HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Aladino A. Gavazzi

ALADINO A. GAVAZZI

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Aladino A. Gavazzi

CHRONOLOGY

1922	born July 24, Exeter, PA, son of Guido and Ambrozino Gavazzi
1940-1982	U.S. Army, Active duty and reserve service, private to colonel, Armor and Medical Service Corps
1945-1946	Export/Import Business, NYC
1946-1950	Veterans Administration, regional office, branch office, and district office, New York, NY
1950-1955	Veterans Administration Medical Center, Brooklyn, Administrative officer and student
1953	Columbia Universtiy, B.S.
1953-1954	Bronx, Columbia-Presbyterian, and Beth Israel Hospitals, New York, Administrative Resident
1955	Columbia University, MSHA
1955-1957	Veterans Administration Medical Center, Hampton, VA, Assistant Hospital Administrator
1957-1958	University of Chicago, Federal Executive Development, diploma
1957-1960	Veterans Administration Medical Center, Chicago, (Research) Assistant Hospital Administrator
1958	Married Nancylee Ray of Chicago
1960-1961	Veterans Administration Medical Center, Dwight, Illinois, Assistant Medical Center Director
1961-1963	Veterans Administration Medical Center, Washington, DC, Medical Center, Assistant Director
1963-1964	Veterans Administration Central Office, Washington, DC, Department of Medicine and Surgery, Hospital Construction, Associate Director

CHRONOLOGY (Continued)

1964-1967	Veterans Administration Medical Center, Martinsburg, W.VA, Center Director
1967-1970	Veterans Administration, Central Office, Department of Medicine and Surgery, Executive Assistant to the Chief Medical Director
1968	Baylor University, Medical Field Service School, Fort Sam Houston, Texas, Diploma
1970-1971	Veteran Administration, Central Office, Department of Medicine and Surgery, Executive Director for Administration
1972-1986	Veterans Administration Medical Center, Washington, Medical Center Director
1973	University of Virginia, Federal Executive Institute, Diploma
1974-1986	Veterans Administration District #6 (includes five medical centers), Medical District Director for Virginia, West Virginia, Maryland, south central Pennsylvania, and the District of Columbia

MEMBERSHIPS and AFFILIATIONS

Academy of Medicine of Washington, DC

Member

Alabama, University of

Guest Lecturer in Hospital Administration, 1968-1970

American Association of Hospital Consultants

Member

American Association of Hospital Planners

Member

American Bicentennial Research Institute

Resource Member

American College of Hospital Administrators

Commission on National Health Insurance

Member, 1972-1974

Education Committee

Member, 1971-1972

Fellow

International Seminar on Education, Lisbon

Regent, 1977-1980

Research and Development Committee

Member, 1972-1973

Task Force on the Report of the Commission on Education for Health Administration, Member

Task Force on Selection Criteria for Health Care Executives

Member, 1972-1973

American Hospital Association, Life Member - 1984

Council on Human Resources

Member, 1980-1981; 1982-1984

Federal Hospital Committee, Chairman

American Legion

Member

Association of American Medical Colleges

Member and Committee on Education Chairman 1982

Association of Military Surgeons of the U.S.

Member; General chairman, 1975

Association of University Programs in Health Administration

International Seminar, Helsinki, 1975

Bologna, Italy, University of

Guest Lecturer, American Federal Health Care System, 1972-1977

Brazil, University of, Sao Paulo

Guest Lecturer in Hospital Administration, Preceptor

Columbia University

Guest Lecturer in Hospital Administration, 1968-1971;

Preceptor 1971-1985

Cornell University

Guest Lecturer in Hospital Administration, 1968-1970

Duke University

Guest Lecturer in Hospital Administration, 1968-1970

Federal Health Care Executives Institute

Chairman, 1968-1976

Federal Health Executives Institute Alumni Association

President, 1974-1975; Executive Secretary, 1985-1988

Federal Interagency Institute Planning Committee

Chairman, 1969-1971

Florida, University of

Guest Lecturer in Hospital Administration, 19768-1970

George Washington University

Assistant Professorial Lecturer in Hospital Administration, 1963-1965; 1968-1970

Health Care Planning Council for District of Columbia (State Health Coordinating Council) Member, and Chairman, Project Review Committee

Illinois Hospital Association

Member

King's Fund College, London

First International Seminar, Member, 1975

Medical College of Virginia

Preceptor and Guest Lecturer in Hospital Administration, 1956-1985

Military Medical Services Corps Chiefs, and VA Ad Hoc Committee

Member 1982-1984

New Hampshire, University of, Health Care Administration Forum

Faculty Member

Northwestern University, Chicago

Hospital Administration Preceptor

Providence Hospital, Washington, DC

Citizens' Board Member, 1976-1977; 1984-1988

Planning Task Force Member, 1977-1983

Royal Society of Health

Fellow

Senior Executives Association, VA Chapter

President, 1983-1985

Trinity College, San Antonio

Preceptor

Washington (DC) Hospital Council

Member

Washington University, St. Louis

Preceptor and Instructor in Health Care Administration, 1972-1977

AWARDS AND HONORS

Administrator of Veterans Affairs

Distinguished Service Award, 1974

Exceptional Service Award, 1981

Distinguished Career Award, 1986

American Hospital Association

Certificate of Appreciation: Outstanding Contributions to the Improvement of Health Care for All Americans, 1983

American Legion

Citation of Merit for Outstanding Service to the Hospitalized Veterans of Washington, DC, 1972

American Legion

Post Mortem Award

AMVETS

Life Member

AMVETS

National Commanders Award, Distinguished Service Award for Outstanding Service to Veterans, 1973

AMVETS

Silver Helmet Award - Civil Servant of the Year, 1974

Association of Military Surgeons of the United States

Ray E. Brown Award for Outstanding Service in Health Care, 1973

Founders Medal, for Outstanding Service to Military Health Care

Disabled American Veterans

Citation for Distinguished Service on Behalf of Disabled American Veterans, 1972

AWARDS AND HONORS

Disabled American Veterans

Life Member, Dwight, Illinois Chapter

Disabled American Veterans

National Commanders Award in Appreciation of the Outstanding Service Rendered to Disabled American Veterans

District of Columbia - State Health Planning and Development Agency

Meritorious Service Award, 1986

Outstanding Service and Dedicated Participation on S.H.C.C.

Federal Health Care Executives Institute Alumni Association

Distinguished Service Awards, 1978 and 1981

Hospital Council of the National Capital Area

Dedicated Service to Hospitals in Area Award

Italian/American War Veterans

Certificate of Appreciation, 1983

Senior Executives Association

President's Award, 1984

Veterans Administration

Performance Awards, 1952, 1956, 1959, 1963, 1965, 1970, 1974, 1980

Veterans of Foreign Wars

Life Membership, Martinsburg, W.Va. post

WEEKS:

We are going to tape an autobiography of your professional life, so I will ask you a few questions to lead into some of the events.

I have a note that you were born in 1922, in Pennsylvania. The next entry I have is your military service. You were in the service from 1940 to 1945?

GAVAZZI:

Yes, and then 1949 to 1981.

WEEKS:

Would you like to talk about your military life?

GAVAZZI:

Yes. I enlisted in the army at the age of seventeen, having graduated from high school and finding it difficult to get a job. They were talking about the draft. I felt that I did not want to be drafted. There was something about the word draft that bothered me, so I enlisted. I wanted to go into the navy, but it was a six year enlistment. The marine corps was four years. Then the army came out with a one year enlistment. My father agreed to let me go for one year because he suddenly realized that I was intent on going into the military.

I went to Fort Belvoir, Virginia, where I took basic training. My first paycheck was $5.37. In those days they paid privates $21 a month. They had coupon books which they gave you for your dry cleaning and to go to the PX and to do other things like go to the movies. I didn't realize that they would take that out of my pay, so I wound up with that $5.37 in my first pay. I got a five dollar bill, a quarter, a dime, and two cents.

I was with an engineer unit. We went to the Carolina maneuvers. The

thing I remember most about the Carolina maneuvers was that a man by the name of Patton who was a full Colonel, mechanized the units from horse cavalry to armored, which intrigued me. Later on I went into armor.

When I returned to Fort Belvoir -- we returned on December 7, 1941 -- at this time I was a company clerk. My job was to type furloughs and everything else. I remember I had my furlough typed up to go home from the 17th of December until the 2nd of January. Everyone in the company had furloughs prepared, and I had to type them. When we got to Fort Belvoir, the first order of business was to destroy all furloughs, cancel all leaves. We were put in the parade grounds in tents. We left on December 10, not knowing where we were going. We went by train. The first stop was Cincinnati, then Chicago, then Des Moines, and winding up in Seattle, Washington, on the 22nd of December. I remember having Christmas Day meal -- and it rained almost every day for weeks. When we got up there it was all puddled. It was a place called Camp Murray, Washington, which is part of Fort Lewis now.

From there we were shipped to a place known as Outer Point in the Aleutians. They gave us five sets of khakis and two sets of ODs (greens) because we were supposed to go to the Philippines. After being out at sea for three or four days, we started going north. The next thing you know we're in Alaska. The next thing they put us on this little island, and our job was to build an air base for the American troops.

Unfortunately, what happened was the Japanese had gotten into the Aleutian chain, into Attu Island and so on, and we were drafted into the infantry to help repel the Japanese. On one of these occasions, I suffered frostbite and otitis media as a result of being pinned down by Japanese snipers and was flown back to the United States to the hospital in Fort Lewis,

Washington. From Fort Lewis to Oakland, California where the army had an evacuation hospital. There I was cured. Then I was assigned to the Cow Palace, which was a staging area in San Francisco. Things got rather dull, so I signed up for what they called ASTP, Army Specialized Training Program.

I applied for languages, and asked for Italian and Spanish, and was given Japanese. I was sent to the University of Washington in Seattle. After two weeks, I realized that I could not learn Japanese. I found it very difficult. Then they gave me German, and they transferred me to the University of Utah, in Salt Lake City, Utah where I studied German. Finishing our training in German, we were assigned to a armored unit where we trained in the Mojave Desert. From there we went to a place called Camp Bowie, Texas. I went overseas from Camp Bowie, Texas, and fought in the invasion of France through Germany. When the war ended, I was in a place called Simbach on the Inn River, on the German-Austrian border.

What is interesting about that is that across the river was the birthplace of Adolph Hitler, Braunau, Austria. We were ready to cross into Austria, but the 1st Infantry Unit moved in and we never did have to cross. The bridge was blown up and we eventually went over when the engineers rebuilt the bridge.

I volunteered to stay over in Europe, but unfortunately the invasion of Japan was being planned and they declared us essential because of our armored background. We got transferred to Camp Cook, California where we were forming special divisions to go and make the invasion of Japan. Fortunately for us, but unfortunately for the Japanese, the bombs were dropped on Nagasaki and Hiroshima. Instead of going over there, we were broken up and many of us were sent home. I was requested to set up a separation center and had to stay

three extra months. I volunteered to stay into the army with the understanding that I could go to Germany with the army of occupation. That request was not acceptable, so I got myself discharged with everyone else and went back home.

I enlisted as a private. When the war was over I was a first lieutenant. I enjoyed the military. As a result, I stayed in the Reserves, and was called back during the Korean War for a short tour, never leaving the states. I retired from the Army Reserve as a full Colonel in 1982. That pretty much covers my military life.

I was wounded twice; once blown out of a tank, lost all of the members of the tank crew. I was the only survivor. I had broken legs, shrapnel in my legs, broken jaw. Fortunately for me there was an oral surgeon at the aid station where we were evacuated. He wired my jaw and saved most of my teeth. Instead of having uppers and lowers, I just have a partial. I was very fortunate.

I enjoyed my military career, my service in the army.

WEEKS:

When you came out, I have a note that you were in the export/import business.

GAVAZZI:

Oh, yes. When I came out of the service I went home because my father was ill. I wanted to stay in California, being discharged at Camp Cook, in the town of Lompoc. Now that is known as Vandenberg Air Force Base. I went home, and there was no work. We lived in a coal mining area of Wilkes-Barre/Scranton. My father wanted me to go to work for the Planters' Peanut Company where he had a friend. I went down for an interview and they said I

would have to wear a Planters' Peanut uniform and spend the first thirty days out in front of the store roasting peanuts. Having been in uniform as long as I had, I didn't think that was appropriate. So I told my father that I was going to flip a coin and I would either go to New York or I would go back to California. He said fine. So I flipped a coin. Heads up, I would go to New York, tails, I would go to California. Heads came up, and I went to New York City -- never having been in New York City before.

I went to work for an export/import company on Wall Street. They dealt primarily with South American countries. One day I had to pick up a buyer from Argentina -- pick him up at the Waldorf and take him down to the office. I took him by subway because he wanted to ride the subway. I brought him up to Mr. Stoner, the president of the company. The buyer told Mr. Stoner how much he enjoyed the subway ride. Mr. Stoner was aghast that I had taken this buyer by subway and not by cab, and commenced to tell the buyer about these Americans who served for their country. It turned out that he was anti-military, anti-Catholic, anti-Jew, anti-Protestant. He was an atheist. When the buyer left, I went in very angrily and confronted Mr. Stoner. I told him that if he was a younger man I would beat the hell out of him. With that he fainted on me. I left him in the office and told a secretary that I was leaving and would be back for my money the next day. I came back the next day. I thought I was going to be arrested or something -- didn't know what had happened to Mr. Stoner. I got my pay and that was it. I started collecting what they call fifty-two-twenty, which meant that you could collect twenty dollars a week for fifty-two weeks since I was unemployed. But having lived in Pennsylvania, I had to apply in Pennsylvania, transfer to New York.

So what I did -- making a few dollars playing professional baseball in

the local town of Tuckahoe, New York, we'd get twenty-five dollars for a game if the collections were good.

One day my dad wrote me a letter and sent some mail that had come. Among them was a bill for my insurance, GI insurance. I looked at the address. It listed 252 Seventh Avenue, New York, as a place that I could pay it. I went down there to pay it at the VA Regional Office. That was my first exposure to the VA.

We had to go pay on the seventeenth floor of the regional office. After I paid it I got in the elevator. The elevator was full, and there was one gentleman telling the people on the elevator that the job they had applied for required that they had to take this examination. They got off the elevator on the ninth floor, and I got off with them. We went into this large room, sat down and started taking the exam like everybody else. At the end of the two hours, the gentleman who gave the exam said, "Have you filled out all these forms?" He went one by one. "If you haven't, put your hand up." I put my hand up. It turned out that I put my hand up every time, and I was the only one. So he asked me to stay behind and fill out the forms, which I did. After I filled them out I asked him how soon I could hear about it. He said, "Three or four weeks."

I said, "Well, I need a job now. I'm not working. Don't you have anything?"

He said, "We have a messenger position open, I think. You might be interested in it. Come up with me." So I went upstairs. There was a messenger vacancy which paid the high salary of $1,496. I took it and went to work the next day. Within a few months the results came in. Then I got a regular job. But I was a temporary employee which meant that they didn't take

any retirement out. I went from the messenger job to mail clerk to file clerk to communications clerk. During this time I developed tremendous pains in my legs where I had shrapnel wounds. I had to go see a physician and went to a physician down the road from the regional office who had just retired, gotten out of the military. He was still wearing his uniform. He examined me and said, "You know you have to go to the hospital. I would suggest you go to St. Albans. The VA has beds over there. You are just out of the military a short time, and you can go over there and have it done." So I said fine. I went over to St. Albans.

The first thing they did was take my tonsils out. Then they treated me for my legs. They removed shrapnel, gave me therapy, and kept me there three weeks. During the time that I was getting therapy I noticed how inefficient things were, how fouled up everything appeared to be. I kept thinking there has got to be a better way. That was in the back of my mind and I kept thinking about it. Then I went to Columbia and did my undergraduate work. I was working full time and going to school on Saturdays, and working in the admitting office at night so that I could go to school days and nights.

When I got my baccalaureate degree, I decided to go for my master's. I applied at the University of Minnesota, at Yale, at Northwestern, and at Columbia.

WEEKS:

In hospital administration?

GAVAZZI:

In hospital administration, yes. I still had in the back of my mind the inefficient operation of St. Albans. The VA had contract beds at St. Albans. I was accepted by Minnesota, Yale, and Northwestern. I had letters of

acceptance. But I did not have one from Columbia, and I was waiting to see if I was accepted or not.

One day they brought a class through and the administrator, Dr. Linus Zink called me and said, "Al, the dean of the School of Hospital Administration, at Columbia (Dwight Barnett, physician, administrator, dean of the school) would like to talk to you." So I went upstairs and he interviewed me and said that the reason they hadn't responded to my letter was they he wanted to see me and hear from the administrator what kind of person I was. I said, "Well, I have been accepted by three other schools and I am about to make a decision."

He said, "Well, if you want to go to Columbia, you are accepted." That's how I got into the School of Hospital Administration at Columbia.

One of the first things they told me at Columbia -- Dr. Barnett, whom you may or may not have known, and Clem Clay.

WEEKS:

I was going to ask you if Clay was there.

GAVAZZI:

Clem Clay took over when Barnett left after two years. Clay continued at the school. They said to the entire class, "You cannot work. You must devote full time to your studies."

I had already made plans to work at the hospital from four to twelve on Friday, twelve to eight on Saturday, four to twelve on Sunday, twelve to eight on Monday, so I could get my thirty-two hours on the weekend. Then twelve to eight on Wednesday. I gave it a lot of thought and decided I was going to keep working even though they said you shouldn't. I did. I continued my work, and enjoyed it very much, and was able to get good grades.

One of the things which I would like to mention is the fact that when I finished my master's degree Columbia had a split program. You went to school for six months, then you had a year's residency. Then you went back for six months. So when I went back after the residency, which I served at the VA Hospital in the Bronx and Columbia Presbyterian as well as Beth Israel in New York, because of the fact that I knew the VA the administrator permitted me to spend a lot of time at the Columbia Presbyterian and also Beth Israel. I did this.

I didn't want to serve a residency. I felt that I was the department head and I didn't have to serve a residency. Dr. Barnett said, "You're going to serve a residency or you are not going to get a degree." So I served it. When I came back he said, "Well, what did you think of the residency?"

I said, "It was great. The best part of the school so far was the residency." I realized how little I knew about the complete hospital. I knew medical administration and I knew housekeeping. But the rest of it, except on the surface, I knew nothing about. Then I finished the other six months.

WEEKS:

Did Columbia have pretty good control over the preceptors?

GAVAZZI:

Oh, yes.

WEEKS:

Some of the programs did not, you know.

GAVAZZI:

Columbia had a very good control and this is why Dr. Barnett went to Brooklyn VA Hospital, where I was working, to see what kind of a person Dr. Zink was -- and his assistant Reuben Cohen, who became a life fellow in the

ACHA. When they assured him that they were interested in the educational aspect of the training, he continued the residency and they still have it today. They would not refer a student to any school that the preceptor was not acceptable to them. They controlled it. They visited twice a year. They tried to keep most of the people in New York City, which I thought was bad. They let them go to Strong Memorial, and as far as Albany, New York and New Jersey. Nobody went much farther than that.

WEEKS:

Did they help you get an appointment, a residency, or did you have to do this on your own?

GAVAZZI:

They gave you four choices. Then they told you which one would probably be the logical place to go.

WEEKS:

They tried to fit the person to the preceptor.

GAVAZZI:

As a matter of fact, I gave them an argument because I wanted to go to a hospital in upstate New York, in Westchester County. Then I said I would like to go to Methodist Hospital in Brooklyn.

Dr. Barnett said, "You can't go to either one."

I said, "Why not?"

He said, "I can't tell you. If you want to go for an interview, go ahead, but you will not be accepted."

I went for an interview with Vernon Stutzman, who was with Methodist in Brooklyn, and I got a nice letter saying that I was well-qualified, but that they had already made a selection. I didn't find out until later why. The

board of trustees and the bylaws indicated that the resident had to be of that religious group. I was not Methodist and I was not Presbyterian, so I couldn't go. But he suggested very strongly that I go to the Bronx where they had a physician director who had agreed to take a resident, but he admitted -- he said, "I know nothing about the residency program." His name was Dr. John Hood.

I remember reporting to him and I said, "Dr. Hood, I am Al Gavazzi."

He said, "Fine. Come on in." He closed the door and said, "Now tell me, what the hell is a resident in hospital administration?"

I explained it to him and he became one of the strongest supporters of the non-physician administrator of any one I have worked with. He was opposed to it. He felt that a non-physician could not administer a hospital. But within six months, he became the strongest supporter of the program of any physician I have worked with.

WEEKS:

I think a lot of physicians have felt this in the past.

I was also thinking, when you were speaking about not being a Methodist and not being a Presbyterian, about some of the Jewish persons I have interviewed who said that it was very difficult -- Gary Filerman was one -- that it was very difficult for a Jew to find a job outside a Jewish hospital. It was likely if you were a Jew that you were going to end up running a Jewish hospital. He got out of it. Sy Gottlieb was another person who told me that. In fact, he said that he made quite a study of this with one of the men at the University of Michigan as to what chances he had. He tried to work out the probability factor. First he believed that if he went to a Jewish hospital, he would always remain in Jewish hospitals. He had less chance of getting

into a non-Jewish, but, if he got in, he had a better chance of going farther than if he had stayed in the Jewish hospital.

GAVAZZI:

It was very true in those days -- this was in the 1950s. There was strong feeling. I know, for example, that we had six Jewish fellows in the class and they all went to Jewish hospitals. A guy named John Adams went to Methodist. He was a Methodist. A guy named Don Corey went to the one I wanted to go to in Westchester County, and he was a Presbyterian. But I didn't know this until later.

WEEKS:

Well, they don't say this overtly.

GAVAZZI:

Oh, they can't. You know that better than I do.

WEEKS:

When did you move out of the regional office? I have you down for being there from 1946 to 1950. Is that right?

GAVAZZI:

Yes. Well, that is another story. I was there from 1946 to 1950. What happened, as I indicated earlier, I went to work accidentally as a messenger, then as a file clerk and mailroom clerk. Then I became supervisor of the mimeograph room. They decided at that time to open up more regional offices than they had. They were going to open a regional office in Albany, in Brooklyn, and in Buffalo. Everything was in Manhattan -- the Manhattan regional office. So they permitted us to put in overtime, as many hours as we wanted, to pull the files of the veterans by geographical area that they were located in. It was during this period that they had a racket going on whereby

you and I would alternate. I would put in four hours on Monday, you would put in four hours on Tuesday. I would go home, and you would sign out for me. All you had to do was sign in, then someone else could sign out. Of course what I didn't know was that they kicked back to the supervisor of the overall unit.

I refused to go along with that. He got ahold of me one day and said, "Why won't you partake in what everyone else is doing?"

I said, "I don't believe in it. I think it's unethical. I believe in being paid for what I work and no more."

He said, "You're just another one of these goddamn GIs."

With that I just beat the hell out of him between the files. They pulled me away from him. He was bleeding, laying between the files. They told me I had better leave. So I left, went home. I lived in an apartment on West 67th Street that didn't have a telephone. There was no way they could reach me. One day a week later I got a telegram delivered to me to report to the regional office to meet the manager, Mr. E.B. Dunkelberger. I thought I was being fired. I went down there anyway and went to the seventeenth floor where the manager was. I told the secretary who I was, and she looked at me and smiled. When I was a messenger I knew all of the secretaries because I was bringing mail. She said, "Don't worry." But I was worried.

I walked into his office. He closed the door. He was a big, bald man with big eyebrows. I was scared stiff. He closed the door and came around and shook my hand. He said, "I want to congratulate you for doing something I was hoping somebody would have done earlier. We have to transfer you. We can't keep you here. We're going to transfer you to the branch office at 346 Broadway." Fine. He said, "That's as of Monday. Of course you have been on

leave without pay all of this time, so you can't be paid. But if you want to sign for sick leave, we'll let you sign sick leave so that you don't lose any pay."

So I said I would like to sign up for sick leave. There were only four or five days involved. So I reported to the branch office at 346 Broadway, and realized that I was promoted. I spent a year and a half at 346 Broadway where I was chief of their publication division.

Then the decision was made to close all of the branch offices. There were thirteen throughout the United States. They cut the staff down from 6,000 employees to something like 1,500 employees. On the walls they had RIF letters by category, by grade and by category. You looked and you saw what was happening. In the meantime you were getting a letter indicating you were riffed effective a certain date, and you had a choice to bump someone else. This went on for four days. I kept getting these letters, one or two letters a day, telling me that I was riffed and rehired, riffed and rehired. I decided on Friday morning that I was going to go home and spend a week at home.

I took a week's leave. Went home. In the meantime someone told me that I should establish service connection for my disability which I had. The records were there with my hospitalization at St. Albans. So I guess they got these records. I came back and found out that the guy who was my supervisor was riffed. I became the supervisor of another unit.

It was at this time that they were opening up the Brooklyn VA Hospital. They were going to close the hospital known as Manhattan Beach and Staten Island. Dr. Linus Zink and Reuben Cohen and John Sheehan called me up and said, "Would you set up the communication program for a VA hospital? We are

going to get a tube system in there. You are going to school, and we think you can probably do something about that."

I said, "Sure." I knew publication. I ran a publication program. So I reported at Manhattan Beach because Brooklyn was still under construction. Then in February, 1950, we went to Brooklyn. We opened up the Brooklyn VA Hospital. That even more intrigued me to go into the health care field.

Here we had this beautiful sixteen-story building and we were taking patients from Manhattan Beach, which is near Coney Island, and from Staten Island, which is across the water -- the narrows. Patients were coming. We had beds, no mattresses. We had tables and no chairs. In the dietetics area they had these big cooking units with water in them. When we tried to let the water out there was no hole in the floor for it to drain. The drain was there, but they had cemented over it. It was a mess! We had these veterans coming in, and we were embarrassed. Finally we decided to bring the mattresses with them. We brought everything from Manhattan Beach and Staten Island so that we could take care of them. Then months later we had to get rid of it -- get it back to Staten Island and Manhattan Beach when the new stuff came. So that was my first really true exposure to health care.

Previously, the regional office handled benefits; the branch office handled insurance -- they had responsibility for veterans in the state of New York, the Virgin Islands and Puerto Rico. That's what that branch office did. And there were thirteen throughout the country at that time. When they closed them, they closed them down from thirteen to five. Then five to three. Then three to one. That's when I went over to the hospital. That was my first exposure to health care.

WEEKS:

In the meantime you got your degree in 1955 -- your master's degree.

GAVAZZI:

I graduated in 1953. That's when I was working in the admitting office on a different schedule which permitted me to get my undergraduate degree, and then started my graduate degree in the September of 1953.

WEEKS:

After graduation with your master's degree, is that when you went to the Kecoughtan-Hampton, Virginia VA Medical Center?

GAVAZZI:

Yes. It was originally called Kecoughtan, occupied by the Kecoughtan Indians and where John Smith first landed before continuing on to Jamestown. There is now a historical statue in front of the VA center marking the landing spot.

WEEKS:

This was your first experience as an assistant administrator, wasn't it?

GAVAZZI:

Correct.

WEEKS:

Is there anything you want to tell us about Hampton?

GAVAZZI:

Yes, because I learned a great deal at Hampton. It was one of the oldest facilities built by the government. It was built in 1869, shortly after the Civil War.

WEEKS:

By the Public Health?

GAVAZZI:

No. It was a federal hospital at that time, not public health. It was used as sort of a domiciliary facility for the the disabled people who had fought on the part of the North. It remained that for many, many years. The thing that I learned was the fact that when I got there everybody wore a uniform, and they had a rank. The manager was called the governor. The assistant manager was called the colonel. Everybody had a rank. I got down there and was wondering what rank I was going to have, but fortunately, before I got there, they abolished the uniform system. The interesting thing I learned about that was the inbreeding. The people had worked there for years and years. They looked upon the administrator as someone who was temporary and how long would he be here? Three, four, five years?

The administrator was a guy named Reuben Cohen, whom I had worked with at the branch office. He was a Jewish boy, in a Baptist belt, trying to break up an informal organization. The quality of care was awful. The patients, if they lived it was because of the fact that they weren't destined to die. It was a hospital and it was a domiciliary. I learned about the informal organization. The informal organization was very strong. I went down there as a single, young guy, and started bowling with the group, and pretty soon I was accepted by the informal organization. Although I was part of the front office, some people tried to use me, but others were telling me how long Mr. Cohen would stay and how long the assistant would stay, and how long the chief-of-staff would stay, and so on and so forth.

Reuben Cohen was bent on getting rid of all the old-timers and bringing in some new blood. He and I worked together with the personnel officer. What we did was to get a lot of people to retire -- those that were not cutting the

mustard. We got the informal organization to work for us. We decided we weren't going to fight it after a while. I told him we can't lick it. He said, "I know we can't. How can we do something with it?"

I said, "Let's try to get it to work for us. Use me as the medium. I'm the young guy. I'm single, and I can get around with the girls, get a lot of information from the secretaries. And the nurses, who are hard-working people." So within a year and a half we got rid of most of the incompetents.

Then, instead of saying how long is Mr. Cohen or Al Gavazzi or so on going to stay, the question came up, we'd better work with these people because if we don't they are going to get rid of us. That was my lesson on the informal organization. It was great. It was better than my master's. I learned a lot more.

WEEKS:

It must be quite different being in a hospital of that type from being in the average community hospital.

GAVAZZI:

It was not a teaching hospital. The people went there to retire. It was a beautiful area, right off Hampton Roads. Everybody fished and everybody played golf. It was a beautiful place to retire.

WEEKS:

The next stop I have for you is going to Chicago. Do you want to talk about the research? And you met your wife there too, didn't you?

GAVAZZI:

I got a call one day saying would you like to go to Chicago because Chicago Research Hospital was having a lot of problems. They were having tremendous turnover. The medical school was moving directors left and right.

Nobody stayed more than two years.

WEEKS:

Was this Northwestern?

GAVAZZI:

Yes. Northwestern pretty much ran the VA hospital. If you didn't work with Northwestern, you left. The directors had been there only a short time. I was asked if I would go up there. They needed somebody up there to sort of bring the relationship between the university and the VA closer together. I would be going up there as an intermediary, and they were going to clean house, and I was going to remain to carry on while they were cleaning house. I agreed to go. I was still single.

When I arrived, I met the administrator, George Leiby, a physician. Ray Q. Bumgarner was the associate administrator, followed by a fellow named Malcolm Randall. When I got there I thought I was going to have quarters because the sixteenth and seventeenth floor were quarters. Correspondence with them, after I had gotten my order to transfer, had been that I would have quarters. When I arrived, Dr. Leiby told me that I would only have quarters for a couple of weeks. Ray Q. Bumgarner said, "Don't worry about it, Al. We'll take care of you. There's something we can work out."

I got there about three o'clock in the afternoon. About 4:15 is when they told me where my room was. They gave me the key. I pulled my car in, moved my stuff in. At around six o'clock I went to eat, and a young dietitian was there who refused to feed me because she didn't have my name with the meal ticket. The meal ticket had thirty-one days. It had breakfast, dinner, and supper. They would punch the ticket. She had a machine in her hand to punch the holes in the kardex. Not having my name on it, she wouldn't feed me. So

I signed a slip. The next morning, lo and behold, the same young lady was there and gave me the same argument. Later that day I met her and told her that I did work at the hospital. With that she appeared to be crying. I found out later that she wasn't crying but that she was wearing contact lenses and they were bothering her. This was the beginning of my courtship with my future wife. We are now married twenty-nine years.

An interesting thing about Chicago Research is the fact that it was pretty well run by the medical school. Some of the interesting things that went on -- one day, around the 17th of December, the administrator, Dr. Leiby, came and said, "Al, I'm going to Africa." He was surgeon for the National Guard for the states of Illinois, Indiana, and Wisconsin. He said, "I'm leaving you in charge."

The week before, the assistant administrator, newly appointed, Malcolm Randall, went on leave to get married in Spokane, Washington. There I was left holding the bag. The chief-of-staff had just been reassigned to Hines. Nobody wanted to be acting chief-of-staff. I had no one to work with me as the assistant and I was left completely in charge of the entire medical center.

On the 23rd of December, I got a phone call about ten o'clock at night from the Maywood Funeral Home out near Hines, Illinois, telling me that a very unhappy family, from Detroit, was leaving his mortuary because the man that was there was not the husband of the lady who had come from Detroit. I had better have some answers. So I quickly checked the morgue and found out that we had three autoposies performed the day before and that day, and found out that one had been buried, and one body was on its way to Springfield to the National Cemetery, and one body was at Maywood. So I called the pathology

resident and said, "Did you do a post today?"

He said, "Yes, I did. One early, two later. I did three all day."

I said, "The two that you did, were they black?"

He said, "Yes, they were all black." So I asked if he checked the tags on the two that he did in the afternoon. He said, "No, I didn't."

"Did anyone check the tags?," I asked.

He said, "Well, I assume the autopsy aide did that."

I said, "Okay, fine. Can you come down here and tell me what happened?" He lived in Evanston.

In the meantime, I went to the admitting office and checked the records, and found out that perhaps the one that was on the train to Springfield might be the wrong one. I got ahold of someone over at the railroad -- fortunately a very helpful guy -- and told him what had transpired. He said they could get the body off in Pontiac, Illinois when the train stops in Pontiac. I said fine. When you get it back in Chicago call me and I will come and get it.

The physician came down and checked. He remembered that one was of lighter skin than the other. He had spoken to the morgue attendant who said that the tags did fall off, but he thought he put them on the right toes.

In the meantime the family comes in -- big, burly people, blacks. They called me everything under the sun. I could make no response other than to say "I'm sorry." Finally the oldest son said, "If you don't get that body at the Maywood Funeral Home for the funeral tomorrow, I will go to the Chicago Tribune."

"Yes, sir, we'll have your father's body there."

At five o'clock in the morning I got a phone call from the railroad that the body was there. I called the undertaker, told him what I was doing. I

got an ambulance, got an aide, went to the railroad. We removed the body and put it in the ambulance, took it to Maywood, left it there, took the other body out, put it in the morgue. After I got it in the morgue, it suddenly dawned on me. What if I had had an accident? All sorts of things could have happened. I was in charge of everything, but I should have gotten authority. Everything worked out fine. That was one of the greatest experiences I had.

Another experience from another standpoint is that they moved me into a room that had two beds and a connecting bathroom. On the other side were two young nurses from Iowa who had reported for duty the week before. We shared that bathroom, and I was instructed very precisely to make sure that when I went in there I would lock their door so that they wouldn't come in on me. One morning several weeks after I was there, I was in the dining room having breakfast and a gentleman by the name of Richard Davis joined us at the table. I was talking to a couple of people about the fact that I was having difficulty finding an apartment and I had to move out. He said he had a room with two beds and was seldom there because his father lived just a few blocks away and he used the guest room. Why didn't I move in with him?

So I said, "Fine."

Richard Davis happens to be the brother of Nancy Davis who is the wife of Ronald Reagan, our present President. He and I became very good friends, still communicate with each other.

Another thing I learned about Chicago Lakeside is the fact that it was set up as a research hospital. After a year of being unable to get patients for research patients only, they agreed to take outpatients because they could not continue the hospital at low occupancy rate with the demand that was not there, since people were reluctant to go to a hospital known as research

hospital. The medical school pretty much told the VA hospital what they would do and would not do. There was tremendous turnover among directors, associate directors, and chiefs-of-staff. I was there three years. In those three years we had three directors, three associate directors, and four chiefs-of-staff. I found myself in charge quite a lot. The one person who turned it around was the first non-physician director they had, a fellow named Dan J. Macer, who was able to bring the medical school to work with the VA rather than tell the VA what to do.

The way he did it was a lesson in itself. The way he was able to win the dean of the medical school; the chairman of the department of surgery, a gentleman named Loyal Davis, the President's father-in-law, a very strong person and an individualist; John Cooper, who was part-time with the medical school and part-time with the VA; Dan Ruge, who was assistant to Loyal Davis and who later became the President's physician. These people suddenly, instead of being against the administration, began to accept the administration and work through the administration, and work very closely with the hospital in getting things done. It was the first time I saw this happen in a teaching hospital. It was a great lesson.

Working with the different chiefs-of-staff was something in itself. They just came and in six months or nine months they were gone. Very topnotch physicians, but individualists who did not want to give into the medical school. They wanted to run the VA as they saw it. Not until Dan Macer and a guy named Schlussel, from Detroit, a physician, born and raised in Detroit, went to medical school there, came did the hospital become independent of the medical school. Maurice Schlussel was a Jewish physician who trained here. He was a bachelor. In his apartment he had speakers all over. He loved

music. He had twenty cases of records when he moved in. He came from Portland, Oregon. He worked with the medical school and got them to work beautifully.

WEEKS:

Up to this point even, you had met a lot of interesting people.

Well, we have you married now, and we have you leaving Chicago. What sort of medical center was Dwight, Illinois?

GAVAZZI:

Dwight, Illinois was a 215 bed hospital located in Dwight where they had, during prohibition, the Keeley cure. The Keeley Institute is the only thing famous in Dwight.

WEEKS:

Is Dwight a suburb of Chicago?

GAVAZZI:

Dwight is sixty-eight miles southwest of Chicago, right off Interstate 66. The population of Dwight when I was there was 3,100. Two years ago I was there at a reunion of the people who had worked there, and it was 3,500. It is a small farming community. The biggest employer of Dwight was the VA hospital which employed 375 people. The only other big thing they had there was the women's reformatory which employed 75 people.

It was an interesting assignment because of the fact that it was a small hospital where I got involved in everything. Some people had been there since 1931 because the VA hospital was the Keeley Institute. They closed it during the depression and reopened it because of political pressures brought on by a gentleman by the name of Dirksen, who was rather powerful in that area. He was a Congressman at the time, they tell me. They closed it and kept it

closed for about eighteen months then they reopened it and made it a VA facility in 1932.

The secretary to the manager at that time became the fiscal officer. She went from a GS3 to a GS12 in her career. She controlled every penny.

This is an interesting story because I went down there, and my predecessor lived in quarters. Most VA hospitals have quarters for the key staff. I had just gotten married about a year and a half. We had a youngster and another one on the way. I lived in Rogers Park, north of Chicago near Evanston. I was transferred down there in February. It was a miserable day. My wife and I went down there to look at the quarters. When we got down there we realized that the guy who lived in the quarters had lived there eleven years. He was a physician. My going down there and moving him out would have been inappropriate. Plus it was in a very busy area. Dwight, Illinois has four blocks in one direction and two blocks in another. That's the main part of town. The railroad runs right through it. The hospital is right across the street from the railroad. It was very noisy. Trains went by all the time. I decided that I did not want to move this physician out. I felt that I might create a lot of problems for myself.

The associate director who was moving out had a house about three blocks away. He drove his car to work every day. We decided to rent his house when he moved out. We bought some of his furniture because he had too much, and we had very little furniture.

So when I reported down there I would walk to work in the morning. As I would walk down the three blocks that I would go I would see the shades going up and people looking at me. After we were there two months they had a party for us. There were only two recreational things you could do in Dwight in the

winter time. That was go to the American Legion on Friday night where they had a fish-fry, and go to the VFW on Saturday night where they had a dinner and dancing. The following week they would reverse. The VFW would have the fish-fry and the American Legion the dinner. For other recreation you had to go to Springfield, Illinois, or go to Chicago.

They had a party for us at the VFW. The mayor of the town welcomed us officially. He said, "Al, we thought when you came down here you were part of the Mafia and were ready to take over Dwight, Illinois."

I said, "Oh, that's why people were pulling their shades and looking out the window as I was going to work in the morning or walking home for lunch and so on."

He said, "Yes. They wondered what kind of an oddball you were that you would walk to work instead of riding to work like your predecessor did."

I told him I didn't think it was worthwhile, plus the fact that I only had one car and my wife needed it. They said that made friends for you. Everyone accepted you. That's why we are having this party for you. It's the first time we are having a party for anybody in your position in the medical center. They were wonderful people. I didn't play golf up until that time. All you could do there was play golf and go to the two places I mentioned, and go hunting during the hunting season. We were there four years, four wonderful years.

One interesting story I would like to tell you which happened there was the fact that there was something we were having difficulty with with the city. The road behind the hospital was used for parking by everybody. What we wanted to do was make it parking for the hospital. That, of course, required the city council approval -- if you could call Dwight a city. And

the mayor's action. One day I was in the laboratory talking about this problem to a lady there who was one of the solid citizens in the area. This little, old lady said to me, "I can help you." She was a glass washer. I said, "You can?" Her name was Stevenson, but there are a lot of Stevensons in Dwight. It is primarily a Norwegian and Danish community. She said yes. I asked how she could help me. She said, "Oh, my son is the mayor."

And she did. Her son and the council -- the member of the council that worked for us in the laboratory that I was talking to, with the mayor, got the council to approve it. But it took eleven years to get this accomplished. For eleven years it had been hanging and nobody would take any action. I was able to accomplish it through this little, old lady who was the mayor's mother. It was great. Dwight, too, was a very strong, informal organization. I was able to work with them. I joined, for the first time in my career, the American Legion, the VFW, and when I left they made me life member of both the American Legion and the VFW. They paid my dues for the rest of my life. I enjoyed it, and made a lot of good friends there.

WEEKS:

That's wonderful experience. I've lived in a small town a couple of times.

GAVAZZI:

Great people, aren't they?

WEEKS:

Great people. But as you say, there is that informal organization.

GAVAZZI:

If they accept you, it's all right.

WEEKS:

Then you left Dwight for Washington. Is that right?

GAVAZZI:

Mount Alto, yes. It's on Wisconsin Avenue. It is now where the Russian embassy is.

I got a phone call asking me to go to Mount Alto. I didn't know where Mount Alto was. As you know, our central office assigns people. They will call you and say, "Lew, we would like you to go to Saginaw or Los Angeles." You have a choice. You can say no, but then you are dead. I didn't want to die in Dwight, Illinois. It was a great place to be but not forever. My wife was a city girl. I grew up in a small town, but I knew she wasn't happy there. The only thing nice about it was we could see her family every other weekend or so.

I said, "Where's Mount Alto?" They said it was in Washington. I said, "I only know of Spokane and Seattle." Not that Washington -- Washington, D.C. I said I wanted to talk with my wife, but I was sure she would be happy to go. I asked Nancy how she would like to go to Washington, D.C. She said she would love it. It would be great.

We reported to Washington, which was an old hospital. It used to be a girls' school, and was given to the VA in the 1930s. It was a teaching hospital tied in with Georgetown and George Washington University School of Medicine, as well as Howard University School of Medicine. There were a series of four buildings connected by corridors and a fifth building by itself. There was an old army mess hall that they had moved in the back which were quarters. I was offered those quarters, and we took them. We had a huge back yard for the kids to play. By this time we had our third child. I

reported for duty and found out how many people that were working for the central office were actually housed out there. That was my first experience with that kind of a setup where we had seventy-five people that were not actually working at the hospital, but they were either housed or they were on our payroll. For example, the Armed Forces Institute of Pathology at Walter Reed, we had sixty-one employees working out there. They were working for the Armed Forces Institute of Pathology. They were really not working for the VA. I had no control over them other than the fact that we hired them. We saw them when they came aboard. We saw them when they did something wrong. We paid them every two weeks, and so on and so forth.

We were only four miles from headquarters so we had headquarters people on our back all the time. At that time, a gentleman by the name of William Middleton, a physician, was the chief medical director. He used to come out every Thursday to have a class with the residents. Dr. Middleton would come out and make rounds. Every once in a while I would have to take him to his apartment -- he only lived a mile away. I got to know him fairly well. He was a dedicated physician, good administrator, very much interested in the quality of patient care and teaching.

While at Mount Alto, I learned how to work in a patched-up hospital because a new hospital was being built, located at 50 Irving Street, which is in the center of the District of Columbia. Originally, they were going to replace the Mount Alto Hospital and build it in Rockville, Maryland. But the people in Rockville raised so much Cain that it never did get built. Then they were going to build it in Arlington, Virginia, near Arlington Cemetery. They objected to the fact that it wouldn't be wise to have a hospital overlooking the cemetery. The politicians decided that it should be in the

District of Columbia, so they decided to build it at 50 Irving Street NW.

They brought me there to the Mount Alto Hospital to help open the new hospital, so they told me. I was very much involved from the ground breaking up through the construction. It was while I was at Mount Alto that four of us, the director, the chief-of-staff and I and the chief engineer were over at the present VA hospital walking through the basement when word came that President Kennedy had been fatally shot in Dallas. I can remember distinctly that one of the workers had a radio on. He heard it and he came out and said, "What does fatally shot mean?" We said that he was killed. He said, "Oh, my God." And he started to cry.

We were making a tour to look at where we were going to put certain activities. We decided to stop it right there. We went back to the hospital, and I can tell you honestly that I have never seen people so saddened. Nobody wanted to work. Everybody was just in shock when we got back to the hospital -- physicians, nurses. It happened while I was at the Mount Alto VA Hospital.

I learned an awful lot about building a new hospital, keeping an old one going, patching the leaks and everything else. It was a great experience.

I left there and went to the headquarters office as Associate Director for Construction. I was called into the headquarters office one day and asked to come to central office to head up the construction program because the people who were building hospitals were engineers. The Corps of Engineers had been building our hospitals with no input from the people who have to work in them. As a pharmacist, you would have no input on the pharmacy, on how it should be built.

The chief medical director, Joe McNinch, a retired general from the army brought me down there and interviewed me. I told him that I was uninterested

in going downtown, that I felt that I should stay where I was to open up the new hospital, and that there were many better-qualified people than myself. He told me that he wanted the person who would come down there to bring people who had hospital experience and to make sure that the people who were going to use those hospitals had an input on how they were going to be built and what was going to be in them.

I said, "Doctor, I am not interested. I thank you for the honor."

He said, "Welcome aboard, Gavazzi."

I turned to Dr. Zink and said, "I don't think he understood what I said."

He said, "You don't understand what he said."

I said, "What do you mean?"

He said, "He's just ordered you into central office."

I went down there -- it was a promotion. I did bring in people with field experience to develop plans for hospitals. Did set up a criteria unit that would develop criteria -- how much space you should have for your pharmacy and so on. During this period, we were directed to close thirty VA hospitals. We were told to make a list. We got committees together from all over the VA, and came up with a list of thirty. We sent it to the congressional committees who sent it back saying no, no, no. Another list was sent forward. Finally a list of fifteen was arrived at. Among the fifteen was Dwight, Illinois, where I had worked.

But we did close those hospitals. It was prior to the closures that the administrator Gleason, who was from Chicago, was a commanding general of the Illinois National Guard, a personal friend of Jack Kennedy. He and President Kennedy had gone to Georgetown Prep, and they were classmates. They knew each

other well. One day I remember we were brought over to the White House to make a presentation to the President, to his chief-of-staff, on what impact the closing of hospitals would have. As we walked across Lafayette Park from the VA headquarters, Dr. McNinch, who wore half glasses, General John Gleason, and I — I was walking and carrying all the support papers, they were walking ahead talking. General Gleason turned around and said, "Gavazzi, I don't want you to say one word." I had been talking to him about keeping Mount Alto open as a nursing home. I did not know that it had been committed to the Russians for their embassy.

We walked over to the White House and went to the oval office. General Gleason mentioned the fact that these hospitals were going to be closed. The President said, "Are you sure that we are not going to get too much of a reaction?"

General Gleason said, "I have the reassurances of the service organizations and everyone that we are not going to get too much of a repercussion."

With that the President looked at me and said, "You haven't said anything, Gavazzi. What do you think?"

I said, "Sir, all hell's going to break loose."

The President looked at me. Gleason's face got red, McNinch had his glasses coming down and he puffed on his pipe. Then I gave my reason. Having come from Dwight, Illinois, I know the impact of closing Dwight. Economically, it was going to be a real tragedy for that community. Gleason said we would give it to the state. I had made my point. Then I said, "Mr. President, Mount Alto would make a beautiful nursing home for our patients when we build a new hospital."

I thought Gleason was going to have apoplexy. The conversation went on a little bit longer. I didn't have any more to say. We walked out. I was the third man carrying the same stuff. We got half way across Lafayette Park and the administrator turned around to the chief medical director and said, "I want to see Gavazzi in fifteen minutes in my office."

I thought sure as hell I was going to get fired. We got over to the building and took the elevator up. We got off on the eighth floor. The administrator went up to the tenth floor. I went into my office, dropped those papers, and went back by Dr. McNinch's office. I said, "Doctor, are you going up with me?"

He said, "Hell, no. You go yourself."

I went upstairs to the administrator's office. He closed the door and asked what he had told me about keeping quiet. I said, "Sir, I had to respond to the President. I can't say to the President, 'I have nothing to say.'"

Then he told me that a commitment had been made concerning Mount Alto and that I should never bring up the suggestion of a nursing home there. That was it.

I left his office. When the decision was made to close those fifteen hospitals, for the next six months we got mail by the truckload. From third graders -- each student in a third grade class, from places like Clinton, Iowa; Miles City, Montana; Bath, New York; Dwight. All of the places that were listed for closures. The corridors, from the first floor up, were just stacked with mail. The decision was made to respond to them all. Certain levels, depending on whom they were addressed to, certain levels of people would respond to them. It was one hell of an experience, I'll tell you.

Then the administrator, Bill Driver, went all over to visit each site, at

the request of Congress, to reassure them that the state would take them over, that people would not lose their jobs. But in a couple of places they nearly lynched him -- Dwight was one of them. He went to a place called Fort Bayard, New Mexico, an isolated old army hospital. The only employer they had in that area of any size then. The helicopter landed and took off again, because the Indians were ready to take his scalp he said. It was a tough deal. Dirksen made it a vendetta to get the administrator, and he did. Gleason left, and Driver took over. When Driver took over they made life so miserable for him that the only person who saved him was the President, Lyndon Johnson, who was very fond of him. But when Lyndon Johnson decided not to run, Driver was removed from that job and made administrator of Social Security. Everyone of us that were involved in closing those hospitals was affected. The chief medical director had to leave before his time was up. I was shown a map of the United States and asked, "Where would you like to go?" I went to Martinsburg, West Virginia. Tremendous experience, but I wouldn't want to repeat it.

WEEKS:

I should think not.

GAVAZZI:

If they close hospitals in small towns, that was for economy. As far as health care, that was the only health care that community had. For example, Dwight. The nearest hospital to Dwight was in Joliet, Streator, or Pontiac, each one thirty miles away.

WEEKS:

Could you give emergency care to community people?

GAVAZZI:

Oh, yes. We did. Emergency care we would give and then they would be transferred to another hospital. Accidents off Interstate 66 would be brought to us. We even delivered babies. If they came to the hospital, we delivered them, then we transferred them.

WEEKS:

Now you are in Martinsburg. And you are the director there?

GAVAZZI:

Yes. My first directorship.

WEEKS:

Is there anything you would like to say about Martinsburg?

GAVAZZI:

I was directed to go to Martinsburg by Bill Driver. Before I went he said, "I want you to go up there and determine whether we should close Martinsburg or replace it."

The hospital was built in 1942 for the military as a rehabilitation hospital. It is located seventy miles from the District of Columbia. It's thirty miles from Hagerstown, MD, twenty-five miles from Winchester, VA -- the only sizable cities. It's in a beautiful location, but miles from anything. It's too far away to get a teaching program with the universities. Before I went there I had learned enough to make sure I went to see the senators and congressmen from that area. I learned during the closure of the hospitals how important they were and the role they played.

I went to see Congressman Staggers. That was his congressional district. I went to see Senator Jennings Randolph and Senator Robert Byrd, who were the two senators from that state and very strong with the veterans' groups. I was

also told by the administrator that I was to remove the Quonset huts there which were built for POWs, Italian and German POWs who were there during World War II. They had built these one-story, long Quonset hut type facilities. So I told both senators and congressmen that this was one of the things, that I would have to move some thirty-five to forty families out. I said of course they'll move out into the community, they'll pay taxes to the community, it will benefit the community. They said fine. We'll write letters to our constituency, but you respond to the letters as you would any normal letter. Only if we call you personally do we want you to take any action. We're going to leave you alone. I was told to close them in six months.

It took me eighteen months. A lot of flack, a lot of letters. But we did close them. They were firetraps. Because of its location, and we needed quarters to attract physicians to that hospital, we laid the groundwork for a replacement hospital. The final construction was done just about a year ago. We built a 360 bed hospital, 200 bed domiciliary, 180 bed nursing home. Brand new, the whole set up.

You might remember that President Ford designated replacing or building eight new VA hospitals. Martinsburg was the last one because a guy by the name of Robert Byrd went to the President and said we need Martinsburg. So, instead of being the eighth, it became the first one to start replacement. It is a beautiful operation. It was built there primarily because of Robert Byrd and Jennings Randolph of the Senate.

WEEKS:

I am trying to think of Jennings Randolph. Didn't he come in on a crucial vote? Was this Medicare?

GAVAZZI:

Yes, Medicare. He was the vote that went in favor of it. Also Social Security. Back in the days of Social Security.

WEEKS:

And both of these incidents were at quite a professional risk at his own side, weren't they?

GAVAZZI:

Yes. He nearly lost the election the second time around. A tremendous guy, very dedicated. He left last year at eighty-seven or eighty-eight years old, and is still doing well.

WEEKS:

That's wonderful!

After Martinsburg you went back to Washington, didn't you?

GAVAZZI:

Back to the headquarters office, yes.

WEEKS:

Is that on Vermont Avenue?

GAVAZZI:

Yes. Here again, I didn't want to go. I was very happy in Martinsburg, and I wanted to go to Wood, Wisconsin. I had been promised Wood. Driver said I could have Wood. Unfortunately, a political maneuver developed where a man from Detroit, a guy named Leon Wallace, a black insurance person, politically strong in the Detroit area, wanted to be a director. So the only place that was acceptable to the service organization was Wichita, Kansas. So in order for Leon Wallace to get Wichita, Kansas, they had to move the guy from Wichita to Wood, Wisconsin. So I didn't get to go to Wood, Wisconsin. I was all set

to go because my in-laws lived only thirty miles away in Lake Geneva, Wisconsin. My wife is an only child so she wanted to get closer to her parents.

Anyway, I was interviewed, and told them I wasn't interested in the job. I gave them six other names of people who would be interested in being the executive assistant to the chief medical director, which is the top non-physician job in the VA in the Department of Medicine and Surgery. I went back to Martinsburg and called Bill Driver and told him that I didn't want to go to central office. I wanted to go close to the Milwaukee area where my wife's family was since she was an only child. He said, "Al, I'm sorry we couldn't help you on Wood because of what we had to do with the man in Wichita."

I said, "I know, but I don't want to come back to central office." I felt everything was dead. I was willing to go to Madison or Hines, any one of those. Nothing happened for about two or three weeks. Then I got a call again to go back to central office. This time I was to have lunch with the chief medical director and the administrator, Bill Driver. I reported to the chief medical director's office. He wasn't there. The secretary told me to wait. Pretty soon the administrator and the son-in-law of the chief medical director came and said let's go to lunch. I thought maybe this young fellow would throw a different light on it.

We went to the Black Angus Restaurant near the White House on Lafayette Park, and we talked about everything other than my coming down there. Then Bill Driver said, "Al, I know you may not want it, but it will be fun working with you again."

I looked at the chief medical director. He said, "Hal, (Hal Engle, M.D.)

didn't you tell him?" We got back over to the central office and the chief medical director brought me into his office and called in his deputy and told him to get the paperwork done for me to come into central office.

I said, "But, hell, I don't want to come to central office."

He said, "It's our decision where you will work." They are right, it's in the regulations.

I said, "Jiminy Crickets, I've been here once before for four years."

They said they felt I was the man they wanted in there, I had been all over, had a lot of experience, been at central office before. They felt they needed someone like me to bring all the directors together and associate directors together and so on and so forth.

I went home and told Nancy, my wife, that we were going back to Washington. I thought she would throw a fit. We had been there four years. She didn't throw a fit. The next day I was walking -- the house we lived in was on the station and just about 250 yards from the headquarters building -- I was walking towards the house and I heard whistling and singing at the home. I thought I hadn't heard that for a long time. I got to the door, and she was whistling and singing away, happy as a lark. Three of the kids were out in the yard playing. They hadn't seen me. I walked in and said, "You didn't like it here, did you?"

She said, "I hated it." For four years she had lived there, didn't say one word about not liking it. I thought that was the greatest compliment that a wife could give a man. She was very happy to go back to Washington. There had been no family life. The hospital was ten miles from town. The only people that were there were the people who worked in the hospital. We had twenty-five quarters for doctors primarily. They were all older than we were.

We had young kids, and I'm sure it was very bad for her. But she never said a word. I thought that was a great thing.

WEEKS:

What did you do when you got back to Washington? What did this job entail?

GAVAZZI:

It entailed many things. First of all it entailed bringing the whole department of medicine and surgery to focus together towards one mission, taking care of patients. There was the chief medical director and the administrator, I was the in-between. I was the unofficial non-medical administrator and chief medical director at the time. I signed his correspondence. After a while he said, "I want you to sign my name to all of this correspondence." It developed where I could sign his name so well that he didn't recognize his from mine.

One of the things that I am proud of having done is the fact that I set up a continuing education program and a management development program, so everybody could get into management, but they had to meet certain criteria. I also set up a rotation system whereby the directors and associate directors and department heads should move every four years because of the fact that management of hospitals, like everything else, is so dynamic, that you become stale in one spot unless you happen to be in a very active place. We set up a program whereby your first assignment would be at a small hospital, as an associate director. Then you would move into a medium size hospital, and then you would move into the large hospital. Each one would have a grade progression. You got more money as you moved up the line. In this way you were better prepared to handle your job.

I also brought into it professionalism, where we didn't demand it, but we said, if you belong to the ACHA, the College, and attend their seminars, you are keeping up with your peers in the private sector — and you cannot isolate yourself in the VA, you have to work with the private sector and work to take care of the health care needs of the people regardless of whether they are veterans or not. We have to share. We would say you could go to seminars. If you want to go to the American Hospital Association convention, unless you are a member of the ACHA, you cannot go at government expense. Even then, you have to get approval. But if you are a member of the ACHA, or another organization related to that, you can go and have your way paid. In promotion it counted. It gave you so many points. If three people equally qualify and one was a College member, one was a nominee, and one wasn't in it, the person that was the member would get the job. Everything else being equal, that one got the job.

After a while we got people joining ACHA. Prior to that the VA was isolating itself. They would not get involved at the hospital across the street, the hospital down the road. As a result, it wasn't good. It was bad because you didn't share the physicians or the equipment and so on. We started a sharing program where, if you didn't have a linear accelerator and you wanted to use ours, we would have a contract. That way you didn't have to send your people fifty miles away. They could come over there, and you reimbursed us. Or if you had something that we didn't have, we would send people to your place. That way there would be no money involved, but we would take care of the patient. That is one of the things I am proudest of having accomplished.

Plus, we established a program whereby we sent a large number of our top-

notch, young executives to get their master's in hospital administration. We sent quite a few. Al Zamberlan is an example. He is in this area. The first year we sent twenty-six, then we sent ten. Then, after a while, we were getting young graduates that wanted to come to the VA, having paid their own tuition.

Another thing I did was to make it possible for residents who completed their training with the VA, if they were good, they did not have to apply and get on a register, and be picked from the register. If they were acceptable to you as the administrator, you could take them and employ them as an administrative assistants. Without going through the whole rigamarole. That worked out. It is still working out very well. We got some bright young people right out of the private sector who had been nurses and so on into the VA. They are now administrators. Those are some of the things that I felt proudest of.

WEEKS:

You should be proud of that. I noted that you yourself attended many of these service schools.

GAVAZZI:

Oh, yes. I continued my reserve activities. I would go, for example, the Army has a Baylor program down in San Antonio. I became one of their professors down there. For the first time in history, I got two VA people to be accepted in their school when I was down there and military officers serve part of their residency in VA medical centers.

I didn't mention my last job in the military. I was a mobilization designee, which meant that if the chief of the medical service corps -- if war broke out -- he would be called to active duty, and I would fill in his slot.

I was the mobilization designee to the chief of the corps. That is the highest you could go as a non-physician in the Military Medical Service.

WEEKS:

That would certainly be a great honor.

This last job as executive director of administration...

GAVAZZI:

What happened while I was in that job as the executive assistant to the chief medical director was that there was a change in administration. A new president, a new administrator -- a guy named Don Johnson from Iowa became the new administrator replacing Bill Driver. When they do that, the chief medical director -- they are appointed for four years -- they can or cannot reappoint them. It's up to them. They decided not to reappoint Dr. Hal Engle because of the fact that he was very close to Bill Driver. Bill Driver had to go so Dr. Engle had to go. A new person came in, a new chief medical director named Dr. Jim Musser, who was a personal friend of Bill Middleton, who was the previous chief medical director three times before him, came in as the new chief medical director. He had a fellow he had worked with before. They were very close. I said one day, "Jim, why don't you take Ralph aboard? I'll be the executive director for administration." That put me more in the line. As executive assistant, you are unofficially on the line because you are working with the chief medical director. But as the executive director for administration, I would be on the line, responsible for the administration of all the VA hospitals. I wanted that. I liked it. So I moved over into that job where I was responsible for the administration of the hospitals from the standpoint of admission, discharges, the whole administrative -- supply, engineering, money, and so on and so forth. I enjoyed that very much.

There was one problem. I was traveling an awful lot, and I had five young children. I would make a commitment to one of the kids that I would be at his Blue and Gold banquet for Boy Scouts, or my daughter that I would be at her affair for the Girl Scouts, or I would be some place with the family, and I would find myself in California, Boston, Chicago, Detroit. After a while, the kids became sort of disillusioned about dad. You don't care about us. My wife was having trouble controlling the five kids, so it was tough on her. I would be gone sometimes two weeks out of a month traveling. Although I would try to keep my trips as short as possible, still I was gone a lot.

One day I said to Jim Musser, "Jim, I have got to get back in the field because I've got to help Nancy with the children and I have got to get to know my children." He, having been divorced, having another wife, appreciated that. He enjoyed his children, and her children as well. He said, "Fine. Where do you want to go?"

I said, "Well, I've moved around to thirteen VA hospitals and I think -- some of them I only spent six months in when I was single -- I want to go to Washington. This way I could stay where I am and my kids could continue school without breaking them up."

He said, "Fine."

So when the medical center director, Tom Ready, retired, I went over to the Washington VA Medical Center. While over there, we set up these regional programs -- the regions that they have now. We set up the medical district process, the medical district planning process, whereby now every hospital has an input on what they feel they need. Prior to that someone in Washington decided what you needed in Detroit, or what I needed in Madison, or wherever it might be. The person in those areas had no input. With the medical

district planning process, they have set up twenty-seven medical districts. I had two roles. I was both the medical center director and the medical district director. Every hospital has an input in the planning process. You set up committee memberships from every hospital, every hospital has a member on every committee. You have a chief of staff's council. You have an associate directors' council. Then you have a departmental council. The departmental councils get together, recommend what they need at their respective hospitals, develop a priority, -- among, let's say, five hospitals -- and they vote. Then they will turn it over to the associate directors' council, then the chiefs-of-staff' council. The chief-of-staff, from the standpoint of what the hospital needs patient-care wise -- the physicians, the nurses, and so on -- the administrative council, what they need administratively -- construction, and so on. They report to the directors' council made up of all the directors of the hospital, with one of them, the medical district director, as chairman. You develop a priority list of what needs to be done, personnel-wise, construction-wise and so on.

WEEKS:

Everyone's participating.

GAVAZZI:

Everyone is participating. Then you develop the priority based upon what you think in that region is important -- what will it do for the patient overall. Not what will it do for you in Detroit, what will it do for me in Saginaw, what will it do for somebody else in Ann Arbor and so on. But what will it do for Michigan. Then you submit your list to Central Office. On that basis you will get money for your projects. Based upon what you said you need, not what they said you need. It's great. It has really worked out very

well.

WEEKS:

We now bring you down to almost the retirement point, don't we?

GAVAZZI:

Yes.

WEEKS:

You had this job with two hats.

GAVAZZI:

I was at the hospital from 1972 until 1986. You are probably wondering why did I stay so long when I set up a criteria of only four years. I stayed there so long because I was being used by Central Office as a consultant for all their programs, having been in Central Office. I was knowledgeable about how the Congress operated. I was very much involved with the three medical schools, keeping them from taking over. It never got dull. If it had gotten dull at any time, I would have dropped it.

Then I got involved in building a new nursing home. The first and only underground parking garage, the only parking garage in the VA system, and a clinic addition, which I started ten years ago, believe it or not. I started that and I was determined to finish the damned thing. It was stopped once by Ford. Then it was stopped by Carter and given back. We almost started construction, then Reagan came aboard and he stopped all planned construction. I had to use my friendship with Dick Davis to get that one shaken loose. I was able at a cocktail party to embarrass a certain member of the Cabinet who took action and asked what the hell I was talking about. I thought he knew, but he didn't. The next week the construction program costing $23 million was out again so that I could go ahead and build. I wanted to stay with that,

complete it, staff it, get it operational. Which I did. I got it all operational in October.

In the meantime, I decided a year ago January, January 1985, I told Nancy, "This is the year I am going to retire."

She said, "You've been saying that for five years."

I said, "Let's plan what we are going to do in 1986 because I don't want to work in 1986." So I retired on January 3, 1986.

WEEKS:

It seems to be agreeing with you.

GAVAZZI:

It is. It's great!

WEEKS:

Al, would you like to tell us something about the development of the Veterans Administration?

GAVAZZI:

I would like to very much, Lew, because I think it's important because not too many people are aware of the Veterans' Administration and I would like to give a little historical background, if I may.

As you may or may not know, benefits for war veterans have been provided in one form or another since ancient times. Ancient Oriental empires furnished pensions for soldiers in order to keep them from deserting. The Greek city states established a system of veterans preference for legislative and magisterial offices. They also cared for the children of those who died in battle and gave pensions to veterans with permanent injuries. The first English pension law was passed in Parliament in 1592. A century later, Great Britain innovated another benefit for veterans, the Chelsea Hospital for Lame

and Old Soldiers. Both of these benefits were imitated later by the United States. For example, we have had a Chelsea hospital, Public Health Service Hospital, Navy Hospital in Boston for years. They just closed it three years ago.

The concept of community responsibility came to the United States with the English colonists. Plymouth colony enacted a pension law which stated that if any man shall be sent forth as a soldier, and shall return maimed, he shall be maintained competently by the colony during his lifetime. By 1776, the concept of benefits was so firmly established that one of the first items of business of the first United States Congress was a pension law. In 1789, the pension measure was enacted which provided that the military pensions which had been granted and paid by the states should be continued and paid by the United States. The Secretary of War was made responsible for the administration of this law. The Congress, however, retained the final say as to who could be placed on the pension rolls.

In 1817 President Monroe urged Congress to establish a service pension for all Revolutionary soldiers in need. This law was passed by Congress and proved to be the first in a long line that followed each war until 1940.

In 1811 Congress authorized the Secretary of the Navy to build a permanent Naval hospital for disabled and decrepit officers, seaman, and marines.

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In 1811 Congress authorized the Secretary of the Navy to build a permanent Naval hospital for disabled and decrepit officers, seaman, and

marines. This home, built in Philadelphia, was not occupied until 1833, and is active today.

In 1851 two other federal homes for invalid soldiers, one in Washington, D.C. -- Mount Alto -- and the other in Harrodsburg, Kentucky were established. In 1861 President Lincoln appointed a sanitary commission to look into the health conditions of Union soldiers. As a result, the commission recommended a medical program for those who returned from combat in need of medical care. This program, authorizing home town medical facilities, was inaugurated and worked well during the war, but was found entirely inadequate after demobilization. In March 1865, Congress authorized the establishment of a national home for disabled, volunteer soldiers, called domiciliaries now. This law further contemplated a number of homes in various parts of the country. The home's first branch at Togus, Maine, opened in 1867.

As I indicated earlier, there is one in Wood, Wisconsin; Milwaukee; the one at Hampton was one of the oldest ones; Dayton, Ohio, is another old one; and Wadsworth, California.

Veterans' benefits remained without change until World War I. On October 6, 1917, Congress developed a new concept of benefits for veterans through amendment of the War Risk Insurance Act. The program included compensation for injuries received in military service, compulsory monthly allotments for the support of those dependents, a system of voluntary insurance -- medical, surgical, and hospital treatment -- and vocational rehabilitation for those permanently disabled in service. Under the medical care phase of this law, prosthetic appliances were made available for those injured in the line of duty. Not until then were artificial limbs, for example, given to handicapped former service people.

The responsibility for administration of these benefits was fragmented between the Public Health Service, the Bureau of War Risk Insurance under the Treasury Department and the Federal Board of Vocational Education. The Public Health Service provided a physical examination for veterans applying for compensation, as well as medical and hospital care. This service was paid for by the Bureau of War Risk Insurance. The fragmentation in the administration of these benefits caused backlogs and delays, generating complaints to Congress.

As a result, on August 9, 1921, Congress created the United States Veterans Bureau, at the same time authorizing hospitalization of Spanish-American War Veterans, without reference to the origin or cause of disability. Today, the Spanish-American War veterans can go into any VA hospital. A 1984 count found some 227 still alive.

In May 1922, the Public Health Service transferred forty-six hospitals, 12,069 patients, to the Veterans Bureau. In 1924 hospitalization benefits were granted to all veterans with wartime service. In 1930 the Veterans Administration that we know today was created. With the onset of the Great Depression, the demand for hospital care increased.

In 1933 all previous legislation concerning veterans benefits was abolished, and a new system was established. Hospitalizations for disabilities, not related to military service, were curtailed. During the remainder of the 1930s, demands for hospital care continued to increase mainly by applicants with non-service connected disabilities.

In 1940, a ten year hospital construction program was approved in principle by the President. This program was to be reviewed annually and coordinated with existing laws. The maximum need for Veterans Administration

was set at 100,000 beds of all types on the premise that this would meet VA needs for ten years.

It was during this time that the Corps of Engineers built these hospitals. They built hospitals in Omaha, Kansas City, Iowa City, Durham, Philadelphia. As I indicated earlier, this is where they were built by people who were builders but didn't know anything functionally about what went into them. That was the job that I was brought in to correct when I went down as associate director of construction.

Prior to the involvement of the United States in World War II, two laws were enacted which were to affect the American veteran. The first, the Selective Training and Service Act of 1940, provided for the draft as well as for veterans' benefits such as re-employment rights, hospitalization, compensation. The second established a low-cost system of national service life insurance for men and women entering the Armed Forces.

I happen to have it. If you were in the service, I don't know if you have it?

WEEKS:

No.

GAVAZZI:

It is a very good thing. It's only $10,000, but it is very cheap.

Prior to 1943, the emphasis on veterans' benefits was cash awards, entitlement to hospitalization, assisting only those who had compensable service-connected disabilities. This was extended to non-service connected conditions provided that the veteran stated under oath that he was indigent and the VA had hospital beds available.

Although the VA expanded during the depression, it was generally

considered a poor medical care system, and had great difficulty attracting competent physicians.

At the end of World War II the system was re-invigorated with new leadership. Doctors who had served in the Armed Forces were induced to transfer into the VA affiliated with medical schools. The number of hospitals jumped from 90 to about 160. Now there are 172 in existence, and 240 outpatient clinics throughout the United States. There is a hospital in every state in the union except Alaska and Hawaii. There is one in Puerto Rico. In Alaska, military hospitals, in contract with private hospitals, takes care of the veterans. In Hawaii there is Tripler Army medical center which has 120 beds designated for VA beneficiaries. It is run by the Army.

Since that time, Va hospitals have remained essentially stable and increased to the numbers I have just given you. They now represent the largest organized system of health care service in the country. However, it is an aging system with an uncertain future.

I would like to mention something about the chief medical directors because they are the ones that have an impact on the VA health care system. The first, of course, was Frank Hines, who was a Brigadier General of the U.S. Army retired. He was administrator from 1923 to 1945. As director of the Veterans Bureau and administrator, he served under five presidents for 22 years. His service to veterans and to his country was outstanding in integrity. During the twenty-two year tenure of General Hines, the number of hospitals increased from 45 to 97. The number of patients treated during this time was approximately two million, the budget around $17 billion.

One of the principal weaknesses of the medical program under General Hines lay in the failure to establish a medical corps within the VA. As early

as 1924, he proposed legislation for the establishment of such a corps — upon the advice of a medical council.

The location of many of the veterans hospitals also compounded the situation because although it was recommended to put many of the hospitals near medical schools or where the large population was, the politicians decided where they should go. It became a political decision. Determination of sites was largely based on, one, veteran population and transportation facilities. General Hines was adamantly opposed to having hospitals located in close proximity to medical centers. He resigned under pressure to become the Ambassador to Panama. he later died in the VA hospital at Mount Alto, a lonely, poor old man with no family. He had no children.

He was followed by General Hawley, who was there for two years. During General Hawley's tenure, House resolution 4717 was signed by President Truman becoming Public Law 293 in 1946, which created what we have now, the Department of Medicine and Surgery. The law provided for residency training programs, twenty-five percent additional allowance with a ceiling of $11,000 for a physician -- for those doctors who had been rated as specialists, as well as those attending meetings held for promotion. Under General Hawley's leadership the medical system rose to one of the most modern and progressive in the world. He proved that federal and civilian medicine could work together. General Hawley resigned on December 31, 1947, to accept the position of chief executive officer of the national Blue Cross Association and later became the medical director of the American College of Surgeons. He was a close personal friend, incidentally, of Omar Bradley.

WEEKS:

What was that about Blue Cross again?

GAVAZZI:

He was the chief executive officer.

He was followed by Paul Magnuson who wrote Ring the Night Bell which tells how the doctors and nurses worked and so on. He was appointed in 1948. He was well known as an outstanding teacher and surgeon, not only in his hometown of Chicago, but throughout the country. He was responsible for building Chicago Research. He put it on the drawing board and had it built. Dr. Magnuson felt that a doctor should not be burdened with responsibility other than those of strictly a professional nature. To him a hospital was an entity with everything going on in it influencing, to some degree, patient care. He felt that hospital planning, even to the maintenance of equipment and choice of supplies, affected the whole being of the patient. This resulted in tremendous controversy between the administrator, Gray, and Dr. Magnuson. General Gray accused him of insubordination when Dr. Magnuson repeatedly had indicated that he had never worked for any one except his patients and that he did not consider General Gray his boss.

At this time General Carl Gray suggested that the doctor might be better off doing something else, which ended his career as the chief medical director of the VA. Later that year Dr. Magnuson was appointed chairman of the President's Commission on the Health Needs of the Nation. In summary, the administrator and the chief medical director disagreed on policy during Magnuson's tenure resulting in many confrontations. They were both fellows of positive ideas, but Dr. Magnuson, felt that there was too much interference with the medical department in the running of the hospital and the authority of running the hospital.

Magnuson was followed by Admiral Joel T. Boone. He was the only chief

medical director to have gotten the Congressional Medal of Honor. He was appointed in March of 1951. During Admiral Boone's term of office organized medicine was highly critical of the VA, giving hospital care to non-service connected veterans. The same thing today. He made many trips addressing medical and veterans' groups and civic bodies defending this entitlement to hospitalization for the non-service connected veteran. He prepared a paper for distribution called, "From A to Z," which did much to correct the prevalent misunderstanding of the VA's medical and hospital programs. During the four years that he was chief medical director he participated in the opening of 48 new hospitals. He retired on February 28, 1955, with the respect and admiration of the entire organization. He was named a consultant to his successor by special appointment.

When Boone retired, he moved into an apartment building near Mount Alto. we had a power plant. What the employees would do every so often in late afternoon or early morning, they would clear its stacks and smoke would come bellowing out. He would look out his window and see that smoke, he would call over there, "Gavazzi, god damn it, tell those engineers not to do that. They are dirtying the air." I told the engineers to do it at night.

He was followed by Dr. Middleton, the only one that was reappointed to be chief medical director. He was chief medical director from March 1955 to February, 1963. One of the first actions as chief medical director was to appoint an advisory committee on research to review the accomplishment and to encourage the growth of research programs. Prior to that we did research helter-skelter. Nobody cared much. But he set it up where it would be working with medical schools and other research bodies. He set up the first advisory committee on problems of the aging. His advisory committee came up

with a recommendation that they suddenly revived the last couple of years. It had been put on a back burner. Now, with the demand that we have with the aged, it has come forward again.

At the end of his first four years in office, he was persuaded to accept a second term. Upon his retirement, there were 169 hospitals, 18 domiciliaries and 217 outpatient clinics.

He established the first position of executive director for administrative services which I indicated to you I held at one time. Now it is called the assistant chief medical director for administration, responsible for engineering, medical administration, personnel, housekeeping supplies, canteen service and budget.

Each new hospital planned or erected during Dr. Middleton's tenure moved away from the concept of providing treatment for a particular disease. Instead, they became general medical and surgical hospitals, with sections to treat mental illness and tuberculosis.

As you may remember, previously we used to have psychiatric hospitals. You had one here, for example, out in Battle Creek. They used to be put out in the boondocks where people were stored with mental illness and they forgot about them. As you know, with tuberculosis, that has pretty much been taken care of, so our tuberculosis hospitals no longer exist as such. He pilot tested the idea of seven-day hospitals at Coral Gables, Florida, which proved very successful, and later led to its implementation. Previously, the VA only operated Monday through Friday. With his idea of a seven-day hospital, additional staff has been provided. Now all the VA medical centers now have seven-day hospitals. He retired on February 28, 1963, to return to the University of Wisconsin at Madison. He died a few years ago. His wife, a

former chief nurse in the VA, is presently a patient at the VA Medical Center in Washington in the nursing home. She is ninety years old.

We come to Dr. Joe McNinch, whom I worked very closely with. You may remember we closed hospitals with Bill Driver, the administrator. During his tenure, the number of applications for hospitalization kept going up. Congress passed an additional Public Law 88-450, which authorized the first nursing homes and 4,000 nursing home beds. He abolished the area offices in Boston, Washington, Atlanta, Columbus, Minneapolis, St. Louis and San Francisco, and changed the titles of medical directors to staff assistant for field operation, relocating them to the headquarters office in Washington. He urged research, emphasizing care of the aging.

As I indicated to you earlier, he resigned to be director of the southeast region of the American Hospital Association in January 1966. Recently he resigned from that and is in full retirement in Florida.

He was followed by Martin Engle, as chief medical director, the first career chief medical director. He came up through the ranks. During his tenure -- Bill Driver was the first career administrator -- the VA had a team in the headquarters office of people from the ranks and professionals who had come up through the ranks. Engle was the first VA career physician to be named chief medical director. He consolidated the former seven area offices and their staffs into five regional medical directors offices, located in Washington.

Formerly the VA hospital budget had been geared to an average daily patient load concept. Dr. Engle changed this by basing the budget on the number of patients treated, patient-mix and related factors. This resulted in speedy discharges of patients who had reached maximum hospital benefits.

To permit more thorough study of issues and problems referring to the special medical advisory group, Dr. Engle reorganized the modus operandi of this group by setting up subcommittees. These subcommittees explored problems in depth and reported back with their recommendations. Dr. Engle furthered the application of ADP. The first time we started using computers within the hospital, and the first computers were set up in the Washington VA Medical Center. He started researching construction and established the criteria for managing medical manpower. He also did a number of things in bringing about labor-saving and safety approaches. Among these were prepackaged, sterile items which decreased the time spent cleaning, packaging, and sterilizing, the permanent-press uniform, eliminating the cost of pressing, and flame-retardant pajamas, to safeguard the smoking risk of patients. He also transferred the processing of certain medical supplies from nursing to supply.

In 1968, he opened a new VA hospital in Gainesville, Florida, a replacement hospital for the old Memphis VA Hospital, and also a new hospital in Oteen, now Asheville, North Carolina. He established an additional blind-rehab center on the West Coast. He expanded nursing home care, activating 4,ØØØ nursing home care beds.

During his tenure we expanded nursing home care, deactivating the additional beds at 63 hospitals, and increased pre-bed and post-hospital outpatient program, promoted the out-placement of psychiatric patients capable of adjusting to a community environment. Prior to that we had the psychiatric hospital that was sort of a storage for the mentally ill. It was decided that we should try placing them back in the community and back in their homes. We tried it, and it worked successfully. To give an example, we had a young man who had been in a psychiatric hospital for thirty years. We placed him back

with his family on a farm, outside of Hagerstown, Maryland, and he worked beautifully. He took care of the cows, stayed with the family, and eventually died there, but never went to the VA hospital. It was a test which proved very successful.

Dr. Engle established a "distinguished physician" program in the VA. This is a program whereby a physician who has international reputation and reaches retirement age is brought back as a distinguished physician, given his own budget to do his own thing and to go out and teach his specialty at isolated hospitals. He created a peer review mechanism to ensure funding of individual projects based on scientific merit. He developed a program of expansion of VA training, particularly in the allied health disciplines. This included health care administration and pharmacy residents and so on and so forth. It has been very, very successful.

Dr. Engle left there and went to work with the University of Chicago. He is presently working at the University of California at San Diego in a consultant capacity. An outstanding chief medical director.

He was follwed by Marc J. Musser, chief medical director from 1970 to 1974. He worked with Don Johnson, the administrator. As I indicated earlier, he and Don Johnson had a squabble and eventually it resolved in his resignation. What Jim Musser did: he was involved in the regionalization program in North Carolina and he brought that concept to the VA. He regionalized the VA 160 hospitals in 37 medical districts resulting in a speedier admission and transfer of patients and improvement in exchange of medical information. This resulted in residents going to the isolated hospitals and physicians from teaching hospitals going to the non-teaching hospitals to look at the patient, talk to the staff, and bring the patients

into the teaching hospital.

His tenure was extended for a year, but he finally retired and died with cancer in 1977 at the Washington, D.C. VA medical center. He was a heavy smoker.

He also reorganized the expansion of VA medical care by bringing a new level of public and professional acceptance which did not exist before.

He was followed by John Chase, chief medical director from 1974 to 1978. The administrator was a former congressman from Indiana, Richard Roudebush. Dr. Chase strived for dynamic management at the existing VA system to ensure that its mission of providing compassionate and timely care of the highest quality to eligible veterans would be carried out with demonstrated increasing cost effectiveness. He directed the VA response to what was believed to be the most massive and far-reaching examination of a federal agency over mandated by Congress -- the National Academy of Sciences three-year, $6 million study of health care for American veterans.

Chase personally designed, directed, and completed a quality of care study mandated by presidential order for comprehensive analysis of health services provided to veterans. He completed the necessary remedial action to correct deficiencies in space, staffing, and specialized medical services disclosed by these and other studies. He established a long range policy and operated a system of decentralized decision-making; instituted a stringent health care service review organization to insure the quality of patient care would be constantly monitored and improved; developed sophisticated data-gathering devices to facilitate national decision-making, including a computerized management information system and a pioneering space and functional deficiency inventory; developed and applied disease-unique length-

of-stay standards.

He retired in July, 1978 from government service, and is presently living in Tacoma, Washington.

He was followed by Jim Crutcher from Atlanta, who was the chief medical director for only two years. (He was under the administration of Max Cleland, the triple amputee, whom you may or may not have known. Max is now the Secretary of State for the state of Georgia.) Crutcher's only claim to fame, I guess, would be the problem-oriented medical record which he, as a former internist, thought was great. He brought that into the VA.

He was follwed by Don Custis, former Surgeon General of the Navy, who came aboard in 1980. Don was a dynamic Navy surgeon. He followed up on the medical district-planning process and the computerized health care. He, more than anyone else, pushed the data processing that Hal Engle introduced. Now every VA medical center has a computer in it. They are all computerized. The long-range goal of Don Custis was to have this on a national scale.

Don Custis was followed by John Ditzler, the former director of the VA medical center at San Diego. After John Ditzler came aboard, there were a couple of reorganizations, because of what was being mandated from the standpoint of the means test, which goes back to what we did in the 1960s, requiring a non-service-connected veteran having an income of $15,000 to $23,000 to pay a certain part of the cost of care. A new administrator came aboard in February -- he succeeded the former administrator, Harry Walters, who really was a dynamic administrator and did an outstanding job of assisting the Department of Medicine and Surgery. The new administrator is Thomas K. Turnage, formerly Director of the Selective Service and a Californian. Last month, July 1986, there was a battle between the new administrator and John

Ditzler, the chief medical director. Effective September 1, John Ditzler will be the new medical center director in San Francisco, having resigned from his position as chief medical director. It is a very sad time for the administrator to have the chief medical director resign when we are having so many pressures from the Congress, and from all groups, in the patient care area of the VA. He will be a great loss.

John Ditzler was succeeded in January 1987 by John A Gronvall, M.D., who has been Acting Chief Medical Director since Dr. Ditzler left in September 1986. Dr. Gronvall is a former dean of the University of Michigan School of Medicine at Ann Arbor, Michigan.

WEEKS:

Who is the chief?

GAVAZZI:

The Administrator of Veterans Affairs is appointed by the President of the United States and is a political appointee. He appoints a chief medical director. The chief medical director has a four-year appointment. He cannot be removed except for cause. However, he can resign, which is what happened with Dr. Ditzler.*

We have, as I indicated, a chief medical director who has seven regional directors. The seven regional directors have twenty-seven medical districts. That's the way the hierarchy office is.

There are two departments, the Department of Veterans' Benefits which handles compensations and pensions. That has a budget of about $17 billion

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*See Appendix A and Appendix B for lists of administrators and chief medical officers.

dollars. The Department of Medicine and Surgery has a budget of about $8 billion dollars. That handles hospitals' patient care and outpatient care as well.

Then we have another Department of Mortuary Affairs. They handle, primarily, the burial and the national cemetery system which the VA inherited four years ago. Prior to that, all cemeteries were handled by the Army. All of the cemeteries, except for Arlington National Cemetery, have been transferred over to the VA for administration and so on.

WEEKS:

I really appreciate your survey of the Veterans Administration. I do have a few questions I would like to ask you. Some of them may be a little silly because I am not as familiar as I should be with some of this.

When you were speaking of the size of the health care system, I think you mentioned that there were 168 or 170.

GAVAZZI:

There are 172 VA medical centers.

WEEKS:

In addition to that you have clinics?

GAVAZZI:

Two hundred and forty outpatient clinics.

WEEKS:

I read somewhere that the bed-count is something like 100,000 beds. Does that seem reasonable?

GAVAZZI:

Originally it was 125,000 beds which now has been reduced to 90,000 beds. At one time it was reduced to 100,000. Now it has been reduced to 90,000

beds and future reductions may occur in the years ahead.

WEEKS:

You must be seeing, according to what I read, one million patients annually, one way or another.

GAVAZZI:

Over a million, over two million. There are over two million outpatient visits, and over one million inpatient visits.

WEEKS:

This outpatient service is fairly recent, isn't it?

GAVAZZI:

No. We have always had the outpatient program. What happened ten or twelve years ago was that they made the outpatient treatment available to the non-service connnected. Prior to that it was only for the service-connected veteran. Then they made it available for some, not all, non-service connected veterans. That's increasing. The outpatient program is increasing, and the inpatient program is decreasing because the veterans are dying. Not many new veterans are being created.

WEEKS:

Someone has said that you have quite a large turnover in your medical staff and in your nursing staff. Is this likely to be more so than in civilian life, do you think?

GAVAZZI:

Not any more so than in the private sector. We have done studies and have found that our turnover is not any greater than the local hospital nearby the VA hospital. One of the things that may make it not very nice for a nurse, for example, is the fact that in the VA a nurse must work a night

shift. They have rotating shifts. In the private sector, you can get straight days and straight nights. In the VA you cannot. Except they will make an exception in some cases.

As far as the medical staff is concerned, we don't have much turnover except for the house staff. The house staff at the VA --about 90% of all physicians spend some time in VA training, either as a student or as a resident. The house staff spends some time in a VA hospital, because of our affiliation with all of the medical schools throughout the United States.

WEEKS:

I see. The house staff, as being differentiated from the full-time staff, they are salaried people.

GAVAZZI:

The full-time staff are salaried. They cannot have an outside practice if they are full-time. They can have an outside practice if they are part-time.

WEEKS:

The other physicians, are they people who work part-time in the VA or full-time, or are they consultants?

GAVAZZI:

Consultants and attendings. In a teaching hospital, all of the physicians at the VA must have a teaching responsibility at the medical school, whether full-time or part-time. In the non-teaching hospitals it is a different story. They are full-time. They work forty hours a week, but they can work eighty hours a week, and not get any extra remuneration -- the physicians, that is. The nurses, however, if they work beyond forty hours, or beyond an eight-hour day, will be paid overtime. That's under Title XXXVIII.

It is a special regulation which does not apply in the Navy or the Air Force or the Public Health Service. It is a special act of Congress and a special pay system.

WEEKS:

These people who are staff physicians, they don't need to have any military connection, do they?

GAVAZZI:

No, none whatsoever.

WEEKS:

So none of your physicians have to have it?

GAVAZZI:

No. It's a non-uniform service. Some people think that the VA, because of the fact that there are a lot of military persons or that they take care of veterans, are uniformed. They are not. They are not military.

WEEKS:

You were talking about a large budget, something over $20 billion a year combined, isn't it?

GAVAZZI:

Twenty-five or twenty-six billion dollars, yes.

WEEKS:

This puts your budget very close to those of some of the federal departments, doesn't it?

GAVAZZI:

It is the third largest in the United States.

WEEKS:

But you don't have department status as far as Cabinet status?

GAVAZZI:

No. They keep bringing it up every couple of years, but they, the Congress, haven't gotten it yet.

WEEKS:

But you do have great support in Congress.

GAVAZZI:

Oh, yes. We have two committees. We have the House Veterans Affairs Committee and the Senate Veterans Affairs Committee who have oversight responsibility for the entire VA program. They are very supportive of the VA. The greatest supporters the VA has are the service organizations, the American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, AMVETS, the Jewish War Veterans, Catholic War Veterans, and so on. A very large constituency with most of their headquarters in Washington. They do the lobbying for the VA. They are very supportive of the medical programs.

WEEKS:

Do they work together quite well?

GAVAZZI:

Not really.

WEEKS:

I was wondering about legislation, if they would work together on deciding to support a certain kind of legislation.

GAVAZZI:

Sometimes they have, and sometimes they haven't. The American Legion is the largest in numbers, but the most powerful one is the Disabled American Veterans, and the Paralyzed Veterans of America.

WEEKS:

When they appear it is quite graphic, isn't it?

GAVAZZI:

The DAV and the Paralyzed Veterans of America have almost direct access to the President -- also the Veterans of Foreign Wars. The others don't have direct access like these three.

WEEKS:

I see. The American Legion can have both foreign and...

GAVAZZI:

The American Legion can have anyone who has served in the military and has an honorable discharge. The Veterans of Foreign Wars, you must have served overseas. The Disabled American Veterans, you must have a disability incurred in the service. The Paralyzed Veterans of America, you must be a spinal cord injury patient. Then there is another one which I failed to mention and that is the Purple Heart Veterans of America. They are the ones who have gotten a Purple Heart for being wounded in combat.

WEEKS:

I hadn't heard of them.

GAVAZZI:

It is a small organization because they haven't gotten together. They are integrated with the other service organizations.

WEEKS:

There must be a lot of competition for membership.

GAVAZZI:

Yes, very much so.

WEEKS:

Then, as you say, in the small towns it becomes a part of the social structure in many cases.

Have you ever seen a figure on your full-time equivalent employees in ratio to patients?

GAVAZZI:

Sure.

WEEKS:

I was wondering how it compared with the private sector.

GAVAZZI:

Let me give you the comparison -- it varies throughout the United States -- let me give you the Washington scene. My staffing ratio at the medical center where we had 840 beds was 1.83. Across the street, the Washington Hospital Center of 800, their staffing ratio is 4.3. Georgetown, a 500 bed hospital, give or take a few beds, has a staffing ratio of 5.1. Howard University, which is right down the street, has a staffing ratio of 5.2. And so it goes.

WEEKS:

By the way, I did talk with Haynes Rice.

GAVAZZI:

He's a fine administrator and a good person.

WEEKS:

And Dr. Cobb. Do you know Dr. Cobb?

GAVAZZI:

Oh, sure.

WEEKS:

The total number of vets in this country must be what, 20 million?

GAVAZZI:

Twenty-seven million at the last count, which is a large constituency. It is a constituency which any congressional member is reluctant to tangle with because, as we talked earlier, there is a small VFW, American Legion, DAV post in every little town. They had better respond to their constituency of veterans if they want to remain in Congress.

WEEKS:

These veterans are pretty patriotic and are pretty much united in what they want?

GAVAZZI:

Very much so.

WEEKS:

I was wondering about your admissions. Somewhere I read that a veteran could come in off the street and ask for admission himself without having a physician refer him. Is this true?

GAVAZZI:

We call them walk-ins. Anyone who has an honorable discharge can present himself or herself to any VA hospital and indicate that he/she is ill, has a medical problem. They will be examined, and, depending upon their condition, be admitted. Usually they go through a screening process to determine whether he or she is a veteran. A lot of people say they are veterans, and they are not. Also, whether or not they are service-connected or not service-connected. If you are service-connected, you get A-1 priority. If you are not service-connected, you will only be admitted if there is a bed available,

unless you are a medical emergency of course.

WEEKS:

Will you be admitted without a means test?

GAVAZZI:

If you are an emergency there is no means test.

WEEKS:

I understand that.

GAVAZZI:

Otherwise, now there is a means test which went into effect July 1st of 1986. That is based upon what your income is. If you are single, the income, I believe is $13,500. If you are married, the income is $23,000. If you make more than that you have to reimburse the VA for a certain amount of health care after you have been hospitalized.

WEEKS:

Somebody brought up the question: What happens if a veteran is admitted for a service-connected disability of some kind, or ailment, and at the same time he has a secondary diagnosis of, say...

GAVAZZI:

If he comes in for a revised stump -- that's an artificial leg. If he comes in for a revised stump and develops pneumonia.

WEEKS:

Or what if he has a secondary condition when he came in, such as some kind of heart trouble? He would be taken care of totally, wouldn't he?

GAVAZZI:

Oh, yes. Every veteran, once admitted, will be treated totally. You may come in for pneumonia, but while you are in there you will be given a dental

examination because many diseases are caused by lack of having the proper teeth and being able to chew and so on. You also get a complete physical to determine whether you have other conditions, where in a private hospital, your physician will admit you for pneumonia and that is all they will treat you for. But in the VA, once you are admitted, you get a complete physical.

WEEKS:

I am glad to hear you mention dental. I was wondering, what kind of dental coverage is there?

GAVAZZI:

There is only prima facia evidence the first year following discharge. After that there is no eligibility other than if you had a fracture or some kind of injury to your face or your jaw that requires special dentures and so on.

WEEKS:

Or surgery?

GAVAZZI:

Like in my case, having been blown out of a tank and fractured my jaws, with lots of teeth, I get treatment for the rest of my life. But it has to be a fracture of some sort.

WEEKS:

Are these dentists in the service or do you contract for this work outside?

GAVAZZI:

Both. Primarily it is done by dentists in the hospital, but there is also what they call fee-basis where, let's say for example, you live in 100 miles from a VA hospital and you require dental care for a service-connected

dental condition, you can go to the local dentist. The VA and that dentist will establish a fee-basis, what the VA will pay, and they will take care of it so you don't have to drive 200 miles back and forth.

WEEKS:

This really makes sense.

Going back to the means test and the amount of money and so forth, does the veteran simply sign a statement that he doesn't make over $13,000 a year?

GAVAZZI:

That's all. Just say, "I only make $8,000." There is no way the VA can investigate that.

WEEKS:

That is probably the best way for a means test to be accepted.

GAVAZZI:

Years ago, if I may add, Lew, we had that. If you came in and you were non-service connected, you had to say how much you earned, how much you spent, how much money you had in the bank, whether you owned your own house or not, whether you had a mortgage on it.

WEEKS:

A regular financial statement then?

GAVAZZI:

A big financial statement. They did away with it because it was so much paper work, and we could not enforce it anyway. If a person said he had $100 and drove up in a brand new Cadillac, we couldn't question the veteran. The Vet might say, "The Cadillac, I am paying on time." So they dropped it. We created miles of records and I am sure most of these records have been destroyed or desposed of one way or another.

WEEKS:

And it probably was resented, too, wasn't it?

GAVAZZI:

Oh, yes. It was very much resented by the... It was demeaning to the veteran to provide all of this information. It is demeaning again to the veteran to say to you, "I have to tell you how much I make." What difference does it make if you and I are in the service, I am fortunate enough to remain in the states or go through three years of combat and never get injured, you happen to be in a tavern, get into a fight, someone hits you over the head, you have a fractured skull. You are service connected, and you are eligible for everything. If I spent three years overseas and never got wounded, I am not service-connected. I am not entitled to anything. Why differentiate one from the other? Especially at a time when you need health care and are in a financial bind.

WEEKS:

That brings up a good point. The person who is service-connected, then gets into a fight in the bar and gets injured, which is a non service-connected injury...

GAVAZZI:

But if he is in uniform, it is a service-connected injury. If he is on active duty and in uniform...

WEEKS:

What if he isn't on active duty? What if he is back home and established?

GAVAZZI:

He is discharged from the military?

WEEKS:

Yes.

GAVAZZI:

And he gets a fractured skull?

WEEKS:

Yes.

GAVAZZI:

If they bring him to a VA hospital he would be admitted as a non-service-connected emergency.

WEEKS:

Is it still a policy that the veteran's family and survivors don't receive benefits?

GAVAZZI:

Yes.

WEEKS:

That hasn't changed?

GAVAZZI:

That hasn't changed. The only thing is that people who died as POWs, their families can get treatment through the VA on a billing set up. We will admit them to a VA hospital, or admit them to a local hospital. It is called CHAMP-VA. That will take care of the wife and children until they reach a certain age. That is the only exception.

WEEKS:

I see, only prisoners of war.

What about the veteran who has some outside insurance such as Blue Cross. Does the government try to collect from Blue Cross?

GAVAZZI:

Under the new law, if it passes, they will, yes. It hasn't passed yet. Previously you could not. There is a clause in every outside insurance contract that says, "We will not pay for treatment in a federal, VA, state, county, or city hospital."

WEEKS:

The government collecting is in the new legislation?

GAVAZZI:

Yes.

WEEKS:

I am asking a lot of questions here which have no connection with one another, but some of these things I have run across or thought of and I just jotted them down.

Is there any difference in the treatment which an officer gets from what an enlisted man gets?

GAVAZZI:

Once you enter a VA hospital, you are a person.

WEEKS:

You don't have rank any more?

GAVAZZI:

You could be a general or a private and you would get the same treatment. No private rooms. The private rooms are determined based upon your medical condition, rank has nothing to do with it.

WEEKS:

If somebody is receiving compensation for a disability and they come into the hospital for treatment and they benefit somewhat -- I mean their

disability is somewhat lessened -- is that likely to affect their compensation rate?

GAVAZZI:

Well, it could affect it up and down. Let's say that you go into the hospital and you have a compensation of 10%, and you stay in the hospital thirty days for that condition. On the 21st day you become 100% until you are discharged. Then you may drop down to 10%, or you may go to 20% or 30%, depending upon what the situation is. There is an interesting thing: If you are hospitalized for a service-connected condition, after the 21st day your compensation goes 100%. A lot of veterans, especially psychiatric cases, will come into the VA hospital frequently and stay thirty days because they want to go above that 21 days and get back 100%.

Service connected disabilities are broken down by 10s. Ten percent is the severity of the disability -- twenty percent more severe, and so on. It goes from 10-20-30-40-50-60-70-80-90-100. When one is 100% service connected, that veteran is unable to earn a livelihood or work and usually needs a family member to care for him or her.

There is an ajudication division in the regional office which evaluates the final summary that is prepared by the hospital. Every service-connected veteran hospitalized, the final summary upon discharge -- the medical summary -- is forwarded to the regional office. It is an automatic thing. There, a group of physicians and lawyers review that based upon the record, and determine whether the compensation should be increased, stay the same, or be decreased.

WEEKS:

This reminds me of something that happened back in the depression time.

I can remember going into a cigar store in Detroit to make a telephone call. There was a man in there behind the counter who was a veteran. One day I overheard a conversation he had with a buddy of his who came in. They were talking about getting veterans' compensation. The one man said, "I don't tell them that I've got this or that because they can prove that I don't have it, but they can't say that I don't have a pain right here that hurts and hurts. I don't know what it is, but, Doc, I've got a pain here." Would that be a likely way to beat the system?

GAVAZZI:

Not today. Years ago you could do it, but not today. With the tests that exist today, you couldn't claim that which you cannot prove. But, you can, for example, if your back bothers you there is no way that they can prove that your back really does not bother you. But tumors, nerve damage, etc., you can detect with linear accelerators and so on. Pains in the head and pains in the back, you can't.

WEEKS:

Your referrals can be from physicians in the private sector?

GAVAZZI:

Oh, yes.

WEEKS:

If you go to a family doctor and he says you had better get into the VA hospital?

GAVAZZI:

Yes, or another hospital can refer you over to the VA. What is happening a lot now, Lew, is the fact that a veteran will be brought in as an emergency to a local hospital. They find out that he has no insurance and is a veteran,

and they will transfer him over to the VA. They will usually call and say they are sending patient X, who is a veteran and has no insurance. He's not that much of an emergency, so we are sending him over to you. Then the VA has to take him.

WEEKS:

Your costs per day are probably less than that of the private sector.

GAVAZZI:

Yes. Anywhere from $50 to $250 different, depending on location.

WEEKS:

Would you care to say anything about the case-mix? I get the impression that you have a lot of psychiatric or mental cases and you have a lot of disabled people. Then you must surely have some short-term stays.

GAVAZZI:

We are finding, Lew, that the biggest need now for the VA is the aged -- nursing homes. Nursing home and intermediate care are the two big needs. The next biggest need is psychiatry. We still have a large number of psychiatric patients. The next biggest need is internal medicine, different categories. Then you have surgery, then neurology. The acute care is primarily surgery and medical. Those are the short-term acute care. Length-of-stay runs anywhere from seven to twenty days. Now, the reason the length-of-stay in the VA hospital is higher than the private sector is simply because in the private sector, you and I have our own doctor admit us on a certain day. We have already been worked up in the office. We go in already prepared. We stay two, three, four days and we are discharged. In the VA, you come in and you tell the doctor, "I don't have a physician. I've got a headache. This bothers me." They have to work you up. This takes two or three days. Then

the treatment, and then, in many cases, there is no place to put the patient. The patient will say he has no place to go or lives in a one-room apartment and needs somebody to supervise medication, or do this or that. That takes additional time. That is why the length-of-stay in VA hospitals is longer than the private sector. Many of the patients coming in, few of them, have their own physicians. They are all what we call walk-ins. They get sick, they come into the VA. Then you have to work them up.

WEEKS:

It stands to reason with all of the severe stress that men in combat have gone through that you will have the psychiatric cases. Then with all of the disability, all the injuries that have been incurred in war, that's another thing that will make it a long-term fact.

I was reading somewhere that Veterans Administration or veterans medicine has greatly improved the number of wounded who survived over what they were in World War I or the Civil War. Today there is a greater chance of somebody being saved who had been wounded. You are a good example yourself. You must have had pretty good care after you were blown out of that tank.

GAVAZZI:

Yes. The helicopter plays a key role in what we are talking about. The ability to evacuate from the battle zone to the aid station, then back to a station hospital. That's the big thing.

WEEKS:

I also read that spinal cord injuries have been handled a lot better. If they can be handled quickly, helicoptered in and this kind of thing. I don't know what kind of treatment they get.

GAVAZZI:

Very intensive care, bladder and kidney treatment. The big problem is the blood in the bladder. If they can treat that and plasma it right away, then they can live a long time. As you know, the life expectancy of a paralyzed veteran, or paralyzed people in general, is fifty times what it was thirty years ago. They could live to be fifty or sixty. Before, they had a life expectancy of five to six years. Now their life expectancy is undetermined.

WEEKS:

It's marvelous. The only thing is that we hope that they can become adjusted. You must have that problem too, don't you?

GAVAZZI:

That is a big problem. Max Cleland, the administrator at one time, the triple amputee, he had a difficult time adjusting, very difficult. It took him years to adjust, but he finally did adjust. As I told you earlier, he is now Secretary of State in Georgia. He is a good administrator.

WEEKS:

Was that the first time that a wounded or disabled or paraplegic was ever the head of the administration?

GAVAZZI:

Well, Roudebush was a badly, severe service-connected war injury veteran. Rufus Wilson, another one, was very severely injured. Rufus Wilson was a paraplegic for a while, and was able to walk again. But Max Cleland is the biggest example of a man completely confined to a wheelchair, with only one good hand. His other hand was very badly mangled, and both legs were blown off. To be the administrator of an agency as large as the VA!

WEEKS:

It is marvelous the way he has been able to adjust to life.

GAVAZZI:

And to compete. He is a great competitor.

WEEKS:

I have also read that benefits to the disabled not only come through the Veterans Administration, but also come through the DOD and through the HHS. Is this true? Are there different kinds of disability payments?

GAVAZZI:

They cannot exceed a certain amount. For example, if you are a 100% service-connected veteran, and you are also retired military, you cannot receive more than a certain amount. Let's say that the limit you could get as a retired military is $20,000 and your service-connected VA pension is $16,000, you are only going to get $4,000 from the military, or $4,000 less from the VA. You cannot exceed a certain amount. The same thing with HHS. You cannot, for example, get Social Security if you are retired military and retired disabled. There is a limitation.

WEEKS:

So they group them together and have a ceiling.

GAVAZZI:

That's correct.

WEEKS:

We were talking about the psychiatric cases. I have read that the younger veterans, particulary the Vietnam War veteran, a young person who comes in with disabilities and finds himself among a lot of older men, say from World War II or World War I even, this creates a problem too getting

these guys adjusted.

GAVAZZI:

It is an adjustment problem. But what they try to do, for example, is to try to get the younger group in a -- let's say there is a thirty-bed ward -- if there are twenty young veterans, they will try to get the twenty young veterans in that one ward where there will be twenty young veterans and ten elderly veterans. They will not intermix them.

WEEKS:

They have them in clusters.

GAVAZZI:

Yes, so that they will have a lot in common, and have the same gripes and so on.

WEEKS:

I read an interesting study one time that was done in England where they have twenty-bed wards -- I've seen them in new buildings, twenty or twenty-four bed wards. They were trying to determine if they should follow the American practice of having so-called semi-rooms where there would be two beds, or at the most, four beds. They did a study among patients and asked the question, "What would you like? Would you like a private room?" They would answer that this would be too lonely. They were accustomed to the big wards. "How about two beds?" Well, that would be all right if the room partner was agreeable and congenial. "What about three?" Well, if you had three, there might be two against one.

GAVAZZI:

So four is the logical one. We don't have anything bigger than four in the VA. About seven years ago they came out and said you have to have so much

square footage, so much privacy, so under the Privacy Act, we had to reduce our sixteen-bed units to four four-bed units. For probably the same reason you indicated.

WEEKS:

Sometimes the simple difficulties are the worst.

What have you done on after-care, when you are trying to send these people home? Have you been able to develop any kind of home care programs?

GAVAZZI:

Oh, yes. We have a big home-base care program. Staff will go to the home, and if the family is agreeable, once or twice a week a physical therapist, pharmacist, nurse, corrective therapist, physician, will go to the home and check on the patient, check the medication, check the supervision of the patient's medication, and so on and so forth. That is one of the programs started three years ago. It's beautiful. It's working beautifully. It is less expensive. Most important, the patient is happy because he is in his or her environment, at home with his or her family.

WEEKS:

I think you mentioned previously that many times the location of the hospital was due to congressional pressure and you might have a hospital out in the boondocks, away from the metropolitan centers, making it difficult for a family to visit. What do you do in that case with home care?

GAVAZZI:

The same way. The team will go once a week instead of twice a week.

WEEKS:

But they will go a distance?

GAVAZZI:

Oh, yes.

WEEKS:

If they have to travel fifty miles?

GAVAZZI:

Sure.

WEEKS:

That's wonderful. So you can move your patients out of the hospital if you can give them proper follow-up and home care.

GAVAZZI:

In some cases where the distance is very great, like in the Dakotas and Montana, we will, if it is a small town, make provisions under the fee-basis program with the people, if there is a hospital in that area, to go up there. Then instead of going once or twice a month, you will go maybe once every three months to see that that hospital is doing the proper thing with that patient.

WEEKS:

Speaking of this working together between the community hospital and the VA hospital, would you like to tell me something about that? How is it done? What kind of services do you exchange?

GAVAZZI:

It's called the "sharing agreement" where you and I -- you would be the private sector hospital, I would be the VA hospital -- we would develop a sharing agreement on a number of things. We could share equipment, so that I wouldn't have to buy a very expensive linear accelerator, but would use yours on a contract basis. If I had a physician who was an infectious disease

physician, you could use him. He would come over and see your patients who may have AIDS and so on. We would work out that kind of sharing agreement. If we have an outstanding open-heart surgeon, or you have an open-heart surgical program, I would send my patients to you if they are emergencies. Otherwise I would have to refer them to a cardiac center. The VA has cardiac centers in different parts of the country. But if I've got a patient and you are across the street from me, and he is an emergency, needs open-heart surgery within twenty-four hours, I would send him to you.

In the agreement, we would determine how much we would pay if I use you more than you use me, I would pay you the difference.

WEEKS:

You would try to find some way to balance it.

GAVAZZI:

Yes. For example, in Martinsburg we had a laboratory that was the best in that area. There were two local hospitals that would use our laboratory whenever it was necessary. They had nothing to offer us. It was a sharing agreement for them, but not for us. It could have been the other way around. We might have had a poor laboratory. The VA hospitals all have to be approved by the Joint Commission on Accreditation of Hospitals so everyone has to have an effective laboratory, effective radiology department, and so on.

WEEKS:

All of your hospitals are accredited?

GAVAZZI:

Yes.

WEEKS:

I was wondering what you do about quality of care.

GAVAZZI:

They all have to be accredited.

WEEKS:

How about your own medical staff committee structure? Do you have a quality of care committee?

GAVAZZI:

Oh, yes. A tissue committee, infectious disease committee, the whole gamat. Just like in the private sector. We have to have everything. The laboratories are inspected by the American Laboratory Association where they send in people who are specialists in laboratory. They have to be licensed. The same thing in radiology. You have to meet certain standards. Not only do you have to meet the federal standards, but you have to meet the local standards.

WEEKS:

The state standards too?

GAVAZZI:

Yes.

WEEKS:

But you are not licensed by the state?

GAVAZZI:

We are not licensed, but we have to meet the same standards. It is not mandatory, but we do it because of the fact that if we didn't we would stand out like a sore thumb. The same thing with the military.

WEEKS:

That goes down to fire and safety and all of that?

GAVAZZI:

The whole works.

WEEKS:

And you do it on a voluntary basis?

GAVAZZI:

Yes.

WEEKS:

That's good to know.

When I was thinking of home care, is there anytning similar to hospice care?

GAVAZZI:

We only have one, a test being done in Los Angeles. We have one hospice. The study ends the end of the year. Then they will determine whether or not the VA should have hospice care, as it is known, or whether they should continue the way they are and contract out. The study will not be completed until the end of 1986.

WEEKS:

We had a faculty member who lived just about a mile from here. He was under hospice care. I would go visit him. In fact, I had him appointed to the editorial board of the Inquiry journal. I would send him papers to review and so forth. He had a great brain. He made a lot of contributions to the field. Those last few months he was going along doing the work that I gave him and doing the work that other people asked of him. A lot of friends got to the point of coming to him to keep him alert and interested in what was going on. I thought then, that last six months was pretty peaceful. He was ready to see it through. It would be a wonderful thing if the veterans had

that kind of service also.

GAVAZZI:

Many of our hospitals, like the one where I was, have what we call an oncology service. We take care of the veteran who has a terminal illness, and work with the family. We tie the home care and oncology service together. We don't have the hospice, per se, but the home care program takes care of that terminally ill patient.

WEEKS:

That's six of one and half dozen of another, I guess. As long as you are doing that.

GAVAZZI:

In L.A. they are actually testing the hospice concept. It will be a two year study which ends in 1986.

WEEKS:

I will be interested to know how that turns out.

GAVAZZI:

We are too, because we are comparing expenses; how mucn it costs that way as compared to the way I just described with the oncology service and the home care tied together.

WEEKS:

There might be other terminal diseases besides cancer or other tumors.

GAVAZZI:

Sure. We have Lou Gehrig's disease. With that you deteriorate very rapidly. Alzheimer's disease is another one.

WEEKS:

I suppose hospice, in the beginning, was to help the patient face the

fact that he was terminal as well as help the family. Also help them through with extra services, even respite for the family at times. I would think that the veterans, as a class, have so many more problems than the average patient in the private sector that if there was some way they could be helped in that manner, it would be very, very good.

GAVAZZI:

Oh, yes. It has great potential.

WEEKS:

You talk about high technical equipment. We have had quite a to-do in Michigan in the past year on lithotripters. We had three hospitals jump-the-gun and buy them before they had approval of the state. The state has turned thumbs-down on two of the three. I have been thinking that there should be some kind of center, for instance in the Detroit metropolitan area we don't need three hospitals with this. Or if they would go together, the major hospitals, and set up a center where they had a few of these things. I realize that patients would have to come by ambulance to use some of the equipment. With the lithotripter, I don't think they would have to come by ambulance.

GAVAZZI:

But it requires three treatments, very expensive.

WEEKS:

Right. But if they could combine some way — that's why I was wondering to what degree the VA cooperates with the private sector for that very expensive equipment.

GAVAZZI:

We go through the same certificate of need procedure, although we don't

have to. We do the same as a private sector hospital. For example, the lithotripter that you are talking about. In the Washington area we agreed to have Georgetown buy it, the medical school. We send our patients to Georgetown, under contract. The same thing happened in Los Angeles. The University of California at Los Angeles wanted to buy one. Then they decided that the VA should have it, they should use it. The VA said, "No. We don't have that demand, but we will support you to get a certificate of need from the California State Health Coordinating Council." Which they did. We write letters of support with the understanding that we will contract. In Washington, there is only going to be one. In northern Virginia, there is only going to be one. There will be one at the Fairfax County Hospital. Arlington wanted it and the orthopedic hospital wanted one. The state coordinating group said, "No, you can only have one." So Fairfax will get it. Right now in the state of Virginia there is only one, at Charlottesville. It costs $12,000 a treatment, and you need three treatments. That's a lot of money.

WEEKS:

Wow! It really is.

Our nephew had to go to Indianapolis from Detroit where he lives. This was covered by insurance, so I had no idea what the total costs were. That seems like a lot of money.

GAVAZZI:

We contracted with one, and we compared prices. They run $30,000 to $40,000 for the complete treatment, three treatments. They have to get that stone completely down.

WEEKS:

And be sure that it is all flushed out.

GAVAZZI:

But it is great. They don't have to operate. It is a great advance.

WEEKS:

Do you do any transplants anywhere?

GAVAZZI:

No. Well, I shouldn't say no. We have done transplants at the University Hospital in Pittsburgh, the VA hospital, through the university. There is a guy there who I worked with in Chicago. He went to Denver and did some transplants of kidneys in Denver. Then he transferred from the Denver VA to the VA in Pittsburgh. That's the only place we are doing transplants at this time. I'm sure there will be others in the future.

WEEKS:

You do the same things on heart surgery? Do you have that done outside?

GAVAZZI:

Open heart surgery? We have centers. You have to do at least 200 operations a year to remain a center. If you fall below that, you are put on probation. If the second year you don't meet the 200 surgical procedures on open-heart, then you lose the program and you don't get funded for it. We have one in Washington, we have one in Richmond, we have one in Pittsburgh, and in Philadelphia. There is that much of a need.

WEEKS:

You also have a spinal cord center too, don't you?

GAVAZZI:

Yes. We have spinal cord centers, for example, in my medical district I

had none. The nearest one was Richmond. The other one was in East Orange, New Jersey.

WEEKS:

Richmond is only 100 miles?

GAVAZZI:

Yes. That's not bad.

WEEKS:

These 240 clinics you were talking about. Are they walk-in clinics?

GAVAZZI:

Yes. Most of them are in hospitals, but there are a lot of independent clinics like Lubbock, Texas. Philadelphia has an independent clinic. I think there is a clinic in Flint or someplace in this area. They were talking about putting one in Flint. There are 240 throughout the country. A lot of them are in Florida, Texas, and California. They have a lot of clinics there.

WEEKS:

Probably a lot of older veterans are in the sun belt.

GAVAZZI:

I know they put one down in Pensacola, one in New Port Richey, one in Melbourne, one in Daytona Beach, North Hollywood, and Orlando Florida.

WEEKS:

What is the range of their services? Do they do one-day surgery, or is it just sort of an outpatient service?

GAVAZZI:

Sort of an outpatient. They refer all of their surgery to the hospital. For example, Orlando would transfer all of their surgical patients to Tampa. North Hollywood would transfer to Miami. Daytona Beach would transfer their

patients to Lake City and so on.

WEEKS:

I have a note here on satellites. I don't know how to define a satellite, but I suppose that is a minor referral hospital, isn't it? A hospital that refers patients to the centers?

GAVAZZI:

We don't have any satellite hospitals, per se. We have what we call satellite clinics. I have described them to you. For example, Wilkes-Barre, Pennsylvania, has a satellite clinic in Allentown, Pennsylvania. The Miami VA hospital would have three or four satellite clinics. But we have no satellite hospitals.

WEEKS:

The satellite clinics, are they administered by the hospital?

GAVAZZI:

By the hospital in the area. Our medical district concept takes care of the satellite clinic you would be talking about. Let's say, for example, that I had all the hospitals in Maryland and West Virginia. Fort Howard, we would call a satellite hospital because Fort Howard was primarily a rehabilitation and nursing home hospital, no surgery, no internal medicine. Those cases would be transferred to Baltimore or Washington. So Beckley, West Virginia would be a satellite because they would do no surgery. Acute care, but they don't do any fancy surgery. They just do routine appendix and so on.

WEEKS:

Beckley. There was a miners' hospital there, wasn't there?

GAVAZZI:

Yes. We have a 150 bed VA hospital now and a 50 bed nursing home. We

have trouble getting doctors in Beckley, West Virginia.

WEEKS:

I guess that miners' hospital chain sort of stirred up a lot of enmity from local physicians who were not working with the miners. It has maybe carried over after all these years.

GAVAZZI:

The chief of staff from the miners' hospital in Beckley is with the VA now. He used to be the administrator of the miners' hospital in Beckley. He came over to the VA.

WEEKS:

I think you have had a very rich and rewarding life as far as your own self-satisfaction is concerned, and to the good you have done for veterans. I am sure that makes it.

GAVAZZI:

I have enjoyed it.

WEEKS:

I am going to ask you a silly question. I don't suppose you have any nursing schools in the VA.

GAVAZZI:

No, but we have affiliations with schools of nursing.

WEEKS:

Do you take nurses for clinical experience?

GAVAZZI:

Yes.

WEEKS:

We talked about dental benefits and you have mentioned teaching

hospitals. Many of your hospitals are teaching hospitals for both medicine and nursing.

GAVAZZI:

Dentistry and the allied fields.

WEEKS:

Do you take hospital administration residents?

GAVAZZI:

Yes. Pharmacy residents too. There are pharmacy residents. I'm sure you know that. We have designated hospitals that have pharmacy residents.

WEEKS:

Wesbury was a pharmacist, too, in the beginning.

GAVAZZI:

Yes, he was.

WEEKS:

He was in the Public Health Service though.

GAVAZZI:

Right.

WEEKS:

One big problem, I am sure, which isn't talked about much is drug addiction among veterans, particularly those in the Vietnam war. Do you find this a big problem?

GAVAZZI:

No, because we have always had the drug addicts only we treated the drug addicts as part of the overall patient load. I think what started all of this was a certain senator who thought he could use having this storefront setup of drug addict treatment, and it backfired on him.

We don't have the problem that the private sector has. For example, in the Washington area we have a drug clinic one mile from the hospital, on Georgia Avenue, which is the drug area — right off the "drug corridor" they call it. About 140 veterans. In the Washington area there are approximately 420,000 veterans of which 200,000 are in Washington, D.C. You take 160 outpatient drug clinic patients, that's not a helluva lot.

WEEKS:

Is that all there are?

GAVAZZI:

That's all there are in the Washington area who come to the VA. I think, in my own personal views, that we are overplaying this issue, blaming Vietnam. I made a study five years ago of where the Vietnam drug addicts came from and their background. They blamed Vietnam. Eighty-five percent of them were drug addicts before they went into the military. They went into the military so they could avoid going to jail. Some of them were drug addicts in high school. Some were drug addicts because they came from homes where both parents were working and they had nobody to talk to when they got home and little, if any, supervision. They got home, there was nobody home, they went out with their friends.

WEEKS:

Are you talking about hard drugs as well as marijuana?

GAVAZZI:

Yes. I don't think that Vietnam did it. Those guys and gals that were drug addicts in Vietnam, were drug addicts before they went to Vietnam. The majority of them. I don't think it is a big deal. The newspapers overplay it as far as the Vietnam veterans are concerned. I talk to my kids just out of

high school. They knew the drug addicts. A very small number. In my four oldest children's school, the student body was something like 2,000. They didn't have more than ten or fifteen. My youngest son, Michael, who is in his sophomore year in college, I asked -- four of the kids went to Langely High School and the youngest one went to McLean High School. He said, "Dad, we know who they are trafficking in drugs. It is a small number. Fifteen or twenty."

It is the ones who are dropouts who go back to the school and get others involved.

WEEKS:

The kids who carry through are not as likely to become addicts as the dropouts. It is something psychological.

GAVAZZI:

I am sure you read about this guy Len Bias, tremendous basketball player who had a tremendous future. The papers in Washington played it more than they did out here, I am sure, because it is local. It is now turning out with the grand jury that a very small number of the athletes were involved with drugs. A very small number of the student body at the University of Maryland, which is a huge school like the University of Michigan, were actually on drugs.

WEEKS:

Athletes are probably more likely to go to steroids or something like that.

GAVAZZI:

Sure, because a steroid will give you more drive.

WEEKS:

Let's take a section of your hospital where you've got the veterans who have been there a long time and are likely to stay there a longer time. Some of them are probably on drugs or would like to be on drugs. Do you have a problem of people bringing in drugs?

GAVAZZI:

Oh, yes. I think every hospital has that. The hospital that I was at had thirty police officers. They do a good job, but we are constantly catching people trying to bring drugs in. Some are former employees. Some are employees, and we fire them. Some are former patients.

WEEKS:

What do you do if you run into this problem on your staff? Using drugs.

GAVAZZI:

We put them on sick leave to take treatment. We try to rehabilitate them. It is mandatory in the federal sector that you try to rehabilitate your drug addicts, your alcoholics. If that fails, we fire them.

WEEKS:

There is a lot of discussion about taking urine tests for drugs, such as the President did.

GAVAZZI:

He wants all federal employees to do it.

WEEKS:

That's not going to be very acceptable to the employees, is it? It's like taking a loyalty oath.

GAVAZZI:

The unions are going to fight it. The VA has unions. I had to deal with

five unions at the medical center.

WEEKS:

Did you have any 1199 people?

GAVAZZI:

They didn't get there, but they got to some of the local hospitals. Haynes Rice had 1199 coming down from New York.

WEEKS:

I interviewed Leon Davis, the founder of 1199.

I have read several good reports on the purchasing in the VA. Evidently you are doing a good job. For instance, you had five hospitals in your region. Do you have some way of cooperating in purchasing?

GAVAZZI:

It is on a national basis. There are three supply depots. One is in Hines, Illinois, outside of Chicago. One is in New Jersey, and one is in California. These three depots do centralized purchasing for the whole VA. There is a huge saving in that, as you know. Vegetables and so on, we do on a local basis. We do it with the private sector hospitals. For example, we go with the Washington Hospital Center and Howard and so on when purchasing vegetables or eggs locally. We save money that way. Most of our large purchasing is done through the depots. We get deliveries once a month.

WEEKS:

Do you have standardized items on your inventory?

GAVAZZI:

Yes.

WEEKS:

What do you do if you want something special?

GAVAZZI:

If a physician wants a special medication...

WEEKS:

Or special instruments.

GAVAZZI:

We have a quality review committee at the medical center level and at the medical district level. We go before that. There will be peers, surgeons, pharmacists or whatever. They will agree or disagree. If they say we shouldn't go any further we drop it. We say,"You can't do it. If you want to buy it out of your own pocket, fine." If they say we should go ahead, we go to the central office and say that we have the recommendations and that we can absorb the additional costs and they will let us buy it.

WEEKS:

So there is a way out.

GAVAZZI:

Oh, yes. Frequently a surgeon can only use a certain type of tool to do surgery. If he or she had been used to doing this wherever they came from -- could be Strong Memorial or Mayo Clinic.

WEEKS:

That brings up another question. Do you have inservice training? For instance, nurses. Nurses coming out of different schools and out of different work situations are allowed to do different procedures. What if they come to your hospital and they don't know how to do things?

GAVAZZI:

They go through a complete ninety day orientation where they will have to learn all of the procedures that we have that are standardized procedures.

One may have done it, and she may have to go through it again. The other one may not have done it. The nurses go through a ninety day orientation where they have to learn the whole VA procedure under supervision before they are left alone on their own.

WEEKS:

Is there any change in the nurse's role, the procedures she can do? Are there independent judgments she can make? The nurses want a more professional role.

GAVAZZI:

Not in the VA. There is no change in the VA. It comes up every six months that they want to do certain things. For example, they don't want to go to the pharmacy to pick up medication. They want clerks to do that for them. We find that the nurses still want to go down because they want to get off the ward. So they go down to the pharmacy to get out of the ward for a few minutes. Also they want the secretaries to write down the doctors' notes and nurses notes on the charts. Some of the secretaries can't even read or write, and they have to learn medical terminology, and they can't do it. The role hasn't changed very much in the VA.

WEEKS:

I was thinking of the nurse practitioners and the clinical nurse specialists.

GAVAZZI:

Oh, we have those. We have physician assistants, too.

WEEKS:

Have you developed that very far?

GAVAZZI:

Yes. When I left the hospital we had six physician assistants. They were working in the outpatient clinic, emergency room, OR, dialysis unit and coronary care unit.

WEEKS:

That was one of the early criticisms after World War II that you had all this supply of medics that aren't being used according to their ability or at least trainability. Now I see you are doing it. Have most of them taken the regular physician assistant's courses?

GAVAZZI:

Yes. They have to be graduates and licensed. They have to go through a licensing process.

WEEKS:

You must know Steve Lipson.

GAVAZZI:

Oh, very well. Steve just left us to go to Ohio.

WEEKS:

I had a note from him the other day. He used to be at Michigan, you know. He is a good friend of ours. He usually comes up here for the Ohio State/Michigan game every other year.

GAVAZZI:

He went to work with Don Newkirk. Do you know Don Newkirk?

WEEKS:

I know him by name.

GAVAZZI:

I think Don plans to retire and Steve is going to take his place. He did

an outstanding job for us in Washington.

WEEKS:

He is really a bright, young guy.

When we were talking about the means test and the ceiling, is there any time that a vet has to pay a part of a fee?

GAVAZZI:

Only if he or she has an income that exceeds that ceiling, then they have to pay part of the cost of the hospitalization.

WEEKS:

When you say he or she, do you have many women vets?

GAVAZZI:

Oh, yes. Ten percent. It has gotten that high since Korea. A lot of women went to the military after World War II and Korea. I go through Fort Meyers. I am a retired military, and we do our purchasing at the commissary. When my wife and I drive through Fort Meyer, we are amazed at the number of women. You see them marching and you see ten or fifteen women with twenty or thirty men, marching with them. It's not the way it used to be.

WEEKS:

As they say, women are getting into everything.

We talked about civilian accidents. We talked about ambulatory care. Do you use second opinion or pre-admission procedures?

GAVAZZI:

We have pre-admission procedures, and they could get a second opinion at their own cost. We come up with one opinion, and if... Our chief of surgery, for example, will determine whether that person should get a second opinion. He feels that his surgeons, once they make the diagnosis which he reviews, is

adequate. But if a person wants a second opinion, they can do it at their own expense.

WEEKS:

I wondered if you do that to shorten the stay or cut down on admissions possibly?

GAVAZZI:

No.

WEEKS:

Another thing that isn't talked about much. Do you think that the suicides in your hospitals are greater in number than in general?

GAVAZZI:

No. Sixteen years at the VA hospital in Washington, an occupancy rate of 88% to 90%, we had two suicides.

WEEKS:

Is that right?

GAVAZZI:

At Martinsburg, four years there, with a different type of patient, in that four years we had five suicides. Most of the suicides at Martinsburg occurred on a holiday. Two on Veterans Day, one on Memorial Day and one on Lincoln's birthday, as I remember it. One was unrelated. All except one, they committed suicide on the eve of that holiday. Melancholy. They were domiciliary members, not hospital patients.

WEEKS:

People who don't have a very rosy outlook.

Do you have any women physicians?

GAVAZZI:

Oh, yes, lots of them.

WEEKS:

The schools are running about thirty percent women now, aren't they?

GAVAZZI:

Georgetown, the last I heard, was 26%. GW was running 35%. Howard was runing only about 10%.

WEEKS:

You talked about the TB hospitals being discontinued as separate entities now. One thing that surprised me when talking to Haynes Rice was to learn that in Washington, D.C. in the ghetto areas that TB was quite a serious problem yet.

GAVAZZI:

Not only in Washington, but in New York and Chicago.

WEEKS:

The thing that most of us forget is that many of the people in those areas are domestics who go out into the suburbs and carry it with them. We can't isolate ourselves.

GAVAZZI:

Not completely.

WEEKS:

This completes that section of the interview. Shall we run over some of your memberships and affiliations?

How about the Academy of Medicine in Washington, D.C. I note you are a member.

GAVAZZI:

Yes. They only have four non-physicians in that. I happen to be one. Well, they have three now because Leon Ginzig died. Leon and I worked together when he was at Downey. Then he went for his Ph.D. Then we worked together in Fort Howard, one of my hospitals, when he set up a testing and development unit out there. Then we lived near each other in Bowie, Maryland, the first time I was in Washington.

WEEKS:

I was sorry to hear that he had died. I met him at AUPHA meetings.

GAVAZZI:

This is a very important group in Washington, primarily physicians. For example, all of the deans of the medical schools belong. The military school presidents belong. It is a very select group. How the hell I got elected, I don't know. My staff, I guess, got me to be elected. It meets four times a year. I am the secretary-elect next year. They bring outstanding speakers from all over the world.

WEEKS:

How large a group is it?

GAVAZZI:

Oh, about 100 at the most. The last count was about 98. It is a bunch of retired admiral physicians and general physicians who remain in the area, real outstanding guys. There is one little guy who is ninety-one years old. He comes to the meetings. He was with Byrd in the the exploration of the poles. He will sit and talk and tell you about his experiences. It is very interesting. They meet at the Cosmos Club which permits no women, incidentally. Last year we admitted women to the Academy.

WEEKS:

Several people that I have interviewed belong to the Cosmos Club in Washington. What is the Cosmos Club?

GAVAZZI:

It is an all male club just like any other country club only it started there.

WEEKS:

Is it a dinner or luncheon club?

GAVAZZI:

Dinner, luncheon, and they have rooms where you can sleep. It is an ordinary private club that they started years ago to gather the elite of Washington. On the third and fourth floor they have rooms that you can rent. This gentleman that I told you about lives there. They have lunch and dinners. And, if, for example, you had a daughter getting married, you could use that if you are a member for a reception.

WEEKS:

What is the purpose?

GAVAZZI:

Just a place to get together.

WEEKS:

Is Dr. Cobb a member of your academy?

GAVAZZI:

Yes.

WEEKS:

You have been guest lecturer at a number of universities, haven't you?

GAVAZZI:

Yes. I helped set up the schools of hospital administration in Sao Paulo and Rio de Janiero. I was invited down there by an internationally known guy in hospital administration from Sao Paulo. I had a physician from Brazil as my resident. When he went back he told them about me so they invited me down for a month to help them set up the first school of hospital administration. Then this fellow's father-in-law and mother-in-law built him a 700 bed hospital when he finished his training. So he wanted me to go down and help him get it started and start the second school in hospital administration outside of Rio de Janiero. So I went down there again. It was a lot of fun.

WEEKS:

Would you like to comment on other lectureships?

GAVAZZI:

I have lectured in Italy a few times. What I like to tell about that is that I frequently give my lectures in Italian. I have a lot of fun with that. I get up there and ask how many understand English. You will have maybe eight or ten, and have maybe 100 people there. So I ask how many understand Italian and everybody puts their hand up. So then I say, "Okay, I will try to give it to you in Italian." I go through it and I usually get a standing ovation for being an American and giving it to them in Italian.

WEEKS:

Your accent is quite legitimate, huh?

GAVAZZI:

Oh, yes. At one lecture that I gave at the University of Bologna School of Medicine, there were a bunch of American students. Italy has a lot of physicians. They drive cabs and are waiters because there are too many

doctors. I gave this lecture and when I got through the professor asked if anyone would hazard a guess as to where I was from. "Tuscany." He said, "No." "Rome." Again, he said, "No, he's an American." So these American students said, "If he is an American, ask him questions to make sure that he really is an American." So they asked about baseball and football. Then they knew that I was an American. I had a lot of fun with that.

WEEKS:

That must have been a lot of fun.

GAVAZZI:

I impressed my son on this last trip we took because we were in a hotel and I got into a conversation with some people. One fellow said, "Gee, you are pretty knowledgeable for being a Tuscan."

I said, "What do you mean?"

He said, "Well, you are from Tuscany, right? You have a Tuscan dialect."

I said, "There is no such thing as a Tuscan dialect because the Italian language by Dante started in Tuscany. So if you speak Tuscan you speak the Italian language." I had to show him my passport to convince him that I was an American. I was watching my son and his eyes were getting bigger and bigger.

Then he said, "How long have you been in the United States?"

I said, "Since I was nine." My son thought his father was important for the first time in his life, I think.

WEEKS:

Was your family from Tuscany?

GAVAZZI:

My father was, yes.

WEEKS:

I have you down with the AAMC.

GAVAZZI:

Yes. I have been involved with the AAMC, have been on their education committee, chairman of their annual meeting. The one nine years ago in Washington.

WEEKS:

I had no idea until I talked with John Cooper just how extensive -- of course I knew there was a AAMC and a council of teaching hospitals, but I never really realized that they have as wide a membership as they have, or had as much influence as they have.

GAVAZZI:

Oh, tremendous. They have a great influence. Before him, Matt McNulty had it before John Cooper. Do you know Matt?

WEEKS:

I know who he is. He was from Alabama, right? That was later though, wasn't it?

GAVAZZI:

He was the assistant director at Chicago Research when it opened. In those days -- this is something I should have brought up earlier -- in those days you could not be the director of a teaching hospital, which Chicago Research, or Lakeside was unless you were a physician.

One thing that I failed to mention was the fact that when I was in the job of executive assistant to the chief medical director at the headquarters office, the American Psychiatric Association would permit no one except a psychiatrist to manage our VA psychiatric hospital. We couldn't find anyone.

I appeared before them and said, "I can get you a good administrator, non-physician, and have the chief-of-staff a psychiatrist. I think we'll have better managed hospitals." I appeared before them the second time and said the same thing. I said, "We can't find any administrator/psychiatrists that are worthwhile. Let me try an experiment. Let me appoint five non-physician directors to any five hospitals that you gentlemen select. If they can't do a better job in a year than a psychiatrist, we'll go back to it."

After a couple of months they agreed. We took five psychiatric hospitals, Downey was one, throughout the country. We put in five top-notch non-physician administrators. Within six months they said, "If you can find that kind of administrator, we won't insist any more that your administrators be psychiatrists, but we do want the chief-of-staff to be a psychiatrist."

I said, "Fine, it's agreed." That was in 1969 that we broke that. From that point on you don't have to be a psychiatrist to be the head of a VA psychiatric hospital.

WEEKS:

That was good progress.

You have worked a great deal at the AHA, too, haven't you?

GAVAZZI:

Oh, yes.

WEEKS:

I have you down for chairman of the federal hospitals committee. You served on the Council on Human Resources.

GAVAZZI:

Yes, for four years.

WEEKS:

You were a member of the American Association of Hospital Consultants.

GAVAZZI:

Yes, I have been for ten years. No office, though.

WEEKS:

And the American Association of Hospital Planners. Your construction work all came in there, didn't it?

GAVAZZI:

Yes, sir.

WEEKS:

You served as a resource member in the American Bicentennial Research Institute? Was that a federal group?

GAVAZZI:

No. It's a general group working on the bicentennial for the whole country, to come up with some ideas.

WEEKS:

That must have been rewarding.

GAVAZZI:

It was interesting. It was frustrating as hell because your decisions were made before you came up with them. We came up with good ideas, but if they were not politically acceptable we had to put them down the drain and start all over again. But it was a lot of fun.

WEEKS:

There are politics in everything, especially in your line of work. You have to always fight that.

About the American College of Hospital Administrators. An interesting

thing to me is your being a member of the Commission on National Health Insurance because when we get to the future I am going to ask you what you think of the future of national health insurance.

GAVAZZI:

I served on that for three years.

WEEKS:

And on the education committee. What were their parameters? What did they include? Was it hospital administration education, continuing education?

GAVAZZI:

Continuing education, primarily.

WEEKS:

I noticed the last time I was down there there were some young people taking the self-evaluation tests.

GAVAZZI:

Yes. This is for advancement to fellowship.

WEEKS:

That would have a connection with the educational requirement too, wouldn't it?

GAVAZZI:

Yes, it would. We came up with speakers, what was needed, how often people should attend, where we should have it. Location, as you know, is a factor. Someone said, "Let's have one in Boise, Idaho." So we went along with that, but we only got about thirty who wanted to go to Boise. We had it anyway, but we are not going to have it in Boise again, I'm sure. Then we came up with the idea of having the congress in -- Dick Stull was in then -- having the Congress in the southern part of the country, Florida, Louisiana,

California. We had a general who was a member of the group, Jim Polkinhorn, who said, "We are closing a base down in San Juan. It is just ten miles from San Juan proper. We have these barracks. We could make them available. We have the officers' quarters that have 100 sleeping private rooms and so on. We have the facilities for lectures. We'll make it available."

So we made that recommendation. Let's go south and let's go to San Juan. We thought Dick Stull was going to have a coronary. He had one a couple of years later. He says, "We can't because it is too expensive to move the staff out there and so on."

We said we thought it would get a larger attendance. He said, "We're getting an adequate attendance here, plus we are committed in Chicago until 1982."

To make a long story short, shortly thereafter we were all removed from that committee. There was a brand new committee.

WEEKS:

Dick was quite an intense man, wasn't he?

You mentioned at lunch about your trip to Lisbon. Was that an AUPHA or American College trip?

GAVAZZI:

AUPHA.

WEEKS:

You served on the research and development committee of the College too. What are their research interests?

GAVAZZI:

Research and administration, for example, multihospital systems. We came up with what would be an ideal multihospital system structure. We took

hospitals in New York, we took hospitals in L.A. We came up with what we thought would be ideal for merging and so on and so forth. Some of the things are being done now by the hospital. What we came up with then, nothing was done right away, but now they are adopting it.

WEEKS:

Quite often that's the case.

GAVAZZI:

Apparently someone backed up and found out it's working. Sister Irene Kraus has just become head of the Catholic hospital order out of St. Louis that is consolidating. Do you know Sister Irene Kraus?

WEEKS:

No. I have seen her name a lot. I was just thinking, I interviewed Sister Maurita. You probably know her. She is out here at Mercy out in Farmington Hills. There are some very bright women in those Catholic orders, aren't there?

GAVAZZI:

There sure are, but there are some dumb ones too. That's their whole life. They are well read, better than most because they have nothing else to do except stay there.

WEEKS:

I often wonder about the future of the church orders.

GAVAZZI:

They are in difficulty. They are going to contracts and they are going to non-nun administrators.

WEEKS:

St. Joseph's, here, has a lay administrator. That's about 500 beds, I

think.

GAVAZZI:

They have also contracted out quite a few in the east. They contracted out a hospital in Cumberland, Maryland and one in Baltimore.

WEEKS:

In the multihospital systems study, did you look at both not-for-profit and for-profit?

GAVAZZI:

Not-for-profit, for-profit, federal, state, county, the whole system. We looked at Catholic, Lutheran and so on.

WEEKS:

You are still the biggest system though, aren't you?

GAVAZZI:

Yes.

WEEKS:

You were ACHA regent for the District of Columbia?

GAVAZZI:

Yes. Haynes Rice succeeded me.

WEEKS:

Then I have the ACHA Task Force on the Commission on Education. That's what we were talking about before. Then there is the Task Force on Selection Criteria for Health Care Executives.

GAVAZZI:

That's when we came up with, for example, the criteria insisting that to get into the College you had to have a baccalaureate degree, with the grandfather clause in. Then we developed the questions which should apply not

only to the private sector but to the federal sector. Ask everyone to answer questions that apply to the private sector as well as the military, as well as the VA, as well as the state, county, and city. Those people were complaining that all of the questions were relating to the private sector, but the private sector people did not have to know anything about the federal, state, and county sector and so on. That is something that has been adopted since.

WEEKS:

So you have a pretty good mixture of questions then?

GAVAZZI:

A mixture of questions not slanted one side but the whole gamot.

WEEKS:

We all should know. As I told you when we began, I sat down here very ignorant of the Veterans Administration. I've seen this hospital here. I have seen them in the Detroit area. I know there is one in Battle Creek, but I didn't know how they operated for sure.

I see you also got into another medical enclave in the Association of Military Surgeons.

GAVAZZI:

Oh, yes. That's a big organization. They are having their 89th meeting in San Antonio. The name military surgeon was chartered by Congress years ago. It originally started off as sanitary officers in the military, primarily sanitary officers were physicians, dentists, and sanitarians. Then it mushroomed and included all physicians, nurses, and pharmacists. Then it brought in the administrators, the social workers, and the psychologists. Now the Association of Military Surgeons is a large organization with a membership of about 22,000. They have a meeting once a year. I have been general

chairman; committee chairman; everything in that. It is a big meeting with good programs, just like the American Hospital Association.

For example, the pharmacy group will have a two-day session where they will bring speakers in from all over the world to bring us up-to-date on new pharmacy procedures and drugs and so on. It is a big organization with the headquarters in Maryland.

WEEKS:

I remember seeing the journal and reading some of the issues of it when I was at the university.

You also attended the AUPHA seminar in Helsinki, too.

GAVAZZI:

Yes, with our friend. That was a tremendous one.

WEEKS:

It must have been. A couple of people from Michigan went to that. In fact, one of the reasons this program started, that I started doing these, was that we had a young faculty member who went to this Helsinki meeting...

GAVAZZI:

John Griffith?

WEEKS:

No. John was the director at that time.

GAVAZZI:

He was with us.

WEEKS:

Bob Allison was who I was thinking of.

GAVAZZI:

Sure. I know Bob.

WEEKS:

Bob came back and said, "You know, I had a wonderful experience. I was in Helsinki." Of course I knew that. He said, "I sat down and talked one afternoon with George Bugbee, nearly all afternoon. I just wish I had been able to record that." That made me think. I had been to Columbia and had spent three days with their oral histories when I was writing my dissertation. I was very much impressed with them. I was getting this degree from Michigan State. I came back and talked with the officials of the MSU library.

I said, "What we should have is an oral history program for the State of Michigan. We should interview leaders in Michigan." We've got the automobile industry here, we've got lots of different things that should be recorded. They turned me down. Later they did it. I got to thinking about it and I called George and asked him if he would sit for my first interview. I went to Chicago and sat with him in the Lakeside Veteran's Hospital where he had an office. I had two sessions with him, a couple of hours each. That was the beginning.

Whenever anybody says anything about Helsinki, I can't help but think I have some connection with it.

GAVAZZI:

The interesting thing on Helsinki is that all of the street signs are in two lanquages. One is in Finnish and one in Russian.

WEEKS:

The Finnish language is something like the Hungarian, isn't it?

GAVAZZI:

I don't know. It's different than the Russian. I kept looking at those signs and they were very different.

WEEKS:

It is different from German or English or Spanish.

GAVAZZI:

Or Swedish.

WEEKS:

Some languages you can trace to Latin or to early English. But you can't, I guess, with Finnish.

GAVAZZI:

I guess so. We discussed it, and none of us could come up with anything. An interesting thing. Another experience that to me was a shocker was going into one of those sauna baths. I don't think Bob Allison was with me, but Barry Green, who headed the school of hospital administration in New Orleans, we were sitting in this sauna bath sunning ourselves with no clothes on, just a towel next to us. In came three or four women with a guy, completely naked, and sat opposite from us. We didn't know what the hell to do. So we all reached for our towels. They said, "No." and we talked back and forth. I couldn't talk. They spoke English, but I couldn't talk.

WEEKS:

That would be quite a shocker. You begin to realize that Americans are quite different in many ways.

GAVAZZI:

George had the room across from me in the school where we stayed. He brought two bottles with him. He kept asking me to come over and drink with him.

WEEKS:

I like George. He had a little trouble with his eyes recently. He has a

restricted driving license. He can't drive at night.

What is the Federal Health Executives Institute Alumni Association?

GAVAZZI:

The forum was an offshoot of that, that George Bugbee had. The Federal Health Care Executives Institute is an institute for Army, Navy, Air Force, Public Health Service, and VA chief executive officers. We had the Canadians in on that. They have two a year. There are usually about thirty attendees. It has been going on since 1948. There is an alumni association. I've been president, secretary, and now I have been elected to be the executive secretary to take over at the next meeting which will be in San Antonio in November with the meeting of the Association of Military Surgeons.

WEEKS:

In this institute what do you do, have speakers come in?

GAVAZZI:

It is a two-week session. Now it is held in Washington. Ray Brown ran it for a while before he died. When he died we moved it to San Antonio where it was taken over by the school. A fellow by the name of Fred Gibbs -- did you know Fred Gibbs?

WEEKS:

Yes.

GAVAZZI:

Well, Fred Gibbs, when he was at GW, ran it for a number of years. Then he gave it up when he retired and we gave it to Ray Brown. You have speakers, you have field trips. They brought in Chester from England every year. After a while people said, "He keeps saying the same thing. We can read what he says and to fly him in and back is quite expensive." So they dropped him.

They have two a year, with thirty people attending.

WEEKS:

Do they publish any of those papers?

GAVAZZI:

Yes, they do. They publish quite a few of them in different publications. It depends. They don't publish a meeting, but, for example, a physician will publish in the New England Journal or the AHA journal.

WEEKS:

Is this different from the Federal Interagency Institute?

GAVAZZI:

Yes. That is another group. That one is a group where people of GS16 and above, from all agencies in government, go to the University of Virginia in Charlottesville. When I went it was six weeks, now it's four weeks. You are exposed to people like the Vice President. Carter talked to one group. All of the cabinet members will come down and talk about what they are faced with, what the day's problems are and how they hope to solve them.

WEEKS:

From the title here it would seem that the committee would be trying to find ways that agencies could work better together.

GAVAZZI:

Work better together and to bring topics that would be acceptable and useful to all agencies.

WEEKS:

The Health Care Planning Council for the District of Columbia. That's different from the association that Steve Lipson was with?

GAVAZZI:

Oh, yes. This is a state health coordinating council for the District of Columbia, like you have for the state of Michigan. Giving certificate of need and so on and so forth.

WEEKS:

Just in passing, I see that you are a member of the Illinois Hospital Association. And the King's Fund College of London.

GAVAZZI:

That was a special group. They brought in thirty-five English-speaking people from all over the world, Australia, New Zeeland, Canada, United States, South Africa, and two Russians who spoke English. We met for three weeks at the King's Fund College to discuss national health care issues facing every country. That is where I met Sister Irene Kraus. She had just moved from Nashville to Providence Hospital in Washington. She hadn't reported at Providence yet. I had written her a letter congratulating her. She got the letter, and she said she hadn't had a chance to answer because she had gone to visit her mother and then went to London.

That was a tremendous one. I had my wife with me, but they put us in a building where husband and wife couldn't sleep together. So she was upstairs, and I was downstairs.

WEEKS:

That was on Bayswater Road?

GAVAZZI:

Yes.

WEEKS:

I was there one time. I have forgotten the names of the people.

GAVAZZI:

Frank Reeves was one of the guys there. Frank has retired. I brought him to lecture a couple of times.

WEEKS:

He was here in Ann Arbor about twenty years ago.

GAVAZZI:

I arranged for him to be in different places. He was going to Toronto. I don't think he came to Ann Arbor that time. I arranged one session for the VA only and one session for all the health care people in the Washington metropolitan area, which included Maryland and Virginia.

WEEKS:

I liked him very much.

Miles Hardie was here. He used to be at the Centre. I interviewed him, so I have one Englishman anyway.

Military Medical Services Corps Chiefs and VA ad hoc committee. That must be a combined ad hoc committee.

GAVAZZI:

Right. I was the top VA non-physician administrator, and we set up a special program. We set up the speakers for the Interagency Institute. We made the original recommendations to the Surgeon General and the Chief Medical Director because they are the ones who run the Institute. Our job was to come up with the speakers. Once they approved it, then it went down to the Institute.

WEEKS:

Is that the Surgeon General of the Army?

GAVAZZI:

The Army, Navy, Air Force, Public Health, and the Chief Medical Director of the VA.

WEEKS:

Is the chief medical director a surgeon general?

GAVAZZI:

He is equivalent to a surgeon general.

WEEKS:

The nearest I have gotten to that is Faye Abdellah, the Deputy.

GAVAZZI:

She is very close to Koop. He got into trouble on that advertisement on smoking, you know. He wanted to testify on abolishing the advertising for smoking. He wanted to do away with it. He was ready to testify before Congress when the lobbyists for the tobacco industry heard about it. They got to the White House and Regan, the Chief of Staff, called him and said, "You will not testify." He had to back off.

WEEKS:

That tobacco lobby must be strong.

GAVAZZI:

They have a lot of money and a lot of support.

WEEKS:

Providence Hospital in Washington. Are you on the board?

GAVAZZI:

I have been on the board for eight years. Then I laid off for two years, and I am back on it again.

WEEKS:

Planning task force. Was that building planning?

GAVAZZI:

They had a five year master plan which I worked on. They built an addition and a doctors' office and a psychiatric wing.

WEEKS:

I don't know how you find time to do all of these things.

GAVAZZI:

I have a very understanding wife.

WEEKS:

That helps. Trinity College preceptor. Were you there when Chuck Austin was there?

GAVAZZI:

Oh, yes.

WEEKS:

I know him quite well. He's in Georgia now, isn't he?

GAVAZZI:

He was, but I think he left.

WEEKS:

I haven't seen him in quite some time.

I have been meaning to ask you -- two or three of my interviewees have been Fellows of the Royal Society of Health. How do you get to be a fellow?

GAVAZZI:

You stay a member, pay your dues for six years. Then they write you a letter asking if you can answer these questions. If so, you send the answers. It's a couple of paragraphs. You don't know if you did the right thing or

not, but the next thing you know you get a letter indicating that you are advancing to fellowship and your dues are increased.

When I was in England six years ago, I decided to check into it. I found out that I was putting my money in the wrong place. They really are nothing, just a name. So I dropped out.

WEEKS:

I wondered what you had to go through to become a fellow.

GAVAZZI:

It was very simple. Had I visited there when I was at King's Fund College, I would have dropped then and there. I was putting $45 every year down the drain.

WEEKS:

The Washington D.C. Hospital Council.

GAVAZZI:

That's Steve Lipson's.

WEEKS:

I was thinking that since the District of Columbia is only a small part of the metropolitan Washington area that it is very difficult for an association to be effective.

GAVAZZI:

That's what Steve found out. The one that he belonged to was only District of Columbia. The other one, Metropolitan Washington Hospital Council, is a purchasing group. They go into Maryland, take in the whole state of Maryland, and take in all of Northern Virginia, and the District. But they are primarily a centralized purchasing organization. We were able to get both organizations, hopefully to get them combined into one, to move into

the same building, to share conference rooms, and to share receptionists and so on, which they have done now. I was on the board when we made that recommendation, and Steve bought it reluctantly. The other fellow didn't buy it at all. Some members of the board were board members of both, so we pushed it through. They're saving money. There is no reason for both of them. There should be only one. We thought if wé got them located on the same floor maybe someday they would get together.

WEEKS:

You must have a lot of trouble in the Washington area with the different states of Maryland and Virginia, and the District, all having, in many cases, different kinds of legislation or different kinds of regulations.

GAVAZZI:

Yes. Let me tell you an interesting story. We had a veteran who died in the hospital. This veteran was from Maryland. No family. We arranged to bury him in the Quantico National Cemetery. We had a contract with an undertaker that anyone who dies, who has no family, we will put them in a national cemetery. This fellow had a Purple Heart and everything. They will take care of him. It's very cheap. At that time it was $350. Our purchasing people had developed the contract which met all of the federal specifications. So what happened was the undertaker met all of the requirements. He transported the veteran from the hospital to the mortuary, to Quantico, Virginia -- another jurisdiction. Remember, he lived in Maryland; died in the District; buried in Virginia. The undertaker met all of the requirements for Virginia, met all of the requirements for the District. He did not meet the requirements for Maryland, but it didn't matter because he died in the District, and there was no foul play or anything like that.

When they went to bury this veteran, one of the pallbearers, grave diggers, dropped part of the casket. As he dropped it, the casket broke open. It was made out of cardboard. That part wasn't bad, but the body was wrapped in a sheet. The contract specified that he could be buried either way depending upon the next of kin. He had no next of kin. The grave diggers refused to bury him.

There was a color guard from the Veterans of Foreign Wars chapter that he belonged to in Virginia who called the newspapers and the TV, and made a big deal out of it. They put him in the holding section of the cemetery. The administrator called me up raising all sorts of hell with me. I said, "Mr. Administrator, it is not my responsibility. It is the responsibility of the mortuary people."

He said, "But he died at your hospital."

I said, "Yes, but the minute we make a contract, we get out of the picture. We've done our job. It met the requirements of the District of Columbia, and it met the requirements of Virginia. We did nothing wrong. We followed the regulations. What we have to do is change our regulations, they are fifteen years old. The price we are paying today was okay fifteen years ago, but they are not today."

We made the television and the newspapers and everything else. The hospital was blamed, the mortuary people were blamed, the undertaker was blamed. We refused to pay him. Eventually, we buried him in a different casket. A new regulation was written to pay them, instead of $300, pay them $650, and the casket must meet certain criteria and so on and so forth.

When you speak about jurisdiction, this is an example. We have a lot of problems. For example, if a veteran is shot in Maryland and is brought to the

VA, the District of Columbia has jurisdiction even though he is shot in Maryland or Virginia. We go through all sorts of problems with that. They fight back and forth among themselves. We take care of the patient.

So you bring up a very interesting point.

WEEKS:

The only thing I haven't touched on here is the Senior Executives Association, the VA Chapter.

GAVAZZI:

Okay. You probably have read in the papers about Congress trying to take certain benefits away, cost-of-living for retired military, Social Security recipients, VA retirees and so on. Six years ago they did away with a special category of people. They said -- Carter did this -- they said, "You, Lew, you have a choice. You are going to head this hospital or this program. You have a choice of remaining in the general schedule or going into the senior executive. If you go into the senior executive category, you will be able to get a bonus and you will get this salary, and you can continue your annual leave. You don't have to lose it at the end of each year."

There were some 2,000 people who were brought into the senior executive category -- that's a pay level. They did away with the GS 15, 16, 17, and 18 for certain executive positions. They came up with senior executive 1 through 5. The bad feature about that was that as a senior executive, your boss can say to you, "Lew, I don't like the way you comb your hair. You and I don't get along. Our chemistry doesn't work. I want you to go back to the job you had before." You have no appeal right.

I saw this as a threat to us medical center directors. Any congressman who had a friend, let's say, in Saginaw or Iron Mountain, Michigan, and this

friend who took three courses in health care, and he could say, "I want John Smith to be the administrator of that VA hospital. Get Lew out of here, and get him back in Washington or someplace."

We went to Congress and said, "We want to be removed from that criteria. We want to go under Title XXXVIII." Under that you can only be removed for cause. We did that to protect ourselves. To safeguard our position, we set up what was called the Senior Executive Association in the VA. All of the medical center directors and the clinic directors, 182 medical center, 240 clinics, of which about 90 have directors. We formed our own association because we felt we could get to more congressmen and senators because each hospital has a congressman. They are located in Congressional districts. Then when they talked about doing certain things we could take action.

For example, we went to bat to have our cap on what we could make, which at that time was $52,000, raised to $65,000. It was a very close vote. I took three days of annual leave and walked through the Congress pigeonholing certain congressmen who were on the borderline. At the same time we made phone calls to certain directors to see their congressman in their respective areas, those congressmen whom we felt we had to win over to our side. On that basis we were able to lift the cap to $65,000.

I was made chairman. They wanted me to be president. I said, "No. We should have a board of directors, and I'll take the chairmanship." So I've been that. In the meantime, all of the other agencies have done the same thing. So now we have one large Senior Executives Association, with direct access to the people who make the laws dealing with federal pay and benefits.

WEEKS:

You should have quite a lot of clout then.

GAVAZZI:

A lot of clout, but it's a lot of work.

WEEKS:

And you have a separate VA chapter.

GAVAZZI:

Yes. I have just resigned from it effective October 1st, because I think it should go to some younger guys who have access to a telephone. I don't have access to a telephone except mine. I'm not about to pay those phone bills out of my pocket.

WEEKS:

You have quite a series of awards and honors. Could we run down through these? Administrator of Veterans Affairs Distinguished Outstanding Performance Award. Need we say more?

GAVAZZI:

They only give two or three a year. You only get one in a lifetime.

WEEKS:

The American Legion Post Mortem Award, is that correct?

GAVAZZI:

Yes, it is correct. It is a group of people over fifty-five who belong to the American Legion and their role is to safeguard the burial rights of any Legionnaire.

WEEKS:

This is using the Latin in its best sense.

GAVAZZI:

It is. They are not dead.

WEEKS:

You have a citation for outstanding service to the hospitalized veterans of Washington, D.C. in 1972. And a life membership in AMVETS.

GAVAZZI:

AMVETS also gave me the Silver Helmet Award. I am the only medical center director to have gotten one. The year I got it, Margaret Heckler got one, Joe DiMaggio got one — there were six given that year. This year they gave one to Ronald Reagan. They usually give the president one. It's solid silver. When I got it it was worth $300, if you melt it down. It's a beautiful thing, and I'm proud of it.

WEEKS:

That's wonderful. And to be among such distinguished Americans.

The Disabled American Veterans have cited you also, haven't they? You have two from them. You have a life membership from the Dwight chapter and the Distinguished Service Citation on behalf of the disabled veterans. And the National Commandery Award.

GAVAZZI:

That's a big award. The National Commander for the whole United States. The others are local, but that one is national. They give it at the national convention.

WEEKS:

The Federal Health Care Executives Institute Alumni Association also gave you a distinguished service award.

GAVAZZI:

Plus $500. That was big. The others had no money.

WEEKS:

And the Italian American War Veterans, they appreciate you too. And the Ray Brown Award. From whom is that?

GAVAZZI:

That's $1,000. That's given by the Association of Military Surgeons. That award, if you go to Chicago, Stu Wesbury has it in the Ray Brown room. He's got the award and the awardees by year on the wall of the room.

WEEKS:

The American Hospital Association library has a Ray Brown collection of his books that he gave them.

GAVAZZI:

This is the Ray Brown room. It may be in the library. They just put it in there last year so that people could see it.

WEEKS:

You've gotten a lot of performance awards from the VA, haven't you?

GAVAZZI:

Money went with those. Those are very important.

WEEKS:

You got an award from the Senior Executives Association.

GAVAZZI:

The Presidential Award, yes.

WEEKS:

The Veterans of Foreign Wars, a life membership from Martinsburg. You got a lot of them.

GAVAZZI:

Do you know what I did? This might surprise you. I took them home. I

had so many of them that I just took them and put them in a locker upstairs in the attic. I don't have any showing. The only one I have showing is my Silver Helmet Award. I don't have a room like you have. If I could get one of my daughters to give up her room, I could bring them back and display them on the wall.

WEEKS:

Do you mind talking about the future a little bit? What do you think the possibilities for national health insurance are? And if it comes, what will happen to the Veterans Administration?

GAVAZZI:

I don't think we are going to have a national health insurance. They've been talking about it for twenty years.

WEEKS:

Just lately I have heard two or three others bring it up again. I suppose this is a recurrent thing.

GAVAZZI:

If it did come about, the VA would play a major role in implementing it.

WEEKS:

Wouldn't this be an example of what could be done? You've had experience here since Warren G. Harding, and before.

GAVAZZI:

Except you've got the 26 or 27 million veterans and the lobby that won't permit it to ever be separated. It would make sense. I think it would be great, but these veterans' lobbies want special medical care for "he who served his country."

WEEKS:

There is no argument against that. These people who are arguing against it are not arguing against veterans as much as they think maybe they can reduce the costs. I doubt whether we could run the Veterans Administration health service any cheaper under another cloak.

GAVAZZI:

I don't think you can. The VA is probably one of the least costly, most well-run health care systems that I have seen. I've been around, and I have seen quite a few of them.

Comparing the hospital across the street, we have, at our medical center, not including the people who are assigned there like the Armed Forces Institute of Pathology at Walter Reed and so on -- some 2,300 employees. Across the street, a hospital not as large has 3,400 employees. Their chief executive officer gets $200,000 a year, with a lot of extras. He has an expense account. He has 17 assistant administrators who make $80,000 to $110,000 a year. I had, at the medical center, three key associates. My salary was $66,000. My chief-of-staff, a physician, medical director they would call him in the private sector, made $64,000, but he got a $16,000 bonus for being a specialist in nephrology. My associate director, assistant administrator, got $46,000. My other associate for ambulatory care got $63,000 plus $15,000 bonus. Those were the only assistants I had.

Besides those -- vice presidents they call them -- they had department heads. The hospital across the street is really administratively heavily laden with high-salaried people. If I had that many administrative people attached to my office, my medical staff would hang me by the neck because they feel that the money should go for the patient care.

The private sector hospitals, except for the Catholic hospitals, do not run as cost effective. One of the reasons that we run efficiently is because we have organizational charts and we have centralized purchasing, we have manuals and so on. We do things right. We have to deal with unions. As I said earlier, we had five unions that I had to deal with and develop a contract every year or two years.

Wilbur Cohen, as I indicated to you earlier, when he was Secretary of HEW, wanted to tie in Public Health Service, VA, and Social Security. He wanted all three tied into one. He started something which eventually brought the downfall of the Public Health Service hospitals. They are no more. I don't think that will ever happen. I don't think you and I will see national health insurance.

WEEKS:

They haven't found a way to make it work.

GAVAZZI:

We have too many congressmen and senators who have interest in their respective constituents.

WEEKS:

And the AMA is a big factor too. The big problem that we have got to find an answer to is the uninsured and the underinsured and the aged. All aged are not poor. We are now aged. We might not be able to pay a $100,000 hospital bill if we had to, if we had no insurance and we had to pay $100,000 bill.

We were talking the other day to a lady who was telling us about her daughter having a baby with a complication similar to Baby Faye's. The child was operated on three times after its birth. First it was taken by Caesarean,

then it was operated on three times over a period of thirty days and died. The hospital bill was $89,000. I hope they had sufficient insurance.

GAVAZZI:

Let me give you an example. We had a veteran who set himself on fire. The Washington Hospital Center across the street has a burn unit. When we realized that we couldn't do anything for this veteran, we transferred him to the Washington Hospital Center. He lived five or six days. They sent us a bill for $37,000. I appealed the bill to the administrator, and explained why I appealed. I said, "You have certain things in there that you did not supply to that patient. I have had my fiscal officer and I have had my medical people look at it. What you are saying you did, you did not do. I have people on my staff who worked in your burn unit and they said that you don't do those things. Your computer automatically spits them in there." So I finally got them to give me a bill of $17,000 or $18,000.

This is where we get into trouble. They just repeat the same thing on your bill whether they give it to you or not. If it is prescribed, they do it. But the medical staff don't do some of those things after the first or second day. Who could afford something like that, even if you had a savings? You could go through it real fast.

We had that problem, Lew, with the retired military who require nursing home care or extended care. Hospitals like Walter Reed and Bethesda will throw them out at a certain point because their primary objective is active duty personnel and their dependents. Retirees get low priority. I can't tell you how often I was asked to take a patient from them who was a retired admiral or retired general, high-ranking officer retired fifteen or twenty years. When they retired they thought they had a good retirement.

Unfortunately, the wife also was elderly. They are both in a nursing home, or she is in a nursing home and he is over at Bethesda or Walter Reed, and he's used up maximum hospital benefits, they cannot afford to go back into the nursing home because he doesn't have the money. The wife is in there taking up all of his retirement money. They have mortgaged their home. We take them into the VA. High ranking people, heroes in our country. Two generals, outstanding heroes in World War II, died at our place. They were kicked out of Bethesda and Walter Reed because of the fact that they had to get them out to make room for active duty people and dependents. They took no consideration of the fact that these people had contributed greatly to the defense of our country in war time. We took them gladly. We gave them the best care possible, and they died there. The sons and daughters said, "I'm so grateful that the VA was here because my mother is still in the nursing home and all of his retirement money went towards payment of her bill. What would we do now? We can't take her, unfortunately."

WEEKS:

There is a problem of the families of veterans. Do you think there will ever come a time when the wife and survivors will be covered?

GAVAZZI:

I don't think so. They are trying to cut the VA now. That would open up Pandora's box. If they did that then they would come up with all sorts of categories. In reality, we cannot take care of a retiree. The priority for a retiree is way down the list, but we take care of them based upon their service during a wartime period. Every three or four years they are discharged and reappointed. On that basis we could cover their service during a wartime period, and we take them in. More and more military retirees are

establishing service connection so that they can meet the needs for health care in the VA.

WEEKS:

I wanted to ask you, how are you affected by malpractice?

GAVAZZI:

We are covered. You are covered by the federal tort claims act.

WEEKS:

So anyone who wants to sue you, you are covered and the limits are set by the federal claims act?

GAVAZZI:

Yes. The government takes care of the whole thing. If a physician or a nurse or any employee of the hospital is sued, the administrator is automatically sued. I have had a lot of lawsuits where my name was attached to them, being the chief executive officer. There are lawyers at each regional office assigned the responsibility for following up on claims against the VA hospitals. They pick it up and carry it to its final conclusion.

WEEKS:

What do they do? Do they negotiate settlements some way or do these get to court?

GAVAZZI:

Some get to court. Some they negotiate based upon what it would cost to go through the process or make a one-time payment.

WEEKS:

You talked about the physicians in Italy driving taxicabs. When we are graduating 17,000 or 18,000 medical students every year, is this going to affect the VA? Is it going to make it easier for you to get physicians? Have

you had to hire a lot of foreign medical graduates?

GAVAZZI:

It had been, but now, with DRGs, and the surplus of physicians by 1995, we are getting more people applying to the VA, also to go on full-time staff at the private hospitals.

WEEKS:

Furthermore, the foreign medical graduates aren't getting residencies.

GAVAZZI:

Not only that, but they are not getting a license.

WEEKS:

They can't pass the exam.

GAVAZZI:

They can't pass the exam so they are not getting their license. Plus, John Cooper's group, the AAMC is taking a strong stand on that, as is the AMA.

WEEKS:

You said that you have had some investigative bodies look over the VA system. That's since the famous Bradley Commission, isn't it?

GAVAZZI:

Yes.

WEEKS:

That was back in the 1940s, right after the war. Then you have periodically had others. Are they congressional committees?

GAVAZZI:

We have the General Accounting Office that looks over our shoulders and check us out. Every service organization has its review body. The VA has its own inspector general, who every six or seven years comes in and does an

inspection. As a matter of fact, they are still at the VA hospital. We have the Joint Commission, we have the AMA, we have the subspecialty groups that come in, the surgeons, the internists, the radioisotope neuclear regulatory agency come in to check our linear accelerators. It is a constant group of people looking over our shoulders to see if we are doing things properly, checking our records, and everything.

WEEKS:

So you are pretty much in the spotlight.

GAVAZZI:

Especially in Washington. Everything they want to test, they come to Washington first. They decide to do an investigation on the mortality rate in open-heart cases, so where do they go first? They get a team together and they go to Washington. Then they tell you where they are going next.

WEEKS:

Is there anything that you would like to say about your opinion of what is going to happen in the health care business in the future? Do you have any feelings about how the VA is going to change?

GAVAZZI:

I think the whole health care system is going to change. DRGs have forced this. I think we are going to have a surplus of physicians, a shortage of nurses. What has happened is that physicians, under DRGs, are pressured to discharge patients when they reach a certain level of hospital stay. What they do is to tell the nurse at two o'clock to discharge Mr. Smith at three o'clock. The nurse will tell them, "Well, I can't discharge him until you write the orders."

He'll say, "Well, I'm writing them now. You go tell him."

She says,"He's not my patient, he is yours."

The physician will scream and holler. The nurse will get frustrated. My daughter, who worked at Roosevelt Hospital in New York, just left the hospital because of exactly what I am telling you. If a physician would say to her, she was acting head nurse, and he would say, "You go tell Mr. So-and-so we are discharging him at this hour."

She would say, "But he is your patient, Doctor." The director of nursing told the nurses, "You are not to tell a patient that he is being discharged. That is the physician's responsibility."

But the physicians find themselves under pressure and they tell the nurse or a secretary and the patients say, "Who are you to tell me that I am being discharged? I want the doctor to tell me." So they become disenchanted, and they leave. They leave nursing in the hospital. They leave nursing in general. They go into marketing, they go with these drug houses in sales. I see that in the future.

I also see a number of hospitals closing, and a lot of the small hospitals merging. They can't survive under the present system. I also see a lot of preventive health programs being developed where, hopefully, they will be able to tell a patient, "If you do such-and-such, you will not have to go into the hospital."

I also see more and more storefront outpatient activities where they will put a small treatment facility in a shopping center. We see them all over the country right now. People want to go -- if they are shopping at the supermarket, and they haven't been feeling well for a week, they will go into the unit. But they won't go to the hospital, they won't go to a doctor's office. So I think we are going to see more and more of those.

I am concerned about the attitude of the politicians toward the health care system. The politicians and everyone else of the younger generation -- when it comes to health care, and I have noticed this through the years. You get a person and say,"Where does health care fit into your thinking, in priority?" New car, new television, new home, this and that. Down at the bottom of the ladder, one through ten, the tenth item might be health care. People don't think of health care unless they become sick, unless a member of their family is exposed to a long-term illness. They go their merry way.

I see more and more lack of consideration of the health care needs of the country. In the military, you ask a line general of a division or a base, "General, Admiral, or Colonel, what are your priorities based upon so much money being available?" Health care will very seldom make the list of the first ten items. He or she will list a whole list of things based upon the military mission, but the health care of his troops is way down at the bottom of the priority list. I have seen this in the military for the last twenty-five years. I see the congressmen and senators doing the same thing.

Efforts to eliminate unnecessary hospital care have failed to control the forces pushing hospital costs upward, including the use of expensive medical techniques such as organ transplant and artificial heart implants. Costs will continue to soar in the future unless society is willing to ration the delivery of medical services. They are doing it in England and the Scandinavian countries, and we must do it in our country.

I testified last Wednesday over a reorganization which forced the chief medical director to resign. I looked at the congressmen who were conducting the hearings. A lot of young fellows, in their thirties and forties. They only stayed to ask a question on a specific hospital. One fellow from North

Dakota raised a question regarding his hospital at Ft. Meade, South Dakota. Another congressman, a young man, -- I don't think he is forty. Another young congressman asked about his hospital in Texas. Another young congressman asked about his hospital in Alabama. Another young man asked about his hospital in New Jersey. Not one, except for Congressman Montgomery, who is the chairman of the committee -- he is in your category and mine age-wise -- he is the only one who asked about the patient care aspect nationally and what will taking this service away from the chief medical director do to the quality of care of the patient. The only one. The others would ask their question and leave. They wouldn't stay for the whole hearing. They kept using the excuse, "I have another committee meeting to go to."

The only people who do the work are the staffers. Only three staffers stayed behind, and two of them were part of the committee, Sonny Montgomery from Mississippi and Hammerschmidt from Arkansas.

WEEKS:

This makes it very difficult when they make it a political issue and want to do a grandstand, especially if they can get on television.

GAVAZZI:

All of the congressmen are up for re-election this year. That's the reason they all made an appearance. I don't think four of them would have made an appearance if they hadn't been up for re-election and speaking on behalf of their respective medical centers.

WEEKS:

They can say, "I was before the committee and our hospital is going to get better attention," or something.

GAVAZZI:

Or, we are going to get $2 million to do such-and-such.

WEEKS:

One of the best questions that I have heard recently is: What is going to come after capitation and after DRGs?

GAVAZZI:

DRGs have done their work. Some of it is good, but a lot of it is bad because under DRGs a lot of patients, as I'm sure you are aware, have been discharged before they were ready for discharge. I would imagine, and talking with physicians, a lot of them agreed, that a lot of the patients die because of early discharge. A lot of them were readmitted. They were home one or two days and had to go back because the treatment was not completed, and the physician didn't take the time to write up the need to keep them in the extra two or three days. They wanted them out under DRGs so the hospital could collect, and he could collect, and then, if things went bad, bring them back. That was a new admission. They could keep them another three or four days.

WEEKS:

What do you think is the probability of the demise of the fee-for-service?

GAVAZZI:

I don't think that is going to die, I think it's going to stay.

WEEKS:

Now that there are HMOs and all of the other capitation plans where they work either on a fee schedule or on a partnership-risk basis, do you think they are going to become accustomed to some kind of fee schedules, or salaries?

GAVAZZI:

I think so. A lot of the young doctors I talk to on that subject are looking at that years ahead -- a salaried position. They are also looking at the forty hours to enjoy their family more, and to enjoy themselves more. Malpractice insurance bothers them.

WEEKS:

Office details would be taken care of.

GAVAZZI:

There will be room for a lot of administrators.

WEEKS:

A few years ago I used to think we have over 2,000 students studying hospital administration. I don't know what it is now. Where are we going to place all of these people? We can't put them all in our hospitals.

GAVAZZI:

A lot of them are going with planning agencies, consulting firms and computer firms.

WEEKS:

They are going into all of these related services. And, again, half of our hospital administration students now are women, more than that possibly.

GAVAZZI:

Incidentally, the women frequently make better administrators than the men. They make better residents. They apply themselves more. I have had about five women administrative residents. They work their tail off. They are willing to learn. They are willing to listen. They don't have any outside distractions.

WEEKS:

They are bright. When I was at Michigan I used to interview candidates. We all did. I was always amazed at how smart some of these women were, and when you could see their school records and what they had taken. I didn't look at the B average, or whatever, as much as I did at what kinds of subjects they had taken. Some of these people would have a nice B average with pretty weak subjects. I was amazed at how smart some of these women must be.

When I first started there in 1962, we had no women. Now they have over fifty percent. They could take the whole class.

GAVAZZI:

GW's program is more women than men.

WEEKS:

And they have a big class, about sixty, don't they?

GAVAZZI:

They have full-time and part-time both. I don't believe in the part-time program.

WEEKS:

We have had one or two part-time when there has been a special condition, where somebody is working in the field somewhere, and they have to support a family or something of that sort. We have let them take twice as long to get through.

Is there anything else you would like to add?

GAVAZZI:

No. I've enjoyed it. I've never talked so much though.

Interview in Ann Arbor

August 13, 1986

Appendix A

Administrators of Veterans Affairs

Brigadier General Frank T. Hines	1930-1945
General Omar N. Bradley	1945-1947
Major General Carl R. Gray	1948-1953
Harvey V. Higley	1953-1957
Sumner G. Whittier	1957-1961
John S. Gleason	1961-1964
William J. Driver	1965-1969
Donald E. Johnson	1969-1974
Richard L. Roudebush	1974-1977
Max Cleland	1977-1981
Robert B. Nimmo	1981-1982
Harry N. Walters	1982-1986
Thomas K. Turnage	1986-

Appendix B

Chief Medical Directors of the Veterans Administration

Paul R. Hawley, M.D.	September	1945-December	1947
Paul B. Magnuson, M.D.	January	1948-January	1951
Joel T. Boone, M.D.	March	1951-February	1955
William S. Middleton, M.D.	March	1955-February	1963
Joseph H. McNinch, M.D.	June	1963-January	1966
H. Martin Engle, M.D.	January	1966-January	1970
Marc J. Musser, M.D.	January	1970-March	1974
John B. Chase, M.D.	April	1974-July	1978
James C. Crutcher, M.D.	August	1978-December	1979
Donald L. Custis, M.D.	January	1980-October	1984
John W. Ditzler, M.D.	November	1984-September	1986
John W. Gronvall, M.D.	January	1987-	

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