

HOSPITAL
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John D. Thompson

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

JOHN D. THOMPSON

In First Person: An Oral History

AMERICAN HOSPITAL ASSOCIATION
RESOURCE CENTER
840 North Lake Shore Drive
Chicago, Illinois 60611

Interviewed by Lewis E. Weeks, Jr., Ph.D.
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John D. Thompson

CHRONOLOGY

- 1917 Born August 6, Franklin, Pennsylvania
- 1936-39 Bellevue School of Men Nurses, R.N.
- 1939-41 Bellevue Hospital, New York City, Psychiatric Division
Staff Nurse
- 1940-41 College of the City of New York, New York
- 1941-45 United States Naval Reserve
Active duty
Warrant Pharmacist, 1944-45
- 1946-48 College of the City of New York, New York, B.B.A., magna cum laude
- 1946-48 Bellevue Hospital, New York City, Prison Ward
Night Charge Nurse
- 1948-50 Yale University, New Haven, Connecticut, M.S., Hospital Administration
- 1948-50 Hartford Hospital, Hartford, Connecticut
Staff Nurse (part-time)
- 1949-56 Montefiore Hospital and Medical Center, Bronx, New York
Administrative Resident, 1949-50
Assistant Director, 1950-56
- 1956- Yale University, New Haven, Connecticut, School of Medicine
Research Associate in Hospital Administration, 1956-61
Associate Professor of Public Health and Director, Program in Hospital Administration, 1961-66
Professor of Public Health and Director, Program in Hospital Administration, 1966-75
Professor of Public Health and Associate Dean for Planning, 1968-74
Professor of Public Health and Chief, Division of Health Services Administration, 1975-1983
Professor of Public Health and Nursing Administration, 1983-88
Director, Program in Hospital Administration, 1983-1988

CHRONOLOGY (continued)

Professor Emeritus of Public Health and
Nursing Administration, 1988-
Senior Research Scientist, 1988-
Head, Division of Health Policy, Resources,
and Administration, Department of
Epidemiology and Public Health, 1991-

- 1966 Yale University, New Haven, Connecticut, School of
Nursing
 Professor of Nursing Administration
- 1975-88 Yale University Institution for Social and Policy
Studies, New Haven, Connecticut
 Professor of Public Health
- 1992 Died August 13, New Haven, Connecticut

MEMBERSHIPS AND AFFILIATIONS

Alexian Brothers Health Systems
Board of Directors, Member, 1986-

American Association of Hospital Consultants
Fellow

American College of Hospital Administrators
Fellow

American Hospital Association
Member
Committee on Hospital Design and Construction, Member, 1960-1961
Council on Education and Research, Member, 1963-1966

American Public Health Association
Member

Association of University Programs in Hospital Administration
Executive Committee, Member, 1963-1971
Accrediting Commission, Chairman, 1973-1975

Boston University, Center for Health Planning
Planning Advisory Board, Member, 1976-1979

Case Western Reserve University, Health Systems Management Center
Executive Advisory Committee, Member, 1985-1988

Catholic Diocese of Hartford, Connecticut
Diocesan School Board, Member, 1974-1979

Catholic Health Association
Board of Trustees, Member, 1980-1983

Community Health Care Center Plan, Inc.
Board of Directors, Member, 1968-1988

Connecticut Hospice, Inc.
Board of Directors, Member, 1980-1987

Connecticut Hospital Association
Member
Connecticut Hospital Planning Commission, Member, 1965-1973

Connecticut Hospital Research and Educational Foundation, Inc.
Committee in Research and Data, Member, 1985-

Connecticut Mental Health Center
Advisory Board, Member, 1964-1977

MEMBERSHIPS AND AFFILIATIONS (continued)

- Connecticut Regional Medical Program
National Review Committee, Member, 1974-1976
- Health Systems Agency of South Central Connecticut
Governing Body, Member, 1976-1979
- Inquiry
Editorial Board, Member, 1983-1986
- Journal of Health Administration Education
Editorial Board, Member, 1985-
- Journal of Health Politics, Policy, and Law
Editorial Board, Member, 1983-1990
- King's Fund College, London, England
Visiting Professor, 1973-1974
- National Academy of Sciences, Institute of Medicine
Committee to Control the Supply of Acute Hospital Beds,
Member, 1975-1976
Committee for a Two-Year Nursing Study, Member, 1980-1982
- Shanghai First Medical College, Shanghai
Teaching Fellow, 1985
- Seoul National University, Seoul, Korea
Teaching Fellow, 1986
- South Central Connecticut Visiting Nurse Association
Board of Directors, Member, 1987-
- State of Connecticut, Department of Health
Ad Hoc Committee to the Division of Health Statistics,
Member, 1975-1978
- University of Leuven, Belgium
Visiting Professor, 1973-1974
- Veterans Administration, National Health Services Research and
Development
Merit Review Group, Chairman, 1974-1980
Consultant, 1977-1980
- Yale Alumni in Hospital Administration
Member

AWARDS AND HONORS

American Academy of Medical Administrators
Honorary Fellowship, 1991

Beta Gamma Sigma (Business Administration)
Member, 1948

Connecticut Hospital Association
T. Stewart Hamilton Distinguished Service Award, 1987

Sigma Theta Tau (National Honor Society of Nursing)
Member, 1982

Society of Sigma Xi
Member, 1968

University of Florida
Darrel J. Mase Distinguished Leadership Award, 1990

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Kavet, J., and Thompson, J. D. Computers can tell you what will happen before it happens. Modern Hospital. 1967 Dec. 109(6):102-105.

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- Webb, S. B., Jr., Stevens, K., Pearson, D. A., and Thompson, J. D. Emergency medical services and the hospital: a statewide analysis. Hospital Administration. 1973 Spring. 18(2):86-103.
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Fetter, R. B., Shin, Y., Freeman, J. L., Averill, R. F., and Thompson, J. D. Case mix definition by diagnosis-related group. Medical Care. 1980 Feb. 18(2 Suppl.):iii,1-53.

Thompson, J. D. The passionate humanist: from Nightingale to the new nurse. Nursing Outlook. 1980 May. 28(5):290-295.

Thompson, J. D. Regulation of hospital costs, volume, and prices. Profile of Medical Practice. 1980. :81-89.

Thompson, J. D. Development of DRGs and their application to planning and reimbursement. In: Perspectives on Diagnosis-Related Groups. Proceedings of a Seminar Sponsored by the Greater Cleveland Hospital Association, the Hospital Financial Management Association of Cleveland, and the Health Care Administrators Association of Northeast Ohio. Cleveland, OH: The Greater Cleveland Hospital Association, 1980.

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- Thompson, J. D. The role of research in health administration education. Journal of Health Administration Education. 1983 Spring. 1(2):113-115.
- Mick, S. S., and Thompson, J. D. Public attitudes toward health planning under the Health Systems Agencies. Journal of Health Politics, Policy and Law. 1984 Winter. 8(4):782-800.
- Thompson, J. D., and Grazier, K. L. Incorporating DRGs into medical and management education. Journal of Health Administration Education. 1984 Summer. 2(3):261-269.
- Thompson, J. D. The measurement of nursing intensity. Health Care Financing Review. 1984. Suppl.:47-55.
- Thompson, J. D. Hospitals. In: Maddex, D., editor. Built in the U.S.A.: American Buildings from Airports to Zoos. Washington, DC: Preservation Press, 1985.

PUBLISHED WORKS (continued)

Thompson, J. D. The uneasy alliance. In: Yaggy, D., and Hodgson, P., editors. Physicians and Hospitals: The Great Partnership at the Crossroads: Based on the Ninth Private Sector Conference, 1984. Durham, NC: Duke University Press, 1985.

Fetter, R. B., Thompson, J. D., and Kimberly, J. R. Cases in Health Policy and Management. Homewood, IL: Richard D. Irwin, Inc., 1985.

Thompson, J. D., and Diers, D. DRGs and nursing intensity. Nursing and Health Care. 1985 Oct. 6(8):435-439.

McMahon, L. F., Jr., Fetter, R. B., Freeman, J. L., and Thompson, J. D. Hospital matrix management and DRG-based prospective payment. Hospital & Health Services Administration. 1986 Jan.-Feb. 31(1):62-74.

Thompson, J. D. Prospective payment system and the volume of hospital care. Health Matrix. 1985-86 Winter. 3(4):31-36.

Thompson, J. D. DRG and the length of stay in the acute hospital. Aging Population: Changing Practice. 1986 May-Jun. :125-133.

Thompson, J. D. Development of the prospective pricing system in the U.S.A. In: Proceedings: Conference on the Future of Health Care Systems in the Three Countries of Korea, Japan, and the U.S.A. Seoul, Korea, 1986.

Thompson, J. D. DRG prepayment: its purpose and performance. Bulletin of the New York Academy of Medicine. 1988 Jan.-Feb. 64(1):28-51.

Thompson, J. D., and Diers, D. Management of nursing intensity. Nursing Clinics of North America. 1988 Sep. 23(3):473-492.

Thompson, J. D. A plea for case studies in the teaching of exotic health care systems. Journal of Health Administration Education. 1989 Spring. 7(2):333-337.

Thompson, J. D., Bice, T. W., and Pearson, D. A. A Report to the Connecticut Department of Health Services. Yale mimeo, July 31, 1989.

Legnini, M. W., Thompson, J. D., DerSimonian, R., and Lynch, J. T. Changes in Connecticut hospital use rates: have small-area variations been affected? Inquiry. 1990 Spring. 27(1):51-60.

PUBLISHED WORKS (continued)

Thompson, J. D. Quality appraisal and cost finding. Journal of Health Administration Education. 1991 Winter. 9(1):67-86.

Guest editor. Arthur J. Viseltear Memorial Issue. The Yale Journal of Biology and Medicine, 1990-1991.

Thompson, J. D. The great stench or the fool's argument. The Yale Journal of Biology and Medicine. In press.

WEEKS:

I have a note that you were born in 1917 in Franklin, Pennsylvania.

THOMPSON:

Yes.

WEEKS:

The next piece of data I have on you is that you have a very distinctive middle name, Devereaux. Is that a family name?

THOMPSON:

Yes, that was my mother's maiden name.

WEEKS:

I think that's a very nice middle name. I see that you are a graduate of Bellevue Hospital School of Nursing and you have a diploma as an RN, which you received in 1939. When I first read this I thought, well, it is so unusual in this day of nursing shortage to find male nurses, so few men are going into it now.

THOMPSON:

That school, actually called the Mills School, was the largest school for male nurses in the country at the time. It was separate from the Bellevue School (for women nurses), but the faculty was the same and most classes were held together with the women. There were about 30 men in my class, which was an average size class. Many of them were from the CCC. Remember the old Civilian Conservation Corps?

WEEKS:

During the first Roosevelt term of office.

THOMPSON:

Yes, and others were, oddly enough, miners from Wilkes-Barre and Scranton, that hard-coal country in Pennsylvania. Historically, a lot of women in nursing schools in New York came from those areas, and when the mines were shut down, these young men were unemployed. They could either bootleg coal, or they could leave the area. About half of my class was from the mining sections of Pennsylvania. It was a very interesting group.

I applied there because my stepmother was a nurse and she said, "If you want to work your way through college, this is the way you can do it. Become a nurse. You can work nights or evenings or whenever you want because, even in the middle of the depression, nurses are in demand. After you graduate, then you can go to school." So that's what I did.

What I didn't realize at the time was that the experience would mark me forever. It is impossible to become a nurse in a place like Bellevue Hospital and not have the imprint remain with you for the rest of your life. There were a few differences in the clinical areas between male nursing education and the program for females in those days. We spent double time in psychiatry and double time in what we called GU, genitourinary diseases. We had no clinical experience in obstetrics and none in gynecology, but we had pediatrics and we had every other clinical service.

WEEKS:

People were more modest in those days.

THOMPSON:

Right.

WEEKS:

There is a question or two I want to ask you about Bellevue just for my own benefit here. The hospital is well known, but the question I want to ask you, did they have a medical school?

THOMPSON:

Oh yes. In fact they had four. Four medical schools were in Bellevue at the time. There were the first, second, third, and fourth clinical divisions. The first division was part of Columbia College of Physicians and Surgeons. The second division was Cornell Medical School. The third division was part of New York University School of Medicine, and the fourth division was called the "open" division, but it was really New York University. So, there were four different services, depending on what medical school was assigned to that ward.

They had medical students and, of course, interns, residents, and the attending physicians were from those universities. Each service had a little different character. New York University physicians were more aggressive, and they were much more scientifically oriented. Cornell and Columbia students tried to play the gentlemen. You knew when you went to medicine, and if you were in the first or general division, you would have a different experience than if you were on a third division medical ward. You knew you would work harder on the third division, because they had more patients altogether and they also had more patients on

research protocols. I don't know why. New York University's wards were always full, while one could take it easy in Cornell where they weren't all that aggressive in their treatment patterns.

WEEKS:

There is a little story I want to tell you. You may know this already but the reason why I ask you about the medical school was that I was reading not long ago about Dr. John Harvey Kellogg of Battle Creek Sanitarium fame. He studied medicine back in the 1870s, and the first place he went was to a water-cure college called Tralls Hygea Therapeutic College, and he was disgusted and left there after six months. He stayed the six months, which was the initial training period, and then he decided to enroll in the University of Michigan here in Ann Arbor and the tradition then was two series of lectures, 24 lectures in each series, and then you got a degree, but there was no clinical experience. There were no laying of hands or any of this sort of thing, which Kellogg wanted. So, at the end of his lectures, he left and he went to Bellevue, and he attended the Bellevue School, and I don't know how long it was, but he got his MD degree from there.

THOMPSON:

Well, the hospital was so large and so busy and you saw so much pathology, there wasn't anything you didn't see. The reason I found it intriguing was that it had an enormous psychiatric service, housed in a separate building, a whole hospital all by itself staffed by superb physicians, eminent psychiatrists. They just taught. They didn't care if you were a nurse or a medical

student or whatever, they just taught. So you went to their grand rounds, you went to their lectures, and you took care of their patients. But in the psychiatric unit, you had far fewer specific patient-care duties. You were there to learn. In the other services, you were there to work and learn, in that order.

WEEKS:

Free labor.

THOMPSON:

But not in psychiatry, oddly enough.

WEEKS:

What is the present-day Bellevue? Is it all psychiatric now?

THOMPSON:

No, it's a large general hospital, but there is only one medical school now and that's New York University. Columbia University now is affiliated with Harlem Hospital. Cornell University is out, and I don't know which of the city hospitals they work in now.

WEEKS:

I was wondering too, I've interviewed a few nurses, four or five, and the subject that always comes up now is what is the role of the nurse today? Is he/she getting recognition? Was that problem back when you were studying nursing?

THOMPSON:

Well, it didn't seem that much of a problem. In other words, the nursing profession was not in the distinct posture that it is now, where the professionalization is an important goal. The

education at Bellevue was good. We had good instructors, but don't forget, this was in the middle of the depression. And nursing was a profession that many minorities were using to upgrade themselves. I remember when I was a senior, we had our first black student at Mills and that was quite a change. Black women students went to Lincoln or Harlem Hospital in those days. They didn't come to Bellevue, but Polish and Jewish and Irish, first generations, particularly the Italians. This was a way that a woman could improve her social status as well as gain an occupation. So everybody was kind of scrambling, I guess, and a college education for nursing wasn't as important a factor. This was a diploma program. This was not a collegiate program.

WEEKS:

I understand. Well, most of the programs were formal programs in those days, weren't they? But I was wondering about, you know, whether there were differences in the way male nurses were treated by physicians as opposed to female nurses.

THOMPSON:

We tended to specialize in either psychiatry or genitourinary diseases, and psychiatrists and GU surgeons, of necessity, particularly in New York, were very comfortable with male nurses and used them perhaps a little differently than women. But you must remember that while I went in the Navy, I could not get a commission as a nurse. When I graduated from Bellevue, I went to work in psychiatry and taught for a while. Some of my students, women students, obtained commissions, and I could not get a

commission in the armed services. They just would not commission male nurses. Now this was primarily because the nurse corps of Army and Navy didn't want them. They wanted that as a female corps only. So that was kind of hurtful.

WEEKS:

The osteopaths must do the same thing, didn't they? They have almost no chance of getting a commission either. We had a lot of barriers to break down in World War II.

THOMPSON:

Well, actually, I eventually became a warrant officer.

WEEKS:

I wanted to ask you, you were a warrant officer pharmacist?

THOMPSON:

Well, that was in the Hospital Service Corps of the Navy and, at that time, the only officers they had were either chief warrant officers or warrant officers. Later, toward the end of the war, they started a commissioned officers corps. So if you were going to stay in the Hospital Service Corps, you either became a commissioned officer or a chief warrant officer. There was no other place to go. That was not true in the Army. The Army had a Medical Service Corps long before the Navy did. If I had been in the Army rather than the Navy, I probably could have gotten in that corps.

WEEKS:

I'm talking with Faye Abdellah, whom you know.

THOMPSON:

Oh yes, she was at the Yale School of Nursing for a while.

WEEKS:

Is she at Yale now?

THOMPSON:

No, she was a teacher at Yale when she was younger. I met Faye when she was involved in some of the early research on progressive patient care.

WEEKS:

Well, that's where I first became acquainted with her—when I was working on progressive patient care. That's how I came to Michigan to the university, in fact. But she was concerned about the question, can we require nursing students to get a bachelor's degree, or can we still have some of these diploma schools? I guess they found out that they almost had to have some two-year courses.

THOMPSON:

The nursing education scene is quite changed. I'm on the faculty of the Yale School of Nursing and have been since I went to Yale. I've taught there and have done some research with people over there. But that's a graduate program; that's a master's degree program. They have two of them. They have the young woman or man who comes there with a BS, RN, and gets a master's in two years, or they have college graduates who have had no nursing at all and who obtain their master's degree in three years because you have to teach them basic nursing beforehand. Most of these nurses,

then, come out as nurse practitioners in some specialty or another. Yale has always, for instance, trained nurse-midwives. They never stopped, so they have a pretty big midwifery program, and they educate nurse practitioners in psychiatric nursing, med-surg, pediatric, and community health. The basic bachelor program has got to be the long-term goal for the nursing field. Right now most graduates are actually from the two-year community college program. What we have to be very careful about is that we don't do to them what they did with the diploma programs. They made it very difficult for diploma graduates to get the bachelor's degree.

WEEKS:

There is no ladder there.

THOMPSON:

No, there is no ladder there. It should be easier with the two-year students, because both programs are seated outside the hospital, and they're both carried out within an educational framework. However, it just doesn't seem like it is working all that well, although several universities are concentrating on that now, in other words, upgrading the two-year graduate to a four-year graduate.

WEEKS:

What about these nurse practitioners going into private practice? Are there many of those?

THOMPSON:

It depends a great deal on the specialty. Many of the midwives graduating at Yale practice within a group of

obstetricians. Obstetricians now are practicing within a group because they don't want to be on call all the time. You'll often find a midwife or two in these groups, and that's a type of private practice. They bill just like the doctor and share in the group's revenue pool. Some of the psychiatric nurse practitioners also are in private practice, but the other specialists, med-surg and peds, tend to still be in hospitals.

WEEKS:

How does the malpractice insurance situation affect these people?

THOMPSON:

There was a big hassle about that. Nurse midwives for a long time had no malpractice problem in that they were able to obtain insurance at reasonable rates even though, as you know, the obstetricians have one of the highest malpractice rates in the profession. Then, all of a sudden, for some reason or another, we can't figure it out, the insurance companies started backing away from the midwives without reason. There wasn't a big flurry of lawsuits. Many of the nurse midwives felt this was a result of pressure from the American College of Obstetrics and Gynecology, but who knows. It is particularly critical because we have always been interested in alternative health care programs and institutions.

The midwives in New Haven got together and established an obstetrical program outside the hospital manned by midwives with physician backup. They would not go so far as to go to home

deliveries. The women came to this institution. It wasn't too far from the hospital, and there was very careful screening. They wouldn't take all women, and it was operating. All of a sudden this malpractice issue came up, and the alternative program folded. They just couldn't afford these kinds of new malpractice rates. Now, in the hospital, midwives are covered by the hospital insurance, so there is no problem there and many groups of obstetricians all have one big malpractice insurance that covers everybody. But the midwives were very, very upset about this.

WEEKS:

I don't see how we can afford to have babies with all this malpractice, and, when you figure out the average cost for insurance per patient, it must be terrific.

THOMPSON:

It is. An obstetrician has to deliver, or as we say, has to catch, a lot of babies to pay for his malpractice.

WEEKS:

I've wondered what we are going to do about malpractice insurance.

THOMPSON:

We are following a case that may give us a direction. New York State, you know, has a program of trying to put caps on malpractice awards. The legislation was written in 1985 and went into effect in 1986. A much more rigorous evaluation of physicians' performances is the basis for the program. The hospitals are the ones that have to carry most of the burden. We

are talking about better records. We're talking about the central reporting of any instance a doctor has some kind of a quality problem. They have taken a license away from a lot of physicians in New York State based on this approach. They say that's the best way to cut down on malpractice. Increase the supervision of the performance of physicians. Since the physicians themselves don't seem to want to monitor each other, the state, the Department of Health, has assumed that responsibility. Now the physicians are angry with Dr. David Axelrod, the commissioner of health. They call him Mike Ditka. He's tough.

We are following one case, which we are developing as a teaching case, where the commissioner actually closed a hospital, and the reason he closed the hospital was because it could not control their physicians. He called the hospital board to a meeting and said, "Merge or close. Thank you very much, gentlemen." And he got up and walked out of the room.

WEEKS:

Well, it takes a strong hand like that to control such a situation because apparently the legislatures and Congress are very hesitant about doing anything.

THOMPSON:

In this case, we tracked the legislative history. There were several New York State legislators who lead the program, and then Governor Cuomo got very interested in it. So they got the legislation passed. Now it's the day-to-day enforcing that I think everybody realized is the hard part. Like you said, you have to

have some tough guy out there. You have to have a Mike Ditka to get it done.

WEEKS:

Well, this is true. I haven't had much experience with the medical workers, but in progressive patient care we did. And I was surprised at what was going on in that hospital with one or two doctors, and they give the whole place a bad name.

THOMPSON:

Well, we got somewhat into this. One of the things that results when you start researching DRGs, you can start identifying what we call aberrant behavior of physicians. We would go to the hospital administrator and say, "This physician is a bummer. You can't afford him." "Take it easy, take it easy," he'd say, "I know he is, but I can't prove it." Hospital administrators are very reluctant to see that physicians are disciplined, even when you can prove errors of omission or commission.

WEEKS:

True, they are hesitant to do it, because the staff won't back up the administrator. They just run into trouble. Well, one question I've been wanting to ask somebody like you for a long time, is there really a shortage of nurses?

THOMPSON:

Yes, there is, and it's primarily due to increased demand for nurses. In other words, there are more nurses working today in hospitals than have ever worked before. We just finished an analysis of this. It's a paradox. We have 20 percent fewer

hospital days now than we had before DRGs went into effect and about that same drop in admissions, but we have a nursing shortage. The paper goes on to explore why this should be so, and we hypothesized that patients are sicker now in hospitals than they were before DRGs were put in place. They are. Because what's happened is they don't admit the simple cases. In other words, you don't see cataracts in hospitals anymore. You don't see any D&Cs in hospital beds. You don't see knee surgery, arthroscopy, and ENT surgery. You don't see any of these cases anymore. They are being treated in ambulatory surgery. But you have replaced those patients with major hips, increased major bowel surgery, and cardiac surgery. When we take a look at Connecticut's data, there was a 20-percent drop in adult med-surg patient days since the beginning of DRGs. But there was an 8 to 10 percent increase in intensive-care days. Intensive care eats nurses. You've got to have many RNs in intensive-care units. Then we went through the various weighting schemes and can see that the case-mix index rose considerably. This means that the patients have more complicated diagnostic and treatment problems, and so there is an increased demand for nurses, and we just haven't been able to rise to that increased demand.

That's only for hospitals. I'm not even talking about Visiting Nurse Associations. When people say patients are being discharged quicker and sicker, that's true. The average length of stay has come down in almost every diagnosis, and these people should have some help in their homes through VNA referrals, but

VNAs can't fill their staff either. So, because of the increased concentration of the patient load in the sicker patients who demand more care, we do have a nursing shortage, but it's demand. We are demanding more nursing service for sicker patients, and we haven't kept up with the supply.

WEEKS:

We are talking about demand. This is sort of throwing us off track a bit, but I've been under the impression that part of our problem today, our general overall problem, is that the patient is expecting too much. You see, you and I go back a generation or two, and I don't know whether you look at what was happening when you were 20 years younger, but I do quite often, and I think that people are going to the doctor more than they need to in many cases.

THOMPSON:

But don't forget when I started nursing, there was no such thing as a magic drug. I was at Bellevue when sulfanilamide came in, and it came in from Germany as Prontosil, and all of a sudden we could cure type III pneumonia, and I mean those people used to die.

WEEKS:

My wife had type III, and I went through that.

THOMPSON:

It was terrible. There was no serum for type III pneumonia. Those pills changed the mortality of that disease. That was a real breakthrough. It was particularly important at Bellevue because we

took care of the poor, and we took care of the alcoholics, and we admitted the bereft, and they were the people who were getting all these weird pneumonias. So from then on through later development of penicillin, we have told the patient, "We'll cure you." So we shouldn't be surprised if he is going to demand a cure. We told him we can replace his heart, we can catheterize his coronary arteries, we can pace his heart. So don't be surprised when he says, "Look, I want this kind of treatment and that kind of treatment, and I'm going to go to a doctor until I get it."

WEEKS:

Well, we have a lot of differences, of course, in treatment, and I wonder about AIDS. What are we going to do about AIDS?

THOMPSON:

Well, AIDS is a very difficult problem, one which throws in bold relief shortcomings in our health care system. The real problem is that we don't have alternative places to treat persons with AIDS. We don't have homes where these people could go when they are just homeless and don't need a hospital. We keep them in the hospital too long, and they are very, very expensive patients to treat because of all the precautions taken to protect the staff and other patients.

I don't know. AIDS is a kind of puzzlement to me. I've been doing some economic modeling of AIDS, and it doesn't have to be that expensive to treat. I'm on the national board of the Alexian Brothers Health System with hospitals in St. Louis, San José, New Jersey, and Chicago. They just opened up a rather large home or

shelter for AIDS patients in Chicago. The Cardinal asked them to do it.

WEEKS:

Weren't they moving out of Chicago?

THOMPSON:

They moved from the middle of Chicago to outside the city. They have a great big hospital right near O'Hare Airport.

WEEKS:

Are they using the old building?

THOMPSON:

The Cardinal obtained a convent from one of the schools which had closed, I think.

WEEKS:

I'm just wondering about using existing buildings.

THOMPSON:

They redid this whole building and made it as unhospital-like as possible. They're finding out some very interesting things. They're finding out, for example, that these patients, who know they are dying, often don't want to go to the hospital to die. They want to die in the home. They didn't expect that. Most thought patients would transfer to a hospital for the terminal phase, but it's not happening.

Our major problem is we don't know how this all is going to come out. Do we need, as we have in Connecticut, hospice beds for AIDS patients as well as a place for the homeless AIDS patients? Most of the AIDS patients in Connecticut are drug addicts, so

that's a whole different kind of treatment problem. Are you going to try to cure the person's drug addiction when he's dying? You know, it's a difficult kind of a business that requires different patterns of care.

WEEKS:

When there really isn't known treatment or known hope.

THOMPSON:

With some of the new drugs—AZT and Pentamidine and others—though you can't cure the disease. You can lengthen the person's life, but, yes, there's no cure yet.

WEEKS:

The question is, is it a good life? Well, I guess all life is good if you're losing it.

THOMPSON:

Well, it's not as bad a life as you'd think as long as they can be kept fairly symptomfree from the pneumonias, and with Pentamidine now you can handle that situation better. I personally am very much into that particular measurement of whether we should or should not continue treatment based on the measurable quality of life. The British are doing research, what they call QUALYS (quality-adjusted life years), and they use this measure as a way to assess whether certain programs for certain diseases should be pursued or not. As you know, in England they have a completely different way of handling end-stage renal dialysis. For an old, old person, end-stage renal dialysis is not fun, and the patients

don't do well. If you are above a certain age in England, you probably will not get ESRD.

WEEKS:

Maybe it's a favor.

THOMPSON:

Well, that is what they say, and they are beginning to really use these QUALYS as an assessment unit. It asks if this person is going to be able to live decently well. I don't know if you remember, we were for a while doing some heroic surgery with cancer. We were left with husks of people. Well, the English won't do that because they say the quality of life for this person would be at such and such a level.

WEEKS:

It's a hard decision to make, but somebody should.

THOMPSON:

As they work on this, and there is a whole group at York University, and oddly enough it was started by their economists. If they can begin to quantify this concept in some precise fashion, then you can plow that into the clinical decision making that goes on in some of these cases.

WEEKS:

Well, the English have had to look at the economics of the thing, because I think they are more realistic than we are in many ways.

THOMPSON:

They are paying it all. We're not.

WEEKS:

You went to CCNY (College of the City of New York), too, didn't you? And you graduated with a bachelor's in business administration. I was wondering when I read that what your plans were at that time.

THOMPSON:

At that time, I wanted to become a hospital administrator. There were two programs, I think, one at the University of Chicago and one at Northwestern. So I made up my mind that's what I was going to do. So I did not get a BSN. I could have cut down the amount of time by perhaps a year, but I felt that didn't fit with my future plans. So I went to CCNY, and I got through in about 3-1/2 years, but there was a 4-year, 9-month, and 26-day hiatus there. World War II interrupted my education. But I did graduate with a BBA.

WEEKS:

With high honors, too.

THOMPSON:

True.

WEEKS:

Your next step, you were working while you were going to school, weren't you?

THOMPSON:

Yes, I was working as the night nurse on the prison ward of Bellevue Hospital.

WEEKS:

Was it terribly rugged?

THOMPSON:

No, that was good duty. There were two sections to the ward. There was a wing for the physically ill. Then there was the psychiatric unit. Prisoners who were remanded, for example, for psychiatric evaluation or were just frankly so disturbed that they couldn't keep them in jail were sent there. If you had anything physical happen to you, they were sent to the other side of the same ward.

I keep thinking when I was there, the big scandal was about this individual who was trying to fix a Giants football game. He was a big gambler. They arrested him and tried him, and he had a coronary in jail downtown, so they brought him up to Bellevue. He was a very interesting person, a very bright man. He ran what they used to call a "layoff shop." In other words, when all the bookies were afraid that the fix was on in a particular race and they were getting too many bets, they would lay off their bets on him and he would like subinsure. He had a crew at the racetrack, and, because you can't make a phone call into the racetracks, he put into place a very elaborate system with semaphores to communicate with his men at the track. If he felt that something was going on, then he'd have all his guys with all this money place bets on such and such a horse, thus drawing the odds down, because he was paying off on track odds. And if the race was fixed, first, he'd collect his bets, and, second, he'd drive the odds down so that when he had to

pay the bookies, he did so on lower odds. He stayed on the ward for quite a while. He used to help me with accounting homework, and I took about every accounting course I could. We used to kid each other, you know, do you want a straight solution, or do you want an answer that's a little crooked. So I learned honest and dishonest accounting at the same time.

Finally, then, he was up for sentencing when he got better. I had gotten to be quite fond of him actually, and I told him I was worried, because he was a recidivist. I mean this was about the fourth or fifth time he had been arrested. I said they're liable to really belt you, just put you in Sing-Sing and throw away the key. He said don't worry, Tommy, I'll tell you I know exactly what I'm going to get. It is going to be two to five, and I'll be out in less than two, and as soon as I get to Sing-Sing, I'll have a job in the accounting office.

WEEKS:

It's amazing some of these people. I was trying to figure out how Yale came in here on the master's.

THOMPSON:

Well, I didn't apply to Northwestern. I applied to Chicago, but I was late and they had already picked a class.

WEEKS:

Taken their 12. Somebody said they had 12 students, because they had a table with 12 chairs.

THOMPSON:

Yes, well that's what we had at Yale. So I called an old mentor of mine, Larry Bradley, who was with Basil MacLean in Rochester at the time. He graduated from Chicago, and he said you can probably get in next year. Actually, I felt I was getting kind of long in the tooth. So he said well Yale just opened a program. So I called up Clement Clay and asked if I could come up for an interview, and I got accepted by Yale. They hadn't closed their program yet. That is why I went to Yale. I actually liked it better, because I already had the undergraduate business background and the Yale program was in the School of Public Health. Although I had been made familiar with public health from the Navy, I felt I needed some more. Of course, I was lucky. Dr. Al Snoke was the director of the program and the head of the Grace-New Haven Hospital at the time.

WEEKS:

Oh, he was director of the program as well?

THOMPSON:

Right, and Clement Clay was the instructor, a very good teacher even though he would drive you insane because he was meticulously demanding. So when you added his precision to Al's vision, it turned out to be a very good program indeed.

WEEKS:

Didn't he later go to Columbia? I think he went there in the early '60s.

THOMPSON:

Well, Dr. Clay felt, and don't forget in those days the education patterns were completely different, the connection between education and practice was very strong. The programs were all one year long. Then you went to a preceptor, a year's internship they called it. Then you got your degree. At Yale we had to write a master's thesis as well. There was a lot more of an interrelationship between the field of practice and education than there is today. We have lost a great deal of that kind of strength. It has been replaced with a concern for research. So Clem felt then that nobody should spend more than three years in academia, that you should go out and become a practitioner again, and then spend three years in practice, and after that come back to academia. It was a kind of a bizarre educational vision, but Clem believed in it.

WEEKS:

Pretty pragmatic.

THOMPSON:

He left Yale at the end of four years and then went to Orange General Hospital, which was a large teaching hospital, and stayed there three or four years, and then went to the Columbia University Program. But he retired from Columbia. He never went back into the field. I guess he realized his original vision wasn't all that valid.

WEEKS:

He was mostly a name to me. I had met him and knew who he was, but I didn't know all the things he'd done.

THOMPSON:

Well, he started the Yale program. Actually, as I understand it, Jim Hamilton got the grant while he was at Yale. Al Snoke then succeeded Jim Hamilton at Grace-New Haven. There was a little hard feeling about the succession, but it wasn't Al's fault. Jim got out of sync with medical school, and the medical school wanted Al, and so Jim left. Before he left, he had actually arranged the grant from Kellogg, when Kellogg was funding schools of public health for programs in hospital administration. Then Al came and took it over, and I don't know who hired Clem Clay. The program was a year old, and they had graduated one class of 12 students only by the time I got there. And, that's true, there was a table at which you could only fit 12 students and one instructor around. Perhaps Clem copied Chicago in that regard. He was a graduate of that program.

WEEKS:

That's a good reason for the size of the class. Al Snoke sat in your chair being interviewed about two months before his death.

THOMPSON:

I loved that man.

WEEKS:

He was quite an outspoken character.

THOMPSON:

Yes, he was.

WEEKS:

He usually had something pretty good to say.

THOMPSON:

He used to scare me to death. He held a weekly seminar with the students when I was a student and continued the session after I took over the program. He had an unusual teaching style. He used to bring his mail over on some days, just pick the day's mail off his desk, bring it over, and sit down and with the students. He'd open a letter and say, "Okay, now what do we do about this?" I'd say, "Al, you know you have some pretty sensitive correspondence there. He made the students promise that everything had to stay in that room. In all the years I was there, nobody ever, ever leaked a word, and they often knew things that were going on in the hospital that people on the outside would have died to know. You're right. He was outspoken. His favorite expression was, "You big dumb nut." And he often called the students by that epithet, but they liked him. He was adored.

WEEKS:

He was quite a hero worshiper of Basil MacLean. He trained under him in Rochester.

THOMPSON:

He had no formal education in hospital administration, he just trained under MacLean for four years. Originally, he was a pediatrician.

WEEKS:

That's right. His wife was too, wasn't she?

THOMPSON:

No, Parney was an internist. I knew them both very well.

WEEKS:

They operated as a team quite often, particularly in the later years.

THOMPSON:

They were inseparable. I never knew a couple that operated in quite that way. He would get angry over some issue and dictate something reflecting his feelings. He used to bring these over to the students too. "Now this is what I dictated," he'd say. "What should I do with it? Throw it in the wastepaper basket?" Whenever he was worried about it, he always gave it to Parney, and if she said throw it in the wastepaper basket, it went there. Or she would take it and soften it so that it wasn't quite so harsh. That's the way they worked.

WEEKS:

You're ready to start in this. Is this the second class, and you got a job part-time at Hartford Hospital? Is that where you met Stewart Hamilton?

THOMPSON:

No, he wasn't there then. There was an old expathologist named Dr. Allen, who was the administrator then. I went up there because I needed money even though I was on the GI Bill. I went up there as a nurse, and they put me on the psychiatric unit. Now,

Hartford had one of the first psychiatric units in a general hospital. So it was a whole new and valuable experience for me.

WEEKS:

Is that right?

THOMPSON:

I was surprised that the unit was at Hartford Hospital, because right across the street was the Hartford Retreat, which, as you know, was a very famous private, nonprofit, psychiatric hospital. The floor at Hartford was a completely different experience for me. I walked up there, and I was scared to death. There wasn't a single what we used to call a camisole (a straightjacket). There weren't any other kinds of restraints, and they only had one isolation room. Of course, I was used to the Bellevue type of unit with these real sick and disturbed cases. I learned at Hartford you can handle these kinds of patients quite differently. They didn't have to use all those punitive treatments, because they had more staff and they were into other modalities. I first experienced shock therapy as a common treatment, for example, and the patients would get well faster. It turned out to be a very valuable professional experience--a whole new way of treating psychiatric patients. Later on I planned and developed a very similar program at Montefiore Hospital.

WEEKS:

And your residency year?

THOMPSON:

I took my residency at Montefiore with Dr. E. M. Bluestone. Martin Cherkasky had come up to Yale and gave a speech about home care, and I was intrigued.

WEEKS:

He was strong on home care.

THOMPSON:

Yes, Bluestone founded the concept. Martin Cherkasky ran the pilot program.

WEEKS:

Do you have a minute to tell me something about Bluestone and Cherkasky?

THOMPSON:

Bluestone was a giant in the broader field of health care. He had visions that very few practitioners had, and he started home care. Montefiore was the first hospital that owned a prepaid group practice. The group was affiliated with HIP. Personally, he was a very austere man, but he had the gift of choosing good assistants. Martin and Mark Freedman ran things for him. You see Martin managed the home care program and the prepaid group practice, and then when Dr. Bluestone retired, Martin just slid over. Now Bluestone, with all his vision, had some peculiar blind spots. He never believed in Blue Cross, can you believe that? He was a gentleman of the old school. He believed that it was the duty of the board of trustees to come up with the money to fund the deficit so that he could fulfill his dreams.

I'll never forget during my residency I was going through the past fiscal history of the hospital, and I was kind of tracking deficits. Montefiore always lost money even though we were getting over a million dollars a year from the Federation of Jewish Philanthropies, and even though the board would often make up the deficit. I think it was 1939 when the hospital experienced an enormous operating deficit. I went to Dr. Bluestone, and I said, "Look at that negative fall in 1939." Now in that year things were beginning to pick up a little bit. We had the World's Fair in New York, and unemployment had started to fall because the British were buying arms. I asked, "How could we lose so much money in 1939?" He said, "We didn't lose that kind of money in 1939." I said, "Dr. Bluestone, here it is. Here is the auditor's report." He looked at me and said, "You know, nobody told me about that." He just didn't think money was that important.

He had no children so all his students were his boys. There was Jack Masur, Martin Cherkasky, Gene Rosenfeld, Mark Freedman, Dave Littauer, and myself who were just about running the Jewish Hospital System. We had an annual birthday bash in December, and wherever you were, you were expected to show up.

I think I was his first non-Jewish son. During my residency, he told me that one of the first things I had to do was to buy a schnorring suit. I said, "What's a schnorring suit?" To schnorr is Yiddish for to beg. He said, "You have to get yourself a blue suit. The hospital will pay for it. Three-piece. It has to look as much like a bar-mitzvah suit as possible. When you go out to

all these groups of supporters to ask for money or to receive their donation checks, you'll need to look like you should." So I went out and got a schnorring suit.

He insisted that you write for the literature. He was very close to Bob Cunningham. Dr. Bluestone would see an article in *Lancet* or some other magazine like that, and he'd tell us to write a précis of that, and he'd send it under your name to Bob, and Bob would use it as a filler. He always said he felt his assistants should be working on an original article at all times, and he would come and ask about progress. One day I said, "Dr. Bluestone, look, the doors of the hospital are open. Patients are coming in and out. This is a pretty complicated place. Please, isn't that enough?" He'd say, "No. You have to write those articles, and you have to run this hospital well, too."

WEEKS:

I guess Martin succeeded him.

THOMPSON:

Yes, and Martin asked me to stay on. I always believed that when the boss goes and you're his assistant, you should resign. But Martin wouldn't hear of it. I had written my essay on home care, and so I knew what he was doing over there as well, so he asked me to stay on, so I stayed there three or four years.

WEEKS:

You were the assistant administrator?

THOMPSON:

Yes.

WEEKS:

So we have you through Yale. We have you working at Montefiore.

THOMPSON:

Just let me tell you one more thing about Dr. Bluestone. When he hired me on after I was finishing my residency, he said, "I want you to see some hospitals in Europe. The International Hospital Federation is having a tour," he said, "but I want you to go to England and France and Sweden, and the board will give you a traveling studentship for three months. Go there and then come back and start to work." Wasn't that wonderful?

WEEKS:

Let's take this tour with you. What did you see?

THOMPSON:

I saw a lot. I had an interest in architecture, and it was the first time that I was able to see some of the old, old hospitals and some of the new hospitals, particularly the ones in Sweden. The Swedish had built a hospital in Oslo for the Norwegians, a big children's hospital. It was just beautiful. These were modern. You see in the U.S., we had not, really outside of Hartford Hospital, begun to build. This postwar boom hadn't hit yet. So I became extremely interested in architecture as a result of that trip. I knew that I would have to take over the expansion plans of Montefiore, because they were going to change the whole hospital. Gene Rosenfeld formerly had that position, and he was going to build the new Long Island Jewish Hospital, and I was

taking his place. I made some friends in England. Captain Stone, who was the secretary of the IHF, the George Bugbee of England at that time, and a very good amateur magician, was one.

WEEKS:

It was a wonderful experience for you. That was in 1950, wasn't it? You were gone three months.

THOMPSON:

Sure enough I had to write an article about the trip and send it to Cunningham, and Bob published it.

WEEKS:

Was this financed by the hospital?

THOMPSON:

The board of trustees just gave me a grant.

WEEKS:

I went there later, 14 years later.

THOMPSON:

Where? Montefiore?

WEEKS:

No, to Europe. The people I saw were those you didn't see on your first trip, but you have made several trips to Europe, haven't you?

THOMPSON:

In fact, I just got back. I was attending a workshop in Germany. This was a very peculiar group, primarily people from various ministries in West Germany. They're considering using DRGs, and they had a lot of misinformation so they decided to have

this two-day session to concentrate on DRGs as a payment system. I was there and John Kralewski from Minnesota and Brant Fries from Michigan because Brant is adapting the DRG approach for long-term care patients.

WEEKS:

What name is that again?

THOMPSON:

Brant Fries.

WEEKS:

He has come since I retired.

THOMPSON:

Yes, he was with us, as part of the original group that was refining DRGs, and then he got into long-term care payment himself and developed what they called RUGs. Then he left Yale and went to New York State. Actually, he went to Troy, New York, to Rensselaer Polytechnic Institute, because they were testing the RUGs new system in New York, and then he came to Michigan.

WEEKS:

Well, maybe we can pick up some of what you did when you went to England and Belgium on sabbatical. That was the year, wasn't it? Because some of the people that you met I think I met. You went to work then after your return from this trip as the assistant director of Montefiore Hospital, and Bluestone was still there.

THOMPSON:

Bluestone was there for the first three years, and then Martin came, so I had four years, I think, with Martin and three years with Bluestone.

WEEKS:

I guess the question is how did you make your transfer to Yale?

THOMPSON:

Well, I got very involved in the physical rebuilding of Montefiore and almost became a specialist in both the programmatic planning and physical planning, and I was able to get a psychiatric unit and a pediatric unit going at Montefiore. Before that, the hospital had been primarily for long-term care.

Then Al Snoke got some Hill-Burton money to start a research program on the design of hospital facilities. So he called me up, and I went to see him. Clem was no longer at Yale, and George Buis was in the program although Al was still its director. So I kind of signed on. The problem with administration at that time, at least I felt this was the problem, was that when a situation came up, you would remember you thought you solved that problem last year. It just didn't stay solved, but there is nothing new so I'll solve it again. I wanted to know how you solve these problems better with more lasting results.

And then there were a lot of other problems we had no answers for, and particularly in design and construction. I said, "Okay, I'll do some research in hospital architecture." Al had put

together a good committee of people that used to meet once or twice a year. Basil MacLean was there, and Al himself, and a couple of architects, and so we really got going. Then one of those happy accidents occurred when I heard that Russell Nelson, who was at Johns Hopkins at that time, had started a program in operations research in hospitals with the faculty at Johns Hopkins Engineering School, not the School of Public Health but with the Engineering School. A faculty member by the name of Charlie Flagle was heading it. They were giving a summer course in operations research, so I just went down and spent the whole summer there. It was a very hot summer, I remember, but I learned the rudiments of operations research, which then was a brand new field.

WEEKS:

Was Harold Smalley in with them, and John Freeman?

THOMPSON:

They came along a little later. At that time, there was Charlie Flagle, a young man by the name of Connors, Harvey Wolf, and John Young. Smalley was at Georgia, and Freeman, I think, left Johns Hopkins and went to Georgia Tech with Smalley.

WEEKS:

That was a new look at the world.

THOMPSON:

A whole new look at the world.

WEEKS:

I came to Michigan just when the group there was starting operations research.

THOMPSON:

That was that whole Medicus crowd. They were good.

WEEKS:

Well, two or three of them. Carl Barth started other programs too besides Medicus.

THOMPSON:

They actually began to refine Connors's and Flagle's nurse-staffing model. Medicus got a big grant from the Bureau of Nursing, and they began to work on the nurse-staffing model. I was applying operations research techniques to physical plans. In other words, I was interested in applying these techniques to the design of hospital facilities. I was not into staffing, although I did take Flagle's model and test it for him because he wanted to try it in another setting, so Barbara Lee and I tested it at Yale.

THOMPSON:

Those were exciting times. Then when I got back to Yale, I began looking around for somebody to work with at Yale. You see Yale did not have that kind of formal Industrial Engineering Department. There were some faculty over in what they euphemistically called the Department of Administrative Sciences, and so I went over there, and we began to start working together and one of the people who was over there, who had just come down from MIT, was Bob Fetter so that is when we began our relationship.

And Al Snoke, like he always used to do, came roaring in with a big problem. He said, "The war babies are going to start having

babies. How much larger does my maternity unit have to be so I can respond to that need?"

WEEKS:

He also had the problem of two hospitals that wanted to be one, didn't he?

THOMPSON:

Yes, but oddly enough they had already merged the OB unit. There was just one OB service, and there was one pediatric service. The rest of them were two and two: one university and one community.

Now his was a fairly straightforward question, but there was no way we could answer that problem at that time without using operations research. That was the first time that anybody had decided to simulate a hospital system on a computer, and we included all the components of the maternity system. So we were doing simulation, and we were comparing mathematical models derived from queueing theory to the Monte Carlo solutions. There was only one computer big enough to take the program and that was up at MIT. We were working with IBM cards in those days.

WEEKS:

Yeah, those were the early days.

THOMPSON:

We would go up with a big batch of IBM cards with the program and the data and try to feed them to the computer, and then, of course, there was always some glitch usually in the program so you had to go back and correct it. We finally got runs that simulated

the system at various volumes of admissions, and we could describe the way the system worked as well as solve the problem.

WEEKS:

That was the early days. I can remember going through that with IBM cards too, but not on as big a scale, of course. Before we leave Montefiore entirely, do you want to say anything more about home care?

THOMPSON:

I wrote my essay on organized home care, and I've always been a firm believer in it and actually contributed to getting a home care program started in Connecticut.

WEEKS:

Oh, did you?

THOMPSON:

Al decided it was time, although Bill Donnelly had started an excellent home care program at Greenwich before the New Haven effort.

WEEKS:

Did they have hospice service there too?

THOMPSON:

I was somewhat involved there, but that was much later.

WEEKS:

Because home care and hospice worked so closely together.

THOMPSON:

They are two sides of the same coin. Hospice wasn't in the ballpark then. Actually, three home care efforts were started in

Connecticut about that time. There was one in New Haven and one in Hartford and one at Greenwich. Dr. Sidney Shindell had gotten the State Department of Chronic Disease involved in the movement.

WEEKS:

Another thing, and this is sort of jumping out of order here, but I want to ask while we are still here, while you were in New York did you see anything of a health insurance plan operation?

THOMPSON:

We had our own HIP group at Montefiore. It was the only group owned by a hospital.

WEEKS:

There were about 30 groups, were there?

THOMPSON:

Ours was somewhat different from the others. All the doctors were on salary by the hospital. It was right across the street from the hospital, and I spent some time helping Joe Axelrod set that up during my residency. Then when I was the assistant director, that was one of my departments. I was charged with oversight of the HIP group. We got up to 30,000 subscribers, and we didn't take any new members, and when Martin Cherkasky came to the hospital, Dr. George Silver started to run it for us. It was an interesting project. The first attempt to measure the quality of care in a group practice setting was done there as well as in other HIP groups. Dr. Henry Mackaver did an audit of ambulatory patient care.

Montefiore at that time was a very, very exciting place. Everything was new. We used to have a saying that Montefiore was not an institution; it's a chronic disease. We used to call ourselves Montefiornics. Once you're a Montefiornic, you are one for the rest of your life. We had all kinds of people who would, while going through New York, always come up to Montefiore. Isidore Falk was one of them, and George Silver before he came to work for Montefiore. They were primarily people in social medicine, and they were considered the radical fringe. We didn't think they were so damn radical, but I guess the rest of the world thought so. Martin Cherkasky, before he took over the hospital, was the chief of social medicine. We were the first hospital that had a Department of Social Medicine. An intern or a house staff man could not discharge a patient at Montefiore. The only person who could discharge a patient was a social worker. The physician could recommend discharge, but the social worker had to say yes depending on whether there was an adequate home to go to.

WEEKS:

To make sure there was a place for the patient to go?

THOMPSON:

Right. Make sure everything had been done for their disease, and many were placed on home care or they were being followed up in the clinics.

WEEKS:

That is some more groundbreaking, isn't it?

THOMPSON:

I mean it was just absolutely amazing. All these were Bluestone's ideas.

WEEKS:

I think that is the fun of working when you can work with a group where there is something new happening, something progressing, something challenging. I guess I asked you about all the people I was thinking about. Russell Nelson was at Johns Hopkins when you were there. That must have been unusual in those days, wasn't it?

THOMPSON:

He was pretty well known by then. You see, there was a time when Russ Nelson, Al Snoke, Stu Hamilton, and Jack Masur were almost successive presidents of the American Hospital Association.

WEEKS:

He is now dead, isn't he?

THOMPSON:

Yes. If you got into that clique, you knew pretty well all the people that were moving and shaking hospitals in those days. That was when Crosby was the full-time director of the AHA. You got to know people on a national level as well.

WEEKS:

I was just wondering if this might be a good place to stop for a minute. I have a good picture of where you were. I have you appointed associate professor of public health and director of the program in hospital administration. Are we skipping over anything?

THOMPSON:

You've got it about right. Those were the days when there were a couple of big issues in education for hospital administrators. One was whether the various programs should become more of a national organization. Up until then, we used to meet annually at each member's program, and then Gary Hartman made the proposal at the Iowa meeting to go for a full-time staff and become a lot more visible and a lot less clubby. The primary men who got behind the idea were Andy Pattullo and George Bugbee. That's when we took on Gary Filerman. For a while, Gary had his office right next to the University of Chicago where George was, and we took off from there.

The other issue was what should we do with the residency? Most programs, all except Cornell, were a year at school and a year in residency. Programs were being pressed for time, so much was happening in the field, Medicare, Medicaid, all that sort of business. There was so much new content—financial management being one, as you know, quantitative analysis being another. So we just more or less had to increase the academic time.

Most of the programs then began gradually to change; at first, opting for a half-year residency training period, and then eventually almost all of them went to two years on campus. We lost a lot. There was a lack of contact with the field of practice when we did that. We had built up a very loyal group of preceptors who would take our students as residents. This was also the time when we started getting more and more women in the programs. The

preceptor-student relationship didn't seem to fit quite as well with women as it did with men. We had to disassociate with some preceptors who wouldn't accept women residents. So a lot of things happened at one time, and we had to change.

At Yale, we were pretty happy. We kept the residency for a while and then finally, like everybody else, did away with it. The one characteristic of the program at Yale was its accent on research, and there weren't too many programs like that. Except at Michigan, Cornell, Yale, and the University of Chicago, there wasn't an awful lot of research going on at that time. There was not a single refereed journal that could publish real research. We finally got some research journals started. Don Reidel resurrected *Medical Care* and started *Inquiry*, and the AHA started *Health Services Research*, and gradually we began to build a health services literature. This was a long and hard trek, because it was very difficult to get promotions in universities unless you had a list of publications in refereed journals. *Hospitals* wasn't refereed. *Modern Hospital* wasn't refereed. If you got to where you wanted your results out in the field, the field never read the refereed journals and still don't. *Medical Care* occasionally gets read by a few practitioners, but *Inquiry* rarely. This is how we began to get separated from the field of practice. We ended up writing for ourselves. We're not back yet to a closeness with practice, and I don't know if we're ever going to get back. It's pretty hard to say.

This also became very important because when you make research a very key component of your educational program, the program has to have a very clear research agenda, and you have to be able to break up the research into pieces that are of a size and a level of complexity that students can handle. I'm talking about master's students here; I'm not talking about PhD candidates. The former involvement is not easy, but you can do it if you have these two things: an agenda and data. Now we were fortunate; we had the Connecticut Hospital Association and Connecticut Blue Cross who were very close to the program and who gave us a lot of data. For example, in the early days of working on DRGs before they were even named and before we knew exactly where we were going, Connecticut Blue Cross bought the tapes of the 18 hospitals that were on PAS out of the 35 in the state. They bought the tapes and gave them to us. We then could take those tapes and match them with the financial information that the Connecticut Hospital Association obtained, because Connecticut has had a standard chart of accounts since 1948. All hospitals had the uniform ways of allocating these accounts to obtain costs per maternity, nonmaternity, and newborn days.

WEEKS:

Was it the same as AHA, or was it different?

THOMPSON:

It was slightly different. It was based on the AHA's *Chart of Accounts*, but there were some changes. The reason for this was because Al Snoke had somehow gotten cost-based reimbursement

accepted as payment for welfare cases in the state. This was before Medicare and Medicaid, in the state of Connecticut, and we were talking about local welfare and state welfare. In order to do that, he had to give the state some believable data about money, so he activated the Connecticut Hospital Association Standard Chart of Accounts and the Standard Accounting Program. Hy Sibley was the first director. So there was a close working relationship between the Connecticut Hospital Association and the Yale program for all those years. We were able then, and I'm not saying Connecticut is typical, but at least we had one state where we could obtain comparative data, which served as the basis for the development of DRGs.

The next step was when we began using this data from Connecticut Hospital Association, the cost data, we were able to track the three critical problems everybody was concerned about post-Medicare. The increase in cost of hospital care could be expressed as actual costs of a service or charges for that service or as costs and charges per unit of population in Connecticut. We could also array the hospitals from the highest-cost hospital to the lowest-cost hospital, either costs per patient day or per patient stay.

The variation among hospitals was very high, over 100 percent between the highest and lowest cost hospitals. Now Connecticut is not like many states. There is essentially one labor market in Connecticut, because it's a small state. People go from town to town, and if you don't like the work where you live, you drive to

the next town. So we didn't have the Illinois and Chicago problem and the New York downstate and upstate problem. It was this variation in costs between institutions that had to be explained. All hospitals in Connecticut are accredited, and there are no proprietary hospitals in the state. Licensing criteria were so tough that the for-profits wouldn't walk in.

It was then with this data that we were able to begin to ask questions about what was going on in the most expensive hospitals and the cheapest hospitals. We were able to hypothesize that it may be due to the case mix, the differences in the types of cases treated. Then Reidel left Michigan and came to Yale, and he brought with him all of the knowledge and lore that was in the two-volume McNerney, et al., study, particularly that about utilization review. So we began to think then, because we had the PAS tapes for the 18 hospitals, that we could classify patients who used the same amounts of resources according to their clinical attributes.

Then the primary resource concern was the length of stay and that was the beginning then of the concept of DRGs. We had Reidel, who knew UR. We had Fetter, who was a superb operations research person and computer massager. And we had me, whose main input was classification of rough clinical categories. We worked a long time together, and the big breakthroughs were out of Fetter's shop, where they developed interactive programs where you could sit doctors down and say, "Now here's a diagnosis. What factors do you think are going to affect the use of resources treating this diagnosis? Is it age? Is it certain complications? Is it the

patient's sex? What is it?" We could sit there and test it on this interactive program, which was called AUTOGROUP.

Then, with that, we could begin to attack the task of taking a whole ICD-8 in those days and break it down into patient groups that were medically meaningful, in other words, the same kind of doctors took care of them. Their use of resources was statistically stable, and we could begin to explain some of the variations in the costs of hospitals.

Then we got into one step beyond simply measuring the lengths of stay and began to assess the patient's cost of ancillary services, so we had to enter the charges and apply the RCCs to obtain costs. There we were with what we thought was a major management breakthrough. In other words, hospital administrators could now begin to see how much it was costing them to produce these "products" (DRGs) and whether the medical staff was treating these patients differently, keeping some patients in too long, ordering too many X rays or too much lab work.

We first envisioned this as a management tool, albeit it reflected a complicated management approach. My hospital is going to have to treat so many DRG no. 468 next year. It's going to cost me so much money for these DRGs, and I can write out a bill of particulars, for that treatment: so much for labor, so many X rays, etc. This was the first time anybody in hospital management could do this. I'm going to tell you we used to have a saying, "Have slides, will travel." We went all over the United States to preach the gospel of hospital product lines, and it was absolutely amazing

how little attention anybody paid to this idea. The first people who paid some attention to it was the AAMC crowd, because they were trying to explain why teaching hospitals cost so much more, and we said one component might be a different case mix. They then assigned two or three of their staff people to research DRGs so they knew them pretty well.

Then again one of these serendipitous things happened. The health officer of New Haven was a young physician by the name of JoAnne Finley, and she was called down to New Jersey by a candidate for governor by the name of Byrne who said hospital costs have become a big issue in this campaign. Some consumer advocates had written an epic called "Bureaucratic Malpractice," which pointed out in a Nader-like way that the New Jersey Hospital Association was running Stale's cost-control commission, and if he got elected, would she become his state health officer? She previously had some experience with Blue Cross in Philadelphia, and she knew all about DRGs, because, as health officer in New Haven, she was on the Yale faculty and had come to the various research symposiums on the new system. She said yes. Byrne was elected.

She was the second woman state health officer appointed in the whole U.S.A., and we met at Mory's, where we told her, "We think we can help you. We have to try it out somewhere." So I went down to New Jersey as a consultant for her. Before she got on board, the previous health commissioner had signed a contract for a uniform hospital cost system called SHARE, which was very similar to the one used in Maryland. So things were almost in place. She is the

real heroine of the DRG trial, because she had a terrible fight on her hands.

WEEKS:

I was going to say I remember she got in some conflicts.

THOMPSON:

My idea of public policy is a mixture of three things: One is politics, one is economics, and one, in our business anyway, is medical care. She turned out to be a very astute politician. I'm going to tell you her opponent was Jack Owen, who was also a very astute politician. He was the head of the New Jersey Hospital Association. It was a fight that we wrote a teaching case about, and it's a classic case. How does a public agency carry out a revolution? She did it because she played politics. The first thing she did was to neutralize the doctors, and how she did it I don't know, but she kept them busy on issues of quality. She'd say to them, "You and I are concerned about quality, and that's all you have to worry about. We're going to take the PSROs (the PSROs were in place then), and we're going to look at every case, not just Medicare and Medicaid cases, and the New Jersey Medical Society is going to be authoring this."

Then, in New Jersey, as in some parts of the country, there was a flight from the core city, and some of the hospitals, as they moved out of the core city and relocated in the suburbs, left the poor. So the hospitals that stayed in the core city were responsible for the care of the poor with fewer resources, because the doctors went to the suburbs. Those were some of the biggest

hospitals in the state. In New Jersey, there are a lot of tough core cities. I'm talking about Patterson, Newark, Jersey City, Trenton. Dr. Finley suggested that every hospital should contribute to a money pool based on their revenue, and the hospitals that gave free care could apply for reimbursement from the pool. In essence, what she was doing was to take money from the suburban hospitals, put it in the pool, and pay that to core city hospitals. Master stroke. I never did figure out whether she did that or whether that came from a real bright nun at St. Joseph's in Patterson. So she had our friend Jack Owen caught. She said, "If you don't come along with this pool, I'll split your damned association."

Of course, Jack was smart enough to preserve the New Jersey Hospital Association. But he then became a bit more cooperative toward the DRG system and, in the end, actually fashioned some compromises that helped his constituents go through the change without major trauma. But there were some dirty days too. His association published a book called the *DRG Maze* that was almost libelous. What Jack was able to do was to carve out of the DRG reimbursement a lot of monies so his hospitals could go on passing costs through for indirect costs and only direct costs of care were reimbursed by DRGs.

I think, considering everything, he did his hospitals a lot of good. He and I are friends. He used to be with the AHA and that was when I was going through the chairs. We knew each other pretty well. The problem was that though he and his hospitals knew of the

relatively small amount of reimbursement attached to the DRGs, the world didn't know. The impression was that all revenue came through via the DRGs.

WEEKS:

He was in charge of the Washington office.

THOMPSON:

That was afterward. He left New Jersey and went to the AHA Washington office. Everybody inside realized he had done such a good job for his hospitals that when they came to pick somebody for Washington, they pulled him out of New Jersey.

WEEKS:

I think he would be good. He has a lot of savvy. I haven't heard from him recently. What is he doing since he returned to the AHA?

THOMPSON:

I think he retired about the same time I considered it.

WEEKS:

You lost contact quickly.

THOMPSON:

Well, I'm not fighting those battles any more you know. I'm doing the research on Florence Nightingale, and I am doing research on the cost of treating AIDS and detached things like that. It's a kind of withdrawal.

WEEKS

He had a health problem, didn't he?

THOMPSON:

I have forgotten that, if I ever knew it. He was a tough opponent. Then, at the end of all that, we went from ICD-8 to ICD-9. So we had to redo the whole system of DRG groupings.

WEEKS:

I got in on a little of that ICD-9 on the publication, and that's when CPHA was trying to get it published in spite of the government and everybody else.

THOMPSON:

Whatever they did, we had to redo the DRGs. Another heroine shows up. It seems like we're always being rescued by heroines. She was former dean of the School of Nursing at Michigan. Then she went on to be in charge of Medicare. Carolyne Davis. HCFA had been funding all our later research anyway. The original grant was from the National Center for Health Services Research, but when we had finished all the conceptual modeling, and we were now looking for a place to pilot the system, therefore, the National Center said well we are going to refer your request to HCFA, and sometime later they picked it up.

We went down to see Carolyne and her group, Judy Lave, and they had to come up with some proposal for HHS, some type of prepayment to follow the TEFRA request. So we went down, and we spent the day down there presenting the refinements and came back. We didn't know whether it took or not.

I keep thinking that it's like when I was a kid in Canton, Ohio. Canton is on the main Pennsylvania line—Pittsburgh to

Chicago—but not all trains stopped there. So they would swing this hook out over the tracks and hang the mailbag on it. Well that was analogous to the time they had to rescue Social Security. Remember when all the predictions were that Social Security was going to be bankrupt? There was a sizable bipartisan rescue train steaming down the track. So, I think HCFA decided, at least this is my idea, we'll put DRGs on the mail hook and see whether that train, when it comes down the track, will pick up the bag. We'll see when we wake up in the morning if that DRG bag is still hanging there or did it get picked up. Well they picked it up. I don't think the federal government has ever moved that fast in my memory. The new DRG stuff was practically steaming. We just finished the ICD-9 regrouping and the new definition of DRGs. HCFA staff priced them down there in Washington, and from that assigned weights. That bill was passed and was in force in every damn hospital in the country in the next fiscal year. We were astonished. We were frankly as surprised as anybody.

WEEKS:

Was there much difference between the state test and the federal weights?

THOMPSON:

There were a lot of differences. In other words, the federal program assigned more of the costs to the DRG. You see, Jack Owen had negotiated a lot of so-called indirect costs out of the DRG rate. They were all, except capital costs, in DRGs now. The important thing is I told you about AAMC. When the negotiations

came around, when public hearings were held, AAMC walked in and were prepared. They negotiated a doubling of the indirect education expense and that's what helped the teaching hospitals—the add-on to each DRG for the indirect education expense. That was based on a ratio of house staff to beds.

WEEKS:

They had a policy then.

THOMPSON:

Yes, they had a policy and a specific program. AHA came to the hearings and said we like DRGs but we want what is known as balanced billing. Balanced billing was a euphemism for we'll take the DRG payment but we're going to charge the patient for the balance of our charges. The doctors, except those who take assignments, have been doing this for a long time under Part B. AHA wasn't even at the table when the negotiations were closed. They were out. CHA (Catholic Health Association) came in and said what we want is a three-year phase-in, and they got that.

WEEKS:

Was Sister Irene Kraus there?

THOMPSON:

No, she was with the AHA at the time. The person who actually ran the CHA action was Patricia Cahill. She was the Washington representative of the Catholic Health Association at that time. They had appointed a big committee to help her, and some of the big Catholic chains were represented on that committee.

WEEKS:

It just seems to me that Cahill connected with the Sisters of Mercy some way.

THOMPSON:

No, Pat actually used to work with Gary Filerman, of all people.

WEEKS:

Oh, that is where I heard the name.

THOMPSON:

Then she became a lawyer and left Gary and started to work with the Catholic Health Association as a lawyer. Then she became so skilled she was put in charge of the Washington office. When these negotiations came up, there she was.

WEEKS:

I just mentioned Sister Irene Kraus.

THOMPSON:

She was the president of the AHA.

WEEKS:

Yes, she was president of AHA. There was a sister from Sisters of Mercy that was president a few years back, and I interviewed her. I wanted to ask you about your various positions at Yale. The last we talked about was when you were appointed associate professor and director. You talked about the early days of the Yale program. You got your appointment as professor in 1966, didn't you?

THOMPSON:

Something like that.

WEEKS:

You were still director.

THOMPSON:

Of the program, yes.

WEEKS:

In 1966, I had you down for, the only time I had seen it, in the School of Nursing Administration.

THOMPSON:

I had a faculty appointment in the Yale School of Nursing from the first day I became director of the program. When I went on the faculty, I was an associate professor in the School of Public Health, and then I became associate professor of the School of Nursing as well.

WEEKS:

I was going to ask you about being appointed associate dean for planning in the medical school.

THOMPSON:

When Dr. Fritz Redlich, who had been the chairman of the Department of Psychiatry and with whom I worked rather closely, became dean, and he asked me to come over and be the associate dean for planning.

WEEKS:

What sort of planning was this? Building planning?

THOMPSON:

Joint program and facilities planning for the hospital and the medical school.

WEEKS:

My impression from what Dr. Snoke says was that there were quite a lot of problems combining the two hospitals.

THOMPSON:

Yes, I was at that time acting as President Brewster's staff man, and we spent one long hot summer and rewrote the bylaws of the hospital, including its relationship with the university and the medical school, and eliminated the two medical staffs. Al was with us. Then we began to address the problem of rebuilding the hospital and expanding the medical school, because some of the new programs for the medical school were being blocked by lack of space.

WEEKS:

Was all this rebuilding--restructuring and reorganizing--did this make difficulties for Snoke? I got the impression that he came under quite a lot of pressure before he got through with the building program.

THOMPSON:

He was under some pressure because we had two very, very powerful men, Al Snoke and Kingman Brewster, the president of Yale, and they didn't get along all that well. When you're in a teaching hospital, at least in a place like Yale, and you don't get along

with the president of the university, you better leave, and so that's what Al did.

WEEKS:

Well, Kingman was a fairly short-tempered person. I mean he hadn't been in the position very long.

THOMPSON:

Oh no, he had been there as provost for a while, and he was a magnificent president from the day he started. He was a scholar, a very good administrator, and a real presence. These were the '60s, and we had one big spring demonstration. It wasn't a riot, but it was almost one because the Black Panthers were involved with a murder, and they were going to try the Black Panthers in New Haven. It really got so bad that they called out the National Guard. But Brewster saved the school. We were not "occupied" by any students. We were not disrupted all that much by all that went on. We had one big May Day celebration. In spite of one bomb and one downtown fire, Brewster's leadership, with the help of the community, kept the university calm.

WEEKS:

That was about the time we were having trouble here at Michigan with sit-ins.

THOMPSON:

I came here about that time. I was asked to teach at the School of Public Health. I was developing teaching cases, and I was asked to present one. It was in the summer, and I drove in here and the whole town was in an uproar, and we had to sneak

around the back to get me into the Student Union where I was staying. The whole town was being stirred up by townies and students. I think it was just a summer session, so it wasn't a major problem because not all the students were here.

WEEKS:

Well, we had a lot of trouble. I can remember back when I was at the university. We were trying to enroll minorities, and we sent special teams to Detroit. We'd go to high schools and go to colleges, even Wayne University, trying to enroll or enlist some of these people to come to school here, and then when we got them here, we admitted them. And one year we admitted two, and they couldn't stand up scholastically. So what do you do? It's embarrassing to cut them off in the middle of a term, but we had to do it. It made an intolerable situation.

THOMPSON:

We had the same program. We were a little luckier than you, I suppose, because we were Yale. We got the best black students, but even at that, it took about twice as much faculty time per student for special sessions and counseling, but we got them through. Of course, when I was associate dean, I wasn't the head of the program of hospital administration anymore. Sam Webb was, so he bore the brunt of that. I was still teaching and had some research going, but I wasn't directing a program at that time.

WEEKS:

Sam has been there a long time, hasn't he?

THOMPSON:

Yeah, he took Barbara Lee's place. He just left. He's not at the university right now.

WEEKS:

I notice Dave Pearson has gone to New Hampshire.

THOMPSON:

Right.

WEEKS:

Do you have any old-time faculty members left besides yourself?

THOMPSON:

No. Tom Bice has just come. Tom was at the University of Washington. He's with us now.

WEEKS:

He's a bright person.

THOMPSON:

Very bright.

WEEKS:

Who is the director now?

THOMPSON:

Tom.

WEEKS:

Tom is the director now?

THOMPSON:

Temporarily. We're looking for somebody else. It's kind of like your place when you're trying to recruit somebody else and couldn't, so John Griffith came back.

WEEKS:

Well, I think it's right that he is head of the combined programs, because he worked so hard bringing it about. Zuckerman, I don't know what his plans are. He's still teaching here, but I don't know if he's satisfied being a teacher or whether he wants to go on to be a director somewhere else, I'm not sure.

THOMPSON:

What happened to your friend Howard Berman?

WEEKS:

He's the head of the Rochester, New York, Blue Cross now. He really got into a go situation there. That's one of the best in the country.

THOMPSON:

Was that after he left AHA?

WEEKS:

He left AHA and went there. He had been at Blue Cross before. He's still in his 40s, so he's got quite a lot of time yet to do things. We've had a nice working relationship. I'm 40 years older than he is, probably, yet we've managed to get these books out so I have a lot of admiration for him. Why don't we talk about your being a visiting professor in Belgium and England back in the '70s?

THOMPSON:

I told you I always believed that when you're the second banana and your boss is replaced, you should put in your resignation. So when Fritz Redlick left the deanship, I resigned as associate dean. His first successor was Lou Thomas, a very famous writer and physician, and so he wanted me to stay. Then Lou resigned, and Dr. Berliner came. Again I resigned, but he said, "Why don't you take a sabbatical till I see whether I need you?" A first-rate idea. So I went over to England with five of my kids and began a six-month stint there and then moved on to Belgium, but I sent the kids back home because they had to go to school.

The Kings Fund College and the English educational situation were radically different from the American situation. At that time, there were two degree-granting programs in hospital administration in all of England, and that was Teddy Chester's program at Manchester and the one at the University of Leeds. Most of the training was done in Kings Fund College for career officers, as they called them, of the National Health Service. There were two groups of these young people. One consisted of recent graduates from the universities who were recruited into National Health Service. Then they had what they called promising young officers. These were young men and women not recent graduates of the university but who had entered the service as a career and did very well and now were being sent for formal education. They didn't mix the two groups. First one was scheduled; then the other group came to the school and would spend about three months at the

college. Then they would go out into the field. Then they came back, and it was a kind of a semiapprenticeship system. I saw two of those classes go through: one, the promising young officers class, and the recent graduates class.

WEEKS:

Did you have a role in teaching?

THOMPSON:

Well, I would just tell them about America and recent happenings there. My main role over there was to get enough time to write up the first big report on what would be eventually called DRGs. It was published later on in a shortened form. Then block out for the Kings Fund the development of a senior staff college. In other words, what the Kings Fund wanted to explore was the formation of a staff college for senior executives in the National Health Service. As part of that, I went around to all of the sites that had any kind of educational effort at all in conjunction with the National Health Service. That's how I got to Oxford, York, Birmingham, and Bath, as well as Manchester and Leeds. I fashioned program recommendations and gave it to the people in the Kings Fund and they liked it. The only thing they didn't accept was that I wanted to get hooked into a university but they just couldn't fashion that. I thought I had the London School of Economics interested even though Brian Abel-Smith is a close friend of mine and of the college.

WEEKS:

I haven't seen his name in quite a while.

THOMPSON:

Well, he's kind of retired. The last I heard he was doing some consulting for W.H.O. You see he's very active in the Socialist Party, and the Socialist Party isn't very active right now.

WEEKS:

Back in the '60s, didn't he write a book?

THOMPSON:

He wrote a book on the history of English hospitals. He then headed the Kings Fund Task Force with a young lady by the name of Oriole Goldsmith, and he wrote another little pamphlet called "Accounting for Health," which was a plea for radical research for the English National Health Service into cost-effectiveness. The English don't usually think that way. He's written a lot of good stuff. He's an economist at the London School of Economics.

When I was over in England, they had the first big joint meeting between the health care economists (everyone they could find in England who had anything to do with health care economics) and the Medical Officers of Health. They didn't understand each other. They couldn't talk to each other. It was the darndest thing you ever saw in your life. But, though he liked the work I did, he couldn't swing the accreditation with the London School of Economics.

I guess the universities are far stiffer about their relationships with other groups than they are in this country. The Kings Fund eventually developed the program themselves, and Maureen

Nixon ran it for some time. She is now the director of the English version of the ACHE.

WEEKS:

I've never been able to get it quite figured out how that complex Palace Court, or whatever it's called, came about. As you entered it on the left, I saw the school and, on the right, there were a couple of big mansions. Once I can remember going there and visiting the director of the Kings Fund, I thought, and he's now retired. I've forgotten his name, too.

THOMPSON:

G. A. Phalp, C.B.E.

WEEKS:

You've been in his office, haven't you?

THOMPSON:

Oh yes.

WEEKS:

I was amazed at the picture window looking out at the little courtyard with a brick fence around it, and they served tea. Now, as far as the staff of the college itself was concerned, the only one I knew was Frank Reeves. Is he still there?

THOMPSON:

No, he's retired.

WEEKS:

But he was there at the time you were there.

THOMPSON:

Yes, I worked with Frank.

WEEKS:

And who else was on the faculty?

THOMPSON:

There was a young economist, young Nick Bosenquet. Maureen Nixon was there before she went over to the University of Toronto and got her PhD and came back to head up the staff school. Pat Torre was Reeves's assistant, and he succeeded Reeves. Pat was an old-fashioned industrial engineer. Then they had a lot of other people come in and out like Brian Abel-Smith, Archie Cochrane. There was a Kings Fund College, and that was separate from the Kings Fund Center, which was located near Marble Arch.

WEEKS:

That's moved, too, hasn't it? It's down on Albert Street or someplace.

THOMPSON:

Kings Fund staff are very astute real estate people. They buy these buildings and put things in them, and then they sell them for a lot more money, so they move, and I think that's what happened to that center across from the Marble Arch. They sold and resold those houses up and down that Palace Court as well.

WEEKS:

I see there's a Holiday Inn that had been built on land that had been bombed out, and so they built a Holiday Inn on it when the war was over.

THOMPSON:

I don't think it is still a Holiday Inn. Somebody else took it over.

WEEKS:

The center was sort of an information center, wasn't it?

THOMPSON:

Yes.

WEEKS:

They had quite a library there.

THOMPSON:

A big library. It also served as the headquarters for the International Hospital Federation, and they had a big equipment-testing program.

WEEKS:

They also did some architectural research, didn't they?

THOMPSON:

Yeah. Most of the architectural studies were done by the Nuffield Foundation.

WEEKS:

Well then, it seems to me that they had classes there for some of the personnel.

THOMPSON:

Yeah, they would be department heads because all the other classes were at the college.

WEEKS:

Hardie just finished as head of that, didn't he? About a year or two ago, he retired to Richmond on the Thames.

THOMPSON:

They had what used to be called the best officers mess in all of London. Did you eat at the college?

WEEKS:

I ate at the center but not at the college.

THOMPSON:

They could really throw a party, passing the port and all that sort of thing. They had a bar at the college.

WEEKS:

They had a bar at the center as well, and just around the corner there was a great bar. Yeah, but I mean just around the corner of the room. Have you been in the new center?

THOMPSON:

Yes.

WEEKS:

Is it bigger, or different?

THOMPSON:

About the same size, perhaps a little smaller. I was there primarily for the library. They had a library at the college, and they had this other library, and they had a reference that I wanted to look up at the center.

WEEKS:

One time when I was at the library, who should walk through but Duncan Neuhauser.

THOMPSON:

Then I left there and went over to the University of Leuven with Jan Blanpain.

WEEKS:

Well, Jan spent two or three months at Michigan in the early '60s.

THOMPSON:

We were at the School of Public Health. Now, there I taught. I gave a weekly series of lectures, which eventually I put in a book. The good thing about it then was those students all spoke English extremely well. They understood more than they spoke, and they were bashful in speaking, but I got to know them very well. I didn't learn Flemish. That university is divided in two parts, a Flemish and a Walloon part.

WEEKS:

They had two languages then?

THOMPSON:

Yes. When I was there, the Flemish eased out the French to a brand new university 16 miles down the road, on the other side of the magic line that they have in Belgium, dividing the two language groups.

WEEKS:

Where is Jan Blanpain coming in?

THOMPSON:

In spite of his name, he is rabidly Flemish. It is very confusing if you really don't know what's going on because names don't mean a thing. Both groups are Catholics, so it's not like Northern Ireland. It's all on what they call Francophone, in other words, if you prefer to speak French. Up until World War II, you could not get a college degree in Flemish in Belgium. Since World War II, the Flemish have really become quite aggressive. Don't forget now, Leuven is the oldest Catholic university in the world.

WEEKS:

The buildings are old, too, five or six hundred years old.

THOMPSON:

They have buildings over there that you wouldn't believe. It is also where Vesalius was from.

WEEKS:

I didn't realize he was from Belgium.

THOMPSON:

He did most of his work in Padua.

WEEKS:

I said he was Italian, but those men traveled all over anyway. All those early physicians didn't seem to stay put, especially if they had different ideas.

THOMPSON:

The best stories of Leuven, you could say, was on the first day of school. Everyone got dressed up in academic robes, if you had yours, and everybody went to high mass at the cathedral, and

then after mass, you'd parade past the Santa Maria De la Sede, which is the patron saint of the university, and you'd bow, and then you'd go to wherever you were to teach.

When the French were moving out, the Flemish were extremely proud of the fact they had completed a revolution and not a drop of blood was spilled, but they were not above slinging rocks around. All the old streets are fashioned with big paving blocks and whenever there would be a set-to, they would all come out with crowbars to dig up these paving blocks.

They would tell one story, and I think it's probably true because it's so typical. Everything in the bifurcation was done by contract. Walloons, you get this. Flemish, you take that and you leave this. The new French medical school is in Brussels, and the old medical school is all Flemish in Leuven.

During the move, the French students formed a chain some 16 miles or so, and they dug up one of these paving stones and passed it down from student to student to student, buried it with great ceremony in the middle of their new university. The next morning they woke up, and there was a hole there and the rock was gone, and there was a note that said that this stone was not in the contract. Back it came and was replaced right in front of the cathedral where it was taken from.

WEEKS:

They are hot-blooded people, aren't they?

THOMPSON:

The students were very nice, and I really got to know them very well.

WEEKS:

Did you teach the American system?

THOMPSON:

The American system along with some statistics, some operations research.

WEEKS:

Did they do much research?

THOMPSON:

They had a pretty good research group. They had a young man trained at Wharton who was an operations research type and was moving into research. Luke Deleasey was his name.

WEEKS:

I stopped in there about three or four hours back in about '72 or '74, something like that, after being in Michigan.

THOMPSON:

They were building a new hospital outside the city, a new hospital for Flemish medical school because the old hospital is Saint Raphael's, which is right in the middle of the town, and they couldn't expand enough so they built some new facilities, and Blanpain was in charge of that.

WEEKS:

We went into a builder's office shack, and a group had spread out, and he was looking at some of them and talked with the

workmen, and I couldn't understand what he was saying but then we went to lunch. You probably ate there many times, in an old abbey.

THOMPSON:

That's the faculty club. It is an old Beginage.

WEEKS:

Then I went on for a meeting of a documentary committee of the International Hospital Federation on which I served for several years. What we were trying to do, and you can fill me in on your visits to Europe to tell me what's happened, but, at the time, what they were trying to do was to set up an information retrieval system on a computer, something that all the western Europeans would agree on, and they were still fighting World War I and World War II.

THOMPSON:

They are still fighting them.

WEEKS:

But when I mentioned Paul Spheric, he was in Deuseldorf and was the head of some German hospital association, I have forgotten the title of it now. And they were the only ones who were doing anything with a computer at that time. I'm just wondering what kind of progress they have made since.

THOMPSON:

They are making progress slowly. You see, they're all interested in DRGs, but there's one big problem in all of Europe. They don't submit patient bills over there. Because they can't make up a bill, it's extremely difficult to fix the volume and cost

of resources that any single patient uses. We have the bills, so we know that the patient had this X ray, this drug, and spent this time in the O.R. They don't. What they're doing, and this is true in France and Portugal and perhaps in Spain, is to use DRGs as a budgetary review screen. In other words, in all these countries, each hospital budget has to be approved by a central office. They then take your diagnostic information and figure out your case mix. They don't price it. They can't price it, because they don't have bills, but they can establish relative weights for each diagnosis. They just say with this case mix, you're asking for too much money.

The Veterans Administration in this country is doing a similar sort of thing, because the VA also doesn't make out a bill. They don't know the patient's specific costs in the Veterans Administration hospitals.

That is the area where most of the argument was around at this last trip in Germany, which I referred to earlier. Finally, one German got up and said, "You know, Germany will never adopt DRGs for two reasons: One is that a German didn't think of them, and two is they are not perfect." I said, "Well, I know for a fact that a German didn't develop them, and I know they're not perfect." But the meeting was held in the Rhinegau District of Germany where they make all the Rhine wines, so I must confess I spent more of my time sampling different kinds of wines than worrying about DRGs or the problems of European countries adapting them.

WEEKS:

The Swedes have a lot of research going on, don't they? Data gathering or something?

THOMPSON:

They are data gathering. They were thinking about it. The people who have used them more effectively probably are the Koreans. We had a Korean, a doctoral student, who was with us when we were developing DRGs so he was in on the ground floor. In fact, his name (Young Su Shin) is on several of the early papers. Korea is adopting compulsory health insurance, but it's a social insurance system where fee-for-service bills are submitted. They use DRGs as a bill screen. A claim is presented for this period of hospitalization, for this diagnosis, for this amount of money, so that it falls into a DRG. They have generated norms for this type of claim around this DRG, and they can then say, well, it's too high or it's not high enough.

This process is complicated, because, in Korea, a physician cannot give you a bill unless he renders you a service. He cannot give you a bill if he just talks to you and gives you advice, because under the Confucian teachings, scholars are supposed to give you advice free. So much of the physician's bill or large parts of the hospital bill are in the drug category, so it is very important to break those out in the DRG.

WEEKS:

Do you match the drug with the diagnosis?

THOMPSON:

We can. The bill, drug, and physician's claim with a written diagnosis enables you to put the combined bill up against norms. All the bills were reviewed by hand before they had this kind of a technique.

WEEKS:

I visited a center in Holland, too. This committee I was working on who met every couple of years in a different spot, and I can remember going there and making the acquaintance of Otto Sijbrandij, who was tall enough to be a basketball player and broad enough and brawny enough to be a Hollander.

THOMPSON:

I think whatever is the Dutch equivalent of the AHA is your group right now. In that building that you were in, I think it's their headquarters, I gave a speech, and all I remember is they gave me the biggest damn Edam cheese I had ever seen in my life. It was big, and I had to carry that thing all the way back to Belgium. In fact, I actually carried it home.

WEEKS:

And you have since eaten it all up.

THOMPSON:

Oh yes.

WEEKS:

I want to ask you a question. In your visiting professorship and seeing several of these different national operations of health service administration and so forth, did you feel the presence of

the Kellogg Foundation? The reason I ask that is that I had a feeling from talking with Bob DeVries, who seems to be traveling all over and has made several visits to Europe, I was wondering if Kellogg is getting out and supporting foreign systems.

THOMPSON:

I cannot say. I didn't see it. There was a certain kind of relationship between Kellogg and the Kings Fund. I think that was before Bob DeVries.

WEEKS:

When Andy was still around.

THOMPSON:

Yes.

WEEKS:

I've known DeVries almost as long as I've known Andy. I knew him when he first came to Michigan. He was hired as the administrator of McPherson Health Center, the one where he did the progressive patient care study. I was just interested, and the reason I heard him mention going to Ireland and meeting Colin McCallin, and I was wondering if that name meant anything to you. It's the only reference I have to McCallin.

THOMPSON:

They are looking at DRGs.

WEEKS:

I don't know anything about their system. This is in the public environment, isn't it? There were one or two things that I wanted to ask you about, activities I have noted. I was wondering

if there was anything that you wanted to put on record about your committee work with AHA. Is any of that of outstanding importance?

THOMPSON:

I don't think so. I found AHA pretty stiff. It just seemed to me that there was an awful lot of post-hoc rationalization. I remember in the old days when they used to put us up at the Chicago Athletic Club, we all used to plan to get there the day before the meeting and meet in the card room. And there was a whole group of younger men from various committees, and I must say that I learned poker. The same guys were playing cards every night, and somebody said well, there was a new man in and he seemed to be awfully dexterous shuffling the cards. And somebody said, "I think it was Walter McNerney or Jim Stephan. He can do more with 52 soda crackers than I can do with a deck of cards."

WEEKS:

I remember the Athletic Club. That's now been turned into something else.

THOMPSON:

They had very good eggs Benedict there.

WEEKS:

I've eaten there, but, of course, I don't remember eating eggs Benedict. I'm sorry I missed them. Is there anything you want to say about the year that you were president of the AUPHA?

THOMPSON:

That was early on when we were just beginning.

WEEKS:

Yes, that was back in the '60s.

THOMPSON:

We were trying to get some solidity into it. My predecessor was Burns Roth. It was an interesting year. Gary was young, and we were just beginning to establish these critical task forces. We got Ig Falk to head the one on medical care and, consequently, it was very successful task force.

I liked being president, but, even then, I remember when I was going to sum up my year, there seemed to be a lack of realization among the membership about the big changes that were coming in health care. It was still then a kind of old-fashioned faculty without a clue that the most important social science we needed was epidemiology so we could deal with the clinical and social changes that were coming. "Blowing in the wind," I summed it, alas.

WEEKS:

Maybe this is a good time, when we just have a few minutes left, for you to look down the road to the future and see what you see coming.

THOMPSON:

Well, I think some action is going to have to be taken on a DRG-like model for physicians' payment. That is an important component of the medical expenses right now, and it could be done. In fact, we have done some preliminary work, and it doesn't look as hard as it seemed. For example, with the Harvard relative values, nobody has criticized their validity. Some specialists don't like

them, but that is not at all surprising. Hospitals didn't like DRGs.

I suspect that all kinds of models—merging clinical data, clinical characteristics of the patient with the financial data—are going to have to be refined, DRGs among them. They are not accepted yet, but when they are, the so-called refined DRGs are able to account for variations in severity. I don't think the refined DRGs are going to be used as a reimbursement tool because there are too many of them. They are, however, going to be very useful in quality control. In other words, if I'm comparing the same cases and somewhat same degrees of severity, and one dies and one doesn't, then I'm better off making generalizations about the hospital where they died.

I think up until now diagnostic survival rates have been too broad. The ones published by the feds, I think, are a good example. Now this is an old problem, and I could have done some historical research into when they were trying to judge the salubrity of the hospital based on the mortality of amputations in the 1860s. They just couldn't do it.

There was some early work there on amputations that were results of trauma and amputations that were a result of disease. That was over 100 years ago. In 1867, Lister published his paper, and then the medical profession was switched to the bacteriological model based on the logical assumption that if we just found the cause of the disease we would have the whole problem licked. Once we know that we don't have to worry what were the characteristics

of a healthy hospital or which hospital wasn't healthy. Well, it didn't turn out that way. In the first place, we still must deal with the chronic diseases, and now we have AIDS.

WEEKS:

And drugs.

THOMPSON:

And drugs. So we are going to have a tough time ahead.

WEEKS:

It just seems to be that we are going to have to get away from some of President Bush's ideas about no more taxes and look for some sin taxes.

THOMPSON:

There is that feeling that a lot of people are beginning to express, by saying, "Let's do Canada right." In other words, let's copy the Canadian health system but do it right, because there are many problems with the Canadian health system.

WEEKS:

There are differences in nearly every problem area, too, and even in the financing.

THOMPSON:

That may not be so bad.

WEEKS:

Who would be the best person to talk to about the Canadian system?

THOMPSON:

Probably Ted Marmor.

WEEKS:

I don't know him. Marmor who went to Chicago?

THOMPSON:

Yes. He's at Yale now. I say he knows the Canadian system because he is at present, as I understand it, working on a rather large study of the Canadian health care system. He is an expert in public policy. He's quite a young man.

WEEKS:

How old is he?

THOMPSON:

I would say 39.

WEEKS:

Wait a year or so.

THOMPSON:

The other person you would want to talk to is the Canadian, Robert Evans, who is a respected economist. I've heard him speak, and he's written some pretty good articles on the Canadian health care system. He's at British Columbia. He writes superbly. He has a very good sense of humor. I heard him lecture at Yale. He is very good, Robert Evans.

WEEKS:

Robert Evans, I'll remember that now. One thing I wondered about you is that you haven't had any connection, have you, with the National League for Nursing?

THOMPSON:

Oddly enough, my last big piece of research was in nursing. I published my first article in the *Journal of the American Nurses Association*. That last piece of research is finished now, and the report was funded by the feds and it has been published by the NLN, so it kind of closes a loop. My first article was on nursing and home care, and my last article was on nursing severity.

Interview in Ann Arbor, MI

July 1989

Index

A

- AAMC (Association of American Medical Colleges), 49, 54-55
- Abdellah, Faye, 7-8
- Abel-Smith, Brian, 64, 67
- "Accounting for Health," 65
- AIDS, 16-18, 52, 82
- Alexian Brothers Health System, 16-17
- Allen, Dr., 27
- Ambulatory patient care, 40
- American College of Obstetrics and Gynecology, 10
- American Hospital Association, 42, 44, 51, 55, 56, 62, 79
- Chart of Accounts, 45
- Army nurse corps, 7
- AUPHA (Association of University Programs in Health
 Administration), 79
- AUTOGROUP, 48
- Axelrod, David, 12
- Axelrod, Joe, 40
- AZT, 18

B

- Balanced billing, 55
- Barth, Carl, 37
- Bath (England), 64
- Belgian health care system, 70-74

Bellevue Hospital (NY)
 medical schools, 3-4
 prison ward, 20-22
 School of Nursing, 1-2, 6, 15-16

Berliner, Dr. Howard S., 63

Berman, Howard, 62

Bice, Tom, 61

Bifurcation, 72

Birmingham (England), 64

Black Panthers, 59

Blanpain, Jan, 70-71, 73-74

Bluestone, E. M., 29-30, 31, 32, 34, 35, 42

Bosenquet, Nick, 67

Bradley, Larry, 23

Brewster, Kingman, 58, 59

Bugbee, George, 33, 43

Buis, George, 35

Bush, George, 82

Byrne, Brendan T., 49

C

Cahill, Patricia, 55-56

Canadian health care system, 82-83

Case mix, 14, 47

Catholic Health Association, 55, 56

Cherkasky, Martin, 29, 30, 31, 35, 40, 41

Chester, Teddy, 63

Civilian Conservation Corps, 1

Clay, Clement, 23, 24-25, 35

Cochrane, Archie, 67

College of the City of New York, 20

Collegiate nursing program, 6, 8, 9

Columbia University, 5, 23, 24

 College of Physicians and Surgeons, 3-4

Connecticut Blue Cross, 45

Connecticut Hospital Association, 45, 46

 Standard Accounting Program of, 46

 Standard Chart of Accounts of, 45, 46

Connors, 36

 nurse staffing model, 37

Cornell University, 5, 43, 44

 Medical School, 3

Cost-based reimbursement, 45-46

CPHA (Commission on Professional and Hospital Activities), 53

Crosby, Edwin L., 42

Cunningham, Bob, 31, 33

Cuomo, Mario, 12

D

Davis, Carolyne, 53

Deleasey, Luke, 73

DeVries, Bob, 78

Diploma program, 6

Donnelly, Bill, 39

DRG Maze, 51

DRGs, 13, 14, 33-34, 45, 46, 47, 48, 49, 51-52, 53, 54, 64,
74-75, 78, 80, 81

Drugs, 82

E

End-stage renal dialysis, 18-19

Evans, Robert, 83

F

Falk, Isidore, 41, 80

Federation of Jewish Philanthropies, 30

Fetter, Bob, 37, 47

Filerman, Gary, 43, 56, 80

Finley, JoAnne, 49-50, 51

Flagle, Charlie, 36

nurse-staffing model, 37

Freedman, Mark, 29, 30

Freeman, John, 36

Fries, Brant, 34

G

Genitourinary service, 2, 6

Georgia Tech, 36

German health care system, 33-34, 74-75
Goldsmith, Oriole, 65
Grace-New Haven Hospital (CT), 23, 25
Great Britain health care system, 18-19, 33, 62-70
Great Depression, 2, 6
Greenwich (CT), 39, 40
Griffith, John, 62
Gynecology, 2

H

Hamilton, Jim, 25
Hamilton, T. Stewart, 27-28, 42
Hardie, Miles C., 69
Harlem Hospital (NY), 5, 6
Hartford (CY), 40
Hartford Hospital (CT), 27-28, 32
Hartford Retreat (CT), 28
Hartman, Gary, 43
Health Services Research, 44
Hill-Burton money, 35
HIP (health insurance plan), 29, 40
Holland, 77
Home care, 29, 31, 39-40, 41
Hospice care, 39-40
Hospital administration, 13, 20, 25, 42-43
Hospital architecture, 35-36

Hospitals, 44

Hospital Service Corps of the Navy, 7

I

ICD-8, 48, 53

ICD-9, 53, 54

Inquiry, 44

Intensive care, 14

International Hospital Federation (IHF), 32, 33, 68, 74

J

Jersey City (NJ), 51

Johns Hopkins University, 42

 Engineering School, 36

 Public Health School, 36

Journal of the American Nurses Association, 84

K

Kellogg, John Harvey, 4

Kellogg Foundation grant, 25, 78

Kings Fund, 78

Kings Fund Center, 67

Kings Fund College, 63, 64, 67

Kings Fund Task Force, 65

Korean health care system, 76

Kralewski, John, 34

Kraus, Sr. Irene, 55, 56

L

Lancet, 31

Lave, Judy, 53

Lee, Barbara, 37, 61

Leeds (England), 64

Length of stay, 47, 48

Lincoln Hospital (NY), 6

Lister, Joseph, 81

London School of Economics, 64, 65

Long Island Jewish Hospital (NY), 32

M

Mackaver, Henry, 40

MacLean, Basil, 23, 26, 36

Male nurses, 1-2, 6

Malpractice insurance, 10-12

Manchester (England), 63, 64

Marmor, Ted, 82-83

Masur, Jack, 30, 42

Mathematical models, 38

McCallin, Colin, 78

McNerney, Walter, 47, 79

McPherson Health Center (MI), 78

Medicaid, 43, 46
Medical Care, 44
Medical Officers of Health, 65
Medicare, 43, 46
Medicus, 37
Mills School, 1, 6
Minority nurses, 6, 60
Modern Hospital, 44
Monte Carlo solutions, 38
Montefiore Hospital (NY), 29, 30, 32, 34, 39, 40, 41
Mory's, 49

N

National Center for Health Services Research, 53
National Health Service, 63, 64, 65
National League for Nursing, 83
Navy nurse corps, 7
Nelson, Russell, 36, 42
Neuhauser, Duncan, 70
Newark (NJ), 51
New Haven (CT), 40
New Jersey, 52
New Jersey Hospital Association, 49, 50, 51
New Jersey Medical Society, 50
New York State, 11-12, 34
New York University School of Medicine, 3-4, 5

Nightingale, Florence, 52

Nixon, Maureen, 65-66, 67

Northwestern University, 20, 22

Nuffield Foundation, 68

Nurse midwives

- and malpractice problem, 10-11
- training of, 9-10

Nurse practitioners

- in private practice, 9
- specialization of, 9-10

Nurse-staffing model, 37

Nursing, as profession, 5-6

Nursing education, 2

Nursing shortage, 1, 13-14, 15

O

Obstetricians, 10

- malpractice for, 11

Obstetrics, 2, 38

- midwives in, 10-11

Operations research, 36, 37, 38

Orange General Hospital (NJ), 24

Osteopaths, 7

Owen, Jack, 50, 51-52, 54

Oxford (England), 64

P

Padua (Italy), 71
Pattullo, Andy, 43, 78
Pearson, Dave, 61
Pediatrics, 2
Penicillin, 16
Pentamidine, 18
Phalp, G. A., 66
Physicians, aberrant behavior of, 13
Pneumonia, 15-16
Poor care, 50-51
Preceptors, 24, 43-44
Prepaid group practice, 29
Progressive patient care, 8, 13
Prontosil, 15
PSROs (Professional Standards Review Organizations), 50
Psychiatric service, 2, 4-5, 6, 10, 27-28

Q

QUALYS (quality-adjusted life years), 18
Quantitative analysis, 43
Queueing theory, 38

R

RCCs (ratio of costs to charges), 48
Redlich, Fritz, 57, 63

Reeves, Frank, 66
Reidel, Don, 44, 47
Rensselaer Polytechnic Institute, 34
Research, 43-45
Research journals, 44, 84
Residency training, 43-44
Richmond on the Thames, 69
Rochester (NY), 26
Rochester (New York) Blue Cross, 62
Rosenfeld, Gene, 30, 32
Roth, Burns, 80
RUGs, 34

S

Saint Raphael's (Belgium), 73
Schnorrning suit, 30-31
SHARE (Standard Hospital Accounting and Rate Evaluation System), 49
Shindell, Sidney, 40
Shock therapy, 28
Sibley, Hiram, 46
Sijbrandij, Otto, 77
Silver, George, 40, 41
Simulation, 38
Sisters of Mercy, 56
Smalley, Harold, 36

Snoke, Al, 23, 25-27, 35, 36, 37-38, 42, 45-46, 58

Snoke, Parney, 27

Socialist Party, 65

Spheric, Paul, 74

Stephan, Jim, 79

Stone, Captain, 33

Sulfanilamide, 15

Swedish health care system, 32, 76

T

Thomas, Lou, 63

Torre, Pat, 67

Tralls Hygea Therapeutic College, 4

U

University of Chicago, 20, 22, 23, 25, 43, 44

University of Leeds, 63

University of Leuven, 70-72

University of Michigan, 4, 8, 34, 36, 44, 47

School of Public Health, 59-60, 70

University of Washington, 61

Utilization review, 14-15, 47

V

Veterans Administration, 75

Visiting Nurse Associations, 14-15

W

Wayne University, 60
Webb, Sam, 60-61
Wharton, 73
Wolf, Harvey, 36
Women residents, 43-44

Y

Yale University, 23, 24, 25, 29, 32, 34, 35, 44, 46, 47, 60, 83
 Department of Administrative Sciences, 37
 School of Nursing, 8-9, 56-57
 School of Public Health, 23, 57
York University, 19, 64
Young, John, 36
Young Su Shin, 76

Z

Zuckerman, Howard, 62