HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Karl S. Klicka

KARL S. KLICKA

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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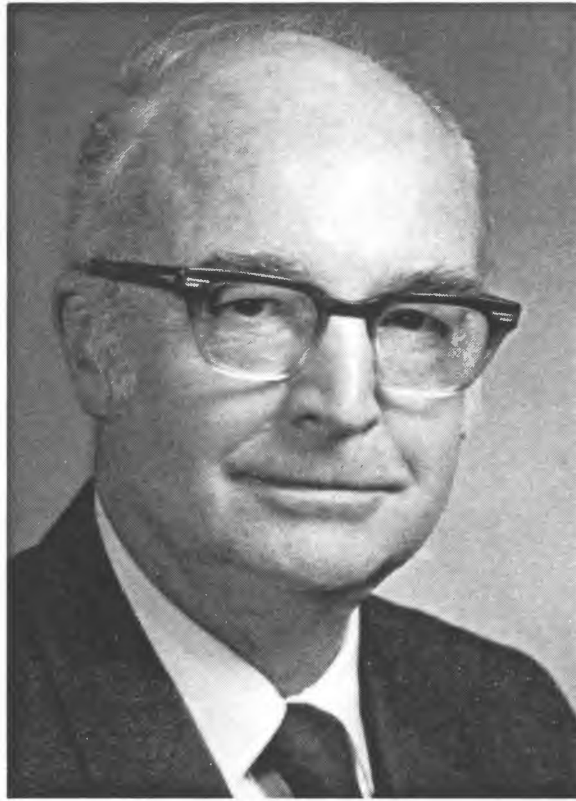

Karl S. Klicka

CHRONOLOGY

1911	Born November 3, Sewickley, Pa.
1933	Allegheny College, Meadville, Pa., B.S.
1937	Western Reserve Medical College, M.D.
1938	Allegheny General Hospital, Pittsburgh, Intern
1939	Womans Hospital, Detroit, Resident in Obstetrics and Gynecology
1940	University of Chicago, M.H.A.
1940-1943	Grasslands Hospital, Valhalla, N.Y., Assistant Director
1943-1946	U.S. Army Medical Corps, General Surgeon, Fifth General Hospital Europe
1946-1951	Woman's Hospital, New York City, Director
1951-1954	St. Barnabas Hospital, Minneapolis, Director
1954-1956	Presbyterian Hospital, Chicago, Director
1956-1959	Presbyterian-St. Luke's Hospital, Chicago, Director
1959-1963	Hospital Planning Council for Metropolitan Chicago, Executive Director
1963-1966	Appalachian Regional Hospitals, President
1966-1976	Peoples Community Hospital Authority, Michigan, Executive Director
1967-	University of Michigan, Program in Hospital Administration, Lecturer
1977-	W.K. Kellogg Foundation, Consultant
1977-	Independent Consultant

AFFILIATIONS AND MEMBERSHIPS

American Association of Hospital Consultants

Member

American College of Hospital Administrators

Fellow

American Hospital Association

Life Member

American Medical Association

Member

American Red Cross, Southeastern Michigan Chapter,

Member Board of Directors, Member of the Executive Committee

Medical Administrator's Conference

Member

Michigan State Medical Society

Member

Society of Medical Administrators

Member

Wayne County (Michigan) Medical Society

Member

AWARDS

State of Michigan House of Representatives
Resolution of Tribute for exceptional services as the Executive Director of the Peoples Community Hospital Authority, 1970

Michigan Hospital Association
Key Award for Meritorious Service, 1977

Tri-State Hospital Assembly
Award of Merit, 1980

KLICKA:

I would be very happy in starting this interview to begin at the senior college level at a time when I was in the process of making a decision as to what I was going to do. Actually there were three routes open to me. My father had been a dentist. He is now deceased. I gave a lot of thought of following in his footsteps. On the other hand, he didn't want me to be a dentist. He felt that being a physician was just a better life than that of a dentist, so he encouraged me in that direction. However, my mother had a business friend who ran a very substantial printing company in Pittsburgh and he offered me a career in that particular business. Anyway, my mother said, "Karl, I have $5,000 that you can use in any way you wish on your graduation from college. You can invest it in a business, or you can invest it in a profession." That was in 1933. I might say that at that time $5,000 was enough to get you through four years of medical school.

I gave a lot of thought to this, to the extent that a young man of that age can think deeply about his future. I decided on medicine. I hoped to go to school in Pittsburgh so I applied at the University of Pittsburgh. As a hedge I also applied at Temple in Philadelphia and Reserve in Cleveland. Wouldn't you know, I was not accepted at Pittsburgh but I was accepted at both

Temple and Reserve, so I went to Reserve.

My medical school days were, I think, pretty typical. I graduated in a position of 35th or 36th in a class of 65, so I would consider that I was an average student. As you look at medical students, it's remarkable how similar they are. Those who come in as Phi Bets from college don't really perform much better than people who come in with average marks. Somehow there is a leveling effect in medical school.

I graduated in 1937 and went to Pittsburgh as a rotating intern at the then new Allegheny General Hospital. They had just completed the construction of a new hospital that replaced a building they had been in for some 50, 55 years.

One important point should be mentioned here. That is that it looked as though I'd get married during my intern year. This was just unheard of in those days, but I had met, fallen in love with, and had become engaged to a young lady who was a technician in the hemotology lab at the university hospital in Cleveland. Sure enough, in midyear of school, in January 1938, we were married. This was important because she was a big help to me in many ways as I then proceeded with my career. There were 16 of us as interns and I was the only one that was married. Today it is the rare intern or resident who isn't married either before he gets into his work in the hospital or certainly during the first year he is there.

Following my internship I went to Woman's Hospital in Detroit for my residency. I had decided I wanted to be an obstetrician and gynecologist. Most interns recognized that, if you wanted to do reasonably well financially in medicine, you should specialize. I am speaking of 1937-1938. It is interesting to realize that at that time general practice was held in low

esteem by medical school graduates. But here we are today in 1979 and we see general practice having a rebirth-but that's a span of 40 years in between.

I came to Woman's Hospital as a resident in obstetrics and gynecology fully expecting to go on and complete a four year residency. However, just one-third of the way through that residency period I was stopped in the hall one day by Miss Charlotte Waddell whose title then was Superintendent of Woman's Hospital. She was a big, very impressive Scottish woman that all of us respected and held somewhat in awe. She asked me if I wouldn't step into her office. I wondered what it was I had done that the Superintendent would find it necessary to call me in to discuss. Nevertheless, I went in. She asked me to sit down, and quite quickly she came to the point.

She said, "Dr. Klicka, what are you going to do with your life?"

I looked at her, somewhat mystified, and answered, "Well, I thought I would be an obstetrician and gynecologist. That's why I am here."

"I recognize that," she said. "I suppose you have never given any consideration to going into the business end of medicine, being a hospital administrator."

I said, "You mean being a hospital administrator, a superintendent of a hospital such as you are?"

She said, "Yes."

"No, I have never thought about it. Why do you ask me?"

Her answer was: "Well, we are looking--when I say 'we' I mean people who are administrators--we are looking for physicians who we feel we could interest in the field. As I have observed you as a resident here, something about your mannerisms made me feel that you might just like the field."

I said, "That's interesting. Quickly I'll tell you that when I came into

medicine I had had to make a decision as to whether I would go into business or go into medicine. If you are saying that I may have an opportunity to be a physician and a business man at the same time, I ought to think about that. It's kind of a rare opportunity to put those things together."

She said, "Let's set up some interviews for you with some people who are in the field." And she did.

I talked with the superintendent of Receiving Hospital in Detroit, who was a physician, and with the physician who was the superintendent at Eloise Hospital in Wayne, Michigan. I don't remember the names of these two physicians. I do remember the name of Doctor Hamilton who was the superintendent at Harper Hospital in Detroit. I also talked with John Mannix who had come from Cleveland to start the Blue Cross plan in Michigan. I still see Mr. Mannix occasionally. We have been good friends ever since my interview with him in 1939.

After I decided to follow Miss Waddell's suggestion to enter hospital administration, she said, "Dr. Klicka, you have two choices. You can either be set to work with a senior physician-administrator somewhere in the country-and I know some I am sure would be glad to have you [she mentioned Dr. Black who was a Brigadier General in the U.S. Army and was managing the Alameda County Hospital in California]-or you can try your hand at something new that's developed in the country. You can go to the University of Chicago where there is a new course for training hospital administrators. I think I can get you accepted. One option means going back to school and taking a course in general business administration, the other means going into a hospital and learning from a senior person, a preceptor. What about this?"

My wife and I talked about it very seriously. We decided that it would be

to my advantage to go back to school to learn the fundamentals. That was a wise choice, I subsequently realized. Miss Waddell not only got a me a full scholarship at the University of Chicago, but, with the help of Dr. MacEachern, who was then with the American College of Surgeons, she got me a fellowship, the huge sum of $40 a month. It did look huge to me. After all, I had been making $25 a month as a resident at Woman's Hospital. Everything is relative, isn't it?

Anyway, my practice of medicine was then limited to the summer following completion of my residency year. I took a position as locum tenens for a local general practitioner. I'll remember that all my life. It was a very, very active general practice out in the Grand River Avenue area in Detroit. I did anything and everything including ten deliveries at home. I'll never forget the delivery of twins at home in Dearborn, Michigan. Very, very difficult, in a way only because one of the twins weighed almost eight pounds, the other six-two, enormous infants for twins. After two and a half months of the grind of general practice, that experience convinced me that I had made the correct decision to go into administration rather than into the active practice of medicine.

We went to Chicago where we spent the next year. My wife was fortunate enough to get a position in a hospital laboratory which helped us financially. We got along quite well.

The outstanding experience at Chicago was not only my association with the other nine students, if you will. (Just think of this: We were the only nine students in the entire United States in 1939 that were studying hospital administration!) The big experience, of course, was the close association with Dr. Arthur C. Bachmeyer. I got to know Dr. Bachmeyer, I think, better

than any of the other students because his son, Robert Bachmeyer, was in the course at the same time. We became very fast friends, and have been fast friends throughout our working lives.

Dr. Bachmeyer, as I came to recognize quickly, was one of the existing giants in the field of hospital administration. He was able to give us a lot of insight into the field as reflections of his experience. His counsel has served me well throughout my working life. The program provided the basic courses in business administration such as economics and accounting and organization, marketing--things I wouldn't have learned if I had chosen to serve under a preceptor. Add to this the importance of the exposure to Dr. Bachmeyer. That year will remain as a very important memory in my life not only because of his interest in me, but in the rest of the students as well.

Towards the end of the year in May he called me in for a conference. He said, "Karl, I have had a call from Dr. Harmon, who is the director of Grasslands Hospital in Westchester County. Do you know about it?"

I said, "No."

"Well," he said, "it's a remarkably fine county hospital. One of the, if not <u>the</u>, outstanding county hospitals in the country. Dr. Harmon has been there a few months having served previously as the Assistant Director of the University Hospitals in Cleveland. Both of you, if you worked together, would have come from the same medical school, Reserve. He is looking for a physician as an assistant."

He spoke to me about the hospital and about the assignments I would have. He then paused and said, "Karl, as you are thinking this over, keep this in mind: I think you could go farther and do worse."

It was an interesting expression. I had never heard it before, and I have

never forgotten it. I have frequently used it in counseling young administrators who have worked for me.

He was right, because in going to Grasslands I found myself working with the attending staff, house staff, and the professional departments in an 825 bed comprehensive care hospital that not only had outstanding medical and surgical services, a tuberculosis pavilion for adults, a tuberculosis building for children, and something that was brand new in the field, a 47 bed acute care psychiatric unit. This was the first in the country. The medical staff was made up of the absolute cream of the physicians from Westchester County, who were all there on a volunteer basis. That was something that no longer exists in this country. They were superb people. I learned a great deal from my association with them.

My work at Grasslands only lasted from June of 1940 to September 1942. The bugle called and I went into the army as a medical corps officer. I went in as most people did--I went in taking my chances on what would happen to me. The army really didn't know what to do with me, because I wasn't a practicing physician. The fact that I had had special training in administration only bewildered recruiters rather than helped them in deciding what to do with me. As a consequence I started my army career serving as an instructor to medical corps soldiers at the Joseph T. Robinson camp in Arkansas.

I was there a year then went abroad as a battalion surgeon serving a group of quartermaster's units for a year in England. Then a very fortunate thing occurred in late May 1943.

I was transferred to Liverpool and assigned to another quartermaster unit under a West Pointer, a young colonel of my same age. He was in charge of

8,000 of quartermaster troops that were going to France as soon as a landing could be made D-Day. We got to know each other very well and quickly. One day he called me in. It was now D-Day plus 3 or 4.

He said, "Karl, I have been assigned a task of taking in 12 Victory ships with 8,000 troops. I am the task force commander. I want you to be the task force surgeon."

I asked, "What will I do?"

"Oh," he said, "you won't have much to do, really. I have to have somebody in that post. We'll take off late in the afternoon one day and land in France early the next morning. Do what you want to do, but don't worry too much about it." But I was a little upset and a little worried.

On investigation I found that in those 12 ships I had 12 officers, six dentists and six physicians responsible, but they were all on two ships! I took the precautionary measure of having them reassigned so I had one on each ship. Then I instructed them all to requisition double the supplies they would ordinarily need just in event something did go amiss. They did this.

Instead of being on those ships for less than 24 hours, we were on them for 21 days. If you saw the recent Eisenhower television program, you will know that Cherbourg didn't fall on schedule. It was supposed to fall very quickly, but it didn't. So, instead of going over and landing at Cherbourg on D-Day plus 6, we were at sea, and in and out of harbors. I was in command of the health and welfare of 8,000 troops, and, believe me, everything that could happen in 21 days to 8,000 people happened. I guess I handled it all right because, when we finally landed on Utah beach and got settled at Ste-Mere-Eglise which is inland a few miles from the beach, the colonel called me in.

He said, "Karl, you did a good job. It could have been rough, but you pulled it off. I am going to do two things for you. First, I am going to recommend you for a citation [which he did, and I subsequently got a Bronze Star. I was one of the first medical officers to get a Bronze Star]. Second, if you would like to be transferred to a field hospital, or a general hospital, maybe I can help you."

I said, "That would be great."

It just happened that the Fifth General Hospital which was the Peter Bent Brigham unit, was in the process of setting up at Carentan. They were the first general hospital ashore. I was reassigned. I reported. I was assigned as a general surgeon to the wards and I began working on lacerating and penetrating wounds of the arms and legs. I was, I guess, at my highest point in this effort when I was in charge of some 90 troops who all had penetrating wounds of the chest. That went off all right. Then I was assigned to a section that had been set up for prisoners of war. When Cherbourg fell, and then Brest, we got all the wounded Germans. I had quite a few of them. I remember having 120 wounded Germans in four tents.

One day the CO came by, he liked what he saw. The CO was Colonel Robert Zollinger. Zollinger was one of the greatest surgeons we have had in the last 50 years, as everybody who is a surgeon recognizes. He came back, and he came back. Mine was the most visited of tents. It became somewhat a joke. He, being of Prussian background, enjoyed walking through these German prisoner tents. All of these German troops conducted themselves with superb military behavior and he admired it. He got to know me pretty well and then he asked me about my background. When he found out that I had been an administrator by training, he said, "We can use you in the front office."

He moved me into the front office and said, "Karl, we are going to make you the non-CO executive officer of this outfit. Our good friend, Carlyle Flake, is a major. He has been with the Fifth General for three years. He needs to be a lieutenant colonel. The only way I can make him lieutenant colonel is to appoint him executive officer. He is an otolaryngologist and he is going to continue to do otolaryngology where we need him. He is going to spend some time up here, but for all practical purposes you are going to be the executive officer, without the promotion in rank. Will you take it under those circumstances?"

Of course I jumped at the opportunity. That was a turning point in my career in the army. I then stayed with the Fifth General and I had the responsibility of moving the hospital forward from Carentan to Toul, and converting an old French caserne, a barracks of the French army, into an acute general hospital. I also supervised the corps of engineers in installing a water filtration plant. And so it went. That was a great experience.

We were very close to the Battle of the Bulge. Some of our officers were pulled out on detached service. We were then a part of the Third Army and I got very much involved in that whole operation although we were 75 miles away from where the real action was going on. We had a tremendous amount of night air raid activity.

During that period, however, we came out of it unscratched. The war ended, I was transferred back to the states with other medical corps officers with a high battle star count. I had four.

A kind of humorous little incident here: All of us loaded up our bags with as much liquor and champagne as we could carry. I guess I overdid it because in the process of carrying my bags from the plane [we flew over from

Paris in DC-3s; we landed in the Azores, then Newfoundland, then Camp Dix] into our barracks, I suddenly had a right lower inguinal pain, and sure enough I had developed a hernia. I ended my army life in a hospital bed back in Cleveland where my wife was living with her folks. When I recovered from surgery, I was discharged.

I was now ready to start my re-entrance into civilian practice. As I reflect back on my three years and four months in the army, I think my thoughts regarding the army are not much different than those of anybody else. You take your chances and you play whatever role circumstances dictate. Fate pretty much determines what is going to happen to you. You have your miserable periods. You have your good periods. I can tell you this, as the years passed I felt sorry for the people who had not had the opportunity in the war. I felt they had missed something I had gained. I did my share of complaining, but we all complained about things. In looking back at it, you felt somehow good about the fact that you had had the opportunity to participate. I felt about this just last week when I watched the Eisenhower film, "Ike." It brought all this back to me in a very, very meaningful way.

So much for the army. I made a lot of friends with the Fifth General people, the Peter Bent Brigham group. Those friendships I made with the Fifth General personnel have been somewhat continuing over the years. From time to time in my hospital career I would run into Zolly, as we referred to Colonel Bob Zollinger. We always had a good exchange.

Now I am ready for reentry into civilian life. I wrote to Dr. Claude Munger who had preceded Dr. Harmon as the director of Grasslands Hospital and was now Superintendent and Director of St. Luke's Hospital in New York City.

(I wrote to Dr. Harmon also. I said, "I know I can come back to work for you because I now have a Civil Service status at Grasslands, but I really would like to start out on my own. I am now 34 years old, and although this may seem young to you, I feel I am ready to start on my own." He accepted that.)

Dr. Munger called me on the telephone the day after he received my letter and said, "I have a position I would like you to be serious about. Can you come to New York soon?"

I said, "How about tomorrow?"

So I did. What this led up to was my interview with several members of the Board of Directors of Woman's Hospital which was just a block south of the Cathedral of St. John the Divine on Amsterdam and 110th Street. A very few days after that interview I was appointed Director of that hospital to succeed a gentleman who was about to retire.

I was at Woman's for five years, a wonderful experience. Looking back on it, the important thing that happened to me there was exposure to the manner in which the quality of patient care rendered by the doctors on the medical staff was measured. Woman's was peculiar at that time, and unique. Remember this is 1946. They had a geographic full-time chief of staff appointed by the board of directors. He was the second person to occupy that position; he succeeded a chap who had gone into retirement. His name was George Gray Ward. Why is that name important? Well, he was among a small group of seven or eight surgeons who formed the American College of Surgeons in the 1920s. He also had developed the first workable, practical medical audit in hospitals in this country. Prior to beginning work at Woman's I had no knowledge of what a medical audit was. I never heard of such a thing. We had never heard

of anything like this at medical school.

It didn't take me long to realize that here I was exposed to a new invention, if you will, with little recognition of the fact that it would one day in my career become one of the most important functions of medical staff control and supervision. Evidently I was smart enough to anticipate what might or could happen. I wrote two papers about it in '48 and '49. One was for Modern Hospital, which was an important journal in those days, and the other was for Hospitals. I became the first hospital administrator in the country to appear in the literature as somebody who knew something about this new technique called medical auditing.

Although George Gray Ward was emeritus, he came in to the hospital very often, and he and I would talk. I learned a great deal from him. His successor was Dr. Albert Aldrich, a superb physician. I learned a lot from him also. I spent five wonderful years at that hospital.

There is one specific lesson I wuld like to leave here in this transcript. It takes the form of an important relationship I had with Dr. Munger, the man who got me the position. Let me identify Claude Munger as one of the giants of the time. He, along with Dr. Goldwater at Mount Sinai in New York, Dr. Basil MacLean, of Rochester, New York, Dr. Carter in Cleveland, to name a few, were not only recognized as outstanding administrators but they also started a new consulting profession. They were called hospital consultants. They did this as a sideline. When Dr. Munger placed me as the Director of Woman's Hospital, it was the understandi g with the board of directors that he would be paid an honorarium, modest but an honorarium, to more or less watch over my shoulder. I was at liberty to go to him at any time for advice and counsel. I realized after I had left Woman's that I

hadn't taken advantage of that privilege as much as I should have. I know why. I was cocky. I felt that I would make a greater mark for myself if I demonstrated that I didn't need his advice and counsel, that I could get along without his help. How dumb! I really missed a great opportunity to spend a lot of time with this man.

Later in life as I told this story to students in hospital administration at universities in Minneapolis, Chicago, and Ann Arbor. I pointed out that as growing administrators they must avoid the feeling that they really do. They should open their minds to senior people who might advise and counsel them. They should be receptive. Fortunately I recognized the unwarranted cockiness when I left Woman's Hospital. And I have tried to be more receptive to the teachings of senior men ever since.

I left Woman's Hospital because of a telephone call that came from Minneapolis from a gentleman who was the president of St. Barnabas Hospital. My name had come up in conversation when he had talked with some people at AHA in Chicago. St. Barnabas was looking for a relatively young physician-administrator to come to Minneapolis to assist in putting together something they called the Hennepin Hospital Center. (Minneapolis is in Hennepin County.) I liked what I heard when he talked to me on the phone, and what I read in the letter he wrote to me. I went to Minneapolis for an interview.

It was an exciting opportunity I was offered. I would come into the picture as the director of St. Barnabas Hospital, a 250 bed general hospital (about the same size as Woman's), but also with the opportunity of becoming director of an assembly of seven hospitals. The plan for this grouping, called the Hennepin Hospital Center, had been prepared for the city of

Minneapolis by the James Hamilton consulting firm which at that time was a relatively new firm established at the University of Minnesota.

I thought about this job offer for a long time, something like four or five months, and had a lot of correspondence about it. The reason I took such a long time to make a decision was based on my reservations as to whether such a grandiose plan could actually be accomplished. Also it was a pretty big move for a fellow from New York going all the way out to Minneapolis. It meant changing my whole life pattern. We liked where we lived. We had a nice home in Bronxville, and I was very happy at Woman's Hospital. I made the decision finally on the basis of my admiration for the dynamic leader, Charles Bolles Rogers, who was the chairman of the board of this new corporation. He was a past chairman of the board of St. Barnabas. So when the board of directors invited me to accept the position of director of the St. Barnabas Hospital, I did so, hoping that, with the cooperation of Mr. Rogers, I might eventually be chosen as the Center's first executive director. He assured me of his support. I resigned my position at Woman's. I was all set to go. It was now the middle of December 1950, the beginning date in Minneapolis was January 1, 1951. I then received a telephone call from Mr. Rogers.

He said, "Karl, I've got something that may disappoint you when I tell you. I am going to leave Minneapolis. I am going to a warmer climate."

"You won't be there to meet me when I come?"

"I won't be there at all," he said. "I am going to leave Minneapolis permanently. My doctors tell me because of an arterial problem I have in my legs that I cannot continue to live in this climate."

This phone call was a bubble bursting of the greatest magnitude. I had placed all my eggs in the basket of his leadership-and he was leaving town,

never to return. If I went there, I wouldn't have the benefit of his experience or his leadership. I had no choice, I went.

I did well in the position of executive director at St. Barnabas but it was difficult in the area of the hospital center development. This was because of the leader, Stanley Hawks, who had been appointed, if you will, by Mr. Rogers when he left. Hawks was a man held in high regard in the community. He was an executive of the newspaper corporation that published The Minneapolis Tribune and the Star. Mr. Hawks really didn't have his heart in this proposed hospital center. He was what I referred to as a reluctant leader. What was worse was that his wife was the chairman of the woman's board of Northwestern Hospital, one of the hospitals that was supposed to be a part of the center. I realized early on the reluctance on the part of the board to become a member of this seven hospital coalition or federation, which is what it was to be.

Approximately one year after I arrived in Minneapolis, I was appointed director of the proposed center while I continued to hold the position of director of St. Barnabas Hospital. I can tell you as the years passed it became increasingly apparent to me that the Center was not going to materialize. There were a number of reasons for it. Essentially I can summarize it by saying that it was a great idea whose time had not yet come. It was a concept ahead of its time. There was a great fear on the part of the other six hospitals that were to form the center that they would lose their identity. At that time that was a very important thing to each of them. The thing that excited me and the others who looked at the concept was that there was an opportunity to replace the obsolescent facilities of seven hospitals with new hospital facilities. This we could have done in 1951 for a cost of

less than twenty million dollars. There were easy savings, that everyone who looked at this plan could see, of some $750,000 a year in the operation of these hospitals. It was so obvious, but still there was this reluctance to move. Not only did we have the reluctance of some of the prestigious board members of some of the hospitals, but also of some of the administrators of the hospitals who were afraid of what might happen to them. So there was job security as a fear. This couldn't be overcome. The center was not planned on the basis of merging seven hospitals. It was to be what we today would call a consortium, a grouping of hospitals working very closely together, agreeing to share many services, to concentrate selected patient care services in certain facilities, and to establish a central office where planning and coordination of the consortium could take place. Minneapolis wasn't ready for a cooperative venture of this magnitude in the early 50s.

I can very well remember on a day of some frustration and discouragement (it was now the spring of 1954) when I received a telephone call from Presbyterian Hospital in Chicago inviting me to come to be interviewed by a search committee seeking a new executive director. My name had been suggested to Dr. Franklin Snyder, who was president of Presbyterian Hospital, by Dr. Edwin Crosby of AHA. Believe me, I was ready, ready to talk to anybody. So I went down. I felt very comfortable with the committee and with Dr. Snyder, who previously had been the president of Northwestern University. Other chief members of the committee included Mr. A.B. Dick from the board of Presbyterian. He was the founder and developer of the A.B. Dick Corporation. There was Phil Clark, who was a successful banker in town. Shortly after that meeting I was invited to become the administrator.

Being the executive director of Presbyterian Hospital proved to be a

wonderful experience. I met some great people. There was a superb board, just superb. The architectural firm that was working at that time to develop a sizeable addition to the hospital was called Burnham and Hammond. That wouldn't mean anything to most people. It didn't mean anything to me until I learned that Daniel Burnham, who founded the firm, laid out the plan for the city of Chicago back in the early 1900s. His two sons were running the firm in 1954. One of them, Daniel, recognized my interest in the history of their firm and gave me what they said was the next to the last copy of the master plan of the city of Chicago. Their father had accepted a commission from the Commerical Club to develop this plan. I still have it. It is one of my great treasures.

I was only at Presbyterian for two and one-half years when the idea of a merger with St. Luke's Hospital was proposed. Presbyterian, an obsolescent hospital, was one of the major teaching hospitals in the city, and enjoyed a close association with the University of Illinois. It was a 450 bed hospital, with a superb medical staff, but it was an old facility and the board was having a hard time raising the money to build the addition then in the planning stage. This is the way it was when I arrived.

St. Luke's, which was about six miles away, was in precisely the same situation. It was a 475 bed hospital associated with Northwestern University Medical School, with a good medical staff and obsolescent facilities. The board didn't know where or how they were going to raise money to replace a portion of their plant.

The story of how the merger developed is interesting. As it was told to me, there were two trustees who lived in Lake Forest, one was from St. Luke's board, one was from Presbyterian's. As they came down on the commuter train

one morning, one turned to the other and said, "Wouldn't it be wonderful if our two hospitals could get together and form one corporation. Then we could rebuild as a combined operation rather than trying to do it separately. The board members are friends; medical staff members are friends. It seems we ought to be able to work together."

When he finished speaking, the other fellow looked at him and said, "Maybe this could be done! Let's talk further about this."

Within a week these two men reported their conversation back to their individual boards. I'll never forget sitting in a board meeting and looking at the board members when this conversation was reported. I'll never forget this initial meeting because sitting just two or three places from me on the board was a very distinguished gentleman whose name was Ralph Bard. Ralph was a man in his middle sixties and a longtime Presbyterian board member. He was six feet four or five, a beautiful man. (I subsequently learned that he had been an All American football player at Princeton.) He never participated in the affairs of the hospital. Ralph Bard would come to meetings, fold his arms and go to sleep. This day, however, as this story was unfolded, I watched him. He opened his eyes and he obviously became acutely interested in the conversation, and he participated in the discussion. Before that meeting was over an ad hoc committee had been appointed to work with St. Luke's. He, Ralph Bard, was named as the chairman of that committee.

When I went to the hospital the next day I asked my secretary if she could tell me who Ralph Bard was. We went down the list of trustees to see what company he was with. He was listed as "capitalist." I was surprised when I saw this. Capitalist! I asked Mr. Snyder, who was president of the board, what that meant.

He smiled and said, "Mr. Bard makes his living buying and selling companies." No wonder he was interested when he heard the word merger.

The ad hoc committee meeting took place very quickly. It was only after a matter of four or five meetings over a period of about six weeks, the decision was made to merge. We had had no study of depth as to whether it was wise or not. It just seemed, conceptually, to be so darned smart for this to happen that it took place.

Pretty quickly I found myself appointed the interim director of the combined Presbyterian and St. Luke's hospitals. It then became my responsibility to try to put the two hospitals together operationally. Putting the two boards together into a corporation was relatively simple because there was such a willingness on the part of the two boards to move ahead. The greatest difficulty at the board level was combining the woman's auxiliary boards. Here we had two quite different types of people on the women's boards. At Presbyterian we had a women's auxiliary of about 450 members who were there as representatives of the Presbyterian churches from all over Chicago. At St. Luke's it was a small board of about 50 women who were the representatives of the social elite of the North Shore of Chicago. Time and patience were required, but eventually the two groups were merged as well as the corporate board whose membership at that time was all male.

The new board took a simple form, 24 board members of Presbyterian and 24 board members of St. Luke's merged as one board of 48 people. Over a period of years they learned that this could have been done better, that they should have made a selection of fewer proper people rather than just leave to normal attrition a reduction to what the board is today, a 24 person board with an executive committee which, I understand, makes most of the decisions for the

corporation.

Two points in this experience deserve emphasis. One was the hoped for economies of scale of the operation; the other was bringing the two medical staffs together. Let's talk about the medical staffs first. This was a difficult consolidation because of the two different ideologies. Both groups, as I indicated earlier, were made up of superb, top quality physicians. At Presbyterian the concept of organizing the medical staff using geographic full-time physicians was already in process. We had a geographic full-time physician serving as chairman in medicine and one in surgery, and we were considering one in orthopedics. These physicians appointed to their position after having been selected by a search committee, remained in the position. At St. Luke's, in contrast, department chiefs were elected every two years, as was the chief of staff. Obviously the two systems couldn't endure together. We had to change to one or the other. This was done over a period of many, many ad hoc committee meetings between the two staffs.

Fortunately four or five doctors on the St. Luke's staff, who were men of great stature, recognized that the route Presbyterian had elected to follow was the route of the future as far as medical staff organizations were concerned. These doctors were of assistance in convincing members of the St. Luke's staff that the Presbyterian pattern should be accepted. I remember the outstanding physician was a St. Luke's neurosurgeon by the name of Eric Oldberg. He was generally recognized as the leading neurosurgeon in the entire area, one of the leaders in the country. Paul Hollinger, in otolaryngology, was another one. Julian, in surgery, was another. I could name other people, but, suffice it to say, success ultimately took place because of the influence and leadership of a few key doctors of St. Luke's

staff.

In recalling the experience of the St. Luke's-Presbyterian merger, I would like to give some emphasis to one aspect that may help others who may become involved in a merger. This relates to the degree and extent of planning that should be done before a merger takes place. Example: During the discussion phases of the merger I was asked, "Dr. Klicka, what do you think? What advantages do you see either to Presbyterian or to St. Luke's to merge? How do you see the service to the community affected by this proposed merger, if it takes place?"

I answered, "Remember, there is no precedent for what we are about to do. There have been no mergers between two large hospitals in this country. I was involved in a merger in Minneapolis when I was there. There was a small 100 bed hospital a few miles from St. Barnabas which asked in effect if we could absorb them. This hospital was not doing very well economically. The request for the merger came from a few doctors who were on the board of directors of that hospital. Our board studied the situation, and administration prepared a pro forma statement on it. It appeared to me that by spending as little as $100,000 on that hospital we could make it more attractive to patients. I was convinced that with good management we could operate it as a satellite to the advantage of St. Barnabas. The small hospital was merged into St. Barnabas and became the St. Andrew's branch of St. Barnabas. We spent $100,000 renovating, buying new equipment and new furnishings. In three months time the operation was turned around from a deficit operation to a profit-making operation. It continued that way for a long time."

I told the trustees of Presbyterian-St. Luke's this story and said, "It all depends on how we merge and what you expect to do. If you are just going

to bring these two hospitals together hoping to save some money perhaps in the construction stage of the new hospital facilities, that's one thing. But are you prepared as two hospital boards to continue the same quantity of service to the community as you are now rendering as individual hospitals? If you were to do that it would be like adding two and two and getting four. That would be acceptable if there were sufficient evidence to indicate that you were able to build new facilities easier and better in one location. But if you are going to add two and two and come up with three, I think a merger would be ill-advised. I think the objective should be to think of two and two coming out with five."

I was assured there would be no cutback in the services, but ultimately there were definite cutbacks. Herein lies the lesson of merging any institutions: Before you do it, you should be sufficiently satisfied from the pro forma statements that good accounting firms can prepare for you. You should also feel that the merged institution will continue the same levels of quantity and quality of service, but hopefully will do more because of resulting efficiencies.

What happened when Presbyterian and St. Luke's merged was that we found that the St. Luke's hospital operation was in a precarious state. St. Luke's had no endowment; Presbyterian had a rather sizable endowment. All of the services in the outpatient department that were part of the overall indigent care services at St. Luke's had been financed annually by money that was either collected in contributions or made by the women's board from their annual fashion show. What happened when the hospitals merged was that that money which previously had been raised in contributions no longer was available for indigent care services. Rather it went into the building fund.

The only thing that was left was the money raised from the fashion show. That was not even half of what St. Luke's had been collecting as contributions. Consequently what we were left with was an indigent care program financed almost totally out of the endowment fund of Presbyterian. We found it necessary to cut back. The merged hospitals were unable to maintain the same level of indigent care the two had rendered individually previous to the merger.

Another very serious consequence was that, going into the merger, we had two schools of nursing, each one graduating approximately 100 registered nurses a year. We were able to modify the nurses' residence at Presbyterian and thereby increase its capacity. Then we changed the students' program from a full three year program to two years during which time they lived in the residence. The third year they all left the residence and went into an internship with outside living arrangements for which we paid them a wage which was essentially two-thirds the wage paid to registered nurses. Conceptually it was magnificent. There was only one other program like that and that was at Massachusetts General. We literally copied that program and put it into effect in Chicago. It required some additional support through contributions because in those days the tuition charged the nurses was not sufficiently great to cover all operating costs. We also had some disenchantment among the trustees because they felt that maybe the school was too big by doubling the size. Administration was urged to find ways of reducing it.

We found ourselves facing the reality of two negative consequences of the merger. We reduced the volume of patients seen in the outpatient department, which was the primary area of indigent care, and we reduced the future program

of the school of nursing. When you put all things together and you looked at the situation as a whole, it was realized that adding two and two didn't make five, it didn't even make four. The merger ended up with something like two and two equals three and a half. It was a great disappointment. The board members recognized this and hoped that time would take care of the deficiencies.

I should say that we were able to provide patient rooms and support services rather quickly. The addition Presbyterian had started to build was to be a six story building. In planning I had encouraged the architects to strengthen the steel structure so that at some future time when we would raze the other inadequate sections of the hospital we could double the size to 12 stories. When we merged, we realized this decision had been a wise one. The architects actually found that we could add seven more floors so we built a 13 story building. When St. Luke's closed in 1957, just a year and a half after we put the merger together, we were able to move St. Luke's to the Presbyterian site. We ended up by operating a hospital of 815 beds rather then 900 beds which was the sum of the two preceding totals. We took care of just as many patients as we had before which was an illustration that a bed reduction can be accomplished by consolidation.

Operating the merged hospital proved to be very difficult. To assist me I encouraged the employment of an available executive from the Commonwealth Edison Corporation of Chicago because I felt it would be of great advantage to me to have the guidance of a person from industry who had some merger experience. Commonwealth Edison over a period of 10 years had merged 10 or 12 small illuminating companies in the suburbs of Chicago into Commonwealth Edison. The retired executive we interviewed had done that job quite

successfully. What I learned from him, however, was that industry does things differently than hospitals.

In the merger discussions personnel had been assured of job security, looking to attrition to reduce the number of employees, but he disregarded this and insisted on severe, fast cutbacks which the board approved. Also as time passed with his direction in the financial area, I think we moved faster toward solvency than perhaps we otherwise would have. Although the two of us worked well together, it was not the happiest of settings. I realized I had been plunged into a new learning experience that was quite different from the management and operation of a hospital facility I had been accustomed to previously.

I was fortunate. About the time I was going through this adjustment I was given an opportunity by Dr. Vane Hoge. Dr. Hoge had been a long-time director of the Hill-Burton program for HEW in Washington. He had come to Chicago on the invitation of a new board of directors formed to set up a hospital planning concil.

I received a telephone call from Vane who said, "Karl, how would you like to be a hospital planner?"

I said, "I am pretty busy right now. What do you have in mind?"

He went on to tell me how, after being carefully screened and selected, he had been employed to head up the new hospital planning council for the Chicago area, he had come to Chicago, rented space, set up the office, and then realized he couldn't stay because his wife absolutely refused to move from Bethesda, Md. In order to save himself total and complete embarrassment he had to find somebody who would pick up his hot chestnuts, so to speak.

I thought about my situation at Presbyterian-St. Luke's and of some of the

disenchantment I had. Then I recalled something that was really critical in my decision to make a change in my career. When I had been at Woman's Hospital in New York City I had become very friendly with a physician named Dr. John Pastori. He was the director of the Hospital Council for Greater New York. He contributed a great deal to the overall planning of hospital services. At the time he encouraged me to do what I could to influence the board of directors of Woman's to work more closely with St. Lukes or Roosevelt, neither of which had a maternity department. He said it would be really good for the city if Woman's merged either with St. Luke's or with Roosevelt. The idea had a lot of merit. Before I left Woman's Hospital at the end of 1950, I strongly recommended this to the board of directors. Two years after I left, I was in Minneapolis, Woman's did merge with St. Luke's. I remember at the time thinking to myself what a wonderful thing Dr. Pastori is doing and that if I ever had the opportunity to lead a planning council in a large metropolitan area such as Dr. Pastori had in New York, I would drop everything and jump at the opportunity. Wouldn't you know, this is what happened in Chicago just at a time when I was beginning to think in terms of leaving Presbyterian-St. Luke's.

So I left Presbyterian-St. Luke's. It was in good hands. I had been through a rare and unusual learning experience. I went into this planning council and helped as its executive director to create, I think, one of the leading planning councils in the country. The only other comparable ones were in New York City, Cleveland, Pittsburgh, Detroit, Los Angeles. So there were about six. I had a small staff; I think I had a total of about nine people. We had the responsibility of directing the planning of 148 hospitals in seven counties, serving six million people in metropolitan Chicago. Our area of

responsibility extended down into Lake County, Indiana. This was because of the curve of population that went into Gary and Hammond. It was a natural thing and the staff in the health department in Indiana accepted this and welcomed our participation in planning.

I had a good, friendly relationship with the hospital administrators in the entire area. I had a good working relationship with the director of the Chicago Hospital Council. I had good friends in Blue Cross, which even then was beginning to think of containment of hospital facilities. The hospital industry was on the verge of a rapid expansion. What our job turned into was a process of evaluating plans of hospitals that wanted to expand, of advising them when they should, where they should, or if they should. The Hospital Planning Council for Metropolitan Chicago proved to be the right planning vehicle, at the time, and it was a happy time for me.

I had some very bright people on my staff that had been recruited locally from academia and consulting firms. My second in command was Rosson Cardwell who had been with Booz, Allen. He was a University of Chicago graduate with a master's degree in hospital administration. A bright, bright young man.

Our recommendations to the hospitals evidently made sense for they were well received. Programs would be evaluated by our staff and then presented to our board of trustees. The board was made up of businessmen representing the real power structure in Chicago. They were blue ribbon people. Our board chairman was E.L. Ryerson who was a retired Chairman of the Board of Inland Steel Corporation. He had his office just a block away from my office. I could see him as often as I wanted to; I spent a lot of time with him. He was, in my estimation and in the estimation of most people in Chicago, "Mr. Chicago." When you have that kind of situation--people on the board who

control the money hospitals would be spending on their building programs--one can appreciate the clout we had. In the period of 1959 to the early 1960s hospitals were not borrowing their major money requirement when they wanted to expand. The normal course of action was to follow a formula that took this form: The hospital would raise a third of its needs; a third would come from accumulated funds from operations; and finally they would borrow a third. That was a pretty universally followed pattern. This all happened at a time when suddenly Chicago was expanding out into the suburbs.

There was a rash of opportunists who wanted to build small hospitals. Many of them were doctors, a lot of them were attorneys, a lot of them were just businessmen who saw an opportunity to build what they thought would be little money makers in suburban communities. The Planning Council was hard-pressed to know how to counter this because, in our judgment, it seemed much wiser for hospitals based in Chicago to establish satellites out in these suburbs or have several adjoining communities band together, organize boards of trustees, and start from scratch. We frequently were successful in accomplishing this.

The council generated a lot of publicity in the press, which was good. Our visits to councils or board of supervisors meetings were usually reported in the local newspapers. We kept the local hospitals informed of what we were doing with the support of Blue Cross and the Chicago Hospital Council. When we became aware of intentions by small proprietary groups to build hospitals, we did what we could to stop them by using a process we established that worked essentially like this: When I would hear about a group that wanted to build a hospital, I would go into the community, talk to the supervisors, council members, or whomever the local governmental leaders were, and suggest

that before they gave a zoning variation, which was what these people had to have before they could build a hospital, that they carefully weigh what the community would give up against what they would gain.

I would say, "Let's take the gain first. The proprietary hospital will pay taxes. Presumably it will solve your health care problems. You won't need to bother about health care because somebody else will be worrying about it and providing it for you. Compare this with providing these health services yourself. You begin by forming a board, with a membership of concerned citizens who wish to participate and become involved. Such a board will operate a community hospital that will serve the community in a way the community wants it to. Tax revenue from a hospital would be inconsequential anyway, and should not serve as an attraction to the community for a privately owned hospital. A community hospital will grow in keeping with the needs of the community rather than the profit level that will dictate the growth of the proprietary hospital.

Over the period of 3 1/2 years that I was at the planning council we stopped about 40 different efforts by profit motivated groups. We missed out on one. That one was in a community with a mayor who wouldn't even talk with me because he said, "I know what you are going to do. You are going to try to talk us out of this. I have heard about you. This community can use that extra building. That will be the nicest building in town."

It turned out that the doctor starting that hospital was the personal physician to one of the crime syndicate people in Chicago. He did a very poor job of running that hospital. Even with crime syndicate supporting the hospital eventually it went into bankruptcy. We had what you could say was almost a 100% batting average, we'll call it 99%.

There were some less than qualified people who wanted to build these hospitals. I can remember some specific instances. In one situation, two men wanted to convert a nursing home that they had built in Morton Grove. It was within 25% of completion. It was big, something like 300 beds. They told me they would be better off if they opened it as a hospital rather than a nursing home. I went out to the site to talk with these two men. They were short-statured, heavy-set fellows dressed in black silk suits. They individually had gotten out of identical black Cadillac De Ville coupes. I asked them what their businesses were. One said he was a plumber. The other said he was a carpenter.

I said, "You apparently have made a lot of money as plumbers and carpenters."

They explained the way they had done it was by being contractors in those fields. I subsequently learned more.

I told this strange story at a committee meeting of AHA, where a psychiatrist, who was a new member of the committee, listened to the story and then said, "You are dealing with the Chicago crime syndicate."

I asked, "How do you know?"

He said, "I know these two men. They built the apartment my brother lives in. I know who they are."

The following day I went downstairs in the building that housed our offices and spoke to Virgil Peterson, who at that time was the Chicago Crime Commissioner. I told Virgil the story.

I asked, "Do you know these fellows?"

He smiled and took me back into his office. He pulled out a drawer filled with documents. He said, "These are all about your two fellows."

"My goodness!" I asked, "What have they done?"

"They own a couple of B-girl joints on Clark Street." He then described their operations for me.

"Virgil," I said, "What you told me worries me a little bit because I really am in the process of stopping these fellows." I told him I had already gone to the council at Morton Grove and had discouraged them from permitting these men to convert their almost completed nursing home to a hospital. "Am I in danger?" I asked.

Virgil asked me, "Karl, have you ever had any dealings with the crime syndicate?"

I asked, "What do you mean? What do you mean by 'dealings'?"

"Have you ever done any favors for them? Have you borrowed any money from anybody who might be associated with them?"

I said, "No, I am just as pure as the driven snow."

He said, "You have nothing to worry about."

"Are you sure?"

He said, "This is my business and I am sure. The crime syndicate has a very consistent code of operation. They will penetrate any kind of legitimate operation where they think there is need for the money they have in great abundance. But if they are stopped by anybody who is legitimate, they are not going to raise a fuss. They merely pull back and look elsewhere. They have countless opportunities so they are not going to take the chance of getting into trouble by harming what they recognize as an honest obstruction to their plans. So keep going."

As we worked with hospitals in the attempt to meet the ongoing, growing needs of the mushrooming suburbs, we found that the idea of encouraging

communities to establish hospital boards, or of encouraging existing urban hospitals to establish satellites, was accepted. The evidence that it must have been a good idea is to look at the Chicago hospital system today. You won't find a single proprietary, or as they are called today, investor-owned hospital in the whole city, because we got on top of the problem early. It was the result of good staff work, a strong board support, and close cooperation with Blue Cross and the Chicago Hospital Council. Today hospital satellites that were established in suburban communities in the early 60s have gone from 200 to 500 to 700 bed hospitals. Most of the satellites are now the main base hospitals with the hospitals that remain in town either being phased out because there no longer is a need for them, or are a satellite now of the big hospital that has a site out in the suburbs.

In the course of my work I learned a great deal about how to work with the Catholic hospital system. In the process I developed a great respect for the manner in which Catholic hospitals were formed and the way they were operated. Our organization worked very closely with the diocesan director priest who usually was a monsignor and who was a direct representative of the Bishop of Chicago. His title was Catholic Hospital Director. He served as the liaison officer with the bishop and the Catholic sisters in the operation of their various hospitals. Chicago had a great number of different Catholic orders or communities (the religious term) operating hospitals. We worked with them the same as we worked with other hospitals. We developed a great respect for one another. As I look at Chicago today with Mercy Hospital right next to the Michael Reese complex I feel a lot of satisfaction with that because the Mercy Sisters were seriously considering leaving the city to move into a suburb to continue their association with Loyola Medical School when we

encouraged them to stay. They did. The same thing happened to St. Joseph Hospital on the near Northside. They today have one of the fine intown Catholic hospitals in Chicago.

One interesting experience I remember was with the Alexian Brothers Hospital. They had a hospital close into the city that was no longer needed in the area because other hospitals nearby had been expanding, but they wanted to continue in the hospital business. We encouraged them to relocate in one of the western suburbs that needed a hospital. They went there and built the hospital. It is now a 350 or 400 bed hospital. It's a beautiful, flourishing hospital. The downtown hospital was phased out. I could give many examples, but I give these at least to indicate that voluntary hospital planning agencies like Camelot existed and flourished at one time. Many of them did a wonderful job with the support of the power structure leadership of their communities.

The Chicago Hospital Planning Council is now gone. It was phased out over the period of the late 1960s during which time the government-sponsored planning agencies, the so-called "A" and "B" comprehensive health planning agencies, emerged. These agencies also have changed. Now community hospital planning is controlled by Health Services Agencies, comprehensive health planning agencies with all their funding from Washington. This process discouraged contributions from commerce and industry to the voluntary planning council of Chicago. Without this it was no longer able to survive.

Now when I go back to Chicago and ask my colleagues if it is better than it was, they say, "There is no comparison with what it was when you were here or under your successor, Hi Sibley, who ran it for a number of years."

Now the government agencies function with staffs that are four or five

times as large as the staff we had and do less work than we did.

The point is, when something can be done as a voluntary effort it often can do a better job than a government agency and with much less funding. With community involvement projects you get financial support from industrial organizations which also provide many board members. Unfortunately this practice is on the wane. Federal funding tends to dry up voluntary contributions.

We still have one planning council left in the United States. That, interestingly enough, is in Detroit, the Greater Detroit Area Hospital Council. It is a combination of a planning council and a service association with Mr. Sy Gottlieb as executive director. It is the only remaining council of this sort in the United States. It does appear as though it will continue because in Detroit there are a sufficient number of representatives from industry who recognize that the regional HSA alone can't to the job to the extent it should be done. The Council through its planning, some of which may appear to be duplicative, is still playing a very important role in this area.

One brief comment should suffice to cover my experience with the Hill-Burton program. It is merely this: In the state of Illinois the demands for funds from the Hill-Burton program for rural hospitals were so great that the Health Department, the organization that provided the administration for Hill-Burton funds in Illinois, was unable to assist any of the metropolitan hospitals with grants. My personal experience with Hill-Burton was only to watch what it did in assisting in the construction of rural hospitals. In my judgment they did a fine job in this regard, because rural hospitals were unable to raise the funds that were necessary. Today as I listen to critical comments made that there was a lot of overbuilding as a result of the funds

available under the Hill-Burton program, I take an opposite position to this. I say that perhaps in some instances hospitals were built for which there may not have been a genuine demand, but remember when we make those statements we are doing it in the light of what we know today, not what we knew in 1945, 1955 or into the early 1960s. I can't point to one Hill-Burton hospital that was built in a rural area for which there was no apparent need. Not a one.

One of the things I missed in my work at the Chicago Planning Council was the action that takes place when one is located in a large hospital setting. I enjoyed the work. From what I have said it can be seen that it was stimulating, but I really missed the action of a big hospital operation.

I was thinking about this one day when a chap came in to see me as a representative of the Board of National Missions of the Presbyterian church, from New York City. In those days, this was 1963, the Presbyterian Church North was distinct from the Presbyterian Church South. The church was governed by the Board of National Missions.

They were located in New York City very near the Presbyterian Medical Center. This representative came in and talked with me. He said he had been directed to talk with me as a possible candidate to go to Appalachia to direct the reorganization of the Miners' Memorial Hospital System, which the Welfare and Retirement Fund of the United Mine Workers was about to give up.

He explained to me that the United Mine Workers hospital system of 10 hospitals had been built in the period 1955-1959. (Here it was now 1963.) The UMW was ready to give up the hospitals because they had proved to be a larger financial burden than the union was prepared to handle. The hospitals had been built by the United Mine Workers on the recommendation of John L. Lewis. He was of the opinion that the miners in Appalachia would never get

proper hospital and medical care unless the union built its own hospitals and hired physicians to come in and take care of the patients. They underestimated the cost of providing the kind of service they envisioned. The first recognition of this decision on the part of the United Mine Workers to give up their hospitals was their announcement that they were going to close four of the ten hospitals. The four were located in eastern Kentucky. One of these was in Harlan, Kentucky.

A Presbyterian minister in Harlan heard of these proposed closings. He realized how dreadful the consequences of this would be for the residents in those areas. He asked the National Board of Missions if it could look upon this as a missionary effort and try to salvage these hospitals. The National Board of Missions proceeded to spend $10,000 to have a survey done by a widely known hospital consultant, Dr. Eugene Rosenfeld. His survey showed that is they could obtain these hospitals at a low and reasonable cost hopefully with the assistance of the federal government, that maybe, just maybe, they could be reorganized and managed in such a way that they would survive.

When the National Board of Missions learned that the federal government was prepared to make eight million dollars available for the purchase of these hospitals from the United Mine Workers, it decided to take the role of enabling agent. It set for itself the task of starting the organization that would take over the hospital system. The government was prepared to give the new organization 3.9 million as a gift and a loan of 4.1 million for a total of 8 million dollars. The union was prepared to accept this in payment for the system then valued at 45 million dollars.

This was at a time when Jack Kennedy was President of the country. He personally decided this should be done. Who knows what his motivation was?

We know he was interested politically in the area, but we were led to believe that there was enough compassion on his part to recognize that this ought to be done for the people of Appalachia.

The hospital system stretched out over a huge area. It involved the western area of West Virginia and of Virginia, and eastern Kentucky. There was a distance of some 250 miles from the most western hospital located in Middlesboro, Kentucky to the most eastern in Beckley, West Virginia. These hospitals varied in size from 50 beds, the smallest, in Pikeville, Kentucky to 200 bed hospitals in Beckley and Harlan. The total complement was 1,050 beds. About 3,500 people were employed. It would have been an economic as well as a health care disaster if they were to close.

I became interested because I was now of a mentality that thoroughly enjoyed planning regional health care facilities. This I had learned during my experience in Chicago. When I was promised the $800,000 to $1,000,000 working capital I needed to get started by the Presbyterian church even though they didn't disclose to me the sources of that capital, I decided to take a hard look at what the Presbyterians called an opportunity.

So Mrs. Klicka and I went down to the area and toured it for a week with a young Presbyterian minister whose name was Young. His father was the chairman of the board of the Chesapeake & Ohio Railroad. He was a very well-known national figure at the time. So Pastor Young took us in tow and we walked and rode through the area. I came away from that experience as depressed as I have ever beer at any time about anything I have ever seen.

Following this I talked with Kenneth Nye. Pastor Nye was the director of the National Board of Missions. I said, "Paster Nye, I am flattered that you asked me to consider this position. It's a hard, dirty job with a great deal

of antagonism from the town doctors in the area against these hospitals. Also there is the feeling on the part of the people of those mining communities that whoever runs this system must live in one of their mining towns. I can't do that."

"Where would you live if you took the position?" he asked.

I answered, "I would live in Lexington, Kentucky. It's close to Frankfort where the governor is situated. I am going to have to see the governor quite often, because this is mostly a Kentucky problem. But I don't think these people would want me to live in Lexington. They would resent it."

He said, "Dr. Klicka, I want you to do this job. I want you to know I understand why you want to live in Lexington, and I will recommend it because it makes sense. You will find that these rural people eventually will forget their feelings. I know a lot of missionaries who live outside the immediate mission area. There's a disadvantage to your living in Harlan or Hazard or Whitesburg or McDowell or wherever you would be, because the other communities would say: 'What's he doing in Harlan or Hazard or in Prestonsburg or in Wheelwright? He ought to be in Middlesboro.' So you would be better off not living in any of them."

Mrs. Klicka and I deliberated long and hard and in the end decided we would do it. We moved to Lexington and thus began a very exciting and unbelieveably difficult career. I was helped by some wonderful people. One was Bert Combs who had been governor of the state, but he was then at the end of his term. He was succeeded by Edward T. Breathitt, an attorney. He and his staff were very helpful. Senator John Sherman Cooper and Mrs. Cooper in Washington were very cordial and supportive. Carl Perkins, who was the Congressman from the Seventh District in rural Kentucky, was also very

helpful. I became very close with the personnel of the Appalachian Regional Commission. I went to Washington quite often.

The people who were my most reluctant associates were the representatives of the United Mine Workers Welfare and Retirement Fund. This deserves special attention here.

I had only been on the job for a period of two months when District 50, which is an area of the United Mine Workers representing the employees in the hospital system, decided that they wanted to have an improvement in their wages and benefits. I sat down with them and said that their timing was off. I told them that I still didn't have the capital I had been promised but hopefully it would come soon. Until then the hospitals would be operating from hand to mouth. The hospital system was surviving on the basis of an arrangement I had made with the Welfare and Retirement Fund whereby it would pay the hospitals' costs the same as Blue Cross would pay costs. So the income from the Welfare and Retirement Fund that was coming to the hospitals was just costs that only covered 50% of the patients. Essentially that was all the income there was.

The doctors in the hospital system were very frightened. Some of them were leaving because of the insecurity of not being on a regular salary. They were receiving a retainer which the Welfare and Retirement Fund had agreed to pay them if they would stay for a year while they adjusted to private practice. Having been on salary and now being on retainer promised to last only a year, provided them with a cloudy future. Without doctors you don't run hospitals.

The doctor crisis was very directly involved in the financial stability of these hospitals. While I was trying to encourage the doctors to form group

practices so they would be self-sufficient, I could nevertheless see that we would be losing a lot of doctors.

I told the employees represented by District 50, "This is no time to be pressuring me for salary increases. Goodness, you people are already making 75 percent more than anybody else who works in a hospital down in this area."

They said, "That has nothing to do with it. We feel we need to have an improvement. We haven't had a salary increase in over a year."

I got nowhere, so I went to Washington to the Retirement and Welfare Fund headquarters. I talked to a woman, Josephine Roche, who was directing the operation of the fund. She was a woman in her middle or late fifties. She was the "right arm" of John L. Lewis who at this time was in a nursing home in early senility.

The Welfare and Retirement Fund was run by a board of three members: John L. Lewis, Josephine Roche, and a representative from the coal industry. Josephine Roche has been authorized by Mr. Lewis to use his vote, so on all issues she was in control. Unfortunately Miss Roche was a woman of no compassion. I realized this early in our conversation.

I had been told that John L. Lewis had encouraged the building of those hospitals, but when he saw them going down the drain because the fund was unable to support them, he lost interest, and so did Miss Roche. When the hospitals were planned and built the cost of providing care to the indigents who would use the hospitals was seriously underestimated. As it turned out about 30 to 35 percent of the patients who came to those 10 hospitals were treated as indigent patients. This was before Medicaid and Medicare. The states were not helping them. The hospitals had a wage structure for their employees which was much higher than that paid employees of other hospitals of

the area, and they had more employees than they really needed. Add to this the fact that they paid high physician salaries and they also had more physicians than they needed. The operating costs literally overwhelmed the fund, it was bleeding to death.

Now back to my conversation with Miss Roche. I said, "Here is District 50, a branch of the United Mine Workers coming to me and demanding increments at a time when I just can't afford it. I would think there would be two reasons why you would be interested. One, if they get an increase, it's going to raise your cost because you will have to pay more for hospital care for your members. Secondly, I would think you would have a direct interest in what I do in attempting to salvage the hospital system that represents an important effort in Mr. Lewis's life. I think we can salvage it if we have a few breaks."

I'll never forget that day. Miss Roche gave me her steely gray glare and said, "Dr. Klicka, we do not have any further sympathetic interest in those hospitals. I can tell you they are your problem, they are no longer our problem. There isn't a single thing I can do."

I asked, "You mean to tell me that you wouldn't even talk with District 50 to convey to them your interest in seeing that the hospitals continue on and to ask them to let up at least temporarily in their wage demands?"

She said, "No!"

This gave me some insight into union thinking. I was shocked but there was little more I could do about it. I went back and continued to negotiate with the union. They threatened to strike. There were some small wildcat strikes, not not a total strike. We had some strikes later on, but not at that time because I said, "You strike and the hospitals will be closed the

next day. If that's what you want do, more power you."

It wasn't just a bluff. They recognized that. The situation was as desperate as I had presented it, and they withdrew. In the meantime, however, the Presbyterian church was not coming through on their promise to find me the money I needed. The church had advanced $25,000; I had been promised 800 thousand to a million. The foundations they went to were saying they could not help. I remember reading a letter from The Rockefeller Foundation commending us on what we were trying to do but saying that they committed their Funds for the foreseeable future to assist the emerging nations of the world, so had no money for Appalachia.

I remember the letter I wrote back to them saying, "It bewilders me! Talk about emerging nations! Good God! Appalachia in America is an emerging nation. Send somebody down to look at it." It didn't help. We didn't get any money from Rockefeller or anybody else, for that matter.

One day when I was in my most desperate straits a man who had come to work for me as my communications director made a suggestion. I have been grateful to him, Ed Easterly, ever since. Ed was a wonderful, wonderful fellow. He had been the press secretary for a series of governors of Kentucky. Bert Combs was one, and previous to him, Happy Chandler. Everybody held Ed in high regard. He knew that area like the back of his hand. He said he wanted to introduce me to a man named Garvice Kincaid.

Ed said, "You tell Garvice your story. He just might be able to help you. He was born and raised in Pineville, a community in the mountain area. He put himself through law school. He is now a very wealthy man. He's in finance, he's in banking, he's in the insurance business."

I did talk with Mr. Kincaid. He was a man of my age, very overweight.

Easterly told me he had had a heart attack within the past year.

After a brief introduction he said, "Come back and see me next week. I'll have a little more time. We can talk for 15 or 20 minutes."

I went back the following week. The 20 minutes extented into two hours. I went over the whole story. When we were finished, he said, "Dr. Klicka, I've never heard of a situation quite as poor as the one your hospitals present. I know you have been to the banks in Lexington and they have given you a short-term loan of $500,000."

I said, "That's right, and it's due next week."

"I know you have been to Louisville, and you have talked to the major bankers in Louisville that carry deposits for the state. Certainly Governor Ned Breathitt thought they could help you, but they have turned you down as a poor risk, something that they as bankers cannot assist."

I said, "That's right."

"So here you are, the worst possible risk. You are losing your short-term loan at the National Bank in Lexington. The bankers in Louisville won't help you. You have come to me. I'll tell you what I'll do. I will give you a mortgage of $750,000 on those 10 hospitals. Believe me, Doctor, they are not worth a dime, but I think you can pull this off. Let's go from here."

I asked, "How soon can I have the money?"

He said, "Next week. This will be a loan from the Kentucky Life Insurance Company of which I am the Chairman. I only ask you one thing: I want to be a member of the Board of Directors."

I said, "I'll tell you what. I have the responsibility of forming this board and I will not only recommend to those now on the board that you be a member of the board but I want you as Chairman of the Board."

He said, "I'll take it."

That was a big step forward. It was essential for me to have working capital and once I had it, things began to fall my way.

I think one of the interesting facets of the early formation of ARH that helped in the ultimate success of the organization, was a concept that I had wherein the membership of the board included two representatives from each of the communities where the hospitals were located. That would total 20 and then with four members at large; we would have 24 board members. Supporting this we would form little organizations in each community we would call hospital advisory councils. These two people on the board from each community would come from those advisory councils. The councils would be made up of 18 people representing cross sections of the people living in the communities. They would have no authority beyond advisory authority.

The ARH story would be incomplete without a brief review of how I began my adventures in Appalachia. Very shortly after opening my Lexington office I contacted the local newspapers in each community and asked them to announce that Dr. Karl S. Klicka, the new director of the Appalachian Regional Hospitals invited everybody who was interested in the early organization and the management of the hospital in their community to attend a town meeting. I asked where the biggest hall in town was. Sometimes it was a school auditorium, sometimes it was a fire house, sometimes it was a court house--the biggest place we could meet in. The meeting was set there.

I held these meetings on successive Sundays, ten Sundays. They were crowded, they were jammed. People came from miles around. They all came dressed up in their best bib and tucker. They listened to the story of how this all came about and how I had planned to operate these hospitals. I asked

them to assist me in selecting one or two leaders in their community, persons who were held in the highest regard in their community. I wanted them to help me in creating this local hospital advisory board. I described the kinds of people I wanted. I said that I didn't want the names next week, or in two weeks, I wanted them right now. I said that I'd like to know within the next few days because I was in a hurry. Those advisory councils were put together in jig time. Suddenly I had a new organization that had a broad base of consumer representation as advisors. So things came together. The communities gave me my board members; Garvice Kincaid loaned me my operating capital.

Previous mention has been made of the general feeling of insecurity felt by the doctors who previously had been employed by the United Mine Workers. I offered them ground without cost on the sites of these hospitals on a long-term lease basis. I suggested that on this basis they should be able to borrow money to build themselves clinic buildings to house independent groups which I encouraged them to form. They all accepted my offer but nevertheless we lost approximately half the doctors. It is interesting to note, however, that as time went by those doctors that remained took care of as many and more patients than had ever been taken care of previously at each hospital. This experience proved an important point. Organized in groups and not working for a salary they had a greater incentive to succeed. They gave up the eight hour day they were accustomed to and now worked as long as necessary to see the patients who came to the clinic. They replaced insecurity with confidence.

The hospitals had been grossly overstaffed previously, and, this, of course had contributed to the high operating costs the Fund had experienced. I told the administrators to freeze all hiring. Personnel then diminished

over a period of six months from 3,500 to 2,500. Employees had not been fired, but those who doubted our ability to succeed left. The adminitrators ran the system just as well with 2,500 as they did with 3,500.

As these steps developed, esprit de corps and enthusiasm characterized the behavior of the administrators. They began to feel they were on a winning team!

An important phase of my work in Appalachia involved my efforts to gain the cooperation of the local community doctors. Unfortunately they held me suspect and refused to hospitalize their patients in ARH hospitals. I went to Louisville to meet with the state officials and the president of the state medical society. I got little support. Then I had a lucky break. The state society meeting took place in April in Louisville. I sent invitations to the leadership of the state medical society to meet with me at a cocktail party I held at a penthouse of the newest and bestlooking apartment in town. It was owned by Garvice Kincaid, who offered it to me to use anytime I wanted to. It was magnificent. I gave those doctors a real party. There weren't many who came--about 20--but they represented the leadership of Kentucky medicine. As they left the party, I can still remember the president of the society saying, "Dr. Klicka, we don't know how you have done it, but you came into this area a few months ago and suddenly you apparently have the backing of the power structure in this state. For my part, I will support you in the future. He did, and it helped. For all practical purposes the antagonism of organized medicine turned off after the cocktail party.

Soon the word got out that you don't have to support this guy but, for goodness sake, stop bucking him. Let's see what he can do. We think he is for real. You see, they had the impression that I was a subterfuge that the

United Mine Workers were using, but finally they came to the conclusion that this was not so, and that ARH was really an honest to God effort to provide a true community hospital service for the mining communities.

In Pikeville we had a 50 bed hospital. We only had two doctors, so it was a survival situation. In the town there was a Methodist hospital and a Catholic hospital. They were obsolecent. The Methodist hospital wanted to move to the edge of town and build a new hospital. I made them a proposal which would have done essentially the same thing. I then proposed to them that if they would pick up the portion of the 4.1 million dollar mortgage that applied to our Pikeville hospital I would recommend to our board that this hospital be assigned to the Methodist Church Association. There was to be one contingency that it would be a Methodist hospital and a member of ARH. They agreed but they wouldn't sign a paper saying they would do it. They thought that would be demeaning.

"We will do it. We don't think you should ask us to commit ourselves to a contract to do this."

I thought a long time about this. I decided the important thing was to provide a new viable hospital for Pikeville. They could take the 50 beds. There was sufficient land behind the hospital to add 200 beds so the 50 beds could be the nucleus of a new hospital. The important thing was not my retention as director of this organization or as president. The important thing was to get the Pikeville people to use the hospital. The Methodists said they would participate and be members of the ARH system. This was my lesson in faith. We did it. We consummated the deal, but the Methodists never did become active members of the Appalachian Regional Hospitals system. I almost gave up Christianity over that one, because it was such a bitter

disappointment. It didn't make any difference in the operations of ARH because that hospital was a loser anyway. I thought the concept of giving those people the opportunity of participating in the ARH system was something they would have welcomed. They didn't want to.

Finally, I'll give an illustration of union support at the grass roots level. There was a doctor in one of the small communities called Prestonburg which is quite far east in Kentucky. He had had bad relationships with the Welfare and Retirement Fund over the years. There was another ARH hospital at McDowell which was about 10 miles from Prestonburg. We had two doctors in this 70 bed hospital at McDowell, but we needed about eight or nine. One of the doctors in McDowell had just been recruited from the outside the area. The troublesome doctor in Prestonburg, Dr. Archer, heard about this new physician. He made an inquiry at the Prestonburg courthouse to see whether this new doctor had come in to register to be a practitioner in the community, as required by law. Dr. Archer found out the new doctor had neglected to register, so he instructed the sheriff to tell the new physician to stop practice and to expect arrest because he had violated a county law. What the new man was doing was not only unethical, it was also illegal.

I thought about this and decided I knew how to handle the situation. I called the district mine representative in Martinville, Ky. I told him what had happened. I said, "Will you gather some of your miners together? I'd like to tell them this story. Maybe they can suggest a solution. McDowell needs this doctor. We need five more, but we need this doctor now. We can't operate McDowell hospital with just one doctor."

He said, "Can you come down to Martinsville on Sunday?"

I said, "It so happens that I am coming down anyway, because I am going

into a mine on Monday in Wheelwright." It was an Inland Steel mine. So I went on Sunday to meet with the miners, they were in the auditorium of the school house. I told them the full story.

The union representative got up after I finished. He said, "It seems like Dr. Klicka makes quite a good case. What do you think we ought to do with Dr. Archer and the county health officer in Prestonburg? Do you think we can do anything to change their minds?"

I'll never forget how one fellow got up and said, "Dr. Klicka, you call the health officer in Prestonburg and tell him that they had jolly well better withdraw [he used stronger language than that] their threat against the doctor in McDowell and forget about arresting him. He'll come down and register. Tell Dr. Archer if they don't do that, we'll be over to Prestonburg in the middle of the week and we'll just tear that town to bits."

I listened to this. You know, they were "dead" serious. The meeting concluded with a cheer supporting me.

I stayed over night at Wheelwright at the inn, a public place. Wheelwright is a beautiful little community set up by Inland Steel as a model community. The houses are all white.

After I checked in at the hotel, I called the medical officer in Prestonburg. I told him what had happened.

I said, "You have lived down here a lot longer than I have. You know how serious these people can be. I'll call you when I come out of the mine tomorrow afternoon at three o'clock. I hope you have a solution to this problem for me."

The next morning I went down into the mine. (That's a separate, wonderful experience.) If you never have been in a coal mine, that's a wonderful

experience. We were in eight miles underground to the area where the mining actually took place. I came out of there with a new respect for coal miners. I might say it's not all that bad. Good air, nice and clean. They know what they are doing. I wasn't frightened for a minute. It was just a marvelous experience. Miners rarely get killed in well-run mines. They get killed in the so-called dog holes, the mines that are run by two or three people, fringe operations that neglect the basic safeguards that they should watch. Well-run mines seldom have trouble.

I came out of the mine at three o'clock. A person said, "You had a call from the doctor in Prestonburg."

I went to the telephone and dialed him.

He said," Dr. Klicka, we had a meeting here in Prestonburg, and we have decided that we can accommodate the doctor at McDowell. If you will have him come down tomorrow and register, we will withdraw the charges."

I said, "Thank you very much."

That's the way things happen in Appalachia. I never had any more trouble with the doctors in Prestonburg.

I think this is a good point to talk about the growing and improving relationships we had with the local medical doctors in the communities in which those 10 hospitals were located. I think the first one we should talk about is Hazard. Let me go back to the beginning and bring it up to this point in the story.

Early on Hazard was a problem. It was a 75 bed hospital that had lost its medical staff with the exception of one physician who was a pediatrician. Right at the outset his problem was one of fear. There had been six doctors at this hospital. They did not see how the new operation could continue with

any security to them in the new organization, so they made arrangements to leave. By the time I arrived on the first of December 1963, they were all gone, with the exception of this one doctor. He told me the seven physicians in town had told him they would not use the Hazard Hospital unless he moved out. This seemed strange because there were excellent clinic facilities in Hazard as there were in all the rest of the Appalachian Regional Hospitals, but the presence of a physician in this hospital served as a constant reminder to the community physicians that these hospitals had been erected by the United Mine Workers as their method of bringing in physicians from outside the area. The town physicians resented this on the part of the UMW. This enmity developed. It was bitter.

The Catholic hospital that the town physicians used was both small and obsolescent. It was a hospital whose time had come and gone. It seemed to me that the situation presented an opportunity to Appalachian Regional Hospitals and to the Catholic sisters who had served Hazard for so many years to join hands and cooperate by consolidating our programs. I made an overture to the Mother Provincial whose office was in Cincinnati. I suggested that they abandon their old hospital and in its place manage the 75 bed Appalachian Regional Hospital in Hazard. I went on to say that her religious order could operate this hospital with complete Catholic ethics.

She said, "There must be some conditions under which you would make this hospital available to us?"

I said, "Only one. That is that the hospital would be operated as a unit of the Appalachian Regional Hospitals. It would enjoy all the benefits that all the hospitals in the system enjoy. That meant central purchasing of food, linens, supplies, pharmaceuticals. It meant using the ARH accounting system.

It meant being a part of the general personnel system, because we felt it important that all the people who worked in the hospitals in the area should enjoy the same usage and benefit package. I will recommend to the Board that you, Mother, be a member of the Board of Directors of the Appalachian Regional Hospitals, or we could have another Sister that you would suggest, or somebody who lives in the city of Hazard."

That was my offer; that in exchange for membership in the Appalachian Regional Hospitals, the Sisters would run the hospital as though it were theirs. It could even be called the St. Mary's unit of the Appalachian Regional Hospitals.

She didn't hesitate long. She just said, "No."

I said, "Why not? This is a million and half dollars hospital. It's a beautiful facility. It's nicely located. It will provide a single, viable, healthy unit for the community of Hazard. Why not?"

She said, "Because we would not have complete control."

I said, "Why is that so important? I told you you could operate this hospital under the Catholic ethic. That means there would be no abortions performed in this hospital. The obstetrics would be run as Catholics hospitals always run this service. Why is control otherwise so important?"

She said, "I can't spell it out to you, doctor, but there might be a time when we would want to do something you or the board might feel was not consistent with the policies of the Appalachian Regional Hospitals. We can't do it."

You know, they never did accept although I repeated the offer to her over the three years plus that I was there. The year after I left, this had to be about 1967, after my successor had continued to make similar offers, the

Sisters decided they would leave Hazard. They closed their hospital, which was now down to two Sisters.

I never forgot that experience. It seemed to me an inordinately large price to pay by a religious community. They preferred to leave Hazard after having devoted some 60 years of service rather than associate themselves with an organization that was quite Christian. After all it had been sponsored by the Presbyterian church, even though they had no control of the organization. The ARH board was secular, and nonsectarian.

Finally a few words about the financial problems. Keep in mind that in Appalachia we were operating in the pre-Medicare, pre-Medicaid period. Underwriting the indigent patient care loan was formidable. The board finally decided to conduct a national fund raising campaign directed primarly to the organizations and industries that had establishments in Appalachia.

We formed a committee and, after reviewing the names of various well-known industrialists settled on the name of Donald C. Cooke, President of the American Electric Power Company for chairman. The power company had its principal offices in Manhattan but had extensive coal mining holdings in three states. They mined coal, generated power, and transmitted power out of the area into a broad market.

It appeared that this fund raising campaign would have a successful future. We had a number of meetings with large mining corporations and with manufacturers of coal mining equipment. Everyone was optimistic that, if properly approached, the major industries that had an interest in Appalachia would provide significant contributions to ARH. For some reason the fund raising didn't succeed. In retrospect, it's hard to tell why it didn't. I think Mr. Cooke was sincere in his efforts but, perhaps, not vigorous enough

in his leadership. The money raised was far short of expectations.

It was then decided that maybe we had better go back to the federal government and ask for support money. There followed a succession of meetings in Washington with the Appalachian Regional Commission. We received sympathetic understanding but no money. It was a difficult period.

We talked about having fund raising campaigns in the individual communities but the idea was not well received by the people in those communities. This was not because there weren't people in mining communities who could have given money, for there were many, but in Appalachia we were dealing with people who had been so accustomed to going to Washington when they needed help that they lacked the vigor and the will to try to provide it for themselves.

It was during this period that I was invited to Detroit to consider an opportunity there. I confess to having a somewhat depressed attitude about the future of ARH at that time even though we were operating successfully and were moving along very nicely, so when the opportunity was presented to me to go to Detroit to consider the CEO position of the Peoples Community Hospital Authority, I responded. I had a series of meetings with these people over a period of four months. I eventually accepted their offer.

Let me say one other thing before we leave the Appalachia story. Our efforts were successful with the physicians who remained as the residuals of the doctors who previously had been "hired" by the Welfare and Retirement Fund, and who stayed and formed groups. Fortunately we had sufficient land beside each hospital so private clinics could be erected by these physicians. I prevailed upon the board to lease the use of this land to them without rental fee. This did provide sufficient incentive to the doctors who then

financed the construction of their group clinic buildings. Each of these hospitals with the exception of the hospital in Man, W.V. now has a private clinic building on its grounds. These clinics operate today as they did in 1967 when they were built as viable functioning units.

When I was offered the position at the Peoples Community Hospital Authority in suburban Detroit I decided to accept it on two counts. I felt I had succeeded in what I wanted to do in Appalachia. I had reorganized the system, I had created a functioning board, I had established a certain harmony among the employees and among the doctors. After devoting three years to reorganizing the system, it worked. We had good administrators, we had good doctors, we were financially sound, we were not quite able to handle the indigent problem but we did pretty well by using funds that ordinarily would have been deposited in a depreciation account. So, the real hardship here was that as the hospitals began to deteriorate as any hospital would--they were 12 or 13 years old, and needed repairs--we did not have the funds available to correct normal wear and tear. Aside from that they were operating better than anyone had thought possible three years earlier.

The second count was that I recognized another challenge in Detroit. I must admit I was always sensitive to challenges. It also gave the Klicka family an opportunity to return to the type of life that we were accustomed to. Lexington was a fine city in which to live, and my wife and I enjoyed it there. My life, however, was actually not in Lexington, it was a working life out in the mining communities. When I realized that I would have an opportunity to live in the Ann Arbor-Detroit area and work with the many colleagues I knew who were established in some of the important hospitals of the area, I took it. This was notwithstanding the fact that I knew that I

would have a very difficult assignment in correcting the problems that existed in Peoples Community Hospital Authority.

Donald Pizzamenti the newly elected Chairman of the Board of Peoples Community Hospital Authority--let's refer to it in the future as PCHA--and a small search committee I met with made it very clear to me that the hospital authority, which had been organized on the basis of P.A. 47 passed by the Michigan legislature in 1946, was in trouble.

The reasons were stated as follows: The chap who had served as executive director had found a way to manage the four hospitals of the system by applying strong lobbying practices in Lansing seeking special favors for the four PCHA hospitals. A few board members of the authority encouraged him. They fell into the bad habit of wining and dining many state representatives, spending a lot of money, holding committee meetings in the hospital, in expensive Detroit restaurants where enormous bills for food and liquor were not unusual.

When this came to the attention of the state Attorney General, he advised the trustees that they would have to stop these practices, otherwise they would be subject to his disciplinary action. Eventually the executive director was discharged and most trustees who had been closely associated with him in his activities resigned. More than six months passed before I assumed my duties in September 1966. My job was twofold: One, operating this system; two, trying to establish a good reputation, for what was basically a very good hospital system with a promising future.

During the six months prior to my arrival, the interim director, Walter S. Wheeler, had been doing a commendable job. Financially the hospitals were strong. The administrators I found there were all well-motivated people who

had hoped for better times ahead, and had stayed with it during the troubled period. In the months following my arrival, the quality of board members gradually improved. Now it is recognized, a very highly regarded group. PCHA enjoys an excellent reputation throughout the state.

The organization of the Peoples Community Hospital Authority is most interesting. The Authority was an invention of a statute introduced into the state legislature by a Charles Cozaad, an attorney who lived in Belleville and had offices in downtown Detroit. The statute provided that two or more communities could build and operate hospitals. The Peoples Community Hospital Authority was then organized in the fall of 1946, with nine community members. Gradually over the years they added other communities. When I joined them there were 23. The makeup of the board provides for complete consumer control. Each community had the right to send representatives who were called trustees, the number based on a formula designating one for the first 20,000 population and one for every fraction of 40,000 beyond that. So in a community with up to 60,000 you would have two representatives, up to a 100,000 you would have three representatives.

When I joined the Authority in 1966, there were 48 members of the Board. Seven of the members were designated as members at large. They were elected by the community representatives, and were given staggered three year terms. By definition in the statute these members at large were to come from the region but not necessarily from the member communities. I think the original intent was that the trustees could use this privilege to select any person they thought would be knowledgeable or helpful from a broad area served by the hospitals. Over the years this privilege was not exercised. Those seven positions were filled by whoever was in control at the time on the board

because realistically each member at large was a vote. As I review my 10 year period with the Authority, I realize that on many critical occasions single votes made the difference between the passage or rejection of an issue. So, although conceptually it may have been a wonderful idea to provide for the election of special talent that was not present in any of the communities, this feature of the statute was never used that way.

Another interesting provision of the statute was the medical advisory committee. The purpose of the medical advisory committee was to advise the board on professional matters and to assist them in any problems that might arise. When I came to the Authority, the membership of the medical advisory committee were the elder statesmen of the staffs. They were doctors who had been around for a long time, and in my judgment offered only average talent. I made subtle efforts to bring in some of the medical experts from the major medical institutions of Detroit and to gradually change the complexion of the advisory committee. I think I acted too soon and without a real sense of political savvy. In any event, I didn't succeed.

This committee continued on, and still exists, primarily made up of two representatives from each of the PCHA hospitals. The members are appointed annually by the chairman of the board, but he does ask the chiefs of staff of the hospitals if they approve the people he is going to appoint. Through the years the committee has gained stature and has been used by the board to assist in resolving sticky, difficult professional problems. The members are regarded as medical statesmen, if you will. They serve a good purpose. There is very little turnover in membership. So once appointed physicians tended to remain on the committee for three, or four, or five years, and this is good. Over the years I found the committee very helpful to me as the chief executive

of this organization. I again say that whereas, early on, I felt that appointees from the PCHA would have provided special guidance, as the years went by it seemed to be less and less needed.

The Executive Director by statute definition serves at the pleasure of the board. When I came to PCHA, recognizing all the problems that existed, I asked for a contract. That was the first contract I had ever requested. I asked only for three years. After I was there two years I asked for an extension of the contract for an additional three years. Following that I asked for an extension which covered my total 10 years with PCHA. So I had three contracts. Although the Authority trustees improved in quality over the years, it truly never lost its political texture, I enjoyed the security of my contract.

There were times and situations when our chairman of the board was very severely challenged by trustees representing the various communities. I didn't feel these challenges were justified. Mr. Pizzamenti was an unfailingly good board chairman, but there was envy, and the opinion of some trustees that no one person should continue as board chairman for evermore. So from time to time, there were strong efforts to dislodge him. I, as the employed executive, was sympathetic with the fact that Mr. Pizzamenti not only liked his job, did it well, but also wanted to keep it. As I viewed the board of trustees, he was far and away the best quality person on that board. I often wondered, if the opposition ever succeeded in dislodging him, what we would get in his place. Anyway he is still there as chairman.

I think it is important somewhere in this narrative to give an overview of what an organization like PCHA is. There are seven other authorities in Michigan that have been developed since PCHA was organized in 1947. However,

they are operating as single, small hospitals with only two or three counties or villages comprising the authority. So PCHA is unique primarily because of its size and the composition of its communities.

It is, in my judgment, the only hospital organization whose board members can truly be called consumers. PCHA trustees are unique because of the kinds of communities they come from. These are strong, urban, blue collar, young executive communities, such as Wayne, Westland, Ypsilanti, Ecorse, Taylor and Trenton. Just naming those communities tells you that they are communities made up of good, solid citizens, but they contain the so-called working class of the area. They are representatives because each of the trustees is a true consumer representative and has been appointed by the elected government of the community. One might ask if it would not be more representative if they were elected. You can discuss that back and forth. In my judgment, no. To be elected means one actually would have to campaign for the elections. Politics would be involved.

Once an election is finished in a PCHA community, the city council or the board of supervisors convenes and determines who will be the best representatives of the community on the PCHA board, one of the most important institutional organizations the community jointly owns with other communities. Over the years I was impressed with the fact that the quality of trustees chosen was generally good.

The mix was always interesting. We had men, we had women. We had a predominant number of whites, and I think most of them were Catholics and Democrats. We had a number of people who were very interested in the union movement. We had several union stewards. We had a regional director of the steelworkers' union. We had four or five blacks. It was interesting that at

no time among the blacks did we have more than one who came across as a strong advocate of affirmative action programs.

By and large, the wisdom of the group continued to impress me. The board influence on administration was through committees. The most active were Finance, Personnel, Planning and Construction. The chairman would appoint ad hoc committees from time to time. The Personnel Committee had a very important role as counselors when negotiations with our union representing the nonprofessional employees were underway. They also met to listen to employee grievances. The Personnel Committee would leave all the negotiations, as they should have, to administration. I used to conduct the negotiations. As the years went by, I hired a qualified personnel director and he handled them.

As mentioned earlier, the Personnel Committee played its most important role in the area of grievances. When employees were reprimanded, or were penalized by a loss of a few days work or were being actually discharged, it was not unusual for them to establish a grievance. We had four established steps in our grievance procedure. Sometimes we succeeded in handling the grievance at step two or step three, but it was not unusual for the grievance to reach board committee level. They never got beyond the Personnel Committee to the board. The committee made its final decisions stick. The members of the Personnel Committee, coming from the rank and file of the population in this area, knew how you deal with union people, actually knew more about handling grievances than we did as trained administrators. We learned something from them that was worthwhile. I think the area of union negotiating needs more attention in our hospital field. As I look at the various courses in hospital administration, I don't think our administrators are sufficiently well trained in handling personnel.

Now some attention to financial management. The PCHA Board of Trustees was the first board I had functioned with that did not have a banker or someone from the investment field on the Finance Committee. This is not to say the trustees were not intelligent, educated people, but they did not have qualifications as investment bankers or analysts. The members of the Finance Committee came from insurance businesses and from the real estate business. Some of them were attorneys, some small business men. The Peoples Community Hospital Authority trustees were scrupulously careful that money matters were handled in such a way that nobody could be critical of what they did. As a state agency PCHA was under the careful scrutiny of the state attorney general's office. It will be recalled that in the year previous to my coming the board had been severely criticized. Having said that, let me emphasize that in the area of finance the process was very simple. Annually the hospitals developed very complete budgets for the central office to review and consolidate. These were line item budgets listing items proposed for purchase, for employee expense, and also for positions administration wished to fill. The budgets were rather rigidly enforced but as the hospitals would proceed through the year they would be privileged to make changes in expenditures if properly explained. This was one of the duties of the Finance Committee: To make rulings on controversial proposals.

All of the expenditures of a capital nature and for supplies were reviewed by this committee to assure that the hospitals individually and collectively were staying within their budgets. When the expense budgets were accepted a schedule of rates and charges was also presented. During most of the 10+ years I was with the Authority the charge schedules that were established in March at the time the budgets were approved generally prevailed through the

year. I recall only a few occasions when it became necessary to raise the rates beyond what had been recommended and budgeted. This was only because of unexpected higher wage settlements with the union or some other cause that required the adjustment. For all practical purposes then, during the years I was with PCHA we had what today we call prospective rates. We knew in March 1968 what our rates would be until February 1969, and so forth.

All the administrators were urged to keep within their budgets, and to beat them if they could. The result of this was that year after year PCHA not only had exemplary per diem cost figures as we would learn from Blue Cross (ours were the lowest in the area for hospitals our size), but we made money, and I mean real money. It was an unusual year that we didn't add two million dollars to our cash flow from operations. As a consequence of that, as this money accumulated and was invested, it became possible for PCHA to do some remarkable things in construction.

I would like to talk about the medical staff oganization of PCHA because there are some lessons here which can be useful. When I joined the Authority in 1966 there were four hospitals with one medical staff. We had one set of bylaws. After doctors were accepted for staff membership in one of the hospitals they were permitted to admit patients to any of the PCHA hospitals. It didn't take me long to realize that this was not a good arrangement because, if a doctor were inclined to do a questionable procedure, he might go to a hospital that was not his general use hospital to do the procedure. If, after having done whatever he did, he were subject to criticism by the medical staff of that hospital, they were hard pressed to discipline him properly because, after all, his primary practice was in another PCHA hospital 12 miles away. He knew he was in trouble in the hospital where he had allegedly

performed a questionable procedure so he avoided going there. If he was called back for a hearing or questioning, there was a tendency for the physician not to cooperate and to fail to keep an appointment for a conference. The system was cumbersome. I prevailed upon our attorney to permit the separation of medical staffs from one another even though they functioned under a similar set of bylaws. This meant that the procedure of gaining membership, and maintaining membership would be the same for all the PCHA hospitals. The rules and regulations that were developed were essentially the same also. Because of some variations of practice patterns of doctors in the hospitals some variation was permitted. This was essential because the Joint Commission on Accrediation of Hospitals gives this privilege to doctors. It seemed rather foolish to be too demanding as far as the parameters we would set up regarding the manner in which doctors practiced.

However, the fact that we established individual hospital staff membership changed everything as far as the discipline regarding practices in the hospitals. For example, if a physician did something the Executive Committee of a staff thought was improper, the committee could take immediate action up to suspending his practice privileges in that hospital. He was finished in that hospital until he could correct whatever he had done. Could he go to one of the other PCHA hospitals and practice meantime? Well, hardly, because each one of the hospitals in establishing privileges for the doctor would ask for evidence that his conduct in the other hospital had been exemplary. He wouldn't be accepted as a staff member unless he had a recommendation from the first hospital. It is true that we did have doctors who established primary practices in one of the hospitals and would then establish courtesy practices in other hospitals. They had to apply for those directly. If a doctor were

under a cloud in his primary hospital, it was difficult for him to use his courtesy practice privileges because those courtesy privileges were limited. A physician just couldn't shift his practice into another PCHA hospital at will. I think I have said enough to indicate that we saw a problem. We corrected it by changing the medical staff.

In developing a staff organization in a hospital system the manner in which privileges are established for a physician in his primary base hospital will largely determine how successfully that system functions with its medical staff.

The state of Michigan has a great number of osteopathic physicians. There are only two or three states that have as high a proportion of osteopathics to M.D.s as Michigan does. The historical reason for this goes back to licensing procedures in Michigan which differed from most other states, and it encouraged a great number of osteopathic physicians to come into Michigan during the days of World War II. They have prospered here ever since. A new school of osteopathy at Michigan State University was established 10 years ago. It is now the largest school of osteopathy in the country. (MSU also has a medical school called the School of Human Medicine).

When I came to PCHA in the fall of 1966, the Seaway Hospital, the PCHA hospital in Trenton, Michigan, was under boycott by the medical staff of that hospital. At that time it was a small hospital, only 76 beds. The hospital was boycotted because of a bold action by the board of directors, who in their wisdom, had cut through the problem of physician control of the Seaway Hospital by appointing osteopaths to the medical staff over the objections of the M.D.s. The medical staff reacted to that move with vehemence, with the boycott. This started during July, I arrived in September to find the

hospital operating at about 20-25% occupancy. I talked to the physicians in an attempt to get them to discontinue their boycott, and to see if we couldn't find a solution to the problem in a civilized way. The boycott eased so I believe my speaking to them helped somewhat, but I was not so naive as not to recognize the fact that as we got into late September and October and November that the demand for beds increased and the doctors came back more or less because they needed the hospital. As tensions subsided I proceeded to try to resolve the problem through an approach to organized medicine. I went to the Wayne County Medical Society and asked them to appoint an ad hoc committee to assist the PCHA in resolving this matter.

This experience was an illustration of why during my entire career I maintained a license to practice medicine regardless of what state I was in or in what hospital I was working. This permitted me to join the county medical society and to become involved in its affairs. This practice paid off for me in Michigan.

After having been at PCHA only two months, having transferred my county membership from Lexington to Wayne County, I was able to approach the president of the Wayne County Medical Society with a request for help. When the president appointed the committee I requested, the PCHA board was astounded, and the medical staffs of the hospitals were astounded. Previous attempts to gain the cooperation of the Wayne County Medical Society to assist with various types of problems had never been successful.

I was successful. Why? Maybe it was a different technique. Maybe the situation was different. Maybe the timing was right. Whatever it was, I recognized that Michigan was ready for a change as far as the M.D. oriented hospitals in their relationships to osteopaths.

The ad hoc committee listened to the medical staff at Seaway, as well as to the representatives of the osteopathic physicians. The committee's decision was to the effect that in their judgment it would be wise for the medical staff at Seaway to accept the two osteopathic physicians for membership for a period of surveillance to see what happened. One of those two osteopathic physicians got into a little trouble, but it was corrected and he had no further problems after that. Subsequently other osteopaths applied for membership in other PCHA hospitals. Today in a medical staff of over 600 physicians, 60 are osteopaths. They consult with the medical doctors. They are members of staff committees. Little attention is paid to whether a physician is an osteopath or an allopath.

As I look back at this experience, I accept it as an example of how one can adapt to changing situations and that one frequently will find that some of the fears one may have had concerning a specific action proved to be unjustified. Most of the osteopaths are generalists or family physicians. PCHA doesn't have many osteopathic specialists. Osteopathic specialists prefer to work in an osteopathic hospital.

One thing that is discouraging in the osteopath-allopath relationship is that there has been little or no reciprocal action by the osteopaths. Osteopathic hospitals do not extend a welcome to allopaths. You could go into a long discussion about this but it would be an opinion discussion, and perhaps not appropriate here.

I'd like to talk a little about my practice as an executive operating a multiple unit system. PCHA was composed of four hospitals with a thousand beds when I joined it in 1966. In 1969 we planned and comstructed (1976) a fifth hospital, the Heritage Hospital in Taylor, a 243 bed general hospital

providing all the acute care services except obstetrics, which was not planned for that hospital because there appeared to be adequate obstetric facilities in the existing hospitals of the area. This new hospital brought us up to 1,250 beds in the entire system.

The management of these hospitals established an organization which placed me as the executive director in the central office where I had some key support people. I had an Assistant Director for Finance, an Assistant Director for Personnel, a Purchasing Director, and we used a Director for Community Relations. We had an architectural engineer who supervised all the various construction programs. I also usually maintained a position for a young, recent graduate from one of the programs in hospital administration, usually from the University of Michigan, who worked as an administrative assistant. One of his other primary responsibilities was that of planning.

Each hospital had an administrator. When I arrived in 1966 there were no assistant administrators but over the years we gradually added them. The reason they weren't there in 1966 was a manifestation of the type of thinking frequently found in board organizations such as ours. They were very tight-fisted when it came to executive personnel. They scrutinized every recommendation for an addition to the executive level. In the central office where I gradually added some executives and in the positions of assistant administrators and of personnel directors in each of these hospitals, this process took 10 years. It took so long because in each instance some trustee would say the job had been done so well by an administrator, why did he need somebody else to help him. I had to point out laboriously that hospitals of our unit sizes were becoming increasingly complex, more demanding on the administrator's time, required more executive manpower. So, as I said, over a

period of 10 years we did add them, but it was slow.

Let's examine the PCHA administration system, thinking of it was five administrations with a central executive in the position of Executive Director. These five administrators all related to the Executive Director, and reacted to his direction. In my position I recognized that these administrators had to be guided in such a way that they followed general principles of good administration and that they kept within the framework of policy decisions which were made by me, often in conference with them. In meetings we held every week, policy matters were discussed. In some instances it was proper for an administrator to follow an action course which was not precisely the way it was done in the other four hospitals. If it seemed justified, I supported it. In other words, in my judgment, the art of operating a system of this type relates very definitely to the balance that is maintained between the central office and the unit administrators. If you hold the rein on them too tightly, they become dull, and will not show initiative. They will tend to shrug off the decision-making responsibilities that confront them, and they will call on the CEO for help too frequently. You expect them to call for help on the difficult problems but most of the time you expect the unit administrator to take care of the problems that come up in the ordinary day in day out operations.

I customarily referred to "my administrators" a possessive term that I considered proper. In operating the five PCHA hospitals as I did in operating the 10 hospitals in Appalachia, I looked upon them as my family. I was possessive about them. I think this helped me in identifying myself with the manner in which they operated. I also recognized that as a father you should not be overbearing to your children. You try to train them to take care of

themselves. This gets back to the term "balance." If you maintain the proper discipline and proper balance in the manner in which you direct what they do, they are more likely to grow and develop in a productive way. This was my objective.

I never developed the type of manual you will see in a Veterans Administration hospital, for example, where an administrator can turn to a manual and look under regulation such and such number for a decision or direction he should follow given a certain situation. That may be necessary in a government managed operation where hospitals are far-flung and communications are slow. In a typical hospital system, serving a limited geographic area, communications usually are good. Hospitals are a short telephone call away from one another. Also the CEO customarily will visit the hospitals reasonably often. Accordingly it should not be necessary to have policy manuals which dictate that certain things should be done in specific ways. This is not to say that a uniform policy will not prevail to guide the unit administrators in what they do. It does say, however, that administrators will handle their activities in ways they have either learned in school, from experience, or in conferences with the CEO and other administrators. This relates primarily to the way they handle personnel, their medical staff, the financial operations of their hospital, and their community relationships.

Personnel practices were set forth in a manual at PCHA to assure uniform handling of grievances, the number of days employees were allowed for vacation and sick leave, information about workman's compensation, etc. Disciplinary measures when necessary must be precise. Just giving administrators similar sets of personnel policies does not necessarily guarantee uniform results.

One administrator will manage his personnel in one way, and another administrator manage his personnel in another way. One will have a happy relationship with his employees another will have an unhappy relationship with his employees. This is not at all peculiar to the hospital business. If you study businesses, take General Motors, Ford, Chrysler as examples, you are aware that grievances appear to be handled differently in various plants. The plants all have the same personnel policies but there is something in the way the supervisors in the plants conduct personnel procedures. This results in problems in one plant that don't exist in another.

Legal opinions are handled with precision. When legal counsel provides an answer to a question, usually through the CEO's office, these are given a number and a copy is sent to each unit administrator for his indexed file.

It seems to me, given a hospital system and given a unit manager, who knows he is going to be observed very carefully by an expert in his field, the CEO, that manager is going to be stimulated and motivated more than if he were responsible directly to the board of directors. Let me make this clear: What you inject in a hospital system that doesn't exist in a freestanding hospital is the expert who is between the board and the unit operation. That expert, that central administrator, has a different and sharper responsibility than the average administrator in a freestanding hospital because that average administrator is judged only by his board of directors. In a hospital system each unit manager is judged by a central executive. That central executive, in turn, is judged by his unit managers as well as by the board of directors to whom he is responsible.

Among the things the unit administrators of a hospital system such as PCHA are stimulated to do is to become involved in the activities of the

communities that his particular hospital unit serves. I pointed out before that at PCHA we had a central office person in charge of community relations. That's a better expression, we thought, than "public relations." Each unit administrator was free to call upon the Director of Community Relations to assist him in whatever he did in his community. We encouraged the unit manager to belong to a service oganization, to respond to invitations to speak to different organizations, and to develop an auxiliary. PCHA auxiliaries include men as well as women as members. Also the unit administrator is asked to work with, and get to know, the trustees of PCHA who come from the communities served by the unit hospital.

Let's take Seaway Hospital as an example. Seaway is in Trenton, Michigan but it relates to four or five other communities in the area. The eight or ten trustees from these communities feel that Seaway is their primary responsibility. We encouraged trustee visits to the hospitals by making it necessary for some of our checks to be countersigned by the administrator and one trustee. That trustee was encouraged to tour the hospital and talk with the administrator about his activities. Other trustees also were encouraged to tour the hospital on a regular basis. When problems arise in the units, trustees usually join the administrator in presenting the specifics of the problem at board meetings.

People have asked if it wouldn't be better for each of the hospitals to have its own board. My answer to that is "no." If the objective of these hospitals is to render essentially the same types of service, and to coordinate their services in such a way as to eliminate the duplication of services between them wherever possible, it can be done much better using a central board than by having individual subboards which in turn relate to a

central board. For comparison let us turn to the business world.

The biggest corporation we have in this country is General Motors. It would be absolute nonsense if every one of its big units (Chevrolet, Buick, Cadillac) had its own subboard. It would mean general confusion. A single board holds a central executive responsible for managing all units. That central executive takes the responsibility for seeing that there is adequate intercommunication between the units, and a good reporting system from the units to the central office, and through his office to the board. Thus the board knows what's going on overall and the individual units also are satisfied that they have a voice, and that somebody is listening when they talk.

Intercommunication extends down into the department head level so one of the positive qualities of a system is scheduling regular meetings for department heads who do similar things in the unit hospitals to meet together to share experiences and to exchange ideas. These meetings should be no less frequently than every two months. At PCHA regular monthly meetings were scheduled (except for one or two months in the summer) for nursing, maintenance, dietary, housekeeping, and medical records--those were the primary groups.

The chairman of these meetings would be one of the administrators. I would say, for example, "Mr. Wheeler, would you please assume the responsibility of meeting on a monthly basis with the directors of nursing, and with the personnel directors of the hospitals? You, Mr. Freysinger, (Freysinger previously one of the administrators now has succeeded me as CEO) would you assume responsibility of meeting once a month with the maintenance directors?" And so it would go.

The interchange between these people was extremely valuable. It also was an assurance to me that these department heads were functioning pretty much along the same line. How else could you be assured that the individual departments in your hospitals were following the same philosophy of management unless you got them talking together? If they disagreed on any matter, whoever chaired that meeting had to settle it, then everybody was expected to agree that that was the way it would be done in the future. It is extremely valuable technique of consensus development. Department heads in individual hospitals (not in a system) tend to get rather lonesome. Every six months or every year they to go association meetings and meet with other people doing the same work, but whereas they exchange ideas at these association meetings, they are under no compulsion to agree to do things in a similar way in the future. That's the difference between a system meeting and an association meeting. To do things in a similar way was the object I tried to establish among PCHA department heads.

I said, "Remember, we have attorneys who are going to be representing the board of directors of the Peoples Community Hospital Authority. When things go wrong they don't want to have to defend a certain action in Hospital A if it is different from what you do in Hospital B. If you recognize that ideology and that concept, it should be relatively simple for you to accept my objective which is to do things in a similar way."

A question is sometimes asked that relates to some of the practices that executive in an important hospital position must carry out if he is to be successful. The question is: How does such an executive motivate important, influential people in the community (those I like to refer to as power structure people) to do things that are in the best interests of the

organization he represents? Can he, or should he seek assistance from his trustees in such matters?

Trustees on the board of directors of a large city hospital are frequently persons who are very important in their own businesses and professions. In their community they are very important. So when trying to get a hearing before the city council or mayor for something special the hospital would like to have done, the administrator is more apt to be successful if he can work through such a trustee than if he attempts to work directly on his own. In other words, learning to use the powerful, influential members of the board can augment the degree of success he is going to have.

Let me give you an example in my career which I touched on a bit, earlier in this conversation. During the period when I was the Executive Director of the Hospital Planning Council for Metropolitan Chicago.

Representatives from commerce and industry decided to create the Council as an organization that would study the various hospital growth programs that were being developed throughout the Chicago area and to make judgments as to which programs were in the best interests of the city. Hopefully the studies would assist the board members of the planning council in making recommendations to industry in general to assist them in their response to requests for contributions to the various programs.

The president of the board of directors was Edward L. Ryerson. He was a retired, previous chairman of the board of Inland Steel Corporation. The board structure of the council in Chicago was made up of chairmen of the board and presidents of some of the most prestigious corporations and companies serving the Chicago area.

When my staff, after studying a program, would give me a recommendation

for board action be it go or stop, I would present the recommendation to the board for their reaction. Their decision carried tremendous weight, so much so that it stopped or started programs throughout the area. Our small staff of 12 people controlled (let me underline that) controlled the development of hospital facilities in Metropolitan Chicago during the three and a half years I was there and for seven or eight years after I left, under my successor, Hiram Sibley. It did it by bringing to bear the power structure of the community. Hospital boards could raise contributions successfully and borrow money successfully if they had the backing of the planning council, but they couldn't do either if they did not have its backing.

In all its wisdom, the federal government decided this planning process was all right for Chicago and maybe 10 other communities that had planning bodies, but asked what about the communities elsewhere in the country that didn't have this kind of organization. So laws were passed to establish comprehensive planning councils countrywide, with federal government support. Unfortunately there were not enough talented people to staff them. Although there were a lot of very well-meaning and well-intentioned persons making up those boards, the whole movememt for planning began to slip back rather than move forward, largely because of lack of qualified personnel.

During this process the use of the word "consumer" emerged. The concept was that the so-called common man needed to have a voice in the affairs of these organizations to protect community interests. What was completely overlooked was the fact that the power of the previous organizations lay not only in the wisdom and intelligence of the board members but also in the positions they held in the community so, when they spoke, things moved.

Voluntary planning councils in the late fifties and early sixties were far

superior to anything we have now and probably ever will have again. As the government agencies intervened they destroyed the process that existed before. One of the really sobering aspects of this is that the voluntary planning councils were all supported by contributions mostly from industry. In Chicago we had several hundred of the major industries that made rather substantial annual contributions to our council. We didn't have a big budget, something like two hundred thousand dollars a year but we did the job that now costs probably two million to serve a comparable population and isn't done as well. When organizations were created with federal funding, the voluntary contributions dried up. It would be just as though we took all our voluntary hospitals and decided that they should all be tax supported and discouraged all the philanthropic support that had been absolutely essential to their growth and development in the past. It doesn't appear that is going to happen. I think people have learned some important lessons.

My early training in the planning field came not from books or manuals that had to do with health planning, because there weren't any available when I went into this in 1959. I looked for them, but they just didn't exist. The planning manuals I read and studied were the planning manuals and guides developed for people in metropolitan and regional planning.

The city of Chicago is one of the best planned cities in our country. It is based on a master plan developed by David Burnham, who I mentioned previously. Burnham was an architect employed in 1904 by the Commercial Club of Chicago which was a power structure organization similar to the power structure I had as a board of directors at the hospital planning council. As I said, Burnham developed a plan published in 1906 that continues to serve today as the master plan for the development of the city of Chicago.

As you look back through history you will find other examples of good city planning. Cities have developed because of the abilities of well-meaning people to accomplish these things, mostly on a voluntary basis. But not always. Some masterful planning has been done by individuals in control. Napoleon III controlled the destruction and reconstruction of Paris. The federal government employed L'Enfant, the French architect, to lay out the city of Washington, perhaps our most beautiful city. In the case of Salt Lake City, undoubtedly the most precisely planned American city, it was the genius of Brigham Young. I would say the planning organizations in our major cities don't succeed unless they have a close working relationship and support of the power structure of the city.

It at last came time to end my career as an administrator. During the spring and summer of 1976, I had made a decision to retire at the age of 65 only because it seemed as good and as arbitrary an age as any. Previously I had no desire to retire earlier than that, but 65 seemed to be kind of a wise figure to choose because I felt that if I were going to become involved successfully at a consultant for two or three years following retirement that I should not wait any longer. I am of the opinion that, if one waits too long to try to serve as a consultant, people will look at you as an old man and will have a much more difficult time establishing yourself. So my advice relative to this is: Do what I did , because it worked for me. Make the change while you still have plenty of pep and vigor. Then people will take your advice and enjoy working with you.

Let me review briefly what I have done. Six months before I retired I had a discussion with Robert DeVries, a Program Director at the W.K. Kellogg Foundation. He had been the administrator previously at a community hospital

in Howell, Michigan. Following a period there he went to the University of Michigan for some postgraduate work in health administration. Within a year he was appointed by the W.K. Kellogg Foundation as a program director. He was a good choice because not only does he have good experience and good education but also he is an intelligent person with good empathy for the whole health field.

In my discussion with Mr. DeVries I asked him whether the Kellogg Foundation could use a person with my particular knowledge and background in the multihospital field? We had our first discussion six months before I retired so he had plenty of time to think about it. A few months before I retired he had a program lined up for me which had to do with the monitoring of programs the foundation was supporting in what they called "management contracts." This was a new concept that had developed and emerged from the practice of shared services where, over a period of years, hospitals had developed a mechanism for doing things together on a sharing basis. Kellogg had supported some of these early efforts.

The idea of a management contract grew from this sharing practice because some of the people in the field recognized that it would be beneficial for an urban hospital to share its administrative talent with smaller, rural hospitals. The organizational pattern which evolved was one by which, on a contractual basis, the central hospital hired an administrator for the small hospital. The administrator would be responsible to the board of directors who headed the small hospital and who continued to set policy. Administratively he would be responsible to the central hospital. This presented a rather peculiar situation with the administrator being responsible both to the central hospital and to the local board of trustees. One

observing this could say it can't work. Experience has shown that it does work.

When I began my assignment with Kellogg there were eight projects underway. In the past two years three projects have been completed and two more have been added. Now there are about 50 rural hospitals in 10 states that are managed by central urban hospitals with Kellogg support, and working surprisingly well.

I returned last week from looking at a new program in Montana where the Deaconess Hospital in Billings has established management contracts, following the pattern I just described, with rural hospitals. I had the opportunity of speaking with representatives from three hospitals where the management contract is now in operation, and with a representative from a hospital considering a contract.

On my return trip I stopped in Omaha where the Nebraska Methodist Hospital has developed management contracts with nine hospitals. I visited two of these. They are some distance from Omaha so we flew in a chartered plane to visit them. I was pleased and satisfied with these visits. Interestingly enough, Nebraska Methodist Hospital started in this field by first developing a shared services program, which now serves some 150 hospitals in four states (Nebraska, Iowa, Missouri, and Kansas) with purchasing, administrative services, and laundry. It's just a beautiful, unbelieveably well-developed service.

Presbyterian Hospital Center in Albuquerque, New Mexico also operates a management program. They have modified their approach from management contract to a lease, which is a much tighter arrangement and covers a longer period of time. In a lease the small hospital relinquishes all its

responsibility in favor of total management by the central hospital. The central hospital manages 14 hospitals through leases, they operate at a very satisfactory level.

In my judgment, management contracts will be used by increasing numbers of small hospitals as they recognize the advantages to them. Government regulatory requirements are becoming overwhelming for small hospitals to cope with. They appreciate the convenience to them to be able to pick up a telephone and communicate with a central source for help and assistance. There is more power, more strength, in these new organizations. I am excited about these programs because I feel I am working in the forefront of a new movement in health services.

I also am working with two consulting firms, and on my own as a health services consultant. I am assisting in communities where there are two or more hospitals that feel they could offer better, more cost effective services to their communities if, rather than working on an individual basis, they could somehow unite their efforts and serve in a more closely coordinated fashion.

Coordinated programs can take several forms, beginning with a consortium up to a consolidation or merger. In a consortium there usually is an agreement to establish a central office headed by an executive whose primary responsibility is the development of coordinated planning and coordination of patient services. Certain programs may be phased out in some of the hospitals and developed in greater strength in others.

These is a superb example of a consortium in Detroit in a group called the Northwest Hospitals Corporation. The hospitals associated here are Providence and Mount Carmel, both Catholic hospitals, Sinai Hospital, and the northwest

unit of the Harper-Grace Hospital of the Medical Center. These four hospitals have done some amazing things. Mount Carmel has eliminated its obstetrical service. A single pediatric service for the four hospitals has been established at Mount Carmel. There is a single adolescent mental health program at Sinai Hospital, as well as an adult mental health program there. The four hospitals are planning the concentrating on neurosurgery in one of the hospitals. Open heart surgery is performed in two of these hospitals. The placement of CAT scanners is carefully planned. They have developed a hospice service all four hospitals can use. Their residency training programs are coordinated. These hospitals have found that they can accomplish all these marvelous things and still retain their separate identities.

I worked with the Michigan Hospital Association, for almost two years, studying the extent to which multihospital arrangements are developing in this state. We found that over 70% of the hospitals in Michigan have some arrangement with another hospital. This might be as simple as one hospital sharing a service with another, as tight as a single corporation operating two or more hospitals. Michigan is in the forefront in multihospital arrangements in the country. We did a survey last year and presently are studying some of the examples in depth. We are presenting a report of the findings at the annual association meeting at Mackinac in June 1979.

In summary I have applied the knowledge I have about managing and operating a multihospital systems in my consulting services to hospitals in the Midwest, East, and South.

There is one more very interesting point I'd like to make. It's very important because it differentiates between hospitals and businesses when they merge or form consortiums or other working relationships. The situation is

important because the Interstate Commerce Commission at the present time is a little confused about what's going on. It doesn't seem to know how to evaluate these new combinations that are forming. I hope the commission recognizes that this is time for caution and observation.

In my judgment there is a distinct difference in motivation between combinations of hospitals and combinations of businesses. Businesses come together or absorb one another or merge because not only are they trying to be more efficient but also they are doing it competitively to obtain a majority market. This is one of the reasons government must be careful of businesses that merge or consolidate because the resulting oganization might prove to be too devastating to smaller businesses that find they can't survive in this environment.

The motivation of hospitals to combine or to share services is not the same as the business motivation. It is purely and simply a recognition that up to a certain point if hospitals combine operations they can gain some advantages of scale. Also by buying the best management available a hospital should be able to provide health services more efficiently in a multihospital configuration than in independent operations. I think it is important that everybody who is interested in the field recognizes that hospitals are not trying to put each other out of business in a competitive way, or to get a corner on the market.

This brings my story up to date.

Interviews, Ann Arbor — May 11, 1979

May 12, 1979

Index

Alameda County Hospital, California 4

Albuquerque, NM 81

Aldrich, Dr. Albert 13

Alexian Brothers 34

Allegheny General Hospital, Pittsburgh 2

Allopaths 68

Amercian College of Surgeons 5

American Electric Power Co. 54

American Hospital Association 14,17,31

Ann Arbor, MI 14

Ann Arbor-Detroit area 56

Appalachia 36,37-38,43,45,47,51,54,55,70

Appalachian Regional Commission 40,55

Appalachian Regional Hospitals 45-56

hospital doctors 46

local advisory boards 46

local community doctors 47

Archer, Dr. 49,50

Areawide planning 27

Arkansas 7

Army medical corps 7-11

Azores 11

Bachmeyer, Dr. Arthur C. 5-7

Bachmeyer, Robert 6

Bard, Ralph 19-20

Battle of the Bulge 10

Beckley, WV 38

Bethesda, MD 26

Black, Dr. 4

Blue Cross 28,29,40

Breathitt, Governor Edward T. 39,44

Bronze star 9

Buick automobile company 74

Cadillac automobile 31,74

California 4

Camp Dix 11

Camp Joseph T. Robinson 7

Carentan, France 9,10

Carter, Dr. 13

Caserne 10

CAT scanner 83

Cathedral of St. John the Divine 12

Catholic hospitals 33-34

Chandler, Governor Happy 43

Cherbourg, France 8

Chesapeake & Ohio Railroad 38

Chevrolet automobile company 74

Chicago 5,14,17,18,24,25,26,27,28,29,33,34,38,77,78

Bishop of 33

University of 4,5,14

Chicago Crime Commission 31-32

Chicago Hospital Council 28,29

Chicago Hospital Planning Council, see _Hospital Planning Council for Metropolitan Chicago_

Chrysler Corporation 72

Cincinnati 52

Clark, Phil 17

Cleveland 1,4,11,27

Coal Industry 41

Coal mine 51

Combs, Dr. Bert 39

Commercial Club, Chicago 18,78

Commonwealth Edison Corporation, Chicago 25-26

Consortium of hospitals, Detroit 82-83

Cooke, Donald C. 54-55

Cooper, Mrs. John Sherman 39

Cooper, Senator John Sherman 39

Cozaad, Charles 58

Crime syndicate 30-33

Crosby, Dr. Edwin L. 17

D-Day 8

Detroit 5,27,55,57,82,83

De Vries, Robert A. 79,80

Dick, A.B. 17

Dick Corporation 17

Easterly, Ed 43

Ecorse, MI 61

Eisenhower, General D.D. 8,11

Eloise Hospital, Wayne, MI 4

Fifth General Hospital 9,10,11

Flake, Major Carlyle 10

Ford Motor Company 72

France 8-10

French army 10

Freysinger, John J. 74

Fund raising 54-55

Gary, IN 28

General Motors Corporation 72,74

General practice 2-3

Geographic physicians 21

German soldiers 9

Goldwater, Dr. S.S. 13

Gottlieb, Symond 35

Grasslands Hospital, Valhalla, NY 6,7,11,12

Greater Detroit Area Hospital Council 35

Hamilton, Dr. 4

Hamilton, James A., Associates 15

Hammond, IN 28

Harlan, KY 37,38,39

Harmon, Dr. 11,12

Harper Hospital, Detroit 4

Harper-Grace Hospital, Detroit, Northwest unit 83

Hawks, Stanley 16

Hazard, KY 39,51,52,53

Catholic hospital 52-54

Health Services Agency (HSA) 34,35

Health services consulting 82

Hennepin County, MN 14

Hennepin Hospital Center 14-16

Heritage Hospital, Taylor, MI 69

Hill-Burton 26,35,36

Hoge, Dr. Vane 26

Hollinger, Dr. Paul 21

Hospice service 83

Hospital Planning Council for Metropolitan Chicago 26-36, 76-79

Hospitals 13

Howell, MI 80

"Ike" 11

Illinois 35

State Health Department 35

University of 18

Indigent patients 24-25, 54

Inland Steel Corporation 28-76

Internship 2

Interstate Commerce Commission 84

Kansas 81

Kellogg Foundation 43,79-80,81

Kentucky 38,39,40,49

Kentucky Life Insurance Company 44

Kentucky Medical Society 47

Kincaid, Garvice 43-45,46,47

Klicka, Mrs. Karl 2,4-5,11,38

Lake County, IN 28

Lake Forest, IL 18

Lansing, MI 57

L'Enfant, Pierre 79

Lewis, John L. 36-37, 41,42

Lexington, KY 39,44,45,56,67

Liverpool, England 7

Locum tenens 5

Los Angeles 27

Louisville, KY 44,47

McDowell, KY 39,49

MacEachern, Malcolm 5

MacLean, Dr. Basil 13

McPherson Community Health Center, Howell, MI 80

Man, WV 56

Management contracts 80-84

Mannix, John 4

Martinville, KY 49

Massachusetts General Hospital, Boston 24

Maternity department 27

Medicaid 41,54

Medical doctors 66

Medical school 2

Medical staff 21-22

Medicare 41,54

Mercy Hospital, Chicago 33

Michael Reese Hospital, Chicago 33

Michigan 4,64,67,83

  hospital authorities 60-61

  University of 14,69,80

Michigan Hospital Association 83

Michigan State University

  School of Human Medicine 66

  School of Osteopathy 66

Middleboro, KY 38

Miners' Memorial Hospital System 36

Minneapolis 14,15,16-17,22,27

Minneapolis Tribune and the Star 16

Minnesota, University of 14

Missouri 81

Modern Hospital 13

Morton Grove, IL 31-32

Mt. Carmel Hospital, Detroit, 82

Mt. Sinai Hospital, NYC 13

Multihospital systems 80-83

Munger, Dr. Claude 11,12,13

Napoleon III 79

National Bank of Lexington 44

Nebraska 81

Nebraska Methodist Hospital, Omaha 81

Nye, Kenneth 38-39

Newfoundland 11

New York City 12,13,27,36,54

Northwest Hospital Corporation, Detroit 82

Northwest Hospital, Minneapolis 16

Northwestern University 17

Northwestern University Medical School 18

Nursing school 24-25

Oldberg, Dr. Eric 21-22

Omaha, NE 81

Osteopaths 68

Otolaryngology 10,21

Outpatient department 23-24

Paris, France 11,79

Pastori, Dr. John 27

Peoples Community Hospital Authority 55-75, 79

administrative system 70-76

attorneys 75

board of trustees 58-60,61,73,76

budget 64

committees 62-64

executive director 60

medical advisory committee 59-60

medical staff organization 64-66

osteopaths 66

personnel manual 71-72

Perkins, Congressman Carl 39-40

Peter Bent Brigham medical unit 9,11

Peterson, Virgil 31-32

Phi Beta Kappa 2

Philadelphia 1

Pikesville, KY 38,48

Pineville, KY 43

Pittsburgh 1,2,27

University of 1

Pizzamenti, Donald 57

Presbyterian church 36,38,43,54

Board of National Missions 36,37,38

Presbyterian Hospital, Chicago 17-20

Presbyterian Hospital Center, Albuquerque, NM 81

Presbyterian Medical Center, NYC 36

Presbyterian-St. Luke's Hospital, Chicago 27

merger 18-26

Prestonburg, KY 39,49,50,51

Princeton University 19

Proprietary hospitals 30-33

Providence Hospital, Detroit 83

Residency 5

Roche, Josephine 41-42

Rochester, NY 13

Rockefeller Foundation 43

Rogers, Charles Bolles 15-16

Roosevelt Hospital, NYC 27

Rosenfeld, Dr. Eugene 37

Ryerson, Edward L. 28,76

St. Andrews Hospital, Minneapolis 22

St. Barnabas Hospital, Minneapolis 14-17,22

St. Joseph Hospital, Chicago 34

St. Luke's Hospital, Chicago 18-20

St. Luke's Hospital, NYC 11,27

Ste-Mere-Englise, France 8

Salt Lake City 79

Seaway Hospital, Trenton, MI 66-67,68,73

Sibley, Hiram 35,77

Sinai Hospital of Detroit 82

Snyder, Dr. Franklin 17

Taylor, MI 61

Temple University 1,2

Toul, France 10

Town doctors 39

Trenton, MI 61,66

United Mine Workers (UMW) 36,37,40,41,42,46,48,52

hospital system 36

United Mine Workers Welfare and Retirement Fund 36,40,41,49,55

United States Department of Health, Education & Welfare 26

University Hospitals, Cleveland 2,6

Utah Beach 8

Veterans Administration hospitals 71

Victory ships 8

Virginia 38

Waddell, Charlotte 3-4,5

Ward, Dr. George Gray 12-14

Washington, D.C. 26,34,40,41,79

Wayne, MI 4, 61

Wayne County, MI 67

Wayne County Medical Society 67

West Virginia 36

Westchester County, NY 6

Westland, MI 61

Western Reserve University 1,2,6

Wheeler, Walter S. 57,74

Wheelwright, KY 39,50

Woman's Hospital, Detroit 2-3,5

Woman's Hospital, NYC 12-14, 15, 27

World War II 7-11, 66

Young, Brigham 79

Ypsilanti, MI 61

Zollinger, Colonel Robert 9-10,11