendento I was given a house next door to the hospital. This was an area that was the largest slum area in Chicago, and it was a dangerous areao We had police protection constantly.

NEWKIRK:

Was this on the South Side?

J"OHNSON:

It was 31st Street and the Outer Drive, just south of Michael Reese Hospital. Our pathology coverage came out of Michael Reese, for example. Their chief pathologist also covered Chicago Memorial.

NEWKIRK:

You mentioned a house. Was there an office in thP house?

JOHNSON:

No. I didn't have an office. That was the whole point. When I went into the hospital, I said where is it? Well, the chief of staff had taken it over, and he was an internationally knovm neurosurgeon. So my first challenge was how do I get an office and get him out of there. So I had to work a deal. The first day, at lunchtime, the switchboard operator-I was sitting in the office of the business manager-she said, "Okay, it's now your turn to run the switchboard." I said administrators don't run switchboards. They had to work out something else. It was a very informal thing. The medical care was really first rate. The facilities were beginning to go downhill., So the [illegible] job I had was to figure out how much money we owed, because that first morning, the milk company came to the delivery door and said they wanted ca.sh or they wouldn't deliver their milk. They were really short on money. So I had to

put together what was owed. The chairman of that board was a man whose father had started the Continental Illinois Bank. His name was William Mitchell. His father, to keep his son active, had set up a large brokerage house called Mitchell & Hutchins in Chicago, and we had our board meetings down in their office, or in the Continental Illinois Bank, because a couple of the officers of the board were vice presidents of the Continental Illinois Bank. The president of the hospital board was Vernon Loucks, whose son now runs Baxter International. So it really was part of the inside 400 in Chicago.

I will never forget the first board meeting when I brought in a list of bills that were owed and it amounted to something like $800,000 on a budget of like $5 or $6 million. I didn't know how they were going to pay it. But I was assured they had endowments. I watched them that morning decide to take money out of the endowments to bring the hospital current. I didn't understand a lot of the conversation, but the business manager had been brought over from the Arthur Young Company, and he was an older person-Art Hartfelder-and he explained to me what was going on. Which was, they were trading things around in that boardroom, so they could consolidate their investments at the same time they were solving the hospital's problems. It was one of my first experiences with teams like that.

NEWKIRK:

Well now, you say consolidating their investments-you mean the investments of the endowment fund?

JOHNSON:

No. Their personal investments they were switching back and forth. They did not violate the restrictions on the endowments. For example, the man that owned the Charles Stevens Company, a large retailer of women's clothing, was one of the people. They owned land, for example, on State Street and Michigan Avenue, under some of those skyscrapers, and they were trading these things around.

NEWKIRK:

So the board meeting was sort of a get together to talk about private business also.

JOHNSON:

Well, and some of this had been put into the endowments of the hospital. It was a very enlightening experience. Once we got past that hurdle, about the second year. . .

NEWKIRK:

So how did they pay the $800,000?

JOHNSON:

Out of the endowments.

NEWKIRK:

They took it out of the endo'iivffients. It must have been a considerable endo'i!vffient.

JOHNSON:

Well, it was around $5 million at that point, which in 1951 was not a bad amount of money. Following that, I spent the next year and a half trying to get the place up to shape and running, and kept badgering the board that it had to be expanded. It had to be expanded because we had 103 beds, a lot of specialized physicians doing things at the cutting edge. For example, one of the surgeons was an early heart surgeon, Ormund Julian, who developed some of the first surgery for mitral valves. It was really fascinating to watch these physicians in medicine. I was aware that we couldn't contain the needs of the hospital for these vital physicians without an expansion. So I prompted the board into looking at finding some money to expand the hospital.

At the same time, the first redevelopment of the slum areas in Chicago occurred in an area adjacent to the hospital called Lake Meadows. They began knocking down a lot of slums and putting in these high-rise homes for people on the South Side. The pressure to develop the hospital caused the trustees to begin to think about the future of the hospital. They made some efforts to raise money, but in a way, a half-hearted way, because they were looking for very large gifts. For example, the chief of surgery, John von

Prochaska, was a friend of Mr. Allerton of the Allerton Hotel in Chicago, and he had a home in Hawaii. So he flew out to Hawaii to see if he could talk him into making the necessary contribution. Well, it didn't turn out. They dealt with the doctor who was involved from Northwestern . . .

NEWKIRK:

Krobison?

JOHNSON:

I don't remember his name.

NEWKIRK:

But you know what I'm talking about?

JOHNSON:

Sure. A.... he was then the vice president of medical affairs at the University of Illinois. Well, that began to sour some of the picture, because the krebiozen episode developed. Ultimately, the board decided that the thing to do was to merge the hospital and get a better deal for all of the physicians. They then went to Wesley Memorial Hospital, which is part of Northwestern. Ralph Houston was the administrator. They worked out a deal to transfer the physicians, some of the hospital staff, and closed out the Chicago Memorial. At the time, they offered me a job to be the number one assistant at Wesley" I said at that point I didn't want to work for Mr. Houston because I didn't like the set-up at Northwestern, and I started to look for a job. This was 1954.

Again, through the aegis of Dr. Bachmeyer and Ray Brown-and incidentally, Ray Brown was the assistant when I was going through the program, and we students thought maybe this fell ow had a chance for some kind of a future in hospital administration. But he was a rookie in those days, too. He'd just come back from North Carolina to be the superintendent of Billings Hospital. So they found a couple of positions for me. The first one-and I went out to visit-was in Seattle, which was Swedish Hospital. The other was Methodist Hospital in Gary where I had served my residency. The interesting thing is that one afternoon I was called that they were inviting me to take the position of administrator in Methodist Hospital in Gary. The following morning Swedish Hospital called me and asked me if I would accept the position at Swedish in Seattle. And I said at the time I had already made a commitment and it would be unethical to back out. In retrospect, I should have backed out. So I went to Gary, and I was in Gary for 22 years.

NEWKIRK:

Well, Ev, when did you get this doctor of philosophy degree?

JOHNSON:

Well, that was a side issue. I sort of slipped right through that. Well, after I had started at Chicago Memorial, I thought that I was pretty close to the University of Chicago-it was only 20 blocks over to the campus-I thought it would be sort of

interesting to continue with some education. So I talked to Ray Brovm, and Ray, being analytical, said, "Why would you want a PhD from the Graduate School of Business? You've already had the basic courses; you won't learn very much. " I said, "Well, that makes sense, Ray." But at the same time, the Department of Education at the University of Chicago was very well known. For example, John Dewey was one of the early people that started that program. It was widely respected; it had an administrative research center that was recogn17,ec'! around the country as probably the foremost administrative research center. So I thought, well, I might as well apply to them. I can learn something that's useful for me. At the same time, I got to thinking that I liked the University and that maybe by the time I was 40, maybe I ought to think about becoming a university official, and maybe eventually a university president.

So I started on the program. I did all the class work in maybe two, two and a half years. I finished up-when I went to Gary, I was finishing up the last of the formal classes, and then had a dissertation to do. What I did there was a dissertation called "Leader Behavior in Hospitals." And what I did was to measure what trustees, department directors, physicians thought about the performance characteristics of administrators. And it was based on some basic research that had been done at Ohio State University. It turned out that the findings-well, the studies that

had been done at Ohio State had been done on school principals, on submarine commanders, on aircraft commanders-a whole variety of different jobs. It turns out that the hospital administrator had to have the characteristics of both a pilot and a principal. I mean the dominant-which really were you've got to be sympathetic at the same time you've got to be authoritative. You got to know how to mix them up.

So that took me-well, I put it off for a while, and Herluf Olsen, who then had done the Olsen study in 1951 and '52 on hospital administration-the education for that. And I had visited Herluf, and he was then no longer the dean of the Tuck School of Business at Dartmouth. I visited with him one summer, and he prompted me to get back and get going and get a dissertation finished. So eventually that's what happened, and I finished it ln '62. And it was a part-time project for me while I was directing the hospital.

NEWKIRK:

You were one busy person.

JOHNSON:

Yeah. I think I was. At the same time, we were busy starting a family and had four kids and a pair of twins in the process. We had four at one point, with the oldest three, which was, when you're trying to do a dissertation, it taught me how to concentrate, I can tell you that.

Once I finished it, I became much more active in the health field. Always I had realized that in the health field you shouldn't do it alone, that you need associations, you need organizations of a regional and a national nature. One of the early experiences was in 1954, I had attended the first annual meeting at the Indiana Hospital Association. I'll never forget that experience. It was held one afternoon in the auditorium of the State Board of Health in Indianapolis. It was a two-hour meeting in which somebody described the elements of a medical record. I went home thinking there's got to be more to an association than this. So I began to campaign for a full-time office. In 1960-61, I was the president of the association, and I managed to convince them that they needed a full-time operation in Indianapolis. The association executive had been Albert Hahn from Protestant Deaconess Hospital in Evansville. He and his wife, Grace, were co-directors of not only the Indiana Hospital Association, but the Tri-State Hospital Association.

NEWKIRK:

And the Protestant Hospital Association, in addition to running Protestant Deaconess.

JOHNSON:

Oh clearly. And on top of it, Albert was blind and had some limitations. Clearly, we weren't going to get very far with that kind of a structure, so I persuaded the association to authorize

a full-time office in Indianapolis. That was done in 1960, and the succeeding president of the Association was Albert Boulanger, who at that time was at Vincennes, Indiana.

NEWKIRK:

Now let me interrupt you.

JOHNSON:

Yes.

NEWKIRK:

We're doing a lot of anecdotes here, and I want to mention that in 1960, I was a new person at the Ohio Hospital Association. Dr. Albert Hahn phoned me one day and said that you and he were working on this project to set up a full-time office at the Indiana Hospital Association, and asked me to come out and interview you. So I guess what comes around, goes around.

JOHNSON:

The interesting thing with that, Don, is I never heard that. He never said a word about that. In fact, I was also arranging interviews.

NEWKIRK:

You were the top person at IHA.

JOHNSON:

[Laughter.] Who knows at that point? What I did, however, was to call Richard, who was at the AHA and collected a bunch of young, bright guys on the staff there, and started HAS, and

MONITREND, and a whole variety of projects shepherded through the Ford Foundation grant to the hospital field. Do you remember that? And so he had a collection of bright, young guys. I had asked him for a suggestion, and he suggested Elton Tekolste. So Tek came down, visited with Al and I one day, and everybody agreed this was the way to go. So Don-they never let me know about you.

NEWKIRK:

Well, I had a job, and had just started it, so there's no way that I could leave, but I was very honored to get the call.

JOHNSON:

Yes. In fact, I didn't know Albert was helping to recruit anybody. So that's the way we started that association, really, on a full-time basis. I had just recently arrived back in Gary.

NEWKIRK:

In '54.

JOHNSON:

In '54, so . . . I was starting to be busy. I was trying to do that, work at the University, and run a hospitaL Pretty exciting times, really.

NEWKIRK:

Let's see. Where are we? It just seems that you have always, Everett, throughout your career-if I could throw this in-reached out. You've been dissatisfied with mediocre work, and of course you mentioned this in relationship to the Indiana Hospital

Association. You were one of the very, very few doctor's degree CEOs of hospitals at that time. I don't mean I'-1Ds. Here is one example of how you were really ahead of the field and pushing.

JOHNSON:

If I had to characterize what's happened to me in a career, I have always been so far ahead of what's going on that it's led to a lot of frustration for me. But I've tried to keep pushing.

There's a couple more interesting stories involved. I had to recognize that I had to walk pretty carefully, because Albert Hahn's son, Jack Hahn, had just become the CEO of Methodist Hospital of Indianapolis. And I didn't want to offend either Albert or Jack or Grace. So I had to walk very carefully on this issue. In retrospect, I know that I did walk carefully because I became a close friend of Albert and Grace's, and of Jack. I think that was a real fortunate experience for me-that I was able to pull that off without hurting everybody's feelings.

NEWKIRK:

Everett, now I know why you did this, but you mentioned Albert and Grace. Just tell us a bit about that relationship so that people understand why you mentioned husband and wife.

JOHNSON:

Albert and Grace were nationally known people in hospital administration, because here was a man who was pretty severely handicapped. He and his wife were dedicated to each other. He

was extremely active in the whole field nationally. I never could understand how he could have accomplised what he did, given the limitation he had. I think he was in some respects very much admired for his work because of his limitations. We all have limitations, and Albert had his own perspective on the world, which wasn't exactly mine. But I had to admire the courage that the man had and the drive that he had to accomplish what he did. And she was his constant companion, and I don't know which one made the decisions. They were that close.

Well, in Gary, I started on a lot of expansion. The hospital, when I came there, was 209 beds. When I left in '75, it was 475 beds and the satellite hospital, Methodist South, was 166 beds. I would guess that-well, lots of things happened in Gary. At the same time that I was administering the hospital, I was doing a lot of speaking and a lot of writing, and I was going around the country pretty much to various speaking engagements, involved in a lot of different activities-the AHA, the College, you name it-I had found something, or had participated in most of the things. The work in the hospital really-I was able to put together a first-class senior group of managers. I managed to run the hospital in a reasonable amount of time although there were long hours. But having a good staff, you could delegate a lot of the things. It you had an idea, you could get one of the associates to develop, and once you had defined what you wanted to do, you didn't have to

spend all your time working out the details. I always felt that as a CEO-in those days we were called administrators-that I was very fortunate. I was sitting on top of an organization that everybody wanted me to understand what they knew. So they were all teachers for me, and I was the student. It's a great opportunity to learn, because if everybody in your organization thinks that they-if you get to understand their problems, you're sympathetic to it. So they are going to try like crazy to teach you what they know and what their problems are. So if you're receptive to it, you can learn a lot.

I began to look at a lot of things. For example, the history had been that the administrative staff all collected together in one area. I got to thinking about that-and of course we were always pressed for room. We were running 93-94 percent occupancy. I got to thinking, you know, this isn't the right way to do it. Who's out watching and supervising what's going on? So I broke up the administrative areas and put people into different parts of the building so that you did not have a central administrative area. That was my office, and we scheduled meetings every Monday afternoon. That's the way we coordinated what we were doing. I set up rotating files so that every senior person could go through everybody's correspondence and see what was going on so that coordination did not become a difficult problem.

Out of the 22 years there, 19 years we were under construction for one thing or another. It just never seemed to end. We never seemed to get enough beds. ·when I came to GanJ, it was comrnon to find 10, 12, 15 patients in the hall every morning. All the rooms were filled, and they were putting additional people in the halls. What finally drove me to do something about it was I came into the hospital one morning and they told me that the night supervisor had put a patient dovm in the boiler room because there was no other room. I said that's got to stop. So you **know**, you put your mind to work, and you work out a system of controlling beds, and so we finally got rid of all the beds in the hall. At the same time, the medical staff was growing by leaps and bounds and these specialties were corrnng in. So we were always 5 percent behind where we should have been. So that kept me busy-my hospital problems.

NEWKIRK:

Everett, you have described a system of sort of absentee management. You're sitting in a central location/ and you have your chief managers spread out around this hospital. Wasn't this a tremendous communication problem? You **know,** we didn't have E-**mail** at the time

JOHNSON:

Or voice mail.

NEWKIRK:

How in the world did you ever keep everyone together? I know you had Monday meetings, but that couldn't do it all.

JOHNSON:

No. What I did was to organize the way I operated, and they knew it. Which was they could see me in the afternoons. The mornings they could not see me because I saved that time for dealing with the medical staff because that's when they were in the hospital. So I have followed a pretty disciplined approach. I don't think things got away from us. I also began to develop some pretty sophisticated information systems. Even back in the '50s . . .

NEWKIRK:

You were way ahead of your time.

JOHNSON:

Well, in the middle '50s, we were even looking at the early RAMAC computers. I had been dreaming of how to centralize all of the scheduling in the hospital prior to that, before the day of computers. I was thinking-they had a system, an old system at Walter Reed Hospital, in which they had some guys buried in the basement that tried to organize everything by paper. Well, fortunately, before we got into doing that kind of thing, the early computers came along. And so I brought in some early people—in fact, I spent some time with IBM-and at that point, they knew what

our interests were and they knew what I wanted to do, and I persuaded IBM not to go into the hospital. That was one of the early decisions they made based on what they saw from what we were doing. Now, of course, they came back around on that later on, but I can remember that one very well.

There's another interesting story that happened. Two months after I went to Methodist from Chicago Memorial, my wife gave birth to a set of twins. Now that's not unusual except that they were premature-they were like 2½ pounds apiece-and babies were dying in the premature nurseries. It turned out we had a first-class diarrhea epidemic. We lost 27 babies in the process.

NEWKIRK:

This was in the hospital.

JOHNSON:

In the hospital. This was one of the first jobs that CDC had for one of their intel1igen e teams. I had a1Jed them and asked them to come up and see if they could find the source of the problem.

NEWKIRK:

What is CDC?

JOHNSON:

Centers for Disease Control of the United States Public Health Service out of Atlanta, Georgia. So they did. And we eventually did find that there were contaminated wells in one of the adjacent

areas to Gary, that-they were bringing the problems into the hospital, but at this time we were delivering around 6,000 babies a year, so it was a big service. And I will never, never forget the number of nurseries that we had to set up. We must have had 8 or 10 different nurseries, because every time a baby became infected we had to close that nursery and start another nursery.

The other experience that I remember very vividly was the early summertimes in '55, '56 and '57, when we absolutely became inundated with polio victims, and having iron lungs all over the place. We must have had 10 or 12 iron lungs going with patients, and it was a horrible experience. You really appreciate Sabin and Salk once you've been through those kinds of experiences. Those are some of the early memories of Gary.

One of the other major experiences was in '64. Lyndon Johnson got Congress to pass a lot of civil rights legislation. Prior to that, the hospital had wards with 8 and 16 beds in them. We had to break all these up, and once I had done that, I wanted to integrate the rooms but they were still, even though we had black physicians on the medical staff, they were keeping the black patients in one room and white patients in another. I was trying to break these customs down.

NEWKIRK:

About what year was that?

JOHNSON:

This is like '60, '61, '62, someplace in there. I was trying to go at it pretty slowly because I knew that there was a lot of emotion involved in this. So we were working at it, breaking down barriers a little at a time. And then '64 happened, and the country erupted with civil rights demonstrations, and we had a lot of demonstrators outside the hospital. We got no credit at this point, for having done anything at all. In fact, the man who became the mayor of Gary, Richard Hatcher, for five terms, was then a young lavryer who probably was the principal driver of the racial disturbances that were occurring in Gary. What I did at this point was, I didn't understand a lot of this stuff. What I did was go down to the public library and pull out a bunch of books on blacks and integration, and whatever else I could from a sociological point of view, to understand what the process was and see if there was something I could do about it. Well, we did have some success, but at the same time, we were front page across the country for some of the civil-rights demonstrations outside of the hospital. This wasn't only Gary. It was Cleveland, it was Detroit, and you name it, but we were part of it. It was an experience.

I will never forget as a result of that one, they had invited me to go to the Mississippi Hospital Association at Lheir annual meeting and describe to Mississippi administrators how you integrated the hospital. So I did my thing. Following my

presentation was the attorney general for the State of Mississippi who simply gave everybody "Billy Be Damned" if they were going to integrate anything. And after we finished our presentation, he said, "Why don't you come over to my room?" I went over to his room-this was in Biloxi-and I said, "Do you really believe what you're saying?" He said, "No, but that's the way you get reelected." That was another insight into human nature.

NEWKIRK:

Did he offer you a police escort out of town?

JOHNSON:

I worried about it, let me tell you. But the interesting thing was I had to go from there to Washington, DC, to talk to the federal lawyers' group about integration. And as I walked into the hotel, I saw a bunch of TV cameras and lights on, and I thought, "Golly, I'm famous already." Well, what was going on was Arnold Katzenbaum, the attorney general, was coming in just behind me to talk following my talk. So they were concentrating on him, and they didn't bother me. Those are the experiences you have that you don't forget.

NEWKIRK:

These were experiences that Everett Johnson had in being out front. How many CEOs in hospitals had gone to the library to study up on that, trying to figure out how to make this thing work?

JOHNSON:

I don't know.

NEWKIRK:

Very few, if any. So again, you're out in front.

JOHNSON:

Well, I think this probably comes from my parents and my brother that I do things like this. Who knows? Anyway, the years in Gary were very happy years. T think we developed a good management program. I think we, in many respects, solved a lot of problems and because I was writing and speaking, I think we became pretty widely knovm a.t that point.

NEWKIRK:

Everett, you've described a lot of things about hospital management in the late '50s, early '60s. Things that you did, trials and tribulations you had. At the same time, you were doing a lot of organizational work at the state and national levels. Tell me a little bit about that.

JOHNSON:

'The state level pretty much was where it went on, with one exception. One of the things-I was on the board and the executive committee of Blue Cross of Indiana. And in those days, Blue Cross simply paid charges. Whatever the hospital sent in as their charges, Blue Cross accepted them. This was real reimbursement. You sent them a bill, and they reimbursed. I got to looking at

that. They had what was called a rate committee. I was on the rate committee and you would see a hospital. For example, in those days a standard charge for an EKG might be $5. You would see a hospital put in a charge for $20. Well, that struck me as this is a tax on the people who are the sickest. I didn't think that was right. At the same time, the AHA was beginning to look at relating prices to cost. Cost to charges was the way it was expressed. And I got to thinking that, you know, we really ought to do something like this. So what I did was to call a bunch of the senior executives in the state-the larger hospitals-and I made a reservation down near Culver, Indiana, at a resort and said, "Guys, I want you to come down here, and we'll talk about some problems for a couple of days. If you want to, we'll play poker at night." Okay. So they came, including Guy Spring, who was the president of Indiana Blue Cross. Not Blue Shield at that time; that was a separate operation. And what I did was to lay out what the problems were, and that to be fair to the public we ought to relate charges to costs. And we talked Blue Cross and Guy Spring into doing this because they, at that point, had 40 percent of all of the insurance business in the State of Indiana. And with that kind of a lever you could force them. That's how we got that . . .

NEWKIRK:

I would guess, incidentally, that they were happy to do it.

JOHNSON:

Oh, absolutely.

NEWKIRK:

You gave them just a little bit of a leash.

JOHNSON:

Yes, that's right. They were glad to do it, and I think it did save money. Ultimately-this may be 20 years later-they asked me to come back to Tndiana when Otis Rowen was tJOVernoT before he was secretary of HEW. They recoqnized that this system had probably saved the people of Indiana more than a billion dollars. But anyway, I got that thing started.

NEWKIRK:

They asked you to come back to Indiana for what?

JOHNSON:

Just for a luncheon to acknowledge **what** I'd done. That's all. The sequel to that was in 1992, last year, a lawyer in Florida by the name of Herb Schwartz sued Humana in a class action suit, because of the excessive pricing for simple things like 4 x 4s, or whatever it was, and won that as a class action suit. And in the process, to establish his case, used the material from the cost and charging system we developed in Indiana. He didn't know I'd been involved. I was involved with him last year on an antitrust suit in Nebraska as an expert witness. We just got to talking about it. He had used Mark Slen, who had been the CEO at Parkview for a long

time, as his resource. But it turned out that this was the sequel and that the basis for that lawsuit began in Florida. Which they won. Humana lost on that one. Anyway, that was another kind of useful experience.

NEWKIRK:

At the national level?

JOHNSON:

At the national level, 1960s.

NEWKIRK:

What had happened to Ray Brown?

JOHNSON:

Ray Brown was-by then I guess he was the chief of everything.

NEWKIRK:

Yes, he had been chairman or president of ACHE, ACHA in those days, and of the AHA. He and Richard had started . . .

NEWKIRK:

Your brother.

JOHNSON:

Richard. They had started the AUPHA-Association of University Programs in Hospital Administration. Richard had written the bylaws for that. In the meantime, I had written some chapters of a book that Richard and Ray published, which was a basic guide for structuring administrative residencies. In the process, each year

I was probably writing three or four articles that were being published.

This reminds me of the first speech that I had to give to the AHA. Strange you remember certain things, but in 1952, they asked me to go to St. Louis and give a talk on how you buy canned goods by specification. We had been buying canned goods on specifications/ and so I went down there, and I can remember vividly-I took a train down there. You didn't fly as much in those days. I had shipped ahead all of the different size cans and things that I wanted, and they never showed up at the hotel. And so at 7:30 in the morning I'm out going through all the local grocery stores and throughout the hotel trying to find the cans. I'm sure it was a miserable speech, but it was a very technical speech. I got way beyond that kind of stuff pretty quickly because that's not much fun. In those days there were not a lot of people to use as speakers. If you wrote an article, pretty soon people were asking you to give talks about it. I think the tragedy of today is a lot of CEOs are not writing. The journals are filled with a lot of academic articles that really don't reflect reality.

NEWKIRK:

Well, and a lot of the articles are written by paid help of the journal, and are not scholarly.

JOHNSON:

No. Well, and most of the journals today, like Hospitals, Modern Healthcare, those are news magazines. They're almost like the National Enquirer, or Life. But they're not useful, I don't think, the way they used to be. In fact, I only, really, today, look at three different journals for useful information: Inquiry, which is the Blue Cross/Blue Shield Association, Health Affairs, which is Project Hope, and Health Care Management Review, which is Aspen. Those are the ones that, to me, still have the most useful articles, and the rest of them, they are either too theoretical, too academic, or they're too newsy. They will keep you current, but that doesn't help you with your thinking.

NEWKIRK:

Okay. Now we've talked a little bit about publications. You must have written dozens and dozens and dozens of articles and hardbacks. What kinds of things do you like to write about? What have you written about?

JOHNSON:

Most-well, the focus has always been on organization and management. It's internal management, it's governance, and it's medical staff. I have always found the medical staff an interesting topic to deal with, because I don't think, historically, we've dealt very well with medical staffs to this day. I'm still writing about it. In fact, Richard and I have

another book coming out. It'll be our fourth book. I think it's pretty typical of the times. The title that will be used is The Dynamics of Hospital Governance and Public Policy, which is really the gut issue on a lot of these situations that we're going to face in the next few years. I think that we don't deal very well with the issues, and I think a lot of our problems have been because we have been poor managers. I still see a lot of poor management in the field and in practice.

NEWKIRK:

Well, now relate that to governance. You mean health care institution governance?

JOHNSON:

Yes. I'm talking about boards of trustees, boards of directors. Sure, there's a lot of criticism, I think, of governmental policy. The fact of the matter is you have to respond to it. And so from an institutional point of view, what are you going to do? I find I am still-and I have been for probably 40 years-disturbed at the governance structure of hospitals because it is not responsive to the things that it should be responsive to. It's responsive mostly to the silent constituencies of board members. 1'..nmany times you don't know what those constituencies are. In other words, the values, realities of operating a very expensive, very important organization, becomes secondary to those personal interests, and I find it very disturbing.

NEWKIRK:

Or if not secondary-I happen to serve on a hospital board, and I know that much of the work that you do is episodic. It is what happened this week and what happened the week before, and very little attention to the broad picture. Where we're going, ultimately, or where we should be right now.

JOHNSON:

The way our curriculum is here for educating health administrators-we give them, I think, pretty good skills. They go out into the marketplace and into these organizations, and their skills rust out because you can't use them. The boards don't let you use them in the right way. Boards feel put down if the CEO begins to think intellectually and respond theoretically to issues, which is many times the way you have to start. So they learn not to use these things, and they rust out. That's, I think, too bad.

NEWKIRK:

And most of these people are not in a position to renew their skills constantly. They're pretty much stuck in a place where they have to work day by day and try to hang together.

JOHNSON:

The tragedy is they know better and they would, if they had a reason to improve their skills, they would. I still-and everybody-you and I both know, for 40 years, the corporate director, when he walks into the hospital boardroom, becomes a

different person, and doesn't think the same way, does not think analytically. Therefore, hospitals and their paid leadership, professionals, don't have a real opportunity to do what they should do. To this day, I don't see that. In fact, I have a belief that every good CEO in his career is going to get fired at some point, simply because he's trying to do the right thing and the board doesn't want him to do it.

NEWKIRK:

You and Everett, to change the subject slightly . . .

JOHNSON:

Richard.

NEWKIRK:

I've gone through life confusing you two. I understand that. Like everyone else. For the record, these twins look very, very much alike. And some of the funniest things that I can recall about you would be to hear someone stand and talk to Everett for five minutes and refer to him as Dick. I'm sure that you've had that happen many times.

JOHNSON:

Oh, sure.

NEWKIRK:

You've talked about these books. What subjects have these books been on?

JOHNSON:

They've always been on management. Mostly internal, in a broad sense, of how you deal with medical staffs, how you deal with boards, how you deal with the leadership of the organization. The titles have been, for example, Hospitals in Transition, and Hospitals Under Fire. Another one was Contemporary Hospital Trusteeship. All because this is where the ball game really gets played. Most people in hospitals, other than the administrative people, don't understand what's going on. My articles, as I review them, are all over the map. A lot of them about management, but even some about canned peas.

NEWKIRK:

Well now, let's get back to this chronology for a second. In 1975, you left Gary Methodist and became president of Bedford Health Associates. Tell us about that.

JOHNSON:

Let me say first-go back to-I didn't finish up on the national associations. Back in about 1964 or '65, I became-well, let me back up before that. About the same time that we were trying to get the Indiana Hospital Association started, I had been active in the American College of Hospital Administrators, and they had their annual meeting always in conjunction with the AHA. They had a townhall meeting to elect a new president, and they were falling pretty far behind in their development, their educational programs.

They had been on a long tack of human relations as the key to all good management. And I was pretty disturbed about that. I can remember one early meeting when the membership intended to vote for the new chairman, or the new president in those days. I can remember a meeting in Atlantic City in which we threatened-several of us-to propose a candidate from the floor if changes didn't begin to occur. Well, we didn't do that, but it became an awakening call that the ACHA was going to have to change. Subsequently to that, about a year or two later, Richard and I thought that the ACHA should have a journal. And so we put together the costs of publishing, and we went to the University Press at the University of Chicago. We got that all lined up and then persuaded the College they ought to have a journal. And that's the journal that's still being published.

Along in the same period, in the early '60s, I thought that the executive director of the College was inadequate and should be replaced. I had been making noises about that for a few years. When I went on the board-in those days it was called the Board of Regents, which is now the Board of Governors. When I went on that board, I raised the issue. It was a very tense time. The strongest ally I had on this issue was Jack Kaufmann. Dr. Sutton from Miami Valley vvas the president. I told him I was going to raise the issue. He had called for an executive session to deal with the inadequacies of the College. In fact, if you look back

at some of those who were running the deficits, the programs were not well done. It needed to be shaken up. Well, what happened was that we finally brought that to a head. I was in the executive committee meeting. It's a very painful experience in my career. The incumbent was terminated and then they set up a process, and that's when Dick Stull took over as executive director of the College. And things began to change. The programs became better. I had always been interested in the educational aspect of the College. In fact, the first five years of the Congress on Administration-that started when Ray Brown was the president, he had asked me to be responsible for setting up all of those educational special sessions and selecting a speaker. Well, you know, that kept me current, because I was reading like crazy all the time in current management theory and identifying people to use for the different seminars. And for the first five years, I did this almost alone. I ran all those sessions, got all those speakers for all those seminars. Now we've got 80 or 90 of them, but for the first five years I had that responsibility. Part of, I think, whatever opportunities I had, were related to the fact that I was close to Ray Brown. I mean, not only personally, but physically. And Richard being there as Ray's number-one assistant, there were many times where we spent-I don't know, probably like every two or three weeks some nights we would spend late hours in Ray's office at Billings. He was director of Billings Hospital.

NEWKIRK:

Richard, your brother, was Ray's assistant, Where?

JOHNSON:

At University of Chicago Clinics, which is Billings Hospital. And Ray had a habit of closing the doors at 5:30 or something, And then you would sit there until 6:30, 7:30 at night and talk about these different issues, And, of course, Ray was probably the most multifaceted, brightest person I've ever scc::n in this business,

NEWKIRK:

I would agree.

JOHNSON:

I mean, he laid so much on me I can't believe. He did it to a lot of people. But I think one of my reflections, in a sense, is that I was closest to him. Although I think the reason Ray used people like me and Richard and you and whoever else not for his own personal purposes but for organizational pu:i::poses. And if he gave you a job and you delivered, then your reward was to get another job. Another responsibility. If you didn't deliver, it was the wrath of God.

NEWKIRK:

That's right. But he didn[1]t use you any more, either. He found somebody e.lse, He opened up, and even Dr. Bachmeyer-Dr, Bachmeyer died in 1952 or '53-but even he had opened some doors early on. You got to have sponsorship, I think, to a degree. Once

you get beyond a certain level, it sort of takes off on its own. As an aside, and speaking of sponsors, I can remember a day, standing on the mezzanine of the Palmer House in Chicago, Everett Johnson said to me, "You should be chairman of the ACHE."

JOHNSON:

You spearheaded that, so.

NEWKIRK:

Well, and I did it not only because of your talents, but I thought it was time to involve not just people running hospitals. The field was getting so much broader they needed a state association too. Well, we were talking about organization. You certainly must have had a fine organization at the hospital in Gary to allow you the time to do all this. My gracious, you must have been out of the office all of the time.

JOHNSON:

It's probably pretty close to what I see—CEOs today out about half the time—I was out about half the time in those days, and that was not typical.

NEWKIRK:

Not at all. Again, Everett Johnson out front. You were a forerunner to that degree, the outside person.

JOHNSON:

Yes, but one thing you got to remember is you got to be the inside person, too. But, with a briefcase, you can do these kinds

of things. And today it's a lot easier with the communicatinq devices we've got. You can be gone a lot more and still be on top of the organization, but I learned some things. I learned, for example/ you better be visible to your organization. I would go to the hospital around 6:30 in the morning. I would have breakfast in the cafeteria with whoever was down there, because informally you can pick up a lot of information about your organization. I had a secretary that would start at 7:30, so that from about 7:30 to 9:00 I could do the kind of dictating that I needed to do so that by 9:00 I was open and free for the activities of the day. I would know, because of that morning breakfast in the cafeteria, I would know more about what had happened the preceding day or two days in the hospital than the other associates who were responsible. The other thing was I learned to walk around. You've got to lead by walking around. You don't have people come to your office. Go to their office. You go sit in t.he surgery lounge and schmooze with the surgeons, or in the doctor's lounge, or whatever it is, or the private dining rooms that they have for lunch. It's the way you impact your organization. You go to all of the clinical sessions. I have been bored out of my skull with some clinical meetings at times, but you go and you learn medicine in the process. That's what I said. I've been lucky. I've had teachers all of w life. They wanted me to learn. That's great. You learn a lot more than you think you'd learn.

NEWKIRK:

It's a rare person who considers an employee a teacher, but you mentioned that before, and that's to be emphasized, I think.

JOHNSON:

They really are. The other element on the College was, obviously, I broke a lot of china, getting rid of the executive director. And they put me out in the boonies. They didn't have me on committees or anything else for a period of years. Eventually, they brought me back into the thing, and eventually I became the chairman officer for a period. So the one thing that I will never forget that I did—I'm, in a sense, compulsive-and what I did was-in those days, they had a monthly newsletter, and the president wrote a column. Well, I knew-one of the things that I've learned in life is to be a part of-you're working for another association, like the College, or AHA, you'd better get to know not the top guy, but the secretaries and the assistants. Just wander around the organization for awhile. Among those people that I got to know was Lynn Wimmer. Lynn was the editor responsible for all the publications of the College. Lynn, therefore, had to worry about these presidential monthly articles and would get them two days before press time or hold up the publication for two days because the guy hadn't gotten his stuff in. When I was president-elect, I decided that the easiest way to do it was to sit down and write them all ahead of time. So when I became the president, I

walked in-and what they do is they have a meeting at the annual meeting when the new officers take over, and meet with the board-so I walked in and had manuals for everybody, with all the columns, and for the first time, I asked them to set up task forces for different issues that hadn't been attended to. And that was the beginning of task forces for the College, because we needed to pay attention to a lot of things.

So one of the things that needed attention was the structure, or the ed11cational programs of the College. Now, today, we've got ones for Fellows. There is a gradation there. In those days there was no gradation and if you had to attend or teach one-be the instructor-you had a mixed bag for an audience and it slowed down the process. So one of the things that I really pushed, and Bill Brines when he was chairman, really got **shoved** through was some kind of a gradation on educational programs for the College, which was useful. I've always said that I did such a bad job as president they abolished the job, because in fact they did. What they did was to change the title to chairman. I had requested that because the field was changing, and that you really didn't need an executive director as a full-time job to be the chief of the organization. He ought to be called president. And so I got them to change the title itself from executive director to president. And then my title never did change, because it happened at the end

of my year. So I was the last president of the College before it became full time. I was never a chairman officer.

Let me finish up with Gary. I went through a long struggle there, beginning in about early 1960s. It became clear that the population was changing and moving. Other areas were developing, and I thought a satellite hospital should be constructed.

NEWKIRK:

You mean other areas geographically.

JOHNSON:

Right. One of the first things I did was to look at a hospital in Michigan City, and I've forgotten the name of it now. I went through that operation to see if we should affiliate it, merge, or do something. I decided that it was sufficiently different and there was not that much in the way of savings that could be made. That was not a useful track to pursue. And so I decided that because Gary was moving south, that we needed another facility in that direction. Karl Klicka, at the time, was the director of the Chicago planning group, whatever the name was. This included-Gary was part of the metropolitan Chicago area. And Karl tried to help-did what he could-to stimulate the fact that we should develop a second facility. The irony of the situation is that it took so long. Other hospitals were started in Munster, Indiana, in Hobart, Indiana, and in Crown Point before I could get the Methodist board to move to build another facility.

We did finally get it started-we bought the land in 1970-and what I did there, in order to show the board what needed to be done, was I called up all of the leading hospital architectural firms in the country, and I said give me your two best jobs. Tell me what they look like and where they are. What I did then was to have a list for the east coast and the west coast. I set up teams with doctors, administrators, and board members. There were probably eight or nine people on each team. I sent one to the east coast and one to the west coast. Their job was to go look at these facilities, which they did for maybe 8 or 10 days to get all this thing done-traveling to both ends of the country. And then when we got back, we put all the information together, and then called in the architects and the engineers and said this is what we find, this is your best job, these are the problems with that job. What are you going to do about it? Out of that we sorted out how we wanted to get the right architects and engineers for the job that we wanted, and we finally picked Schmidt, Gardner, & Erickson because of this study, which was a hospital architectural firm in Chicago. I then said to the architects, "I am sick and tired of building add-ons to a hospital." We had different floor levels. We had been buying city blocks. One of the things I did in my life was buy a church for the hospital and turned it into a parking lot, because we needed all kinds of-I thought-crazy things.

This trip also convinced the board to buy a lot of land. So we bought 115 acres outside of the city limits of Merrillville, Indiana-just outside-so that we would have sufficient land in the future. If you look at a lot of hospitals, they're landlocked, and I wanted to avoid that. I then went to the architects when we got them selected, and said, "Okay, I want you to design a 700-bed hospital, but we're only going to build 165 beds. But that's going to tell us how to develop things so that we never have these kinds of problems I've been putting up with in my whole career in Gary." That's exactly how that hospital was designed. It was one of the first all-private-room hospitals in the country. Then I had to go negotiate that deal with Blue Cross. They paid for it. They were just beginning to come around to those things in those days. So that was the experience in Gary. I think what happened in Gary was I got bored.

NEWKIRK:

Well, you had a full career in Gary. My *God*, 21 years or so.

JOHNSON:

That's right, 22 years.

NEWKIRK:

Twenty-two years. Most people call that a career.

JOHNSON:

Yeah, I know. But I think I really got tired of lookihg at the same problems, and it became pretty obvious to the board that

I was beginning to try and push them in ways that I don't think made good sense now. So we had a parting. And I then talked to Tom Weil. Tom had just started his own consulting in Katonah, New York, and so I moved out there with Tom and spent about six or seven months with Tom. Great guy, very bright, very dedicated, but I sure didn't like the New York-Westchester area. I just did not . . .

NEWKIRK:

Well, neither did he. 1 think he's moved to North Carolina.

JOHNSON:

No. Asheville.

NEWKIRK:

Yes, that's right.

JOHNSON:

But Tom was a New Yorker by birth. Anyway, useful experience. Short, because I was unhappy. So I came back and decided to set up my own consulting operation, which would be called the Dunes Group, and I had an office in an office building in Michigan City and started doing full-time consul ting. I had really followed what Richard had done, because by then he'd been in consulting for a number of years with A. T. Kearney and then his own firm.

NEWKIRK:

Why didn't you go in with Richard?

JOHNSON:

His other two guys didn't want me in there. They thought there was too much to handle. And they were probably dead right. We would probably have torn up the place. And so I started in that and I got-I found out that-I had a couple of people working with me-and you find that it's very lonesome stuff. It was not-I had always been used to sending somebody to the post office or do this or that of the administrative staff. Well, all of a sudden you're all alone doing these kinds of things, and it was not my cup of tea. So we stayed with the-I called that the Dunes Group because we were living in the Dunes. We did that from 1977 through 1979, or '76 through '79. And I got pretty upset-I wanted more intercourse with things that were going on, plus the long drive up to O'Hare to get planes was an hour and a half, almost two hours some days-that was no fun.

NEWKIRK:

You felt a bit isolated.

JOHNSON:

Yes, absolutely. So along about that time I said to Jewell Johnson . . .

NEWKIRK:

Your wife.

JOHNSON:

Yes, right.

NEWKIRK:

We have to explain that.

JOHNSON:

I said that, you know, I'm not particularly happy with this. We ought to go someplace else. About that time, the Georgia Hospital Association asked me to come down and do a couple of speeches at their annual meeting in Savannah. And it was just before Christmas, so we came down here and it was beautiful, in the 80s. When we finished and went back and we were living in Michiana Shores, Indiana, we had to shovel our way into the house through all the snow. And in fact, one of the cars didn't get dug out until April-there was that much snow on the lee side of Lake Michigan. So we said, you know, this is not our cup of tea. We knew we wanted to go south, and we were considering Jacksonville and Atlanta. Before we made a decision, Georgia State University-well, I have to back up again. Once I had come back from Katon.ah with Tom Weil, I had always had an active relationship with the hospital administration program with the University of Chicago. I had always been a lecturer, I had always been a preceptor, and so when I came back from New York, they asked me, because I was no longer in the hospital, would I become the associate director. And I did become the associate director of the program at the University of Chicago on a part-time basis so I cou1d continue consulting. This was the time in which. . .

NEWKIRK:

You had shut down the Dunes Group.

JOHNSON:

No, I was doing that at the same time. I was teaching at the University of Chicago and doing the consulting-doing two things. In 1979, Odin Anderson was retiring. Odin was retiring up to Wisconsin, and Ron Andersen was going to take over his position at the Center for Health Administration Studies, which is a euphemism that is called CHAS.

NEWKIRK:

At the university?

JOHNSON:

At the University of Chicago. And they wanted to know if I would become the director of the program. I said I didn't really want to do that, and at the same time-because I wanted to move south-at the same time Georgia State called. The director there had been George Wren. George was a classmate of mine from the master's program. George had started this program. He ran into some difficulties here of a personal nature, and so he took early retirement, and they asked me if I would come and run the program. That was 1979. So we moved to Atlanta in 1979 and became the director of the Institute of Health Administration at Georgia State University, which was a program in the College of Business Administration. It had always been my belief that hospital

administration programs were basically administrative in nature and did not belong in medical schools, graduate schools, or public health colleges. And so it was the match that I was looking for. And the arrangement provided was that it was perfectly acceptable to do consulting along with carrying out your responsibility on the faculty. So in June of 1979, Jewell and I moved here, and they appointed me director and professor of the institute.

The program at that point was a lock-step program leading to an ME?'-.degree . They had two other faculty members, Max Holland and Knob Knobel, who were both--all three of us v,ere professors. It was the only time in my life I've ever seen everybody a full professor with tenure. I got tenure about a year after I came. I looked at the program, and I said, you know, this is not what the world is all about today. You need-and this was at the stage where now the industry-owned chains had developed, the nonprofit chains are developing-it was clear that an HA curriculum alone was inadequate to train people to be senior executives in the health field. The College of Business is a large one. It's the fifth largest in the country. It has about 8,000 students of which about 2,400, 2,500 are master's or PhD students. It had 12 different departments. So I looked at this and I said, "You know, we ought to take advantage of it because we are a part of it." Then, with mostly Max Holland, developed the combination MBA-MHA degree, which

is a two-degree program. It really meant we had to go-the students went three academic years in this program.

It became the longest and the first in the country with both degrees. And we did it, because I thought that a hospital was a business and it was also a community service, and so you'd better know both fields. So that's how we got into the MBA-MHA program.

NEWKIRK:

Now they did not have a choice. They took a dual degree or no degree. Is that correct?

JOHNSON:

That's right. We changed the whole thing. We dropped the lock-step. We put the students in the regular curriculum for the MBA. We cross-listed a couple of courses, like, for example, business law included health care law because there is that peculiar aspect to it. We cross-listed strategic planning because we wanted to use health care examples and not industrial examples. So the program became 120 quarter hours, including a three-quarter residency. The experience I'd had at Chicago was that George Bugbee had abolished the three-quarter administrative residency, had made it simply-which was difficult-the summer between the first and second year you did something in the health field, which was I think an incidental activity. I thought that the students suffered from not having exposure to the real world of practice. This program had always had the residency. When we went to the

double-degree program, we maintained the residency, which made it a three-year academic program.

NEWKIRK:

Is it still a summer residency?

JOHNSON:

No, this was . . .

NEWKIRK:

It's a three-quarter residency. What kind of residency?

JOHNSON:

l'·Jell, rrtost of thern, practicall}T all of tllem in those daJ_IS, were hospitals. What they did was-and we teach year around here-there's no summer break. We restructured everything. You can start any quarter, and you can finish any quarter. When you have administrative residencies and you've got 30 students to place, you don't want all of them to come out in June because you' re going to have a terrible time finding residencies. We wanted it spread out throughout the year so we didn't have that one peak period. It worked for us, so that the students went for basically seven quarters on campus, and then three quarters in a residency, which is essentially nine months. And practically all of them were hospital residencies initially. Over time since then, as the field has changed, we have modified the curriculums to a degree. Now we have about 60 percent of the students going into hospitals and about 40 percent are going into all kinds of other

things. The other residency placements besides hospitals are now managed care programs like Kaiser Permanente, PruCare, business firms like Georgia Pacific, Delta, Coke, because these companies have big health insurance contracts. Some of our graduates manage those programs. We have other students going into what I would call the single-line proprietary businesses in health care, like T-Square. We get students now going into managing physicians' office practices. We've got-some groups in town that are 50 and 60 physicians, and we've had residencies with those folks, so the opportunities for varied experiences are increasing, and we're taking advantage of that.

As this began to happen, we began to think of another kind of degree that we needed. Because we were in a large school of business with 11 other kinds of specialties, and looking at what was going on in hospitals, we thought a good idea would be to create an MHA degree related to a functional business specialty. We now have an MHA degree with a functional specialty in marketing, finance, information systems, risk management information, human resource management. These programs are designed for older students who have work experience and are in these fields and want to stay in those fields. So what we do is, they get the HA curriculum, plus they get a second curriculum in that functional field. For example, if you want to go into managed care, the MHA degree with a functional business specialty in risk management and

insurance is a good combination. We are now at the point where about a fourth of our students are in these specialized MBA programs. I don't know of another concentration if you would call it that.

It's more than a concentration, because there's 35 or 40 quarter hours in the functional field, plus the 45 or 50 hours in health administration. As far as I know we're the only program in the country offering this kind of thing. The only place you could offer it is in a large school of business. But the idea is to develop these functional specialty areas based on health care experience. We haven't had time really yet to assess its impact, but I think it's a useful degree.

NEWKIRK:

It's a real advantage to, I think, to have those things available. You have a concentration, but they're more limited because of the fact that they are inflexible.

JOHNSON:

These are almost the equivalent of a master of science in that business specialty, and all of industrial engineering departments do have MS degrees in specialized fields. This is really a combination of that and HA, just as we did it with the other programs for the generalists.

NEWKIRK:

So would you then conclude about your own program that you're drifting away from what we would traditionally call hospital administration as a concentration?

JOHNSON:

No, I don't think we're drifting at all. I think that most of the other programs in the country are drifting away and we are not. Everybody on our faculty has had a lot of management experience. They are not basically academic. Therefore, we see that our obligation is to the field. Most of the other programs have dropped-years ago they dropped the three-quarter residencies in the summer. I think that handicaps the students. I've run into students from other programs that don't even know what a radiation badge is, for example. Or even what the standards for the Joint Commission are all about. Or any kind of a thing related to health care or hospitals. I don't see, in the coming environment, and I think it's going to be a very severe economic environment for hospitals-I think people have to have operating experience and I think this is the only way they're really going to get it. There is no way, in my view, that you can, through a two or three month, summer incidental experience, know what really goes on in health care. You've got to have a prolonged exposure to it. I think, and our reputation of our graduates is, that when they go into an

organization, they know what they're doing. I think a good part of it is the fact that we still maintain the residency.

NEWKIRK:

You talk about a three-quarter residency. You' re talking about three academic quarters.

JOHNSON:

Right, which is nine months. And some of them stretch out to a year.

NEWKIRK:

Xavier, for instance, in Ohio, has a year residency. I'm not sure whether they have the breadth of experience that you have here. I think most of them are in hospitals or closer to health care centers. Coca-Cola, for instance-I don't know how many of the programs, maybe you do-they have industrial residencies. I don't think any of them do.

JOHNSON:

Is that :eight? lL1;.dt's good simply because health insurance coverage J_s expensive in these companies, and they have learned-maybe it's unique to Atlanta-that they need this kind of expertise to direct these programs.

NEWKIRK:

Everett, my question might be then, if they go to Coca-Cola or Delta Airlines for residency, they still don't know anything about hospitals.

JOHNSON:

No, only what they've learned here, although one of the other requirements that we have is while they're students, they must work in health care. The way our courses are scheduled is that they are five hours a week but they're split on 2½-hour sessions like on a Monday/Wednesday or a Tuesday/Thursday. So that they can work, and we want them to work. In fact, one of my biases is to think that you ought to push people pretty hard because when they get out into practice, they're going to have more things to do than they have time to do, so they might as well get used to the habit while they're in school.

NEWKIRK:

Anybody who obtains a PhD while working full time would think that. That's how it started.

JOHNSON:

Yes, I guess that's right.

NEWKIRK:

How many students do you have? Incidentally, for the record, we are spending a lot of time on a program because I'm not sure whether we have interviewed a full-time director of a program, actively, at the time of interview and I think this is going to be a significant contribution. Everett, how many of your people go directly into health care work? Do you have any idea? Have you done any nose count on that?

JOHNSON:

Yes, well what do you mean directly? After a residency? Or eventually?

NEWKIRK:

After completing the program.

JOHNSON:

Oh. They all do. There's a -well, we have had-let me go back. Normally in the past, the first few years, we had maybe 65-70 students. It has gradually increased to where in 1993 we have 105 students in some part of the program, wherever it is, but our total responsibility is 105 at the moment. They will all wind up in health care unless most of our-well, 52 percent of the students are women. Now, they might get successful the old-fashioned way, and marry money, and then never have to work. But practically all of our students will wind up-their career goals are health care, and they wind up in health care. You see over time, older students that have been out-alumni-for 15 years or so. Sometimes you see them drift off into some other field, and that's pretty typical of all of the programs. If you look at any of the alumni rosters and programs, you' 11 see a pretty heav r sprinkling of non-health-care activities for their alumni. That's, I think, less true here, but it's also true here.

NEWKIRK:

As a scholarly exercise, suppose I were 100 years younger than I am, and I wanted to go into your program. Walk me through it. How would I do this? How are you organized to take students and then how do they progress in the program?

JOHNSON:

Once you apply, you have to be admitted first to the College of Business at the graduate level. That requires a GMAT with at least a 500, and probably a 550, overall score, with at least a 28 percentile on the quantitative and 28 on the verbal. You also have to have a grade-point average of 3.0; that's a B average. If you've got less than that, if you score higher, like a 640 or a 660 or whatever on the GMAT you can offset less than a 3.0 on a GPA. Our average is now around 550 for a GM.AT score. We will ask the student to work at least a year if they're mature, two years if they're less mature. Half of our students come from undergraduate-a year or two out of undergraduate. The other half or our student body are people already in health care, usually 28 and up, most of them having had some form of a clinical experience during their initial health care career. What these people have done is to see that the road to general management doesn't happen unless they go back and get a generalist kind of background in education. So we have a few nurses-name any job in a hospital, we

probably had, sooner or later, somebody that represents that, or several that represent that kind of career.

And then once they're here, we tell them that you have to work while you're in school, and particularly we want you to work in a hospital. We have enough connections around tov,m that all of our students could get hospital jobs if they wanted. We have had a few, and every year we have two or three that don't believe that they need to work-their family's supporting them, or whatever-they've independently got enough money. Generally those **students find out when it cornes tirne for the residency, they have** a much more difficult time because they can't show any track record. So that's another reason we want students to work. You will go through the program starting with the introductory courses. You will typically have one HA course and two business school courses. And you are going to have to have courses in statistics and calculus and information systems. Everybody has to be computer fluent. Practically all of our students have their ovln computers now. That wasn't true when I came here. Of course, there's computers all over the university. About the only place that doesn't have one is my office. I figure I got other people who can do my work for me on those things. I just really haven't had the-in terms of time, I really don't have enough time to sit dovm and fool with it and learn it. Maybe I will in other years though when I retire.

NEWKIRK:

Typically what are the HA courses they take the first year?

JOHNSON:

They will take . . . I am not good at describing things. They will take-the initial first year they'll take medical care concepts and analysis, health policy and regulations. Then there's a combined course that reflects microeconomics called health and hospital economics. There's an administrative course in the second year on organization and administration of health care institutions. They also get a combined business law course with health law, legal environment of health care. They get a course in human resource management in health care. They get a marketing course in health care, they have an operations management course in health care, and then a strategic policy course in health care. Now, in addition, on the MBA side, they're going to be taking applied decision sciences, managerial accounting and control, organizational behavior, corporate finance, marketing management, the economic environment, which is a macroecon course in computer-based information systems. They also will wind up with a couple of electives, and this is one that we're going to change to a requirement next year, which is in ethics and policy in health care. But basically it's an ethics course, which we think-most of the students take it now on an elective basis, but we're going to

require it in the future. So that's the way that the curriculurn is designed.

NEWKIRK:

All right, I go to school, work part time, full time, whatever . . .

JOHNSON:

Generally 20 to 30 hours a week.

NEWKIRK:

Tvventy to 30 hours. All right, I have a three-quarter residency, followed then by-can that residency be taken at any time within those . . .

JOHNSON:

No, it's taken at the end. You must complete coursework.

NEWKIRK:

At the end of the coursework.

JOHNSON:

Yes. When you finish the coursework, which is 105 hours on campus, you get the MBA. degree and that's followed by a three-quarter residency, and our residencies are anywhere from San Diego to Boston and spots all the way in between, partly, I think, because we're part of the old-boy network and it's easier for us to get residencies. You don't always get them because when hospitals are downsizing, politically it's not very smart for the CEO to bring in a resident and pay them. And our students are

roughly getting stipends of about $2,000 a month. Well, they get finished maybe 55 percent to 60 percent/ stay on with the institution if it's a hospital.

NEWKIRK:

Four, five, six?

JOHNSON:

Yes. We have a very high percentage. Also that's true in the other kinds of activities/ that if they go into like managed care, or managing physician practices, typically we've got a high retention rate, and I think that's the reflection of the fact that we've done an acceptable job here.

NEWKIRK:

I would certainly say so. Fellowships are the vogue now.

JOHNSON:

Fellowships in my book are a substitute for the residency. You might as well fold it into your program. That's the way I look at it. I may be hard-nosed on that, but I think they've found out that the students couldn't carry the water that they needed to when they started to work, and therefore they came up with these kind of things.

NEWKIRK:

Some say that our programs used to train people to go to work and now we educate them to go find out what work is all about. Now your residency, being a long one, relatively long-three quarters

at the end of the coursework-would certainly seem like it's almost a "built-in fellowship" in quotes.

JOHNSON:

In fact, I think it is. One of the other features-what we do is when a student's been here and completed their first year, they fill out a rather simple form. But then we sit do½m as a faculty, and we want to know two things about the student. One, what kind of a career do they want to have? Our job is to get them ready for the kind of career that they choose. It's not what we choose for them. And so we ask the student what kind of a career he wants. It could be university hospitals, it could be community hospitals, it could be investor-owned hospitals, it could be chain hospitals-vn1atever the selection is, that's the student's prerogative, we think. And we will try and select a residency that fulfills that career target for the student.

The other question that we want from the student is, tell us what region of **the** country you want to **be in** when you start your career. Because where you do your ac:Lministrative residency, your first job is going to occur in that part of the country~. So if a student says West Coast, that's where I really want to live and work. we will get a residency on the West Coast for them. Or. if they say-the only restriction we give is we tell them you can't say Atlanta. The reason you can't say Atlanta is everybody wants to stay in Atlanta once they've lived here-not everybody, but

that's really the popular place to live-and we would swamp this town. There is not much turnover in administrative positions in Atlanta, simply because it's a nice place to live. So the one thing we tell the student is you can't have Atlanta.

NEWKIRK:

Well, you also have a lot of students working in Atlanta.

JOHNSON:

Sure. There are 43 hospitals of one kind or another in metropolitan Atlanta. And not all of those are appropriate for residency.

NEWKIRK:

Is there anything else about the Georgia State program that you can think of that we haven't covered?

JOHNSON:

I tend to think this is a very traditional kind of program. It's a historically traditional kind of program. I am of the opinion that historically we are right in what we did in this field in the way we educated people. I know that may sound anachronistic today, but I still see the results of what we do and the results of other programs, and I am satisfied that we are doing okay with our program.

NEWKIRK:

Let's switch subjects, then, if we're finished with that one. Let's talk about the health care system. All of the graduate

programs like to talk about policy. We' re turning out policy people. I don't know who's going to do the work if everybody's going to make policy.

JOHNSON:

I always have problems with that because I say tell me a job that's policy. The only one I can think of is maybe a staffer on the hill in Washington. Other than that, you got to get your fingers dirty working in management. And that ain't policy-only rarely.

NEWKIRK:

Well, we agree on that. Whenever I see-just for the record, I work in a program-also a graduate program like this and whenever I see a student put on their-what I call their wish sheet, the thing they send off to say to an employer here's what I want to do in the health care field, and they put the **word** policy in, I take it out. There's only one Hillary Clinton **making** health care policy in the country as far as I know,

but . . .

JOHNSON:

That's right.

NEWKIRK:

An:[V!ay, we agree on that, don't we? Talk to me a bit about the future of health care, and we will get into some policy stuff. Where are we going?

JOHNSON:

I don't know. I think it's the most mixed-up confusing situation that I have ever seen. We have a lot of global thoughts that I do not believe can be realized in practice. For example, talking about community pools for insurance, I don't know how you mandate that unless you have a totally federal program. And then you could still have problems with it. That's just one example. We talk about global budgets-I don't know who's smart enough to set the budget ceiling. I can see all kinds of trouble coming. We talk about managed care as an answer. Managed care has severe limitations. It's sort of like if you want to cut down your hospital expenses, the first year it's a hell of a lot easier to do it than the subsequent years. I think that's somewhat the same boat that managed care is in. What I would say is I would like to see, because I've seen too much abuse of it, I would like to see a minimum benefit insurance package that if a company is going to provide it, it has to at least meet the minimum standards. I've seen too much abuse of that and people, carriers making too much money over the years with insurance policies that are totally inadequate in coverage. And they hoodwink the public.

NEWKIRK:

Where are we going to go?

JOHNSON:

I have always thought that fee-for-service medicine was a useful, pragmatic way for physicians to practice. Unfortunately, I see more and more abuse. I see physicians with $1 million, $1.5 million incomes. For a long time-what I've done for the last 10 years is worked for hospitals negotiating hospital-based physician contracts. And in a sense, writing the contracts. So I've had a lot of experience dealing with anesthesiologists, pathologists, radiologists, radiation therapists, whatever, oncologists, whatever the hospital-based specialty is. I have seen enormous incomes that I don't believe are appropriate for medicine. I know that has also happened in lots of other fields, rarely with a family practitioner, but not infrequently with neurosurgeons, or orthopods, or ophthalmologists, or whatever else. Those excesses are going to drive the system, I think, ultimately to salaried physicians in large multigroup specialties. And if I had to pick a model, the model I'd pick would be Mayo. Mayo has highly sophisticated medical enterprises with easy access between the specialties. You get two bills at Mayo. If you're a sick patient, you get a hospital bill and you get a clinic bill, and that's it. I think it's an abomination for a patient to go into a hospital and get six, seven, or eight physician bills plus a hospital bill. Those are driving the system over the brink. So in the long run, what are we talking about? I think you're going to see large

multigroup specialty practice. I think you're going to see them very closely tied to hospitals. I don't think this is going to come about easily. I think it's going to come about with a lot of stress, strain, and pulling on the system.

On the finance side, I would hope we are not going to go toward a one-source governmental payment for health care. I want to see a pluralistic system continue. At the same time, I think that the insurance supervision of commissioners over carriers has been poor, that has to be strengthened. Somehow maybe-and regulation of insurance is a state activity. It seems to me that at least for health insurance, we're going to have to arrive at some kind of a federal control on insurance practices. What we've done is with experience rating, we have tried to eliminate all the costly elements so that you can sell a policy that you hope nobody's going to get sick and have to collect on for only a minimum amount. Then when that happens, we start throwing in deductibles-co-insurance, and maximum ceilings for the life of the individual, all kinds of things-all of which in the long run are counterproductive. But I don't have an answer. I don't believe we're going to get there through a grand design. I think we're going to trip and stumble our way into it. I think that resource-based relative value systems had to come. I think they're going to probably spread beyond the Medicare group. I don't see my way clearly through how this is going to happen except I'm pretty sure

it's going to happen peacefully, and it's going to happen. If there is another downturn or a recession, it's going to have to be done quickly. But that's about all I know about it.

NEWKIRK:

President Clinton-now we'll put this in for history, I guess-President Clinton has said that what he wants us to do is to provide coverage for everybody and institute a global cap. This seems somewhat oxyrnoronic. What's your feeling on that? Can we do it?

JOHNSON:

I don't think either one can work. Community rating was a nifty idea back in the '30s, and Blue Cross used it, but they got chewed up by the commercial carriers when they came into business. I'm not sure community rating can work. It's a nice idea in principal. I don't think it's going to go.

Global caps-I just can't imagine how anybody is smart enough to make it work. If they try it, the real issue is going to be, once we get ourselves into a mess, how do we back out? And nobody's answering that question. We're only taking the first step. But we need to ask the question, if we take this step and it doesn't work, what are we-how do we unfix what we've fixed? How do we back out? They're not even talking about that in Washington, or anyplace else that I know. That really bothers me. I have a belief that health care is a very special thing. I'm glad

that I spent a lifetime in it. I think it's a tough world, I think it has its share of frustrations, but it's got satisfaction.

I wouldn't change fields if I had to come back and do it all over again. But we' re in the process-you know, the process of medical care is very intense. It is a methodology where we have to have highly skilled, highly trained people at the worker level. We have to have very expensive technology for diagnosis and treatment, all of which tends toward a very high-cost operation. Nobody has ever come up with the idea about how to simplify the methodology of diagnosing people treating people so that it is not labor-intensive and not capital-intensive. And until we get to that point, the costs are still going to exceed, always, the rate of inflation. But people are not looking at the reality of what medical care is all about. The only time they get serious in looking about it, other than not paying for it, is when they're a patient, and then they want everything. Understandable. It's not trite, but it's been very common that Americans believe that they can live forever, and they're going to get treated forever. It seems to me that it would be reasonable and humane to say that beyond a certain point, no heroic measures for saving patients. I saw a lady patient, 90 years old, having two hips replaced. Now that's the kind of stuff that I just don't understand. I understand why it happens, but I just-that was a greedy orthopod that was doing that one.

NEWKIRK:

Well, some say, I've heard some say, and I think I believe it, that Americans are spoiled rotten when it comes to health care. You've traveled around the world and you've seen stripped-down medicine and the figures on health care-statistics. It just seems like we have to have every bit of stainless steel and glass available or we're not happy. What do you think?

,JOHNSON:

Plus disposables. Once you look at the systems in other countries, you begin to understand how extravagant our system is. And it doesn't have to be that extravagant. But we're all running the Ritz Carlton. I think it's nice if we can afford it, but everybody-somebody who's never had the exposure, even though they're sick. But if our resources don't permit it, then we shouldn't be having it.

NEWKIRK:

At this point in time, at 14 percent of the gross domestic product going to health care, can we afford it? I can remember a time when everybody predicted that it would never go above 10 percent because we couldn't spend it.

,JOHNSON:

My view of the percentage of gross domestic product is 14 percent-it could go to 18, simply because of a very simple thing. Medical care is discretionary spending. If we elect to spend our

money for medical care and we want to give up something else, we'll do it as Americans, and there's no other control on it. I think Clinton is being foolish to believe that he can put a cap on the expenses of medical care. It's a fool's paradise that we're in. My only concern-I've got several concerns-but the most serious one is that he will disrupt the system so badly that he'll destruct an awful lot of the fine things we have in place.

NEWKIRK:

Talk about rationing. Do you think that rationing is the answer? You sort of breezed past that a little while ago. There are some that say we have explicit or implicit rationing when things happen like happened to me. I had belly surgery over the holidays and I was in the recovery room, and a nurse came over and said, "What can I do for you?" I said, "Well, I really have to go to the bathroom." She said, "Well, it's right over there," and showed me the door. I went over there and I came out, and my gurney was gone. So now, the care shifts home. Isn't that rationing in a way?

JOHNSON:

Sure it is. Outpatient surgery. Yes, but when I started, back in the early '50s, women, after deliveries, would take 10 days in the hospital. I can remember detached retinas used to take three weeks in the hospital. Now they're an outpatient procedure. The knowledge and technology of medicine has moved ahead very

rapidly. I don't think it's rationing in a strict sense. But we've always had rationing in another sense. We have always used the economic divisions in our society to ration health care. We talk about people without health insurance. They're rationed out of the system on an economic basis because they don't have the cash to pay for it. We don't have rationing. . .

NEWKIRK:

As the elderly were, before Medicare?

JOHNSON:

Sure, right. No question. We do not have, and I would hope will not have the rationing that you see in countries with a national health system, in which a line is the rationing device. They've just got to get up to the head of the line. Americans are intolerant of that kind-just watch somebody waiting for a bus or a cab. The same kind of thing. We're intolerant of that. I think that's one of the vital things in our society that's hard. Impatient and impulsive-and I don't want to see us lose that. We may, in this process of what's going on. I feel a great sense of empathy for a physician. When I see managed care programs, having physicians call them before they admit a patient, determining the number of days of stay, or expensive treatments-they've got to go back and get approvals from a managed care operation. The drive there is to control costs, keep it as minimal as possible. "They essentially are telling the physician/ use your best judgment to

use the least amount of medical care as you can on this patient. And then you turn around, and you go into a courtroom, and you see a physician being pilloried for malpractice because the plaintiff's attorney says to the physician, did you do everything that's absolutely possible for this patient to save him? And the physician is caught on the horns of a dilemma. And that's not fair. We do have to modify that.

I was part of the first preconference to set up the first malpractice commission back in the early '70s, '73. And it was a meeting held out at Santa Barbara where Bob Hutchinson ran the Center for Democratic Institutions. I can remember very vividly the trial lawyers saying the contingency-fee system was right and that everybody had the right to go after physicians and hospitals on these kinds of things. I'll never forget those conversations. There has to be a limit on malpractice. I know that when I first started as an administrator, back in Chicago, in 1952, we had lots of them, and we won. And we didn't have to pay. Eleemosynary exemption existed, and I went to the insurance company and said we're going to pay it. We did something wrong, and we ought to pay it. And so in the early '60s, we lost the eleemosynary exemption, which I think was all to the good. We should never have had it in the first place.

But over the years, I went from maybe one or two days a year being in courtrooms to the middle '70s, spending three to four

weeks a year in courtrooms, because there were that many lawsuits. And we very seldom lost one. We did lose some, and I learned there, in the courtroom, that justice is an ideal seldom reached in a courtroom. Juries can be cockeyed in their decision making, and so can judges, and that the system is really tilted-the judicial system, I think, is tilted against medical care because of jury sympathy. Juries don't understand it; I've been expert witness in courtrooms on technical matters and seen half the jury sitting there, asleep. This is not the way we need to do business.

NEWKIRK:

Technology. Let's try that. Let's talk about how technology is either cost-effective or expensive. What do you think? Where is it going?

JOHNSON:

Gosh. More complicated and more expensive. The fundamental issue that I see with technology is you're driven-you meaning the administrative staff-you're driven by physician needs, and we sometimes cannot separate true need from faddish physicians. Physicians are as inclined to be faddish about a particular technique as I guess we are about hula hoops or anything else. It's not easy to separate those issues. The real essence of where we need to go in technology is going to be there. But we need to use replacement technology rather than add-on technology. An example of that is we got CAT scanners, and then we got MRis. And

what really should have happened is that we should have developed the MRis to replace the CAT scanners. But you go to a hospital now, and what do they do? They give you the CAT scan first, and if that's not diagnostic enough, then they run you through the MRI. So you've got add-on technology. This is a free market, and I understand why those things happen. But it would be nice if hospitals and medicine would be able to put more pressure on the manufacturers to wait for some of these developments until they're more refined. One of the other rules I learned a long time ago was never buy the first generation of new technology. Wait for the second generation. I got the hospital early on into the first renal dialysis kind of stuff. And it was atrocious. This was back in the early '60s. I learned then it's not the way to go. You need to wait—let the medical center, let the university medical center develop it. And then you get the second generation. Otherwise, you're going to spend a lot of money and get very little results.

NEWKIRK:

That's great hindsight, but.

JOHNSON:

Yeah.

NEWKIRK:

What do you do when you're under pressure by the medical staff and everyone else, the board included?

JOHNSON:

Well, I think too many managers take too much on themselves. What I would do, and I did have a technology committee, not interested in just the newest widgets coming along, but the task of that corrrrnittee was to look ahead three to five years. vJhat technologies should the hospital be in? How do we get there? You don't take the average physician. You're going to have to find some peculiar guys to do these kinds of tasks for you. But they're around, and if you need to, you can buy some outside help for them. But that's the way I think you need to go about developing the technology. It's too often, and I see it today all the time, a group of important physicians-you know the old rule, 20 percent of the physicians admit 80 percent of the patients. The guys in the 20 percent have got all the leverage and so they come and they tell the poor CEO we got to have this gadget. And what's he going to do? He goes out/ and he buys it. And it doesn't work right. Or the maintenance on it isn't right. Or it doesn't have the right bells and whistles, or whatever it is, he shouldn't be put under that kind of pressure. If you think ahead and have a technology committee that's got to run through that with their peers who are going to be more broad-minded because they're focused differently, then you've got a chance to control it. I very rarely see that in a hospital.

NEWKIRK:

There are many cases too where technology is cost-effective.

JOHNSON:

The gastroscopic, arthroscopics. HMOs buy this stuff for their surgeons and save a bundle of money. So this really is the good news, I guess.

JOHNSON:

Sure, a lot of the laser stuff is good. A lot of the laparoscopic stuff is great. It gets people out, the body isn't abused with those kind of techniques, as much. Sure, there are a lot of good things. I would still hate to think-you know when I first started, I can remember, in central supply you always had two or three people that did nothing but match barrels and plungers and sharpen needles. And that's all gone. And thank God it's gone. With all the disposables, we've got a trash problem, I understand that, and we've got medical waste problems, but I'd sure rather have that than what we would-we would be, cost-wise, out of the ceiling if we were still doing things like that.

NEWKIRK:

If the labor costs were high-if you go to China, this is not the case. They still boil rubber tubing and sharpen needles and so forth. As a matter of fact, they sharpen disposable needles.

JOHNSON:

Yes, that's right. And reuse disposable syringes.

NEWKIRK:

Everett, let's go over some names of people you recall, and give me your impressions and anything else you want to talk about. You know a lot of people. Start with Boone Powell, Sr.

JOHNSON:

Boone is one of a kind, I think. I guess I first met Boone through the College. Probably during the days of the early Congress on Administration. And Boone and I became good friends. Every time that I would go through Dallas, I would go over to Baylor.

NEWKIRK:

He was at Baylor University Medical School.

JOHNSON:

Yes. In Dallas.

NEWKIRK:

Ev, he had an absolutely fantastic hospital.

JOHNSON:

Big hospital, huge hospital. And Boone was something else. He knew everybody by name, up and down the organization. He was nuts about keeping the place neat and up-to-date and attractive. Boone was a-he wasn't born in Texas, but he sure acted like he was a Texan all of his life. He had a style that was absolutely unique, whether it came to raising money, replacing buildings, whatever it was. Whenever I think of Boone, I always think of

there's a guy that always went first-class. And he knew how to do it. I remember one day he went out to the parking garage, and I don't know if it was a Lincoln or a Cadillac he had, but it was sitting there with the engine running. Well, why was the engine running? Because he had his dog in the car, and he didn't want the dog to get too hot. Just a typical Boone Powell approach.

NEWKIRK:

Let me interrupt you. Along the same line, I went to Puerto Rico for a meeting one time, and, lo and behold, when we got off the airplane, there was a limousine, in San Juan, Puerto Rico, waiting for Boone. And it was probably the only limousine in San Juan, but you can bet Boone had it.

JOHNSON:

I've been in Dallas. He'd take me around to see this person or that person. He could reach to the top echelon of the people in Dallas. He was-Boone was humble. Boone was extravagant in style, but I think he was a very human being. I really appreciate Boone. He cared about doing things right. That's what I always remember about Boone.

One of the other really very special people in my life was Ray Brown. I think probably Richard and I knew Ray Brown as well or better than anybody else in the field, simply because we were physically near each other and intellectually interested in the same things. Ray was-the tragedy today is that young people don't

know who he was. But he was sure one of a kind, and a real force and leader to develop hospital administration. I don't think we'd be today where we were if it hadn't been for Ray Brown. He was one of the most generous people in terms of hospital administration that I know. He was always willing to give his time and intellect for the professional affairs of health care. Extremely bright. Highly motivated. I always used to kid him about being a lousy golfer, and he was a terrible golfer. But he always thought he was better than he was.

One of the nice things that I remewber happening-it was about seven or eight years ago. The Duke Group asked me to talk to the alumni and describe to them what I thought Ray Brown would be thinking about the way things were going in health care today. And Ray's widow, Mary, was there with one of their daughters-I've forgotten which one. Afterward, Mary came in-I was talking to Mary-and she said I didn't know anybody knew Ray that well. Because I could interpret-and to this day I could interpret and tell you what I think Ray Brown would be thinking about the different things going on.

He was, in effect, a marketer, an entrepreneur, in the finest sense of those words. And that's what he strove for. I can remember his frustration when they asked him-and he turned it down several times-to be vice president of administration for the University of Chicago. Zilld he really wanted to stay running

Billings-or running University of Chicago Clinics. And they finally-Lowell Coggeshell, who had been-well, the organization of the University of Chicago is different than most universities. But Coggeshell had been essentially dean of the medical school in the division of biological sciences and then a vice president of the university. And he really insisted on Ray becoming vice president for administration. I can remember the terrible frustration that Ray went through trying to manage that universityo I'll never forget, one day I went into his office to see him, and he said, "You know, I spent X amount of time and effort to save $200,0000" It was really a huge effort he had to go through, and he said, "I turn around and find out that the guys digging over in Egypt had just spent $300,0000 And I didn't know anything about it or couldn't control it.• Those are the kind of frustrations that he went through. Bernie Lachner experienced the same kind of stuff when he became a vice president at Ohio State. And interestingly enough, they both quit and went back to hospitals. And I think that's part of the reason. Maybe there's a manifestation that we like to control things. That's why we run hospitals. I don't know.

NEWKIRK:

Being a university official is no place to control anything though. That's one of the early lessons.

cJOHNSON:

By the way, I mentioned earlier I thought maybe I wanted to be a university president when I got to be 40? When I got to be 40, I looked around and I saw all the campuses in flames and all the riots going on, and I thought that was no place for a sensible person to be. So I decided that health care was a lot better place to enjoy life than in a university. So I didn't go. I had started and was being considered at a couple of small colleges r but I decided that was not for me at that point. I never went over to that career.

NEWKIRK:

J. Milo Anderson.

,JOHNSON:

My preceptor. J. Milo was the son of a Lutheran preacher. He went to St. Olaf College and had the unfortunate luck of coming out of college at the bottom of the Depression, and went to work for the Continental Illinois Bank. He was there for a number of years and decided that he could do better in life-I don't remember if he'd married Helen at th.is point or not. Helen had been a nurse. Anyway, Milo went to the program at the University of Chicago in something like 1941 or '42. He then became the administrator of the Women's Hospital-Lying In Hospital, Chicago Lying In Hospital-at the University of Chicago, and from there he went to Gary. From Gary at Methodist, he went to Ohio State to

open up that new medical center hospital. Anyway, Milo I always enjoyed. I think Milo taught me a lot, and yet I don't think that he taught me anything very specific. I think he had a very pragmatic sense about what was real and what could be done. I think indirectly, having spent a year with Milo and then being friends with him after that, I did learn a lot from Milo. Another one that comes to my mind is Len Goudy.

NEWKIRK:

Len Goudy?

JOHNSON:

Len Goudy. Len was, at the time that I knew him back in the early '50s, was working at the American Hospital Association as, I don't know, some kind of a specialist-this was the old 18 East Division Street-the old Latin School building that the AHA was housed in. And Len was only one of three or four people on the staff. You had George Bugbee, and Charlie Dolayol, and John Sturm, who ran the magazine, and Matt Foley, and Len Goudy. And that was about it except for Helen Yast running the library, and that was about the total extent of the AHA's staff except for secretaries. And Len eventually-he was a Canadian, had run a hospital in Canada-how he wound up with the AHA I don't remember. But Len was the guy that first began to use me for speaking engagements around the country that the AHA was sponsoring. I remember Len for that. Eventually he left and went to running a hospital in Peoria or

Rockford-I've forgotten where-and stayed there until--well, he died. He had brain cancer.

Another interesting, special guy was George Bugbee. '(,\Then I first knew George, he was the director-I guess in those days executive director-of the American Hospital Association. I always thought he was a very formal, prim, stiff kind of guy. George is much warmer than that when you got to know him, but he always had a certain reserve to him. I think George was a true intellect. He could see major problems long before other people could, and figure out ways to approach them. I think real credit goes to George for the old Hospital Care Commission-or Cost Commission-that Dr. Bach_meyer was the executive director. It led to the Hill-Burton Program. George was the guy that dreamed all of this stuff up and brought it out, and figured out ways to get the job done. If I had to think of one person whom I would call a statesman for heal th care, it would be George Bugbee. Really a very special guy, I think.

NEWKIRK:

Dick Stull.

J"OHNSON:

Dick Stull was--when I best knew Dick was when he was director of the College. I'd known Dick before that. Dick was a graduate of the certificate program at Duke. I'm not clear about his total career. I knew that he was a football player at one point. I

guess that's the way he got himself through college. Dick, I guess when I first knew him, was out at University of California at Berkeley running those hospitals. Dick was-in a different way, he was a leader. He was always cost-conscious. He was concerned with always keeping revenue and expense in balance and to have a good balance sheet. But Dick was also good politically. He knew how to get people to do things. He came in, and in quick order, straightened out the finances of the ACHA. and began a decent educational program. I will never-I will always be grateful for what he did there, because I think he saved the College. I think that it would never have developed very much without Dick Stull's leadership and I think that what it is today is largely due to the care and attention that Dick gave to the College.

NEWKIRK:

You're being kind. You may have saved the College by forcing the resignation of the prior executive director.

JOHNSON:

Yes, but Dick's the guy that did it. Another interesting fellow that gave me some insights was Madison Brown, who was a physician. When I knew Madison, he was with the AHA. In some ways, Madison was an enigma, I think. He did one thing for me that helped me. When you do a lot of building in the hospital, you change people's habits, and people get disturbed with you, because you're always changing things around. Golly, I guess I made a lot

of changes when I was in Gary. I got a lot of people disturbed. At one point, the board began to ask some pretty pointed questions, and I was smart enough to think maybe I was getting out on thin ice. And so I asked Madison to come down to Gary and to interview some of the board members. And I'll never forget it. Madison did it, and he was a very polished person, I think. So when he finished these interviews, he came into my office one evening and said just sit and talk. That was in the wintertime and it was late-early evening. He said, "I can tell you what's going on. You've got too much energy for this place." I said, "Oh, that's interesting." He said, "You know, you're pushing them too hard and too fast." Well, it takes an experienced guy to be able to identify that. I said, "Well, what am I going to do about it?" He said, "Well, start doing all kinds of things outside. This place can only hold so much energy. So spend your energy on other kinds of things in health care." That's exactly what I did, and it saved my job. Madison was very thoughtful in that advice, I think.

NEWKIRK:

Dr. Bachmeyer and Malcolm D. MacEachern are the two original people in this business in my mind. They were totally different people, but they were the same era, and both were physicians. Dr. Bachmeyer came to the University of Chicago from Cincinnati and then-I don't know if he was the dean there, or what . . .

NEWKIRK:

University of Cincinnati Medical School.

JOHNSON:

That's right. And one of his jobs at Chicago was not only the medical school, but the hospital. Dr. Bachmeyer was the most formal man I have ever met in my life. You got the impression that he's totally straight arrow. He had no sense of humor; totally dedicated to his work. Now I know that in retrospect this is not what he really was. But he was a very human being and a very caring individual. But let me tell you, he was very intimidating in a classroom. Dr. Bachmeyer is the one that really started the University of Chicago Clinics on their financial program and made it succeed. In fact, he became the director of the hospital. Wait a minute. Otis Whitecotton, Dr. Whitecotton, had been there, and I don't know what, but Dr. Bachmeyer was not satisfied with what he was doing. Whitecotton had left Billings to go to Alameda County to run that chain of hospitals. I think Dr. Bachmeyer forced him out and then brought Ray Brown in at that point. There was an interesting story that the job wasn't vacant when Ray came, and it looked like Otis Whitecotton was going to stay. So Ray got put on the shelf for about three months up at the University of Michigan until they could work out and unscramble that job situation.

Dr. Bachmeyer was, I think, the first true intellect to look at hospital administration-health administration-in a broad perspective and really say what it ought to be and what it could do. And if you go back and look at the volumes that were printed under the Hospital Cost Commission in 1946 and '47, some of those ideas are still as valid and viable today as they were when he worked them out in the late '40s. His associate in that project was Maurice Norby, who then became the deputy director of the AHA. Maurice did a lot of the writing, but the ideas were Dr. Bacrnneyer,s.

NEWKIRK:

Did you actually know Dr. MacEachern?

JOHNSON:

Yes, I knew him. See, I came at the tail end of the first generation is what I'd say. Yes, I knew Mac. He was based in Chicago because the American College of Surgeons ran the standardization, or the old original accrediting program, for hospitals. And Mac was the director of that. Mac had been an obstetrician-gynecologist in Canada. How he got to the U.S. I don't know. When I knew him, he was running the accreditation prog-ram, which is the precursor to JCI-iliO. Interesting guy. He knew about everybody in the country. He knew what was going on. He was a fountain of information-told a lot of stories. I'm never sure that Mac was-he was a doer, not a thinker, I guess is the way

I would put it. But a charming guy. He could tell a million stories.

He had a hearing problem. And you knew, if you were speaking and you weren't making much sense, you could see Mac look, reach under his thigh where he had his batteries, and just turn them down so he could go to sleep on you.

He was one of the original characters. And then he had-he apparently had a lot of honorary degrees and so on. He always had a bunch of scholastic honorary keys in his lapel. He must have had two dozen of them always hanging there. He was one of a kind.

But again, he made his contributions to the field. He wrote the first text on hospital management. It's a thousand and a hundred pages. Hospital Organization and Management. Interesting. I don't have it here any more. It 's at home . Interestingly enough, about 10 years ago-I forgot who the publishers were-they asked me if I would rewrite that book and update it. I thought, well, that's quite a challenge. I looked at it, and I said you can't do i L It would be 10,000 pages now. And it would be changing so fast that it's useless to try. And so that's the message I took back to the publishers. But he did. And I tell you { there were a lot of doctors who swore by that book. If they had only one book on hospital administration, it was Dr. Mac's, and they all knew it-presumably because of the accrediting process. But you lived by it. Mac came up with the idea that it was a

conflict of interest for doctors and administrators to be on hospital boards. That's where that idea arose. He said there's a conflict of interest. You shouldn't be there. Well, that, I think, was a disservice to the field. I understood why he said it at the time, but the first hospital I ran-Chicago Memorial-had three doctors on the board, in violation of Dr. Mac's principle, I learned, in that hospital, that it was valuable to have doctors on your board. You really needed them. I have always believed that. And to this day I believe it. If I point to you in Atlanta, Georgia, and tell you which hospital I think is the best, it's Piedmont Hospital. Why is it the best? Because the chiefs of the eight services at Piedmont are the board, plus three individuals, plus the CEO. That's the board of Piedmont Hospital. They give excellent medical care. It is absolutely the right way to go in my book. It's not-you can handle conflicts of interest. In fact, in the AHA I think i had to write the original definition of conflict of interest and how you solved it. I can remember going around the country giving speeches on that one. All of this stuff tends to interlock, really, over time. Well, those are just some of the people that I can think about offhand.

NEWKIRK:

Thank you very much. That's very interesting to just go down a list. We've sprinkled these throughout the interview, but as a summary, this is very interesting. Dr. Johnson, are there any

other items that you would like to enter into this interview that seem of any historical value?

JOHNSON:

Well, the most unsafe thing to do is to talk about the future, because it'll be here, and you can be judged by what you say. I would summarize a career by saying that it's been a happy one. I can't think of doing anything that would have been more satisfactory. That's true for Richard, too. For both of us. I've almost got a split personality on these kinds of things. It's been totally satisfying. I've thought for a long time, and I still believe that it's true, and I look for it when we interview prospective students. In a nutshell, I think that you are a better person if you pay rent for being here in this world. I think somehow, you got to pay rent. I think you pay your rent when you're in hospital administration or health administration. It's-you know, there's elegant ways to say that, it's concern for the fellow man and humanity. My wife's got a nice way to say it. She says, 'Brighten the corner where you are.' And that's another way to say it. But that, I think, is still the essence of health care. If you don't have that sense you're not going to be good at it. If you have it, you will put in more energy and effort than really is required to do the job.

NEWKIRK:

Our sincere thanks to you for this contribution to the history of health care administration, Dr. Johnson.

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