HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

John Horty

JOHN HORTY

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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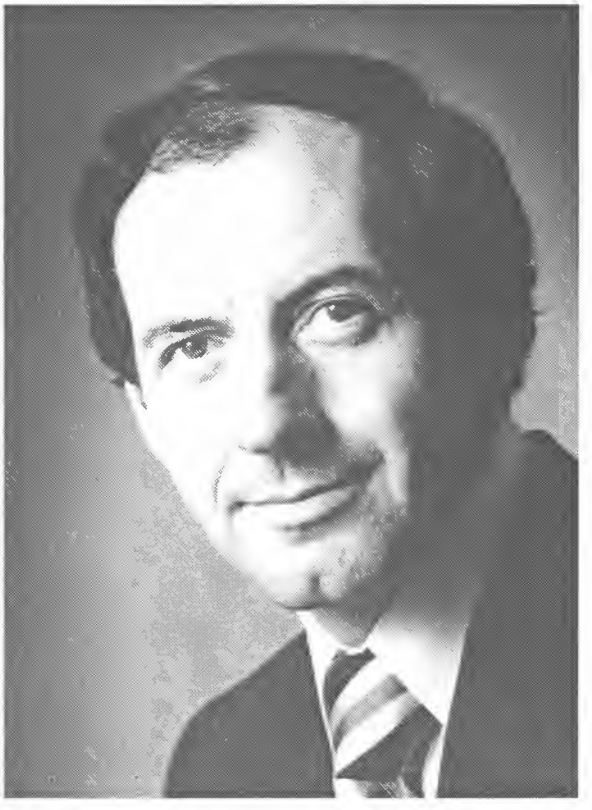

John Horty

CHRONOLOGY

1928	born Johnstown, PA, October 21
1950	Amherst College, BA (cum laude)
1953	Harvard University, LLB
1953-1955	U.S. Military service
1956-1959	Shahade, Horty and Shahade, Partner
1956-1968	University of Pittsburgh, Graduate School of Public Health, School of Law, Professor
1966-1971	Aspen Systems Corporation, President
1971-	Horty, Springer, Mattern, Senior Partner
1974-	National Council of Community Hospitals, President

MEMBERSHIPS AND AFFILIATIONS

American Bar Association

Special Committee on Electronic Data Retrieval, Member

American Bar Foundation Advisory Committee

on Statutory Laws of the State, Member

American Hospital Association,

Life Member, 1972

American Hospital Association, Special Committee on the Provision

of Health Services, (Perloff Committee) 1969-1970, Member

American Public Heatlh Association, Subcommittee on Health Law,

Chairman

American Society of Hospital Attorneys, Charter Member

Aspen Systems Corporation, President, 1966-1971

Association of American Law Schools, Jurimetric Committee,

Member

Cambria County (PA) Bar Association, Member

Central Medical Center and Hospital,

Pittsburgh, Board Chairman, 1975

Estes Park Institute, Board Chairman, 1982-

Modern Healthcare Magazine, Columnist

National Council of Community Hospitals, President, 1974-

Pennsylvania Bar Association, Member

Pi Sigma Alpha, Member

Sisters of Mary of Presentation Health Corporation,

Board Vice Chairman, 1981-1988

HONORS AND AWARDS

American College of Healthcare Executives

Honorary Fellow, 1965

American Hospital Association

Award of Honor, 1971

Life Member, 1972

BOOKS

Hospital Manual and Quarterly Services
University of Pittsburgh, 1958

Students' Guide to Hospital Law
University of Pittsburgh, 1963

Action Kit for Hospital Law, 1972

Action Kit for Hospital Trustees, 1973

Patient Care Law, 198-

Medical Staff Law, 198-

WEEKS:

Thank you for agreeing to do this oral history. Basically it relates to your professional life. I see four major accomplishments, but I am sure we will talk about more than the four. One, your efforts to develop hospital law into its present specialty. I give you the blame for that. Your activities with Wes Eisele and the Estes Park Institute, and your work on the AmeriPlan, which I hope we can go into fully with so many references to the Perloff committee. Lastly, your connection with the National Council of Community Hospitals. I imagine that will be an interesting segment too.

Let's leave off the four major components for a moment and go back and pick up some of your early history. I have your birthdate as October 21, 1928, and birthplace as Johnstown, Pennsylvania.

HORTY:

That's correct.

WEEKS:

Is there anything about your early life or your family that you would like to record?

HORTY:

Nothing that is particularly relevant to the professional life except, perhaps by coincidence, my family had a medical background although I wasn't much aware of it nor did I dwell much on it. Some of my great uncles had been early graduates of Hahnemann Medical College, had come back to Johnstown, and were friends with a physician by the name of Lee who founded the Lee Homeopathic Hospital in Johnstown, Pennsylvania, which is now the Lee Hospital. Our family always had a close affiliation with that hospital. My father was on the board for years and years, as chairman of the executive

committee. Long before I was born, our family's property which was on Main Street, the home that they had lived in, became a Warner Bros. theater. They sold the house to Warner Bros. One nice result was that during much of my youth I had a free pass to all of the movie theaters in town, not only a free pass but I could take as many people with me as I wanted. I had lots of friends as a result.

Within the last five years Lee Hospital has expanded and taken over the State Theater and has made it into an auditorium. In a sense where my family once lived is now part of the hospital. I remember Lee very much as a child, the hospital and the physicians. But I had no particular interest in either law or medicine. I think had I had my choice as a child I would have gone to West Point and ended up in the army. Or become an archeologist. As a matter of fact, after I became a senior at Amherst I really enrolled at Harvard Law School probably because I hadn't thought of anything else that I really wanted to do. I didn't even have the remotest desire to become a lawyer.

Johnstown, at that time, was a nice town to live in. This was before, during and after the 1936 flood which is less famous than the '89 flood. Before the steel mills stopped being much of a factor in that community's economy. My father was a superintendent in the steel mill and then ran a coal mine. We lived up in Westmont, not down in Johnstown. I remember the 1936 flood. As a child I remember the water coming up, although we were up on the hill, but we could look over and see the rivers leaving their banks.

WEEKS:

I have a vague memory of going through Johnstown sometime after the flood and seeing marks on the buildings that were left by the flood.

HORTY:

The marks stayed for a long time. Then they put monuments in some places showing how high the water was. The 1936 flood wasn't destructive the way the '89 flood was, which came as a wall of water from the breaking of the crest of the South Fork dam. The '36 flood was really just an abnormal amount of rain. Johnstown is in sort of a V and water feeds very quickly from all of the upper valleys and the water rose over a night and a day and within that time it was -- I don't remember how high exactly -- certainly over fifteen or sixteen feet in downtown Johnstown, but there wasn't the destruction. My great aunt lived downtown. She was one of the founders of the Daughters of the American Revolution. She had an extraordinary collection of books. They were, of course, in her library on the main floor. I remember spending most of the summer after the flood washing, as best we could, those books and setting them out page by page in the sun and turning the pages to dry them. Of course they were never the same, but some of them were usable.

WEEKS:

When I think of Amherst College I always think of Calvin Coolidge. He was one of your famous graduates, wasn't he?

HORTY:

I don't think many of us thought much of him either.

WEEKS:

As you mentioned, you went on to law school at Harvard and were graduated in 1953.

HORTY:

Yes, and at Harvard every individual who was a senior at that time at least -- I don't know what their policy is now -- had to write a thesis to get

out of Harvard Law School. It was one of the last requirements. I took as my subject the liability of hospitals for negligence of their employees. One of the reasons I did was because there wasn't any liability for negligence at the time. I figured it was about as easy a paper I would ever have to write. It turned out that while there wasn't any liability there were an awful lot of cases and I attempted to show that there should be liability. Every state had a number of cases. I ended up spending literally weeks in the library with a tremendous amount of references. I was really thankful when the whole thing was done and gone. But it really was my entry into this field, because when I left Harvard, in 1953, I was immediately drafted into the army during the Korean War.

While I was in the army the chief executive officer, then called the administrator, at Lee Hospital after speaking with my father read the thesis and sent it to Hospitals magazine where it was published.

WEEKS:

Is that right?

HORTY:

Yes, in three particular segments. It came to the attention of one of my early heroes, a man by the name of John McGibony who was a physician, in the Public Health Service. John was then a professor of hospital administration at the University of Pittsburgh, a new graduate school of public health which was put together by a grant from the Mellon Foundation. John read the thesis, was looking for someone to perhaps write a book on hospital law. When I came out of the army I had a letter from him asking me to come down to Pitt and talk to him. So I did. In a sense, that is how it started. This was 1956.

WEEKS:

That was just before you entered the law firm of Shahade, Horty and Shahade?

HORTY:

I didn't enter it. We founded it. We were three kids who had gone to high school together. The Shahades had gone their separate ways to college. They were twins. When we found ourselves out of law school and back in Johnstown, we decided to become a law firm. Rather unique in the sense that at that time in a small town, by and large, young kids didn't put together a law firm. We had no prospects, we had no clients, we just thought we would be happy and have fun practicing together. So that is how that law firm started. It didn't last very long, except in form because five or six months after we started it the National Institutes of Health gave me a grant to do a book on hospital law and John McGibony gave me an appointment at the graduate school of public health as a research associate. Sam Shahade, one of the partners, came with me to Pittsburgh. We only intended to be there two years, have time enough to write the book and go back to Johnstown. Bill Shahade, the other partner, stayed to mind the store. There wasn't much to mind. The two of us went to Pitt. I recruited several other people just out of the army which really was the nucleus of the people who wrote what became the hospital law manual. Eric Springer, who is still with me in our law firm; Nathan Hershey, who years later took my chair at the University of Pittsburgh and is still there. Nathan was a classmate of mine at Harvard Law School and a fellow basketball player at Harvard. Eric was with me in the army during the Korean War. That's how I met him. He went back to New York and became a clerk to a New York Supreme Court judge. I recruited him there. Kenny Hirsch, who was

also a classmate of mine at Harvard and is now, I think, general counsel for Macy's Department Store in New York. Zack Salem who was also from Johnstown, a little older than me, and now an attorney in Miami. Those were the people who went with me to Pittsburgh.

They were all contemporaries, they were all friends. We really were to do research on hospital law, and it was only as we went on that we realized that there might be some value in a book. We decided that it ought to be loose-leaf, that it ought not to be just a text. The one text in the field at the time -- the only person who had ever written anything that I was aware of in hard cover in 1956 was a man, lawyer, from New York City by the name of Emmanuel Hayt. He and his wife had written a book, but it was pretty much confined to the law of New York as of the moment they finished the book. He had a practice in New York City confined pretty much to hospital collections. He would handle the problems of collecting hospital bills. We felt that hospital law was an area that was likely to grow and that the book ought to be loose-leaf. The problem was that we didn't know how to sell it, to market it. We ended up with two books instead of one.

The concern in the '50s and '60s, was the extent to which lawyers or writers could give legal advice to laymen where there was not a client/attorney relationship. Being concerned about that, and also realizing that in order to be scholarly, we would have to put out an entirely different book on the legal aspects of hospital law. We decided to do two books, the same chapters, much of the same writing, but without a lot of the legal reasoning, for the chief executive officer who was then called administrator. Then another book for the hospital attorney. That left us with a marketing problem, because we knew that no attorney would pay any money for the book.

Attorneys in 1956 and '58 were not getting paid to be the hospital's attorney. They normally would be serving on the board and they would donate that service free. By and large hospitals got pretty much what they paid for. They got some pretty bad legal advice. Mostly because the attorney had no other hospital client, had no familiarity with the medical-legal, and there wasn't much in writing that you could look up.

As a result of all of this we had about five or six thousand manuscript pages, and a decision as to how we were going to publish them, and then after we published them who was going to buy them. So, we packaged it together to sell to the chief executive officer to give to the attorney. He would keep one volume, that was his. Then he would give a volume to the attorney. During that time I went to Chicago once and called George Bugbee, who was then running the American Hospital Association. I did not know George at the time. It was before the modern headquarters. They were still in that building on Division Street.

I went in to see George, told him who I was, where I was, what I was doing. I said that I had really come to him for advice as to how I could publish and market this book. I had the funds to do it from the National Institutes of Health, but I didn't have any idea how to go about it or what to do. He listened very patiently, as George always would, very kindly. He said, "John, I don't think there is any market for this at all. I think I would just put it in a library some place and go back and practice law. I don't think this thing will sell." George always remembered that as being one of his poorer prognostications, because it did in fact sell very well, and still does. It is now owned by Aspen Systems Corporation.

WEEKS:

Your idea of the looseleaf format, did you have an update, data pages coming in at times?

HORTY:

We updated it quarterly. That was the yearly subscription. So we sold the original book and then we sold the early subscriptions. This was all done by the University of Pittsburgh. It was not done by us. And the funds that came in were used to put together the Health Law Institute at the University of Pittsburgh, which eventually became the Health Law Center. It was at the graduate school of public health and I was director. Much of that really was a result of my discussions with a man that I guess I admire as much as anyone else, Tom Parran who was the dean of the graduate school of public health at the time. A very, very astute and delightful person who was willing to take a chance on doing this. He sort of left me on my own to put together a budget, sell whatever I could, get whatever research grants I could get and the staff to run the Center with the money that I would bring in.

WEEKS:

Did you do most of your selling by mail?

HORTY:

Yes, totally. We did have booths at the American Hospital Association annual meeting. Often I would be on the program, or one of the other fellows would be on the program. We did a lot of speaking. I think that helped to sell the book. I was on the road -- I suppose I gave fifty or fifty-five speeches a year to hospital associations, hospital councils, and to individual hospitals. I was pretty much a fixture at the New England Hospital Assembly, the Association of Western Hospitals, the Tri-State, and state hospital

association meetings.

WEEKS:

Is Tri-State still in existence?

HORTY:

No. I think it just went out of existence this year.

WEEKS:

I heard that it was going out.

HORTY:

Maybe it was Upper Midwest or whatever that was. They have merged a couple of them. Of course Western is out completely. It is now the Health Care Forum. I guess the only two that still exist are the New England, the Mid-Atlantic and the southern one. That was really the staple of education in this field in the 1950s and '60s.

WEEKS:

Was Tom connected with Pittsburgh? He was, wasn't he?

HORTY:

He was the dean of the Graduate School of Public Health, the founder of the school. He was still Surgeon General, I think, when the Mellon people asked him to come to Pittsburgh, build a building, attach a graduate school of public health to the University of Pittsburgh, and the medical school which was already there. They gave him an endowment for the school and sufficient funds for a building.

WEEKS:

I wish I could have known him because I have heard -- Bugbee, as an example, talks a great deal about the days before Hill-Burton when Parran was getting money into the system...

HORTY:

John McGibony ran the Hill-Burton program for the Public Health Service.

WEEKS:

He did?

HORTY:

Yes, before he came to Pitt. My department chairman, Jim Crabtree, who later became dean of the graduate school, was Parran's number two in the Public Health Service. So he really brought a lot of people with him. Jonas Salk, of course, and Hammond, the inventor of gamma-globulin, and several other people. Bob Olsen... So it really was a distinguished faculty at that time.

WEEKS:

Had McNerney left there by that time?

HORTY:

McNerney was there up until three weeks before I arrived. He left to go to Michigan. He was an assistant professor in John McGibony's shop at Pitt. I met McNerney much later. I did not know him at Pitt.

WEEKS:

A contemporary, I wonder if he is still at Pitt, Tom Fitzpatrick.

HORTY:

No, no, he's not. He was much later. He went through the program while I was on the faculty. Then he came back later as a professor and has left as far as I know. I am not too close to the school now.

WEEKS:

I haven't seen him in years, but I knew him when he was at Michigan. In fact, he hired me. I have always had a warm feeling for him.

HORTY:

When I first settled in I had a suite of offices in the back of the building on the second floor. On the other side, in another suite of offices, was the Hospital Council of Western Pennsylvania with Bob Sigmond.

WEEKS:

Tom was with them for a while.

HORTY:

That's right. Tom was with Bob for a while.

WEEKS:

That was before he came to Michigan, I think.

HORTY:

That's right.

WEEKS:

All these things pop up.

HORTY:

It is all incestuous, as usual.

WEEKS:

I wanted to ask you about your Students' Guide to Hospital Law.

HORTY:

That was really for use in the other programs. We were doing some teaching, obviously. I taught a class in the law school, taught one in the medical school, because there weren't any attorneys that were doing anything in medical or hospital law at the time. A lot of the other programs in hospital administration around the country began asking for something that can be used as a textbook. So we put that out. It wasn't meant to make money, but to be used in whatever class might be taught in whatever program. There

almost none at the time, we were almost the first. We just would re-issue it from time to time. It was always soft-bound. It wasn't hard to write, since we just cut and pasted out of the law manual.

WEEKS:

Then you also had the trustees' guide, too, didn't you?

HORTY:

Yes, an early one.

WEEKS:

I have two other titles here; the Action Kit for Hospital Trustees...

HORTY:

That was much, much later in the story.

WEEKS:

That's in 1972-73.

HORTY:

We did do a trustees' guide while we were at Pitt. It wasn't much. And we began, while we were at Pitt, to do some seminars and educational programs, directed at trustees. I helped with one of the first programs that I ever saw or heard of for trustees, in Wisconsin. I have no idea what the date was, but what struck me was that it was organized by the Wisconsin Hospital Association and the trustees were brought by the chief executive officer and if the CEO didn't bring trustees, he couldn't come. In other words, it was the first time that I had ever seen an attempt to pull both of these people together in an educational environment. I spent two days with them. I thought it was very successful as a method. At that time, which I suppose was the early to mid-'60s, there was almost no joint education of anybody. The idea that physicians would go any place with anybody to get any education about

hospitals was just ridiculous. This was long before Estes Park. That is the first I ever remember seeing a program that was meant, over a couple of days, to educate trustees and CEOs together.

WEEKS:

Did Kenny Williamson enter into this in any way? I know he was very strong on getting active work with trustees established and I think he also was instrumental in starting the Trustees magazine, wasn't he?

HORTY:

I don't know that. Kenny, when I knew him, really was running the Washington office of the AHA.

WEEKS:

I thought there might be some connection there.

I was connected with the Health Administration Press at Michigan for a number of years, in fact sort of grandfathered it. One of the books that we tried to get written was one by Arthur Southwick. The criticism that we received was that Art talked about law but he didn't talk about regulations.

HORTY:

That, I think, is true. When the book was finally published that is pretty much what it was. Art is a very good legal scholar. One of the reasons, I am sure, -- Art and I never talked about this -- but one of the reasons is that regulations are physically hard to obtain. This is one of the reasons that the Emmanual Hayt book only covered pretty much the law of New York. The idea of trying to look at the law outside of the judicial decisions in the other states was just a monumental task, almost impossible to do. One of the things that we did, when we published the hospital law manual, was to put in many of the chapters a state-by-state analysis of the law which meant

we had to look not only at the cases but also at the statutes and regulations.

In 1957, I spent the entire summer -- this was right after I came to Pitt -- left Pittsburgh in June, traveled every state capital west of the Mississippi River, talked to the attorney general and the state health department person and picked up all of the state regulations. There was nothing published then that you could get in libraries. So it would just have been beyond Arthur's ability, even at a school as good as Michigan, to have gotten this kind of stuff. They were not issued in any form. In fact, this problem, which was the availability of statutes and the availability of regulations, not just federal but state, licensing, Hill-Burton, zoning, all kinds of things that impinged on the hospital field, was something that led us at Pitt into an entirely different area. One of the things which I guess I am most proud of is the beginning use of computers in law.

The research problems of trying to keep up with the development of hospital law on a continuing basis, as part of a center for hospital law, and to try and stay on top of the legislation being passed in each state, and new regulations, in a field which was really just beginning to be regulated, was almost an insuperable problem. So, we began to experiment with the idea of using computers. Computers, at that time, were vastly different things than they are today. In fact, there was only one computer in the University of Pittsburgh. It was in the main building -- the Cathedral of Learning. One of the statistics that I have always carried around with me was that the electricity -- this was a vacuum tube computer, it wasn't transistorized yet -- the electricity to operate the computer, when they ran in the special lines to do so, was the same amount as it took to run the rest of the Cathedral of Learning. So a computer then was a vastly different thing.

I guess we were sort of ahead of our time, but over a period of a couple of years we experimented using our own funds and using some small grants that we got from local foundations and we put together a system to search law, to search the actual text of law, rather than an indexing system which was what everyone was doing at the time. That capability, which was far ahead of the computers of the day.

About four years later we received a grant from the Ford Foundation of several million dollars to look at the whole question of the use of computers and law. The system that we came up with is the system that is now used commercially by WestLaw, West Publishing Company, and everyone. It is not much different than what we invented and were using at the University of Pittsburgh under the Ford Foundation grant in 1966-67. We used the data base for the Hospital Law Manual, but its value went far beyond that. At that point we had our own computer and I was running more than just a health law center. I had five hundred employees and our own computer as large as the computer in the university. We had twenty-three contracts with state governments to place all of the text of their statutes into the computer. Also we began legal publishing by computer. We established a company up in Minnesota. The first book ever published out of a computer, typeset by a computer, was the Hawaii Statutes, which was done on contract from the government of Hawaii. We also did work for the Internal Revenue Service, the Congress and for the Defense Department. One of the things we did was to put into a computer, in full text, every secret and top-secret treaty in the United States.

WEEKS:

Is that right?

HORTY:

So it will be able to be researched. This was on a contract from the Pentagon. It was all as a result of a funny sort of mishap.

During one of the trade crises, during the Kennedy administration, John Kennedy decided to issue an executive order which would have required that all construction in military bases overseas that the materiel, whatever would come from the United States, would be shipped to that base in American ships. When the word evidently leaked out of the White House that he was going to sign this order, there was a flurry of activity in the embassies of a number of countries in Washington, and they began to go to the State Department waving treaties with the United States on base construction which said that the materiel would be bought locally or shipped in ships with their registry. The Pentagon couldn't find the treaties. The reason they couldn't was that there was a whole room full of treaties and they were filed by country. That was it. So you had absolutely no idea of where these things were. Over three days the assistant general counsel for international affairs of the Defense Department and his entire staff kept going through file drawer after file drawer trying to find whatever countries had treaties that would be affected by this executive order.

The result of that was that we got a contract to put them all on the tape and as far as I know the Pentagon still uses it.

During the Johnson administration, after we put the United States code into our computer, I got a call from Vice President Humphrey's office asking us to do a search and put together one book which was the powers of the vice presidency. It was absolutely amazing the kinds of things that a vice president is responsible for that nobody knew he could be responsible for,

things like serving on the battle monuments commission. So then the president asked us to do a search of the same kind and we did a book like that for President Nixon when he came into office.

Computer law research, for a while at least, dwarfed the whole health law thing. Although we were still keeping the hospital law manual up-to-date, we were still doing some seminars, and we were still writing articles. Bob Cunningham was the editor of Modern Health Care, then Modern Hospital, and I was doing a monthly column for him -- did so for about twenty years.

By 1969 we had become so big and spread so far afield from the graduate school of public health that we had our own building in Oakland, where I had the computer and another place where we were in the Webster Hall Hotel. We finally consolidated them all together. And with the help of the university, after Parran's death and Chancellor Ed Litchfield's departure from Pitt, we decided to take the whole company public and take it out of the university. We did so as Aspen Systems Corporation, with the university as the largest shareholder in the company and me as president and next largest shareholder. So the genesis which started with the hospital law manual became a public company with the hospital law manual still in it. And Aspen Systems Corporation today publishes the hospital law manual.

WEEKS:

This is the Rockville...

HORTY:

Yes, that's right. But its major thrust when it was founded was the use of computers in law. Much of what you see today in computers is what we did. In fact, we went from keypunching, literally using a keypunching machine, to the use of more sophisticated typing machines, and on to the use of -- one of

the first uses of scanning equipment. I had at one time sixty-five persons who typed on two shifts. Their typing pages would be inserted in a scanner, the scanner would read it and would put it on the computer. The scanners that today we have in our law office that will do this kind of thing are small. That scanner took up an entire room by itself. Then, finally, we began to use the first of the cathode-ray tubes which enabled us to input the data directly on the magnetic tape, without going through anything else. We went through several generations of computers in those years.

WEEKS:

This is interesting because I remember the early days of CPHA when Vergil was just beginning and he had offices all over Ann Arbor before he built that beautiful building. It just seemed to me that Vergil's trouble came in that he was buying a lot of the computers -- either buying the computers he was using and they were going out of date before he paid for them. The result was that they were practically bankrupt before...

HORTY:

I don't think anyone in that era understood how quickly this whole field was going to advance in terms of computer power. Vergil really had the same kinds of problems that I did and that was the question of storage and retrieval of massive amounts of data. My data was text. We were searching the text, not searching any indexes. Vergil's was statistical data, but it was still vast amounts of data coming in there and being input into the computer. I went through four generations of IBM computers between the time I started out and when I sold the company. We went from that vacuum-ray tube to the first of the magnetic tape computers, the IBM 1401 to IBM 1410, to a 650 with discs that would hold all of the state statutes. We had all of the

statutes of every state on discs. We could run a search on anything in all fifty states and the federal government. We also had, as time went on, a lot of judicial decisions of the United States Supreme Court and various states in full text. That data was massive. We were doing a lot of work for the Pentagon; I went to the CIA at one point because I was interested in what they were doing and toured their computer facilities and their data and found out that I had more data at Pitt than they did, because of the tremendous amount of textural material that we were dealing with.

Your observation is absolutely correct. I kept having to spend tremendous amounts of money on computing power because each advance allowed our searches to become faster and cheaper. We were looking towards the use of these data bases and the ability to search, by the legal profession. We were about fifteen years ahead of the computing power to make it financially feasible to do so. It is really only in the last four or five years, I think, that this has been a routine part now of most law offices. In fact, when we sold Aspen Systems Corporation, and I resigned as the president and went back into the practice of law in 1971, we did not bring into the law firm a computer to do this search until last year. Even though it was exactly the system that I had put together and knew.

WEEKS:

You must have had difficulty handling privileged information, too, didn't you?

HORTY:

As I said, we had a lot of top-secret information. Then we had all kinds of safes so we could lock this stuff up. The difficulties of handling classified materials -- in fact, we went through what seems in retrospect

awfully silly discussion but it wasn't silly at the time. With contracts we had with the Air Force and with the Pentagon, we had discussions as to whether the computer itself had to be put in a lead-lined room so that no one could get the emanations from the computer; that all of the typing of these documents would have to be done in a secure environment, lead-lined, because electric typewriters gave out emanations -- I'm not aware that the Russians got any particular advantage out of what we were doing.

Even in those years when we were doing a lot of that at the University of Pittsburgh, I was still doing things in the hospital field. For example, I was a consultant to the Secretary of Health at the time of Medicare when Alanson Willcox, who later became general counsel of the AHA, was general counsel of the DHHS, which was HEW. He asked me to be a consultant particularly on the question of compensation arrangements and contracts for radiologists and anesthesiologists. That problem has been with us forever. I made several proposals in the Medicare law.

WEEKS:

That was one of the big compromises, wasn't it?

HORTY:

Well, it sure was. I was not involved in what happened, but I did go make a pitch for the inclusion of these people in the Medicare program, as hospital-based people, to Wilbur Mills. I was relatively young at the time. I had never met Congressman Mills. I think I was relatively forceful in what I was advocating. Wilbur Mills said to Alanson, "Will you get that kid out of this office? I made my deal and I'm not changing it."

WEEKS:

Would you like to describe Alanson Willcox? I don't have really anything

in the record of him except just a reference now and then.

HORTY:

Well, I knew Alanson when he was at HHS. Then when he left HHS he went to the AHA. Then I used him as a consultant drafting HRI -- as a result of Ameriplan. He and his deputy. Alanson was a very precise, careful, very good lawyer, conservative, and a delightful person to be with, just a super legal mind. He knew the federal law better than anyone I had met. He was just a nice person, always, to be around.

WEEKS:

That is good to know something about the characterization of him because his name does come up. Of course he has been dead several years, hasn't he?

HORTY:

Yes.

WEEKS:

Just going back a moment to the computer operation. It just dawned on me that you probably would not have been able to do this without a magic grant from the Ford Foundation. The start up costs on that must have been tremendous.

HORTY:

That's right. The several million dollars that the Ford Foundation gave me, with supplementary grants from local foundations, Alcoa and Westinghouse and so on, but they were really in the $25,000 to $50,000 range. It was really what allowed us to put it together and to be able to put in massive amounts of data base. It was a very controversial project. Most people felt we were dead wrong. Most people felt that the way to go about searching anything was to index, then put the index into the computer. You could store

that much quicker and in a smaller space. We did a number of studies showing, at least to my satisfaction, that no matter how good the indexing was there was no way an indexer could anticipate the inquiries of the future.

WEEKS:

That's right.

HORTY:

And the amount of time and effort and energy needed to index -- you could build a computer capacity to take as many index entries as you wanted because it was always a lot less than any text. The problem of indexing was the skill of the person doing the indexing. About that time I was very much aware of and working with a lot of legal publishers, West Publishing Company, a number of publishers who were publishing state statutes, compilations of state statutes. In fact, later on Aspen attempted to buy some of them. Their tales of what was gone through to index a set of state statutes was incredible. I remember going to one of the publishers that was just putting out a new publication of the Michigan statutes, and the entire index was being done by one man. And a room the size of this hotel room, maybe 20' by 20' was absolutely every space on every part of every wall was covered by pages of handwritten index entries. One of the difficulties was the emotional and mental problems that indexers with that kind of an indexing task would have. Most of the publishers would give these guys six months off after a job of that magnitude.

One of the things that we were looking for was a way to search things so that we could come up with combinations of things that other people wouldn't think of. I think that my concern and the reason we went to full-text searching was our very great unhappiness with the indexes of all of the state

statutes. Everybody placed things in different places. You would be half way through looking up something in all fifty states and find that in one state it was put in some different place. Then you would have to go back through those states that didn't seem to have that statute to make sure they hadn't indexed it there. We really, I felt, had to go a different direction. We just didn't have the computing power to make storing and searching commercially feasible.

With the treaties, for example, who would have anticipated when all of these treaties were first signed, that someone would want to know that particular fact, or would want to know what treaties required payment of the wages for local soldiers. Also, the bringing of liquor into certain countries was all classified. Well, to search that -- no indexer is going to find that but by searching the text you could get it. In any intelligence work, the whole purpose of intelligence is to put together seemingly unrelated things. The ability to search a man's name, hotels that he has stayed in, people he has met, no one could index that kind of thing because you would never know what you would want later.

So, we were driven in that direction. One of the experiments we did used all of the lawyers in the health law center. We all indexed twenty-two cases on hospital negligence law. I suppose at the time the five or six of us knew more about hospital law than anybody else. Then we compared the index entries. They weren't at all the same. What I thought was necessary to index somebody else would miss. They would index things that I didn't. It drove us into the direction of full text.

One of the by-products of this is word processing -- in fact I went into our firm's word-processing office yesterday, and said, "Here is a document

that I am doing a presentation on the relationship between the hospital board chairman and the hospital board and I decided after reading it over again that I wasn't going to call it the hospital chair -- we now can't say chairman -- that I was really more comfortable with hospital chairperson." I said, "Can you change the word chair to chairperson?" She just made one change on her cathode ray tube and it picks it up wherever it is in the document.

That is nothing more than what we invented to help in the drafting of legislation. If you look at the problem of drafting legislation, you can input it and you can search all of the words to make sure that you have used the same words everyplace in the statute. Wherever you intended to use that word or phrase, that it is always the same. This is why we were able to sell twenty-three state legislatures contracts to put their statutes on the tape. It would then be used by the legislative draftsmen in making changes and amendments in the statutes. So, what we see now as word-processing was then, in its infancy, a method of drafting statutes. I used this technique in the Perloff report and in HR 1, which was the bill that came out of the Perloff work.

WEEKS:

Yes, I noticed that. We want to do a master index of these eighty-some...

HORTY:

You put them on tape and do that. That's the only way you are ever going to connect all of the people who talked about Alanson Willcox, because if you give that to someone to index they will miss Alanson Willcox the first ten times unless you tell them, because he won't appear important. He will only come in and out in a couple of sentences. Unless you tell them that every

proper name has to be indexed. It seems to me that from a technical point, if I were doing this I would do it exactly the same way that I would have done debriefings for agents in the CIA. You put everything in and later on you sort out. You were able to put in inquiries. Programs exist for this and the input isn't that expensive any more. That is exactly the way I would do it, exactly the way we did it twenty-five years ago.

WEEKS:

It is amazing what you have done. When I look at anybody who is collecting data I am impressed first with the tremendous amount of it they collect. Then, two, I begin to wonder what they do with it.

HORTY:

That is always a problem. You collect it and then you can't find what you've got. I think even today in our own law firm, where I suppose we are still the largest repository of hospital law material anywhere, we've got trouble finding stuff. We are all flooded with the available amount of data.

WEEKS:

Aspen continues this work?

HORTY:

Well, I sold it to American Can Company who has now sold it to a Dutch company. I think there are several reincarnations. The kind of thing we were doing and which I hoped commercially to do when we founded Aspen, was to put this computer searching into lawyers' offices. We were just too far ahead of our time. When I sold the company to American Can they stopped doing that. They continued to do hospital seminars and they continued to publish the hospital law manual and other books in the health care field. Let's assume that the American Telephone and Telegraph is involved in an antitrust suit and

this can go over several years. The court testimony, discovery, depositions, runs five rooms of file cabinets. One of the things Aspen still does is to put all of this into the computer for exactly the kind of searching that we do. One of the early applications of this that I did for AT&T when I was still at the university was to take all of the testimony given by everyone from AT&T before a congressional committee over the last three years, put it in the computer so that when the president would come down to Washington to testify he would know in advance whether anything that had been said before was inconsistent, so that he couldn't be trapped by one of the committee staff saying, "Well, Mr. So-and-so, your vice president was here last month and he said..." That's the same kind of data organization job I did when I was president and that Aspen still does.

WEEKS:

Or it might be that his own prior testimony might be...

HORTY:

That's exactly right. "Didn't you say six months ago..." His answer to that would be, "I haven't the foggiest notion of what I said six months ago." Nobody recollects things like that.

WEEKS:

I have tried my hand a little at indexing just to learn what the problems were and I discovered myself that in a long work, several hundred pages, that I might treat an item differently in different places.

HORTY:

But Aspen still does the program of seminars which we started and still does the publishing.

WEEKS:

They advertise quite extensively.

I wondered about these Colorado names, Aspen, Estes...

HORTY:

Well, there is no connection whatsoever. Aspen Systems Corporation started as Aspen Corporation just because I liked the name and I like to go there. I have never skied there. I skied in college, but I have never skied afterwards. But I like Aspen as a place. I felt that when you name a company you ought to name it something that was friendly and nice. Something people sort of like and they did like Aspen. They like the name. It had no connection with Estes Park. In fact, I was not connected with the establishment of Estes Park.

WEEKS:

You were going to continue with your story after Aspen Systems Corporation.

HORTY:

After I sold it to American Can. That's when I was still an adjunct professor at the university, but not doing anything. Eric Springer and myself and Clare Mattern, who was executive vice president at Aspen, the three of us decided to form a law firm with another woman, Louise Symons. Our theory at the time was that we would devote one-third of our time to publishing a replacement for the Hospital Law Manual, one-third of our time in education which would either be in college classrooms or doing seminars or speaking, and a third in the practice of law, and that we would limit our law firm only to hospitals, that we would only represent hospitals. The theory was that all three of these activities would, in a sense, aid each other by allowing us to

teach what we learned and research so that we would be better as lawyers by having to do the writing that we were doing in publications. So, what is now called Action Kit for Hospital Law, our first publication, was one of the first endeavors for this law firm. It is also a looseleaf publication with a newsletter. There is no difference between attorneys and CEOs. We just have the one set.

We made one other change and that is: whereas the Hospital Law Manual was regular book size, this is 8 1/2 by 11 and looked more like the usual notebook kind of thing. The reason we did that was that so many things today are forms and things of that sort that we wanted that size. An ancillary problem was that when you are setting typed forms you are paying a lot of money and it is easier if you have space to work with.

The law firm started that way. We put together a seminar every year for our clients and we tried to keep a balance among the activities. The only thing I can say about the plan to keep about one-third/one-third/one-third is that the law practice part of it has now grown to the point that -- that's not to say that the others aren't very important, it is now a much larger enterprise than any of us assumed it would become. We now have four publications instead of one publication, one for trustees, one for medical staffs and one for nursing supervisors. They are all looseleaf and they are all published -- the one for trustees and the nursing are published every other month and the medical staff and action kit are published every month.

WEEKS:

Who do you list as publisher?

HORTY:

We have a company that does it called Action Kit for Hospital Law

Publishing. It is a sister company to the law firm. I am responsible for both.

WEEKS:

Is this the proper time to talk about Estes Park? How did you happen to become associated with it?

HORTY:

My friend Eric Springer was the first person from our group to speak at Estes Park. He must have met Wes Eisele or met someone and was asked to speak at the annual meeting that Wes used to have at Estes Park in Colorado, which was usually held in September. Eric would go to that. Several years after that I was asked to speak. I told them I had no great affinity for YMCA camps and my schedule wouldn't permit it.

So, it was several years later that I first began to speak. I think the first time I spoke at an Estes Park Institute, although Vergil has all these records and knows exactly how many times everybody has given speeches, it's on his computer, one of the first times certainly was at Sun Valley. I remember that Eric and I did an afternoon program on medical staff bylaws and responsibilities of hospitals and medical staffs and we infuriated the doctors in the audience so much that most of them walked out. We were continually seeing peoples' backs as they walked out of the theater.

Both of us then really became part of the program, oh, I guess around 1974 or '75. Both Eric and I have done every Estes Park Institute since then.

WEEKS:

Didn't this begin with the University of Colorado?

HORTY:

Yes, Wes, as you well know, was a professor of preventive medicine at the

university. He did this as part of the university. Toma Wilson, who was his assistant in the university, also helped establish the program. He did one a year. Then he sort of branched out doing two or three. People would ask him to come to various parts of the country, like New England and Wisconsin. They did a couple there. Then Wes reached retirement age at the university. This was before I had much connection to it. He offered to continue to conduct the institute and the university wasn't particularly interested in that. I suppose because of mandatory retirement policies and so on. They felt that they would merely continue it themselves. They had a certain difficulty getting any faculty, since none of us were particularly interested in that.

Then Swedish-Porter Hospital, Swedish Hospital particularly, but Swedish-Porter medical staff agreed with some other people, Bill Robinson and others in Denver, to use some start up costs to fund a separate institute, the Estes Park Institute, to conduct these. About three years after that, I guess about '76 or '77, they asked me to come on the board of directors. So I have really been connected with it in corporate capacity since about 1977 or '78.

WEEKS:

You are presently chairman, are you?

HORTY:

I have been chairman since 1984.

WEEKS:

Wes seems to be still vigorous.

HORTY:

Yes. In fact, we just completed a conference in Williamsburg, Virginia, which was the hundredth Estes Park conference. Now, there were other smaller conferences, but the bigger conferences... A number of the people that you

have referred to, Art Southwick, for example, and others were all present in Williamsburg for a dinner and some reminiscing. Wes is retired from active day-to-day participation in the institute, but he comes to every one of the conferences and he is on the board, and his input is valuable.

WEEKS:

I was amused at the little things he does to make the meetings more cheerful, the M&Ms that are handy or the little things, the extracurricular activities that he plans.

HORTY:

I think that the traditions of Estes Park... I guess our firm has tried to do the same things with the seminars. You are really dealing with people, in trustees and physicians, who are not getting paid to come. In fact, they are losing money. The hospital chief executive officer or any of the management people, their salary continues whether they are in Honolulu or at the hospital. But for a physician he is losing income when he is away from a practice. The same thing is true of trustees who have management responsibilities in their own business. So I think we try to make it as attractive to people, not only as a learning experience but also to entice them to come and enjoy themselves and bring their wives.

WEEKS:

Originally these were for physicians, basically, weren't they?

HORTY:

The original idea, as best I remember it -- as I said, I wasn't connected with the genesis -- but the genesis really was an attempt to educate physicians about quality control and the use of a lot of Vergil's data. Vergil Slee was at the beginning. And to look at the necessity and the value

of doing medical audits, and some of the initial things that we did from a legal standpoint was to look at the legal aspects of medical audits and the legal aspects of what you did with the data that resulted. I guess partially as a result of Estes Park, partially as a result of our own activities, a major part of our practice is dealing with problems of physicians who have either competence or behavior or health problems in a hospital, both in seeing that they are treated fairly and also seeing that they don't harm people. I would say half of our practice.

WEEKS:

Have you seen Al Snoke's book?

HORTY:

I know of it, but no, I have not.

WEEKS:

He has a chapter in which he addresses this problem of the medical staff and their members who stray from the beaten path. It is amazing. It is almost a horror kind of story to read. It must be a great problem legally. It must be a great management problem.

HORTY:

It is a management problem; it is a legal problem; it is a governance problem. From the early sixties the courts have looked at the treatment given physicians in hospitals in terms of their appointment, their clinical privileges, and in any termination of connection with the hospital. The law really goes back to the civil rights era where the first cases were brought by black physicians in the south attempting to get on to medical staffs and being denied, and osteopathic physicians in New Jersey who were denied medical staff privileges. Much of the law and the legal framework for this was established

as a result to get appointments on hospital medical staffs which were often blocked by physicians already on the staff. This was long before any one was looking in any organized way at the quality of medical practice within an institution as a method of delineating or limiting clinical privileges.

So, much of the law of protection and due process in this field really developed in response to the civil rights kinds of claims and to claims that physicians couldn't get appointments. Then, in the early seventies when the Joint Commission did its revision of standards and began to look at quality assurance and quality questions, a lot of the legal action began to shift to the curtailment of privileges. At the same time we saw almost a technological explosion of new kinds of techniques and thus new kinds of clinical privileges, laser, MRIs, and combinations of diagnostic and treatment entities. All of these raised questions of whether what had been done to a physician was fair, justified by the evidence and whether it has been done for professional reasons. So, we had the appointment question; we then had the question of privileges, which is different from appointment. Finally in the mid-1970s, the contention began to be raised in court that the whole process was a sham, that the purpose was not to examine the clinical behavior that the purpose was to prevent the individual from practicing a particular specialty or prevent him from getting an appointment in the hospital in order to protect the economic advantages that the physicians already on the medical staff enjoyed and thus the questions of anti-trust laws first being applied to the hospital field surfaced. Then the subsidiary question to that, the one that bedevils still, the extent to which an exclusive contract for the provision of radiology, pathology, or anesthesiology services constitutes a violation of the Sherman Antitrust Act. Over the past several years, the courts are now

holding that it does not.

The whole direction of quality assurance, quality analysis in hospitals has been shaped and inhibited, to some extent, by the law and by the contention by any physician who doesn't feel he is being fairly treated might make, when he gets in to court to protest either termination of his privileges, limiting of his privileges, or failure to get appointment, or failure to get more privileges.

I guess Estes Park, in concentrating on that quality issue, of necessity sort of dragged us into it because of the due process. I guess from my standpoint then you can't examine what I have just said without then looking at the relationship between the medical staff and the hospital. The responsibility of appointment, the responsibility of privileges, the responsibility of limiting those privileges, is the hospitals. The medical staff traditionally has seen itself as a relatively independent group of professionals, each of whom is responsible to no one but himself. It is very difficult to make them function in a corporate environment, people who don't see themselves as part of any corporation and, in fact, are not. In most cases they are independent practitioners who receive an appointment, but if they choose not to use the hospital they don't have to, they are not employees in ninety percent or more of the hospitals in this country. But the question of the relationship of the medical staff to the hospital and the inevitable disagreements between the medical staff, or certain doctors on the medical staff and the hospital about competition, quality of the hospital care or services or personnel, concerns over management, concerns over regulations within the hospital are serious issues. The balancing between the duty of the physicians on the medical staff to aid the hospital in regulating physician

conduct by appointment and by granting privileges and by monitoring and by utilization review, and then the, to some extent, adversarial relationship between the medical staff and the hospital when it comes to issues of competition and control and so on, really has produced a tremendous amount of tension in this field over the past fifteen years.

This tension hasn't been particularly helped at times by some parts of organized medicine, the AMA and others -- California Medical Society particularly, who have taken an in-and-out position, not consistently but sometimes, that the physician is really independent of the hospital. I guess that I have been involved personally in that controversy for fifteen years. The AMA and other medical societies are not particularly happy with what I have written and what I have said. The only thing that I can say in my own defense is that the courts tend to agree with me and not with them.

The whole question of quality review in hospitals, which is not going to go away, it is going to be with us as long as we have medicine -- once the Joint Commission, once the courts, once malpractice begin to look at the actions of a physician and to compare the actions of one physician to the actions of others and to accept expert testimony from one physician saying "not only would I not have done it that way, but the standard is not this." Once this happens you are never going to get away from the necessity of both rigorous quality review but also, the reverse of that, the flip-side of that, the protection of the physician's rights so that he doesn't get badly treated for reasons that have nothing to do with his clinical competence. I think there is always going to be this kind of tension.

Then when you put in the contentions of anti-trust and so on which frighten the heck out of people because in an anti-trust suit you can sue the

physicians individually and get damages from them, punitive damages, if it is found that they are acting towards one of their brethren in an anti-competitive manner. So you up the stakes of what would ordinarily be a colleague review. The other factor in this was the growth in the 1960s, '70s, and continuing today, of a whole body of legal knowledge, legal precedent in the courts which held that the hospital, as a corporation, has a duty to patients to see that they received decent treatment in the hospital. And that treatment was not confined to that which was provided by the hospital employees but was also that which was provided by the physicians acquainted to the medical staff of the hospital. That story is going to continue to unfold. I'm beginning to see cases in which patients are successfully contending that the hospital should have looked at the actions which the doctor took in his private office. That would have been unthinkable fifteen years ago.

All of this really intensifies the need to eventually find some kind of relationship that allows the hospital to do its corporate job and at the same time protects the rights of the individual physician. We are just continuing to struggle forward in this. I find all of it fascinating.

WEEKS:

It seems to me that another complicating factor is that physicians usually feel threatened. They are threatened by what might happen, what might happen if Medicare is passed, what might happen if they have to have a fee schedule?

HORTY:

I think quite rightfully so. In the first place, physicians are independent creatures. The selection process and their selection of a career is in part, I'm sure, determined by the fact that they did not want to be part

of an environment where they would be inside a corporation and subject to a lot of controls. Over the last twenty years government has moved into this field as a payor and regulator. The amount of physician discretion is considerably less than it was twenty years ago. Then you put on top of this an examination of clinical conduct which would not have been examined twenty years ago, within the hospital or by plaintiffs' attorneys, and you have people who, in many cases quite rightfully, feel that they can't adequately practice their profession without continually worrying about all kinds of outside factors, some of which are totally beyond their control.

And also, physicians don't like lawyers. That is not just because lawyers sue them. Lawyers, by and large, are different kinds of people than physicians. Lawyers like to play with words and physicians don't like that kind of stuff. They want to get an answer, get on with it, get their job done and go on to the next one. Lawyers are seen by them as slippery. I don't think physicians are particularly wild about management, because management wants to put them into some kind of a box, into some kind of a place, into some kind of control. Here is a profession which increasingly has had to adapt to a corporate environment which thirty-five years ago was totally foreign. But at this point we are dealing with an entirely new breed of physicians. This kind of problem will go away. The physicians aged forty or forty-five and above are rapidly becoming less than the total of practicing physicians.

I have some of the same feelings. Lawyers don't like to be part of an organization. Yet our law firm which was three people is now eleven with a support staff of close to fifty people. Because of the way in which we work we are a corporation; we are not just a band of independent practicing

lawyers. Once you grow to the point in any business where you are dealing with four or five million dollars you can't run it on the back of a scratch pad. The constraints of any kind of business are the kinds of constraints that physicians are finding today.

WEEKS:

While you were talking about physicians and corporate structures and so forth I wondered what is your opinion of the value of the Kaiser Permanente? What little I know it seems that the doctors who are members, or partners, in this group seem to be working quite well.

HORTY:

Well, my feeling is that whether they like it or not that physicians and lawyers are going to increasingly end up in groups. The number of solo practitioners in law, outside of the smaller towns, is much less than it used to be. I don't say that it will ever disappear, but I think that multi-specialty clinics are going to increase in terms of the total percentage of the practice. It is not going to happen overnight. It's not going to happen that fast, but it is going to happen. Just because of the difficulties with the turf fights, the referral fights, the problems of getting business, the need to advertise in one form or another, the need to get the savings that you can get from a corporate kind of operation. It is not just the Kaiser Permanente, it is the Carl Clinic in Illinois, the expansion of the Cleveland Clinic to other places in this country, the expansion of Mayo. There is a number of others around the country. Now we are seeing heart centers and other kinds of things which are not just cardiologists; cardiologists, heart surgeons, internists. I think that inescapably we are moving in that direction. It is going to affect the hospital and it is going to affect the

medical staff.

What no one yet has really focused on is that the hospital, which is often seen as inefficient, is inefficient, to the extent that it is, because it is operated as a hotel. It has no idea whether a physician is going to show up with a patient today or not. It has no idea whether a patient is going to stop in the emergency room or not. It has to have a tremendous amount of stand-ready-to services where the overhead continues to run whether you've got any customers or not. At some point we are going to look at both the problems of selling the product, on a hospital scale, and the problems of the efficiency of the product. We haven't up until now. That involves another look at how the staff connects to the hospital.

I have been chairman of a hospital in Pittsburgh, Central Medical Center, for the last ten years or longer. We have had over those years a number of financial problems with a new hospital. It was one of the first new hospitals in Pittsburgh in a long time. Pittsburgh is not an expanding area in terms of population. One of the largest catastrophes that I can recall in the first couple of years when I was chairman of the board was what was to me personally one of the happiest moments of my life and that's when the Steelers won their first Super Bowl and the census of the hospital dropped fifty percent, because every doctor who could fly got on a plane and went to the Super Bowl and then took two weeks off in the Caribbean. You just wouldn't have that if...

WEEKS:

I am sure we are going to see many changes. I would like to talk to you about some of the changes before we leave. I have a list of things I think are going to change. Maybe you wouldn't mind commenting on them.

One thing we didn't talk about was the Estes Park Institutes were also

international in some years, weren't they?

HORTY:

Yes. We did one institute in Britain and one in Norway. That wasn't an institute. It really was a faculty retreat and we took invited guests with us. The second one was just faculty. The first one I arranged the faculty for the British part of it and also the publication that came out of it. We really have not been doing that since then. The reason is that we felt that it was more important to use that kind of time, energy and money to have a retreat every year in the United States so that the faculty of Estes Park would get educated by others. We felt that there was enough we could do in this country. Every summer for the past four summers we have had a week retreat at Sun Valley. The latest one ended two weeks ago. We invite several people to come and talk to the faculty and stay and interact for the three days. We invite several chief executive officers to be with us also. I think we have gotten a lot out of those.

WEEKS:

You have mentioned some of the principal faculty members. Are there any others that you would like to mention?

HORTY:

At the present time the core of the Estes Park faculty is the Lelond Kaiser who is professor of hospital administration at the University of Colorado. Will Fifer who has had a long and a very satisfying career as a speaker and as a researcher as well as an internist. Dick YaDeau who was a practicing surgeon in Minneapolis for many years and had been on the Estes Park faculty and on its board for many years. Dick is now full-time engaged in establishing hospital-based HMOs. I am president of the company that he is

using to do that, although I don't have an active role in the day-to-day. At present we have several of these up and operating around the country, in Nevada and in Ohio. They really do address the question of how a medical staff and a hospital together can provide an insurance package for the people in their community that prevents the kind of discounting that might occur if others do it.

Then another member of the Estes Park faculty, and very central to it, is Spence Meighan who is a psychiatrist, originally from Scotland, but who really has talked for years of the relationship between boards and hospitals. Sandra Gill who is an operations consultant. She really looks at the interaction of committees and people. And Andre Delbecq, who is dean of the business school at Santa Clara University, is on the faculty as well. Then we have a number of others. John Tiscornia from Arthur Anderson; Patrice Feinstein who was the number two person at HCFA during the first four years of the Reagan administration. Patrice really was the person who, from a policy standpoint, put together the DRGs. Linda Haddad of our firm speaks on several topics of law. Hugh Greeley who used to work for the Joint Commission and now does his own consulting. He is really very knowledgeable about credential and things of that sort.

Estes Park Institute's theory is that we are looking at emerging issues and are treating them in the programs. One of the people that has now become a part of the faculty is Jack Trout who is the head of Trout and Reis Advertising Agency in New York. Jack is the author of the two very well known books, one called Positioning and the other called Marketing Warfare. He is about to come out with another one. We spoke about it in Sun Valley. So, we have been broadening from the quality issue, from the medical staff issue, to

others. At the hundredth anniversary we had a special program on where we saw the future going. The panel, I think, illustrates the directions and that is we used Cliff Graham who is the Deputy Planner for the British Health Service, John Iglehart, a writer for the New England Journal of Medicine, Uwe Rinehardt from Princeton, and myself, as a panel to discuss where we thought Britain and America were going in the future.

WEEKS:

I imagine the hundredth meeting celebration was nice that Wes was honored.

HORTY:

It certainly was. He was given a scholarship in his name to the Society of Internal Medicine by the board of Estes Park Institute. So it was really an honoring of what has happened. Then a looking ahead at what is going to happen and trying to, in an increasingly competitive environment, to keep Estes Park as vital and as competitive as any other organization attempting to educate.

WEEKS:

What did you decide you were going to do in the future?

HORTY:

Well, do a better job than we have been doing up to now. And I think we'll look at other educational opportunities. We are not going to change the direction of the Institute, but you have got to continually renew what you are trying to do. Any educational program that stands still is going to go downhill.

WEEKS:

That's right. There is so much in the way of competition.

HORTY:

Sure. There is a lot of noise out there. I think Estes Park has a very loyal following. Our meetings are sold out, but you can't sit around and assume that that is going to continue forever.

WEEKS:

It is remarkable what you have done in the few years that you have been doing it. You consider the one hundred institutes in itself.

HORTY:

I think that is a tribute to Wes' vision and a very intuitive ability to spot good speakers and keep them interested and keep them on the program and thus attract people. The program which was sufficiently attractive that people enjoyed coming and coming back.

WEEKS:

Wes impresses me as a very modest man who certainly has accomplished a great deal in his life and is eminent in his profession and yet he is like an old shoe.

HORTY:

He is awfully comfortable to be around.

WEEKS:

I think we have to say something about the American Academy of Hospital Attorneys. It started out as the American Society, is that right?

HORTY:

Yes.

WEEKS:

Does this work under the umbrella...

HORTY:

Of the American Hospital Association. It is part of the AHA. When it was established -- I have even forgotten the date -- Eric Springer and I were two of the first people who were part of it. I am not very active in it, but the number of people in it now mirrors the growth of law as an integral part of this field.

WEEKS:

How many members are there, approximately?

HORTY:

Gosh, there have got to be over two thousand.

WEEKS:

Is that right? It doesn't seem possible.

HORTY:

It shows how many lawyers there are around.

WEEKS:

What does the Academy do?

HORTY:

It has committees and programs. It has an annual meeting. It does education of attorneys in the hospital field.

WEEKS:

It usually meets in conjunction with the AHA?

HORTY:

No, usually not. Eric Springer was a speaker at it this spring.

WEEKS:

Could we talk about the AmeriPlan now? I picked up something that Kenny Williamson says about the beginning of the AmeriPlan or the need for it. I

don't know what comes first, whether the attitude of the AMA toward Medicare -- they were suspicious of that while it was being formulated -- or whether Dr. Crosby who was head of AHA at that time realized there were a lot of problems facing the hospital field and... Didn't he form a special committee, not the Perloff Committee but another committee previous to this to study the problem?

HORTY:

I'm sure he did, but I had no connection with any of that.

WEEKS:

But he was thinking of financing.

HORTY:

Yes, and I think even then people were beginning to be concerned about Medicare and concerned about the price spiral going up.

WEEKS:

So then he formed this special committee.

HORTY:

Which really did not begin with the idea that it was going to come out the other end with a report of a certain kind. There were two attorneys on the committee, myself and Sherwin Memil who practices out on the west coast. One of the things that Sherwin, who then represented some of the proprietary chains, said to me was, "This is all going to be a big waste of time. Besides, if they don't like anything we come up with we will never see it again. I'm not sure I want to serve on this committee."

He and I talked and I went to Ed Crosby and said, "Could we get an agreement that if the committee comes up with a report that it will be published whether the AHA board agreed to it or not?" He said yes. So that satisfied Sherwin and satisfied me. But that, to some extent at least, I

think put in both of our minds that there ought to be a report and that the report would be something "publishable" in the sense that you want to read it. Attorneys tend to think in terms of that anyway.

The Perloff Committee really had a long gestation period of people getting to know each other, to feel comfortable with each other, discussing lots of issues, not really centering on anything for a long period of time. I don't think it was until about three months before something had to be turned out that we began to think in any shaped way that what we were looking at was a proposal for very radical reform. Or that radical reform was needed. So, to assume that the committee members or any of us had in our minds that we were going to come up with a plan was pretty far from the fact. But it all tended to coalesce together and the actual report, the draft of it, was written over a period of about three weeks in hotel rooms in New York City by myself and Mike Lesparre who was then at the American Hospital Association, with Sherwin's help and Ed Connors and a couple of others coming in and out. But the actual drafting of it was done by Mike Lesparre and myself. There is an old saying, "You write the minutes of the meeting and you control the meeting." If you write the draft you really control to some extent the thinking. It was at that time that I think we really began to see it as a blueprint of what the hospital structure of the future might be, what the structure of the hospital field might be. Many of the concepts that are in that report did not really take shape until very late in the committee's deliberations. What to me, at least, was amazing was that in the report there was almost unanimity once everyone sat down over a period of two meetings, three days each. And that committee was about as disparate a bunch of people as you could want, but there was an agreement that the thing made sense and

that it ought to go that way. There was very little change other than rewriting what we did because we weren't comfortable with the way we said things or the way we organized it or how we put things. But the concept was almost like everyone said, "Yeah, that's right."

WEEKS:

My impression was that you were a group of people meeting frequently.

HORTY:

One weekend every month.

WEEKS:

For what, eighteen months?

HORTY:

Yes.

WEEKS:

And that you spent a lot of time and voluntary effort to do this. It was a great contribution that you made just in the effort if nothing else.

HORTY:

And this was at the time when I was just establishing the Aspen Systems Corporation.

WEEKS:

And you were busy with that.

HORTY:

I had some other things I was doing as well.

WEEKS:

I met Earl Perloff shortly before he died, probably three or four months. I was very much impressed with him as a person.

HORTY:

Earl was an ideal committee chairman. Much more ideal than I would ever be, because he had the ability to move things along to get people to work together. By and large without intruding his own ideas, although he had ideas. My tendency is much more to move the committee along my ideas than it would be to permit everyone else's ideas to flow in and I think with that kind of an effort, with the need to get trust and like-thinking among people who didn't think alike. He was just a super person to chair a committee.

WEEKS:

It almost seems from what you say that taking the first year or fifteen months where everybody could talk and everybody could give his ideas and no action was really taken....

HORTY:

That, I think, was one of the crucial parts of the success of that committee.

WEEKS:

You were all talked out by the time you got down to it.

HORTY:

And there was a lot more agreement than anyone thought there was. I was able to use that technique one other time after learning what I did on the Perloff Committee. I'll tell you when we are talking about NCCH. I think the committee was unique in the sense that it had enough time, there wasn't the pressure of a deadline, and it was very fortunate to have Mike Lesparre who was very good with writing and Sherwin Memil who was a super attorney. And the other people, all of them were very thoughtful, very humorous. Such as Steve Morris, who was a long-time friend of mine and president of the AHA.

WEEKS:

I haven't met Steve.

HORTY:

These were people who I thought represented the best in that Association at the time.

WEEKS:

You met once a month. The structure, the organization, do you want to speak about the national commission and the state commission and so forth and how they fit together?

HORTY:

Well, no, not particularly. I think a lot of that report is not likely to have ever been possible to get through in the form in which we had it. I think that what it did was to -- the key elements were the fact that you had to look at financing of both medical and hospital services together, that we felt that the hospital corporations, because of their control of facilities and thus of assets, ought to be the organizing parts rather than an insurance company. And that, at the time when national health insurance and those kinds of issues were very much before the public and before the Congress, that a certain amount of local organization was necessary in order to get that kind of a structure. I think the achievement was perhaps foreshadowing what we are seeing now, and that is that an individual hospital has to have some relationships with others. That it's the hospital infra-structure that we are going to have to build from, that that is where the borrowing power and the assets are, and that, as we discussed earlier, physicians practicing as solo practitioners isn't where we are going in the future either.

As you know, AmeriPlan eventually became House Bill 1, introduced into

the Congress, and I was responsible for the drafting of that with Alanson Willcox, whom I used as the draftor of it. We made one bad, I think, drafting error which I never would do again. That is, I let Alanson talk me into (I think he was perfectly correct from a drafting standpoint) drafting the bill as an amendment to the Social Security Act which made the drafting process incredibly difficult, but he had staff people who knew Medicare and it was easy for them to do it and it was easy for the Congress to understand it. But it prevented you from ever finding it, so that when you began to try and get people to understand it it was a jumble. I think one of the lessons I learned from that drafting process was that you can always change it later to make it palatable as legislation, you better make it, whatever the concept is, attractive as a concept when you are drafting so that the Congressmen and Senators and media and others understand it as a concept from the beginning rather than as a series that looks like change paragraph three on page ninety-two from A to B. Nobody can put that kind of thing together again.

It was introduced by Representative Al Ullman who was later chairman of the Ways and Means Committee. It was a viable piece of legislation for a period of time, didn't go anywhere, but mostly because other things occurred. And also, national health insurance went away. At about the same time, contemporaniously with the introduction of this bill -- Wilbur Mills was still chairman at that time, Ullman was number two, just about the same time Mills was in some relatively important and serious discussions with Ted Kennedy over a compromise national health insurance bill which HR1 would have been a counterpoint to had that thing moved. It didn't, and HR1 didn't. With anything, legislation particularly, timing is everything. So, the Perloff Committee Report, while I think a persuasive document, and the resulting bill,

while I think a persuasive bill, the timing wasn't right. But where I think that it has made its impact is in thinking about competition and about a difference in the way in which you look at the hospital field. I think that that report and its main thought is going to be with us for a long time.

WEEKS:

Some people have thought that the HMO movement possibly came out of that.

HORTY:

Parts of it. When you look at what I said about Dick YaDeau doing hospital HMOs and some of our thinking with respect to those. It is lifted right from AmeriPlan.

WEEKS:

Maybe even the expanded Medicare with the catastrophic insurance.

HORTY:

Perhaps. I think one of the things we felt very strongly about in HR1 was we had to cover everything. We had to deal, not just with acute inpatient hospital care. I think the attempt to put health care together as a system without going into a nationalized system, to me was one of the major accomplishments of that report.

WEEKS:

The report was in general terms too.

HORTY:

Well, it was deliberately in general terms so that people couldn't pick it apart.

WEEKS:

If you get into specifics, that's where you get into trouble.

HORTY:

That's right. Then you end up with three things that everybody concentrates on and the rest of it floats off into the distance. I think we were able to hold peoples' attention on the report. An illustration of that is, the only bit of controversy in the entire report was one word. In the preamble and in the first paragraph at my insistence, one of the few things people debated on the report, I put in that health care was a "legal" right of the American public. That is the way the report went to the AHA House of Delegates. When it came out, the word had been deleted. If you look at the AHA adoption of the report it is not in there. That is where all of the flack was concentrated.

WEEKS:

Didn't the AHA reverse their opinion and support of this bill?

HORTY:

After a period of time, other leadership and other thinking prevailed.

WEEKS:

Was this after Crosby's death?

HORTY:

Yes, and after Kenny left Washington.

WEEKS:

There is a strange period there. Madison Brown acted as interim...

HORTY:

Yes, while they were searching for a new permanent chair.

WEEKS:

So he really couldn't do much.

HORTY:

That was part timing as well. Kenny was not as influential as he had been for the time he remained in Washington. There was a lot of infighting within the organization, as we could expect.

WEEKS:

Kenny, I guess, made some unsavory remarks about Nixon, didn't he?

HORTY:

Oh, I don't think that was of much importance. I think it really was a question of personality clashes within the AHA at the time. It did have the effect of not mobilizing much support for the bill. But, in the greater scheme of things, I don't think there was a chance that bill was going to go anywhere anyway. As is often the case with the first pushing up of an idea, it is the concept that matters.

WEEKS:

No doubt it will be influential for many years to come.

HORTY:

In fact it already has been.

WEEKS:

I was thinking of another thing. Al Ullman was not re-elected was he?

HORTY:

That's correct. But the bill was dead before that, long before that.

WEEKS:

You could say that basically the plan favored quality care for all persons.

HORTY:

That's correct, and that was its thrust.

WEEKS:

And it had five or six major components of care.

HORTY:

That's right. Defining the components that was a very great task. Trying to decide. That was really my first exposure to a concept that I have had to deal with from then on, defining eligibility, defining criteria, defining payments, defining care. The whole category of what I have always called the "working poor" that move in and out of the welfare system, or any system. It is really one of the major problems that any system has to deal with.

WEEKS:

I wondered if in your discussions you tried to find some way of settling the problem of who was poor in Mississippi, for example.

HORTY:

The difference of poverty levels in various states. There are many aspects of that problem, and the whole question came up again.

...at a later date when I was helping to draft what became the Gephardt-Stockman competition bill where we had to deal with eligibility, criteria for eligibility, coverage and criteria for coverage.

When you are dealing with whatever you call it, whether you call it the working poor or the near poor or whatever, they are not just people from a particular state or a particular part of a state, they are the low income that go in and out of the system of eligibility that people who by the nature of their job work for a period of time at a level where they are paid well above the poverty scale and are furloughed and then come back and go back and are in and out of eligibility.

Then you've got the young who work to some extent that have got parents who could afford to care for them but they are out on their own and living in Aspen, Colorado, for the skiing. Then finally you've got a whole pool of people who are illegal aliens, who appear on nobody's rolls, you never hear of them until they show up in an emergency room, but they are there and they produce babies and they have illnesses and require treatment.

The whole question of the working poor is going to devil any system that tries to deal with this unless you are going to have universal coverage, which we are leaning towards today. Even in Britain, even with the nationalized system, you've still got the people who come from Bangladesh and who are there for six months and come from the islands and are there for three months, come to visit their relatives and live in the same apartment with them and suddenly need care, they are not on the rolls, not officially, but they are there. I think everyone, with mobility the way it is today, everybody has got these kinds of problems. It poses difficulties whenever you ask any local -- I include the state -- any local government to assume the costs of care of people who may have tangential relations to the community that's paying for it.

WEEKS:

In the report I noticed several times, at least I think it was several times, that reference was made to physicians. They must be a part of this, they must be a major part of this. I can understand you had physicians on your committee. What was the discussion about the role of the physician? How is he to be paid? Did that sort of discussion enter into it?

HORTY:

There was a lot of discussion about that. I think quite correctly a lot

of it was left out of the report for the simple reason that just as health care is a "legal" right became the focus of attention so would physician compensation, to the point where the headline on the report would have been "Report Asks That Hospitals Pay Physicians," "Report Asks that Physicians Pay Hospitals," "Report Says States Will Hire Physicians." That's the hook that any reporter would grab and the rest of the report would have gone by the boards. In fact, I was fairly insistent on keeping that kind of thing out of it just for that very reason.

It goes back to an incident that I had years ago when I first started work on the Hospital Law Manual. I had already received a grant from the National Institutes of Health and started writing the chapters. One of the chapters included the legal question of whether hospitals could employ physicians. There was large controversy in the 1950s over what was known as the corporate practice of medicine and whether corporations could practice medicine. Well, corporations had been practicing medicine for fifty years. The Sante Fe Railroad, for example, would have physicians who were on its payroll. So did many industrial companies, who gave treatment to employees. There were lots of others. But this was still a very hot issue, particularly with the AMA. It was one chapter of the table of contents that I submitted to the Institutes of Health. The AMA, of course, didn't pay any attention to the grant, but at some point they found out about this and there were very heavy objections lodged with NIH that this book was going to be a book on the corporate practice of medicine. Well, it wasn't at all. My response was that we did not write that chapter. When the book was issued, it was in table of contents and the chapter had a tab, but nothing was in it. So far as I know the chapter has yet to be written. There was no sense submerging the whole

book in this question. I think physicians' compensation is one of those issues and we are going to see that when we see the report come in next year about physician compensation under Medicare.

WEEKS:

That's going to be an issue.

HORTY:

That's right. The next Congress is going to have to deal with that.

WEEKS:

Was there an acceptance of the idea by the general public or by the news media? I don't remember.

HORTY:

AmeriPlan? I don't think there was a tremendous amount of publicity given it. I think in part that was because it was felt that the report was out, the next thing was to get a bill written, to get a sponsor. That would be the time for publicity. Then, as we discussed, the political landscape changed both in Washington and at the AHA. So it didn't get near the publicity it otherwise would have. There was some publicity given the report. Earl Perloff was on various shows and did various things, but I think the timing of real publicity would have been when the bill was introduced and AHA problems stopped that.

WEEKS:

It was probably just as well you didn't have too much publicity.

Before we leave physicians; was there any discussion about screening of physicians? My impression was that any licensed M.D. could be a part of it.

HORTY:

That's correct. That whole issue was avoided, because again it was an

issue that would have clouded the report. There is no question, however, that when you get down to writing the rules about how you are going to run one of those enterprises, that question had to be addressed. We knew it had to be addressed, it just wasn't logical to put that kind of detail into the report.

WEEKS:

If you could get the framework approved...

HORTY:

That's right. Then you could do what was necessary.

WEEKS:

Or, as we have often heard, then we could do it by regulation.

HORTY:

It is almost the same thing that occurs in a hospital merger. You put two hospitals together, you do it at a corporate level, and no one discusses but everyone realizes that you have now changed the standards for medical staff competence -- one way or the other. It will have to be addressed, but no one ever addresses it going in.

WEEKS:

There is one more thing that I think I should ask. Was there any discussion about the entry into this system? Would a patient go through a gatekeeper?

HORTY:

No. The gatekeeper concept -- I'm sure it was discussed in the committee, again that is the kind of detail that wouldn't have been put in the report. Remember, at the time of that report the concept of the gatekeeper was a lot less understood. There was only a couple of places in the country where that concept had even been tried. Puget Sound was one. It had less of

a punitive connotation then. It was sort of seen less as a financial constraint as perhaps a director of traffic. I think we just decided not to address either aspect of it, financial constraint or the gatekeeper.

WEEKS:

I would also like to ask if there was a conversation about nursing homes? I noticed custodial care.

HORTY:

Nursing homes -- you can't look at any kind of system without nursing home care and the difference in levels of nursing home care between custodial with some medical and acute or skilled, as they call it now, nursing home care coming up. And how much are you going to pay for what? How much are you going to pay for the cost to "warehouse" grandma and how much are you going to pay for people who will be there for a period of time and gone? How much are you going to pay for the chronic person who is there for the rest of a very long life, as the result of being on a ventilator or being unable to care for themselves. There was lots of discussions. Our feeling was that nursing homes had to be brought into the system. There was concern then with the quality of care in nursing homes. So they were included, but getting into the financial questions, we didn't, because in part everybody understood that it was a bottomless pit. You could pour in all the money that you wanted to and there would still be a desire for more. We have since learned that all of medical care is a bottomless pit.

WEEKS:

Defensive medicine, I think, and the use of all the technology has become a very expensive factor. I won't even go into financing, because I don't think there was much in the report about it.

HORTY:

There wasn't. There was a recognition that financing mechanism in place, which on the federal level was limited to the elderly and to some extent the poor -- to a lesser extent the poor than any of us would want, because in some states it was being siphoned off into nursing home and custodial care. And the Blue Cross part of the package, the commercial insurance part of the package, left lots of gaps, lots of problems. At least there was a recognition that the system of financing wasn't working, that we didn't want government to take it over, a la a British style national health insurance, but that something would have to be done to regularize the financing. We are back again to coverage, eligibility, who is in the plan and so forth.

WEEKS:

I was trying to think of this in the element of time; was there any discussion about the multi-hospital system?

HORTY:

No, none whatsoever that I can recall. Now, by my memory of fifteen years ago, hospitals systems by and large didn't exist. There might be a two hospital system. I should, however, say that I define multi-hospital systems as close coordinated legal control of the hospitals. I don't define multi-hospital systems as the Voluntary Hospitals of America or Sun Alliance or any groups where each hospital retains its own governance. Those are service organizations. Even at that time I would not define as a multi-hospital system even the Catholic systems, because they were so loosely controlled they weren't controlled at all. Each individual hospital basically ran itself.

WEEKS:

Was there anything said about contract management?

HORTY:

No. The concept was three or four years later.

WEEKS:

But there was quite a lot of talk about peer review and the quality of care.

HORTY:

Yes. Dealing with the quality question was central to the whole thing. Again, you look at it in its context in time. That was exactly at the time when the Joint Commission was beginning to look at redoing the Standards. In fact, I had been the legal counsel of the Joint Commission to rewrite the Standards. I did the drafting of those standards in 1970-71, the drafts that went to the various committees of the Commission. I was still -- this was all on a voluntary basis because I was running Aspen Systems Corporation, I wasn't in the practice of law -- I was the AHA's representative in that process. When Ed Crosby asked me to serve on the Perloff Committee I said to him, "I can't do both. I just don't have the time."

He said the standards were pretty much in place, "Would you come on the Perloff Committee?" So, I did. That really was the last I dealt with it, but that was very much on all of our minds. I might add parenthetically that the standards we ran through our computer programs in Pittsburgh and made them consistent, just like a state standard.

WEEKS:

You just mentioned computers. How about record-keeping? That was talked about too, and data banks.

HORTY:

Yes. That may have been my influence. I think again we were looking at

what was going to happen and the real value of a single medical record. Even today what could be done isn't being done. In fact, in two Hospital Health Plans that Dick YaDeau is putting together there is a computer capability that we had there that would allow the same medical record to be used, to be called up by the doctor in his office off his own P.C. and by the hospital. And if the physician referred to a specialist, instead of waiting three days while somebody carries the record over to the specialist, all you do is call it up. That stuff ought to be child's play today, and it isn't.

WEEKS:

It's amazing what happens in some of these instances. We have a friend who has been waiting for a report for a week and in calling the office she asked the question, "If there is anything wrong would you call me?"

"Yes, we would have called you." So I guess it is the case that no news is good news.

HORTY:

Which is marvelous because most people don't assume that.

WEEKS:

Of course DRGs weren't involved nor were severity indexes.

HORTY:

No, in fact there wasn't really much quality data of any kind.

WEEKS:

This brings back to mind; somewhere along the line did you have any connection with Paul Lembcke?

HORTY:

No.

WEEKS:

He was one of the medical audits people ----

I think we are down to a point where we should talk about the National Council of Community Hospitals.

HORTY:

Well, the National Council really was the outgrowth of a set of clients that I had when I went back into the practice of law in 1971. One of the first people who came to see me was the representative of the Catholic Hospital Association. That was at the time of the Federal Cost of Living Council, during the Nixon administration, just beginning to regulate hospitals costs. The Catholics and the Protestants together retained me as a lawyer to negotiate with the Cost of Living Council and eventually we brought suit against the Cost of Living Council and won, just before it went out of business. That was a very controversial set of clients, because their coming to me was perceived by the American Hospital Association as a vote of no confidence in the lobbying that the AHA was doing in Washington with the Cost of Living Council. The frustration that had built up by the Protestant hospitals and the Catholic hospitals was such that they felt they ought to seek other help. It pretty much ended my relationship with the American Hospital Association, and resulted in a fairly wide rift between me and Alex McMahon who ran the Association, who had just been selected a couple of years before.

What we did in representing those people was basically seen as being anti American Hospital Association. When that legal action moved from the Cost of Living Council and the courts, it moved to an attempt by President Nixon to renew the legislation of the Cost of Living Council. Those groups were not

happy with what was being done in the Congress. So I and the lawyers in Washington that I had hired, John Hoff and Ken Shaner, began to lobby the Senate committee on behalf of these two organizations to effect changes in the bill to eliminate hospitals. We basically got those changes. Our amendments would have eliminated hospitals from regulation by the Cost of Living Council had the mandate been renewed by legislation.

That was not perceived as a particularly friendly act either, by certain people in the American Hospital Association. I was, rightly or wrongly, appalled by the lack of effective hospital lobbying. I was not a lobbyist. I had never done any lobbying before. In fact, the only thing I had done was a couple of times on behalf of the AHA I had testified before Congressional committees. But Kenny was still in Washington, so I had no experience. What bothered me I suppose the most was the lack of understanding on the part of people on committees that dealt with hospitals about what a hospital was and what its relationship to physicians were and what its relationship to financing and its real ability to control costs. Much of the arguments that we had with the Cost of Living Council was that it was not the hospital that put the patient in it but that it was the physician and that somehow it was the hospital should be able to control these costs. Obviously this debate still continues. Hospital efficiency is dependent upon physician efficiency. At some point that is going to be definitively addressed. But it was even then, sixteen years ago, as much an issue as it is today. Nobody understood. They felt either that the hospital was telling the physician to put unnecessary people in the hospital or that they were not controlling the physician's actions or they could just tell the physician that he didn't need to do these operations or whatever.

In any event, we were able to successfully see that it should not be in the bill, but the bill never got out of committee anyway so it didn't matter.

At the close of that, we disbanded the committee of Protestants and Catholics that was responsible on behalf of those two associations for this litigation. Everett Johnson, who was then running Methodist Hospital in Gary, Indiana; and Dick Johnson, who was in consulting, brothers, and myself and Bill Wallace who was running United Hospital in Minneapolis, the four of us met and decided that, reluctantly, very reluctantly, we probably ought to continue our lobbying activities. One of the things that motivated me was not that I wanted to lobby, but that I had now some attorneys in Washington that I had taught the hospital field to, worked with lobbyists and I felt that I ought to try and keep them in it. So we established something called the National Council of Community Hospitals, the four of us. We took in ten hospitals. I became the president of it. It was and is a non-paying job. In fact we set the membership dues and I pay dues as if I were a hospital. I did that originally so that no one could criticize my being in it. Obviously several of the initial hospitals that came into the council were people who had been active in the Protestant and Catholic battle, Sister Myra James from Penrose Hospital in Colorado Springs; Bill Feury who ran the Memorial Hospital in Chattanooga; Bruce Perry who was running then a hospital in Columbus, Georgia; Charlie Mason from Peninsula Hospital in Burlingame, California; Cecil Hamiter who was running Baptist Hospital in Gadsden, Alabama; Baptist in Memphis -- Frank Groner was the head of that. These were the early members.

What was sort of interesting was we never gave out a membership list because we were afraid of the kind of retaliation it was going to have. For several years this "renegade" organization had in it a number of people who

were well into the hierarchy of the AHA. Most of the flack and most of the unhappiness over the establishment of this group was directed at me as the president. It certainly didn't help my relations. It was funny because, as I've told you, over the years I used to speak to many, many state hospital associations. I suddenly spoke at none. That whole speaking field dried up.

WEEKS:

You said Frank Groner was a member. He was a former AHA chairman, wasn't he?

HORTY:

Yes.

WEEKS:

I am also trying to get something else in chronological perspective too. I can't remember the year that Kenny Williamson left Washington, but before he left it must have been before you...

HORTY:

That's correct. I doubt the organization would have been founded as long as Kenny was there. That was before the Cost of Living Council problems. There just was a difference in the perspective of the Association, at least in my perception at that time.

The organization first concentrated on, (at that point we were probably twenty or twenty-five hospitals,) the Carter Cost Containment Bill which the President put into the Congress in an attempt to constrain costs while Califano was Secretary of HHS. We did everything we could to defeat the Carter Cost Containment Bill.

In the course of that, when it finally went to a vote in the House, a very unknown Congressman from Missouri, whom I had met earlier, came to me and

said that although he was a Democrat he was going to oppose the Carter Cost Containment Bill on the floor and that he had attempted to get help from the AHA in terms of learning about it and had been unable to and would I help him. So, I spent about a week giving prepared position papers and then a speech for Dick Gephardt and he came out against it and helped beat it. We became friendly as a result.

About six months later we were having dinner and I said to Dick that I felt very uncomfortable going back up on the Hill after we had beaten this thing, but hospital costs were still going up. What should be done? I disliked just opposing things. He said, "I feel the same way. I feel somewhat responsible as a Democrat who broke with my own party, my own President, and I am getting a lot of flack from people even though we won on the House floor. What should be done?"

Well, we had been studying some issues with a professor then at Stanford, by the name of Alain Enthoven who we employed as a consultant for the National Council of Community Hospitals. We were beginning to draft a bill. Dick was very interested. Strangely enough the bill was resembling what AmeriPlan would have been. So, he said he would be interested in working with us on it, but we ought to have a Republican and did I know anyone who was interested in health? I didn't but I knew a staff person by the name of Don Moran who was a staff person for a Michigan Congressman, David Stockman.

So Don Moran talked with Dave Stockman, and Stockman was interested in working with Dick Gephardt. We constituted a staff drafting committee which was John Crosby, who was Dick's staff person; Don Moran and John Hoff, who was in the law firm that we used as counsel to the National Council of Community Hospitals. The three of them would meet once or twice a week to work on the

concepts of the bill. Then once every other week, depending upon how we had done, Dave Stockman, Gephardt, and myself would sit down and work on it. The amount of time we spent on this thing was great, because of the complex issues, because of the financial problems, and sending for assessments and projections of what it was going to cost us if we included this but didn't include that, covered this and didn't cover that, would we cover eyeglasses, what about the near poor? All of these issues bubble up as you go along in this kind of a plan. I logged about sixty hours worth of time with Gephardt and Stockman and the other three setting and making the cuts that enabled us finally to draft what became the Gephardt/Stockman Competition Bill. I think the bill itself would have been more of a vehicle in the Congress if the Republicans hadn't won the election in 1980. Very shortly after it was introduced in the summer of 1980, Dave Stockman became an advisor to the main candidate, Ronald Reagan, and went in as director of OMB. Don Moran was his health person and eventually number two. One of the first things that David realized was the way the Reagan administration saw it they weren't going to have the money to put into much of the coverage that we wanted in the Gephardt/Stockman Bill for the poor and for the near poor. That bill, if it had really been given the kind of analysis and care that it would have gotten under other circumstances, I think was a feasible way of handling the problems of the poor within the system. One of the things we did was basically nationalize Medicaid and handle it on a federal level, which I still believe is correct.

WEEKS:

Benefits and all?

HORTY:

Benefits and all. How you dealt with the near poor and the aliens and other people. Obviously that work led to other legislative things that NCCH has done and one of them is the Moore-Gephardt Malpractice Bill which is an attempt to limit liability to out-of-pocket costs, the cost of treatment and convalescence and the cost of putting the patient back to where they ought to be, but not attorneys' fees and pain and suffering. So, you begin to get a handle on the cost of malpractice and you also take it out of the court system. I think that that bill (which is still alive) may well be a Medicaid experiment where those physicians in high risk areas such as OB/GYN and pediatrics get protection if they agree to take Medicaid patients, which is one of their concerns.

NCCH has done a number of these kinds of things. We have always limited our activities to federal lobbying just because we are a small organization. We have limited our membership to around one hundred hospitals, both big and small hospitals. We have a small staff in Washington. Katie Bolt is the executive director, full-time lobbyist. We use Swidler and Berlin as a law firm with John Hoff. John devotes a good share of his time to NCCH. At this point I am comfortable that we have made a contribution.

We obviously had differences with the American Hospital Association who felt we shouldn't exist, and with the Federation of Hospitals which represents proprietary hospitals. I have always been very, very strongly convinced that the hospital system in the country, which was and is predominantly non-profit in terms of its organization, received a lot of strength from that. I was not happy with the encouragement of hospital chains and for-profit organizations in this field.

At this point, however, in the last couple of years, perhaps coincidentally since Alex McMahon left the AHA, our relations with the AHA in Washington and with Jack Owen in particular, who is the head of the AHA in Washington, have been fine. And with the Federation as well.

Almost coming full circle back to the quality issue in Perloff and the whole question of relationships of hospitals and doctors, the anti-trust question, the peer review problems. Two years ago we put together a bill which was sponsored by Congressmen Henry Waxman and Ron Wyden and Ed Madigan in the House and Senator Orrin Hatch in the Senate to protect physicians when they were engaged in peer review and hospitals from anti-trust suits. That bill became the Health Care Quality Improvement Act in 1986.

We also established a data bank which will become a national data bank for all actions taken against physicians by hospitals and for results of malpractice settlements and verdicts against physicians so that in credentialing the hospitals they would go to the data bank and get information about physicians when they move into town from somewhere else.

WEEKS:

That is badly needed, isn't it?

HORTY:

From my own standpoint the Health Care Quality Improvement Act is one of the things I probably will always be most proud of. I hope that it works as well as we would like it to. Here were predominantly regulatory Democrats, Ted Kennedy and Henry Waxman, sponsoring a bill to protect physicians and hospitals. I think that it indicates the kind of good legislation that could come out. There the American Hospital Association, Jack Owen particularly, was very, very helpful.

WEEKS:

What is the legal protection that offshore insurance companies have?

HORTY:

Well, it is not legal protection. It is merely a method of organizing that gets around certain insurance laws within states where the hospitals may be located and allows them to have an insurance company which is under their control. In a lot of states corporations not in the insurance business can't go into the insurance business. This has been a pain in the neck to us in Pennsylvania because the hospital I am chairman of in Pittsburgh, Central Medical Center, has founded an HMO. This is back in 1972. But we were never able to market it ourselves, because in Pennsylvania an insurance company is the only person who could market an HMO insurance policy. That was the law that was changed two years ago, and we just have received permission now to market our own HMO in Pittsburgh. Before it was being marketed by Metropolitan Life Insurance Company and by Blue Cross. Now we will market it ourselves.

WEEKS:

That makes a big difference, doesn't it?

HORTY:

It sure does.

WEEKS:

You mentioned Central Medical Center and you mentioned Modern Healthcare. You also are in an advisory capacity or board capacity to the Sisters of Presentation?

HORTY:

Well, yes. Sisters of Mary of the Presentation is a small Catholic

hospital system located in Fargo, North Dakota. It consists of three very small hospitals and two nursing homes in North Dakota and one larger hospital in Illinois. A number of years ago they asked me to go on their board. I am the only lay person on the board, as the vice chairman of it. I did so mostly because I had not any experience in the problems of trying to operate a tiny rural hospital very far from sophisticated medicine, in the wilds of western North Dakota. It has been a very, very rewarding experience.

One of the most rewarding parts of it is that over a period of years we have really put together a really tight organization of those four hospitals. That has been done by having a yearly educational retreat involving all of the doctors and all of the trustees. To the point where, even though they were located miles from each other, they became friends and then were willing to say, "If you guys over there need the money this year, we will tighten our belt and wait until next year." Whereas before, none of them were willing to wait one little bit. They didn't care what happened to St. Margaret's down in Illinois and St. Margaret's didn't care what happened up in small town North Dakota. By putting the people together and making them comfortable with each other, it has been a very interesting experience.

WEEKS:

I want to touch on the fact that you are a Fellow of the American College of Healthcare Executives.

HORTY:

Yes, for a long time. I think I was the first attorney member.

WEEKS:

And you received the Award of Honor...

HORTY:

That was part of the Perloff Committee. Everybody on the Perloff Committee got the award and a life membership in the American Hospital Association. I think for a period of time they would have liked to take mine back. I don't think that's the case now.

WEEKS:

Can we talk for a few minutes about the future? I think we will agree before we begin that there are going to be changes.

HORTY:

Yes, and I think you can't know them. You can give informed predictions on the basis of what you know, but if you go back -- at least when I go back -- and look at what has happened during the time that I have been in this field, much of it wouldn't have been predicted. The only thing that you can predict is that the problems that existed twenty years ago will remain. The solutions or the ways in which they are being dealt with may change. But problems of quality, problems of cost, problems of coverage, problems of eligibility, problems of moving new technology into this field, none of those are going to change in the sense of going away.

The future is going to be attempting to balance the available dollars with organizations and protocols to try and care for as many people humanely as possible.

There are problems that exist today that didn't exist in any serious form twenty years ago. All of the problems of when you terminate life support, how much care should be given to the person who is comatose and/or terminal, how much cost and time and energy should be spent in those cases? Those weren't problems twenty years ago, because there were very few of those people around,

they died. Now we have the ability to keep people "alive" indefinitely. We also have the ability to bring people into life that require an inordinate amount of resources. These are issues which go beyond both my competence to solve and my willingness to solve them. I don't think (like abortions) I don't think that society is likely to deal rationally with these issues in my lifetime. In fact, in the seminars that our law firm conducts -- four seminars a year -- for hospital docs, trustees and so on, we don't even talk about it, because it produces an awful lot of heat but no light whatsoever.

WEEKS:

It's an emotional issue.

HORTY:

That's right. So, those kinds of issues have become large issues where they weren't twenty years ago. Obviously no one would have predicted that we would have an almost "medieval" epidemic in AIDS. If we were doing this interview in 1965 or 1970, we would have said that epidemics are a thing of the past. "We have now got the ability to deal with an epidemic." "We won't have those things." But we clearly do at the present time. We are dealing with an epidemic, however, that because of the people involved in the epidemic it is not being dealt with as a health issue. It is being dealt with as a civil rights issue and as all kinds of other things.

I guess one of my feelings about the future is that the complexity of these issues has increased exponentially while I have been around, nothing is a one-issue problem any more. They all have several issues and several legal issues. When I wrote the Hospital Law Manual with five of us, afterwards when we were keeping it up to date -- without much egotism involved, I can say to you that I knew all there was to know about hospital law. There wasn't that

much, and I knew it. Today, with eleven people working in our firm, I don't know it.

WEEKS:

But you have a computer to help you.

HORTY:

All that does is give me more information than I want, than I can digest, than I can remember. The complexity of every issue is tremendous today. Thus, our law firm must specialize only in hospitals.

WEEKS:

Are you getting much in the way of AIDS?

HORTY:

Oh, yes. Every hospital has AIDS problems. Every hospital needs AIDS policies, they need guidance as to what to do with employees, what to do with members of the medical staff, what to do with patients, how they interact together, what kind of consent you get, do you test or don't you test, when do you test, what do you do with a physician on the medical staff whom you know has AIDS and continues to treat patients, what do you do with the physician in intensive care pediatrics and he has active AIDS? These are problems that thirty years ago didn't exist. Today, we get them every day. That is not going to go away. Neither are the rest of the problems which become more and more complex.

Sexual harassment problems didn't exist in this field ten years ago. That doesn't mean that there wasn't sexual harassment, there were just no legal problems. We had a client four months ago -- they had a residency program in the hospital and had made the decision that a female resident would not be advanced for the fourth year residency. This is always a painful

decision, whatever the specialty was. They communicated it to her. That obviously is a painful conversation. I've been in those kinds of conversations when you are telling someone that they are no longer going to work for you. Obviously they are going to protest and they are going to attempt to persuade and so on. You run out of words after a while. You have said what your reasons are, you don't want to appear hard-nosed, but you don't know how to end the conversation. In this case the residency director ended the conversation by saying, "And besides, now you will have more time to spend with your children at home where you belong." Which absolutely ended the likelihood that this thing was going to be done in any reasonable manner. She had a sexual harassment suit right there.

The legal issues, the financial issues... To me it is the complexity and it's the attempt to govern these hospitals with voluntary boards spending very little time attempting to deal with increasingly complex social and medical issues. I guess one trepidation I had when you called me to do this thing is, oral histories are done when you are about to die. It's the last thing you do, the capstone of your career and you tell all you can tell. I don't intend to quit practicing law. I intend to be around for a long time. What I say is going to look awfully anachronistic in the next five years even.

WEEKS:

It may. First, I must say, you are one of the younger persons I have talked with. Most everybody has been retired.

HORTY:

I know. My wife, Chris, when I told her said, "Does he know something I don't know?"

WEEKS:

I chose to approach you because you are the authority on hospital law and you babied it along from the first. It is a little bit different. You represent an interesting phase of hospital administration.

HORTY:

I guess when I look back on it, I have been in this field for close to thirty some odd years. I have seen everything from Hill-Burton forward. In fact, one of the first pieces of legal advice that I ever gave, while we were writing the Hospital Law Manual, when hospitals learned that there was an attorney at the University of Pittsburgh they began to call and ask for help. Because in 1956 the Ford Foundation made a very large grant to all of the hospitals in the country, non-profit hospitals. But they had to prove that they were non-profit and many of them no longer had their charter nor knew where their charter was, had no way to prove the fact that they had been chartered and were non-profit. The first legal advice I gave was how to prove yourself to be a non-profit hospital.

WEEKS:

Is that at the same time that Hill-Burton...

HORTY:

It was after.

WEEKS:

Your hospital health plans and other HMOs have a very bad financial picture right now.

HORTY:

Ours don't.

WEEKS:

Yours is in the black?

HORTY:

Yes. The reason is -- and this cuts against the conventional wisdom of HMOs -- if you are going to run an HMO you have got to run it with the docs. That's my feeling. It goes back to AmeriPlan, it goes back to everything that I have believed throughout my career. If you cannot get the physicians to understand that they have a responsibility for the fiscal integrity of the HMO, you can't make it, because otherwise you are subsidizing the HMO to get hospital business. You can't do it. So, I think that the success of the Kaiser HMOs has been the physicians holding to those HMOs. The success of the HMOs that we are doing will be that the physicians are in governance and they are responsible for the fiscal integrity of the plan.

WEEKS:

This is very important because I think in Washtenaw County, the next county to this, we have four HMOs principally. Only one is in the black.

HORTY:

That is because no one, from the time I first came into this field, whether it was commercial carriers, the Blues, or Medicare, has in any way, shape, or form attempted to involve the physician in the financial process. They have taken the position that somehow the hospital will control the physician so that care is delivered efficiently. And it hasn't worked.

Even during the Cost of Living Council, where the Cost of Living Council put a cap on physician fees, the whole thing busted out the sides because what you ended up with was instead of having one visit you had five patient visits or three visits or whatever. I'm not saying all physicians did by any means,

but you could just see the utilization go up. I don't think it is possible to control conduct unless the individual has a financial stake in it.

At the moment I am legal counsel to the hospitals in western Pennsylvania in trying to negotiate Blue Cross contracts. Part of the problems with that is that Blue Cross wants to hold its costs down, the hospitals want more -- they say costs are going up -- and both of them hit each other over the head. Meanwhile, the physician component of the system is completely unchecked. Yet hospitals don't admit any patients, hospitals don't determine how long they can stay there (Medicare may) but in Blue Cross the hospital doesn't determine it, so the costs are, some of them, are not within the control of the institutions. As I said earlier, the selling of the product which is health care and the efficiency of delivery has got to be put into one organization which has physicians, the hospital and insurance together. Until we do that we are just barking into the wind.

WEEKS:

The last reports for 1987, at least, most of the Blue Cross Plans -- we don't say losing money -- are...

HORTY:

They are dipping into their reserves. Same reason. There is no way that we know of to control hospital costs.

WEEKS:

A follow up on that is that in New York State, I believe, if a Blue Cross Plan can prove that it has to dip into its reserve then it can go to the state government and get permission to raise rates.

HORTY:

That is the case in all states, because the insurance commissioner has

jurisdiction over Blue Cross. Blue Cross is separately incorporated in all states, not as an ordinary insurance company. That is usually the case. They must retain their reserves at such and such a level. But just one example, take New York State, on one hand they are saying that hospital costs are going up and with the other hand the state itself upon new regulations has required that residents cannot work thirty-six hour shifts any more which is going to require the hiring of a ton of physicians, most of which don't exist, to provide this kind of coverage. I'm not saying it's not a good idea. I'm just saying that it is costly.

WEEKS:

Maybe this is one way the physician glut, the large number of graduates graduating from medical school is increasing...

HORTY:

The problem with physician glut is that it has always been spread in a very weird way -- where they are needed, they ain't; where they are not needed, they are. Most physicians tend to like to live in attractive places, not the western part of North Dakota nor in the Bronx.

WEEKS:

This is true. We went through a recruitment effort trying to help a small hospital near Ann Arbor. It's surprising. We tried to paint a good picture of the community. It was a nice hospital to work in. The community is in a lake area, with recreation, but it was thirty-five miles from Ann Arbor and from cultural things or East Lansing in the other direction. The school system would have to be of top rating because the young physician doesn't want to come and bring his children to a poor school district. There are many things that enter into it.

HORTY:

As long as you can find a physician who can make the kind of money he wants to in the areas that are attractive why should he go out there.

WEEKS:

So they all end up in the big cities.

HORTY:

They end up on the fringes of the big cities.

Interview with John Horty

Detroit Metropolitan Airport

July 27, 1988

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