HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Sister Irene Kraus

8

SISTER IRENE KRAUS

In First Person: An Oral History

Lewis E. Weeks
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HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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Sister Irene Kraus

CHRONOLOGY

(Items with indented dates are extracurricular memberships and affiliations)

1924	born in Philadelphia, July 25
1941	entered the Daughters of Charity
1942-1949	grade and high school teacher, St. Patrick's Academy, Richmond, VA
1949-1952	catholic University of America, B.S.N.
1952	St. Vincent's Hospital, Bridgeport, CT, postgraduate course in OR supervision
1952-1953	St. Mary's Hospital, Saginaw, MI, OR Supervisor
1953-1955	carney Hospital, Boston, MA, OR Supervisor
1955-1961	Lourdes Hospital, Binghamton, NY, Administrator
1957-1961	Central New York Regional Hospital Council, Manber, Peard of Directors
1959-1961	Binghamton State Hospital School of Nursing, Member, Advisory Board
1959-1961	Broome Technical Community College, Member, Advisory Peard
1961-1962	Sisters Hospital, Waterville, ME, Administrator
1961-1962	New England Hospital Assembly, Member, Accounting Comnittee
1961-1962	waterville Hospital Council, Member, Citizens Committee for Home care
1962	Maine Hospital Association, Chairman, Nursing Home Liaison Committee
1962-1963	Providence Hospital, Detroit, Assistant Administrator

1962-1964 Archdiocesan Council of catholic Nurses, Member, Board of Directors

1964-1969 Providence Hospital, Southfield, MI, Administrator

1964-1969 Michigan Society for Mental Health, Qakland County Olapter, Member, Board of Directors

1965-1968 Archdiocesan Hospital Council, President

1965-1969 Michigan Blue Cross, Member, Board of Trustees

1965-1969 Greater Detroit Comprehensive Health Planning Board, Member

1966-1969 Qakland Community College, Menber, Advisory Board

1967-1968 Michigan Hospital Association, Vice President

1968-1969 Michigan catholic Hospital Conference, President

1968-1969 Michigan Society for Mental Health, Qakland County Cllapter, President

1968-1969 Greater Detroit Area Hospital Council, President-Elect

1969-1975 St. Thomas Hospital, Nashville, TN, Executive Director

1969 Tennessee Hospital Association Area Wide Planning Committee Member

1969 Tennessee Hospital Association Joint Liaison Committee with the Tennessee Nurses Association, Member

1969-1972 catholic Hospital Association, Council on Research and Develop:nent, Member

1970-1971 Middle Tennessee Hospital Council Program, Olairrnan

1971-1974 catholic Hospital Association, Cllairrnan Officer

1971-1975 Mid-Cumberland Comprehensive Health Planning Council, Board Member

1972-1974 Tennessee Hospital Association Joint Liaison Committee with the Tennessee Medical Society, Member

1972-1974	American College of Hospital Administrators, Ethics Comnittee, Member
1974-1975	Nashville Mental Health Association, Board Mernber
1974-1976	American Hospital Association, Board of Trustees
1974-1978	St. Vincent's Medical Center, Jacksonville, FL, Board Member
1975	American College of Hospital Administrators, Ethics Corrmittee, Chairman
1975-1976	American Hospital Association, .Advisory Panel on Malpractice, Member
1975	Florida Atlantic University, M.B.A.
1975-1983	Providence Hospital, washington, r.x:., President
1977-1979	Maryland Hospital Education Institute, Member of Board
1977-1983	St. Ann's Infant Home, Hyattsville, MD, Member of Board
1977-1983	D.C. Hospital Association, Board Member
1977-	Health Providers Insurance Company (AHA), Board Member
1978-1980	National Capital Hospital Council, Board Member
1979-1981	American Hospital Association, Chairman Officer
1980-1983	The District of Columbia Statewide Health Coordinating Council, M2mber
1983-	Health Providers Insurance Company (AHA), Ebard Chairman
1983-1986	St. Vincent's Medical Center, Jacksonville, FL, President
1986-	Daughters of Charity National Health System, St. Louis, MO, President

AWARDS and HONORS

American College of Hospital Administrators

Fellow, 1966

One of Top Ten Women for Detroit, 1968

Zonta Club of Nashville

Recognition Award for Community Service, 1971

Niagra University

Honorary Doctor of Letters, 1980

American Hospital Association

Distinguished Service Medal, 1986

WEEKS:

Sister Irene, I would like to talk about your early life. I note that you were born in Philadelphia on July 25 and that you entered the Daughters of Charity at a very young age. You were barely out of high school.

SISTER IRENE:

That's correct.

WEEKS:

Then I note that you immediately began teaching school. Would you care to talk about what your goals were and what you hoped to do when you entered the order?

SISTER IRENE:

The reason for my joining the Daughters of Charity was that I wanted to be a Chinese missionary. That was my ambition and my greatest interest in those days. In the thirties many Americans were going to China as missionaries. Our order in Maryland, where I was living at the time, sent Daughters of Charity to China. That was why I entered the order. You see I never got there. The war came and the churches were expelled from China. Therefore, I was never able to go.

WEEKS:

Do the Daughters of Charity have a particular charge?

SISTER IRENE:

We cover all of health, education, and welfare. We have many elementary schools, high schools, and a few colleges. We have hospital work of all kinds. Health work, I should say, because we have many clinics, home nursing programs and very extensive social services. In social work we used to have many institutions: infant homes, homes for unwed mothers, orphanages, etc.

Most of those institutions are slowly disappearing because the care of infants and children is now taking place in foster homes. So, our social work is more in family placement and counseling, guidance, and working in the offices of Catholic charities.

WEEKS:

I also note that you attended the Catholic University of America. Is that the school in Washington, DC?

SISTER IRENE:

Yes, it is.

WEEKS:

How did you happen to go from teaching into nursing?

SISTER IRENE:

With us it is not necessarily a matter of my deciding. We are in God's hands. It is just like in the army of the United States: You are moved around. The same is true with us. However, when they change you from one major kind of work to another, they consult with you. I was consulted. I went in 1949 from teaching to Catholic University to get my degree in nursing. I was asked if I would like to do it, or if I would have any problems if I were assigned to it. I didn't. I really wanted to be a nurse. I had no problem.

WEEKS:

It worked out well then.

SISTER IRENE:

It worked out very well.

WEEKS:

I have you taking a special course in operating room nursing.

SISTER IRENE:

When I finished my course in nursing with a bachelor's degree, the order wanted to assign me to operating room supervision. Of course I had no experience and background in it. That is why I was sent to Connecticut where there was a year's program in operating room supervision. I took that program.

WEEKS:

Were all these programs under the Daughters of Charity?

SISTER IRENE:

Yes.

WEEKS:

That's when you came to Saginaw, Michigan?

SISTER IRENE:

After I finished the program in Connecticut I was assigned to St. Mary's in Saginaw as operating room supervisor.

WEEKS:

After that you were at Carney Hospital in Boston, weren't you?

SISTER IRENE:

As operating room supervisor at Carney Hospital in Boston. That's right.

WEEKS:

Then you went into administration in Binghamton, NY. In Binghamton you began to have community involvement in the Central Regional Hospital Council of New York.

SISTER IRENE:

It was based in Syracuse, NY but Binghamton was in that region. Just like the Metropolitan Detroit Council covers Port Huron and all that area, the

Syracuse region extended south to the Pennsylvania border, but with its headquarters in Syracuse.

WEEKS:

You served on the advisory board, while there, of the Binghamton State Hospital School of Nursing?

SISTER IRENE:

Yes.

WEEKS:

Later you were on the board of the Broome Community Technical College?

SISTER IRENE:

Yes, I was.

WEEKS:

Your next assignment, as I see it, was in Waterville, Maine.

SISTER IRENE:

That's right.

WEEKS:

That was a small hospital, wasn't it?

SISTER IRENE:

Yes, 80 beds.

WEEKS:

I am trying to understand their assigning you to these different places. It looks to me as though you are a person they send out to problem areas.

SISTER IRENE:

You can't say they were problem areas. It was because there were specific things they wanted to accomplish. In Maine they were going to double the size of the hospital and build a brand new hospital. I had had some

construction experience in Binghamton. We had built two new wings while I was there. They wanted somebody with construction experience to go up to Waterville -- and I fitted that category.

WEEKS:

I wondered because I noted the difference in size of these hospitals.

SISTER IRENE:

I don't think it ever had anything to do with the size of the hospital, as much as it had to do with the need at the moment.

WEEKS:

You must have worked with the community in building this new hospital.

SISTER IRENE:

You may have noted that I didn't stay in Waterville very long. I was there only a year and a half. I was there for the planning of the hospital. I was never there for the building or construction of it. The reason for leaving was again, a particular need in Detroit. Providence Hospital was downtown on West Grand Boulevard. They were going to build a brand new one in Southfield. They decided that it would be better to move me at that time and move somebody else up to Waterville, which is what they did.

WEEKS:

Providence Hospital in Detroit was a great old hospital, wasn't it?

SISTER IRENE:

It certainly was.

WEEKS:

I remember it. My mother was a patient there in the early fifties. I remember being in the hospital.

SISTER IRENE:

We sold it to an entrepreneur. We moved out to Southfield. He immediately took the nurses' home and converted it into a nursing home. They were trying to do something with the hospital building itself. After many years of being unsuccessful they tore it down. I understand there is none of it there now.

WEEKS:

It makes my heart sick to go into Detroit and see everything leveled.

SISTER IRENE:

That building looked like a castle.

WEEKS:

You were out at the new Providence Hospital in Southfield in the beginning?

SISTER IRENE:

Yes. I came to Southfield in 1962. We broke ground within a month after I came. We moved into the new hospital in March of 1965. I was here until 1969. I hardly recognize it now though. When I was here last week I could hardly find my way around. They have added wing after wing.

WEEKS:

That's the growing edge of Detroit.

SISTER IRENE:

Whoever selected that site had great foresight. When we broke ground there wasn't a sign of another building. you could look to the north or the east or the west -- except for the Northland Shopping Center there were just fields, empty fields and now it is completely surrounded by condominiums, by office buildings, by hotels.

WEEKS:

A couple of years ago I interviewed Mr. Rothman who lived in Oak Park not far from Providence. I hadn't been in that neighborhood in a long time. I was amazed. We left Detroit in 1947, now it is different. I recognized very little.

In Providence Hospital, Southfield, you began getting into community affairs. Do you want to mention anything about the Michigan Society for Mental Health or your Blue Cross board membership?

SISTER IRENE:

There was nothing unusual about them. The unusual thing in Michigan was the decision by the Catholic hospitals to form an association. There were at that time about 35 Catholic hospitals in the state of Michigan. Some of the administrators -- I specifically remember one from Lansing and one from Grand Rapids -- approached me to see if I would take a leadership role in trying to form this. we did eventually form it and I was the first president. That was an innovation. There weren't too many state Catholic hospital associations around the country at that time.

WEEKS:

What percentage of the community hospitals in the country are Catholic?

SISTER IRENE:

By actual hospitals, about 12 percent. If you take beds, it is about 20% of the beds. The Catholic hospitals tend to be larger.

WEEKS:

I notice your hospitals are. So we are talking about 700 or 800 hospitals.

Michigan Blue Cross is having its troubles now, you know. Mr. McCabe,

the president, has been given an ultimatum.

SISTER IRENE:

Bill McNary was there when I was there. I guess he is retired.

WEEKS:

He is down in Sun City, Arizona, I believe. I had hoped to talk with him. I don't know whether he is coming up north or not. I hate to make the trip way out there.

Michigan Catholic Hospital Conference. That was the name of the Michigan Catholic hospital association. You were also in the Greater Detroit Area Hospital Council. Who was the head of it at that time?

SISTER IRENE:

Gene Sibery.

WEEKS:

I talked with him about six weeks ago. A delightful person.

SISTER IRENE:

Where is he now? New York?

WEEKS:

He is in Des Moines. He is president of Iowa Blue Cross-Blue Shield. He flew in in his plane. I met him at the Ann Arbor Airport.

SISTER IRENE:

He flies his own plane?

WEEKS:

No, he has a pilot. It must be a Blue Cross plane.

Your next move was to St. Thomas in Nashville. That is quite a hospital too, isn't it?

SISTER IRENE:

Yes. Again, I was sent there because they were going to build a new hospital. St. Thomas needed a new building, the old one went back to the 1800s. They had just selected a site and were going to start with the blueprints. The Sister who was administrator there had just been appointed to a high position in our order. Southfield was up and operational now for four years so they asked if I would go down and build that hospital in Nashville.

WEEKS:

You were getting a reputation as a builder.

SISTER IRENE:

I went down there in the summer of '69. For the building of St. Thomas in Nashville there wasn't even a blueprint. From 1969 to 1971 or 1972 we worked on the blueprints. We finally moved in in 1974.

WEEKS:

You were a specialist for on-the-spot building. Does the order have architects? Not just going out and hiring them, but does the order have architects on staff?

SISTER IRENE:

We usually use local people. If there is not enough expertise locally, we will bring in somebody else that is experienced. Most of our hospitals are larger, as you probably noticed. We usually have architects who can do this job but, if they can't, they bring in consultants themselves. In Nashville, the local architects who had been doing work for St. Thomas for years really did not have the expertise to build the type of modern facility which we wanted. They brought in a consulting firm out of Atlanta who had done many hospitals. But we were not even satisfied with that. We knew we were going

to spend thirty million dollars and that was a lot of money in 1969. We didn't want a duplication of an old kind of a hospital with just new bricks and mortar. We wanted all that modern technology could offer. So, St. Thomas hired an outside consultant, Jack Ryan of Ryan Advisors, to help with the planning.

WEEKS:

Things are changing so rapidly.

SISTER IRENE:

You just can't keep up with it.

WEEKS:

You served on the Catholic Hospital Association. I was trying to remember if this links up with Sister Maurita of the Sisters of Mercy.

SISTER IRENE:

Definitely. It was Sister Maurita who was president of the Catholic Hospital Association at the time I was elected chairman of the board. Sister Maurita and I were very closely linked together.

WEEKS:

She is a very nice person.

SISTER IRENE:

Yes.

WEEKS:

I interviewed her a year or so ago. At the time I interviewed her, the Sisters of Mercy had the largest chain of the not-for-profit Catholic hospitals. What do you have now, 39?

SISTER IRENE:

Thirty-eight of our own and five nursing homes. We have three hospitals

that are not run by Daughters of Charity but belong to our system. We are getting close to 50 institutions now.

WEEKS:

What area do you cover?

SISTER IRENE:

From the Atlantic to the Pacific.

WEEKS:

You have them in every part of the country.

SISTER IRENE:

If you look at a map showing their placement, there is a noticeable gap east of the Rockies through the plains where we have no hospitals. We are in 19 states and the District of Columbia.

WEEKS:

Sisters of Mercy are in about three states, as I recall. This must be a tremendous job of administration.

SISTER IRENE:

It is. It keeps me busy.

WEEKS:

You served on the American College of Hospital Administrators. I have you down for the Ethics Committee.

SISTER IRENE:

I was chairman of the Ethics Committee. I also served on the Nominating Committee. I am also on their program this February, so I do remain active with the College.

WEEKS:

You did that first work when Dick Stull was there, didn't you?

SISTER IRENE:

Yes.

WEEKS:

Stu Wesbury has changed things greatly, great progress.

I have you next at Florida Atlantic University getting your master's in business administration.

SISTER IRENE:

Yes. It was an interesting experience. I had my bachelor's in nursing. I had never received my master's. I had been sent once to St. Louis University to get my master's in hospital administration. I was only there four days when the order assigned me elsewhere. Again, there was a need. I went to Binghamton, NY then. The Sister who was in Binghamton suddenly became ill. They didn't feel they could move anyone from any of the existing hospitals. I was out in St. Louis just starting my course so they called me back and asked me to do it. Every few years the question arose about my returning to complete my studies, but I was always in the middle of a big building project.

I would say, "When I finish this..." When I finished that then it was always something else.

WEEKS:

In these movements you have been making, when we say, "They sent you," who are "they?"

SISTER IRENE:

"They" are whom we refer to as the Provincial Council, or as you would understand better as the board that runs the order. They make the decisions as to the placement of the Sisters.

WEEKS:

I was interested the other day in something I read about an area north of Chicago where a Catholic hospital was to be built, but the Vatican....

SISTER IRENE:

It wasn't a matter of a hospital being built. It was in Waukegan, Illinois. The Sisters who were running that hospital wanted to withdraw from that work. They did not have enough Sisters to continue to run it. They wished to sell it. A for-profit group gave them the best deal.

WEEKS:

That was Humana wasn't it?

SISTER IRENE:

An order of Sisters had also presented a proposal for it, but their bid was not as good as the for-profit. People blamed it on the Vatican but I don't think that is completely accurate. It was Cardinal Bernardin, the Archbishop of the Chicago Diocese, who said they should not sell a Catholic hospital to a for-profit chain. So he told the Sisters that they really should sell to the other religious order, whose price was a little less.

WEEKS:

In an ownership position such as this, where does the money go? Does it go back to the order?

SISTER IRENE:

No. The money would go, in this instance, to make up for debts, accounts receivable, etc. I don't know all the details -- I can only surmise that if they had a debt that needed to be paid off for the hospital, it would have to go for that. In our order we put all our indebtedness together in an obligated group. If we had a hospital from which we were withdrawing, that

money would go towards paying off the debt within the obligated group. It would not go to the order. That would not be appropriate. Assets of the corporation stay with the corporation.

WEEKS:

I wondered what would become of capital in this case. When you want to build a new hospital you have to have capital so you raise it in the community...

SISTER IRENE:

So that is why it must go back into the community. I can't really say for sure in this case because I really don't know. With ours, because our institutions are separately incorporated, that money cannot go back to the order. It must go back into the community in one form or another. We just sold a hospital in El Paso. We sold it to a for-profit, but that money which we received is paying off the debt. We withdrew from the hospital because there are too many hospitals in El Paso. They were all running at a low occupancy. It didn't make sense. It was a good planning as well as a business decision which we made. We wanted to keep the Daughters of Charity in El Paso in health so we are going to start clinics for the poor there.

WEEKS:

Your next move was to Washington, was it?

SISTER IRENE:

Yes. I went from Nashville to Washington, DC.

WEEKS:

That's where you met Steve Lipson.

SISTER IRENE:

That's right.

WEEKS:

That situation in Washington was quite difficult to manage, I imagine.

SISTER IRENE:

Very difficult.

WEEKS:

It's a city but in the greater metropolitan area there are more than one state, Virginia and Maryland.

SISTER IRENE:

My move to Washington was a return for me to the Province of my origin. Our order throughout the United States when I entered in 1941 had two Provinces or regions, the Eastern Region and the Western Region. When you entered the Eastern Region, that is where you stayed. The Eastern Region in those days covered Maine to Florida and as far west as Detroit. The Western Region, whose headquarters was in St. Louis, began in Indiana and Illinois and then went all the way to the West Coast. When I was here in Detroit, because we had grown so large nationally and it was hard to govern these two regions because they were so large, not just geographically but in numbers, that the United States was split into five regions: Northeast, Southeast, East Central, West Central, and a Far West Province. Detroit, up to that time, had come in the Maryland Region but now comes in the East Central or Indiana region. So, the Sisters who were here in Detroit came under the East Central Province, although actually some of us were from the East Coast.

At that time they said, "We are going to try to get everybody back in the region to which they belong. Give us a little time." They were dealing with thousands of people, actually about 2,500 Sisters plus about 200 institutions. They just couldn't move everybody back to the place of origin, so I was asked

to stay on in this Indiana region for a while. That's when I was transferred to St. Thomas in Nashville to build that new hospital there. I was told that when St. Thomas was finished I would be allowed to return to my own home area.

In 1975, when St. Thomas was up and operational, I returned to the Maryland Province. That was the reason for my assignment in Washington. This fulfilled a promise to me that I would be returned to my home area.

So, I went to Washington in 1975 and was there until 1983.

To run a hospital in the District of Columbia is a tremendous challenge, for the reasons you said, for the political environment, and for other reasons. The cultural environment is very difficult also. Our hospital, Providence Hospital, is the oldest hospital in continuous service in the District of Columbia. So, we have quite a heritage there. They do a lot of care for the poor. It is basically why our order was started in the first place in 1633 in France -- for the care of the sick poor. We love Providence because we feel in a special way an affinity for what has happened there.

WEEKS:

That's an interesting statement. I talked with Bob Cathcart. We were talking about the founding of his hospital back in Benjamin Franklin's day. The Pennsylvania Hospital was founded for the sick poor and the lunatics. The people who were without care, and were on the streets, were taken in.

SISTER IRENE:

Society didn't want them.

WEEKS:

While you were in Washington, I am sure you met or worked with Al Gavazzi.

SISTER IRENE:

Al Gavazzi! Yes. He served on my lay board at Providence. He has retired now.

WEEKS:

I interviewed him about a week after he retired.

SISTER IRENE:

I had a letter from him not long ago. I know him and his wife and children very well.

WEEKS:

I think he is a very capable man from what I have been able to learn.

We have you in Providence in Washington. I noted that you served on St. Vincent's Medical Center Board in Jacksonville before you moved there. Were they preparing to build?

SISTER IRENE:

They built while I was on the board, not while I was the Chief Executive Officer. I was a board member during the planning of their new building.

WEEKS:

St. Ann's Infant Home was one of the institutions you mentioned in addition to your hospitals.

SISTER IRENE:

That home, St. Ann's Infant Home in Hyattsville, MD, a suburb of Washington, is only five blocks from Providence Hospital. St. Ann's now, although they still take care of children, have many of these children now for day care only. There are still the newborn infants there waiting for adoption, or there are children the courts have placed there until their home environment is ready to receive them back. That's the kind of child homes

take care of now. They also have unwed mothers there. They have 20 or 25 beds for unwed mothers that live there and then come to Providence Hospital to deliver. The baby then goes back to St. Ann's until the girl decides that she wants to keep her baby, or the baby is put up for adoption.

WEEKS:

We seem to have so many troubles in our lives for which we are unable to find answers.

SISTER IRENE:

The type of care that is being given to these people has so changed over the years. I can remember when I was in Detroit we had a home for unwed mothers in Farmington. At that time that home was always filled, so the archbishop, at that time Cardinal Dearden, decided we needed another one. He asked our order if we would staff another one if the diocese would build it.

The order said, "Yes." They started planning, and I helped the Cardinal with the plan. Our order assigned Sisters to the work. We drew up all the plans. They were ready to go. They went to the United Way to ensure they could get funding for it. United Way refused to fund it because they said there was no need for it.

We said, "We are over crowded in Farmington."

They said, "Society is changing. You are not going to have as many unwed mothers because abortions are going to reduce the numbers. Also society is finding the unwed mother very acceptable and they can stay at home as single parents. So we will not finance another building."

When they couldn't get the funds from United Way, the archdiocese decided not to build. This was a smart thing because society did change. The single mother keeps on working or the girl stays in school. Although there are still

a few who seek the shelter of our home in Hyattsville.

WEEKS:

I feel old-fashioned.

SISTER IRENE:

I do too. What it has meant to us in running those kinds of institutions is, that your whole way of dealing with those problems has changed: you have to change with them, if you want to continue the work to which you feel committed and our Order is very committed to this.

WEEKS:

Your supply of nuns entering the order seems to be diminishing. What is going to happen?

SISTER IRENE:

I don't know. The drop is dramatic. When I entered the order, I think we had eight or ten enter that year, which we considered very small. Post World War II -- 1945, 1946, up into the early '60s -- the numbers went right off the graph with 75 one year. By the late 1960s those numbers started coming down. We are lucky if we have 10 or 12 in the entire United States enter in a year. We are right back to the numbers when I entered 46 years ago. People say -- and I have never had time to look up the history of it -- cyclically that is what happens. You have the ups and downs and it goes along with what is happening in society. Almost always, following a war, the numbers increase dramatically and then after things get settled down and not so stirred up, the numbers go down. When something drastic happens that shocks everybody, religious entries go up again. You can see the rationale of that. When something terrible like World War II does occur, people begin to see how fleeting the things of this world really are. They think, "I am alive

today but I may not be alive tomorrow, so I had better be careful how I live." It makes people focus their attention more on eternal values, than the fleeting values of this world. Therefore, they think more of the value of values, and so opt to go in that direction. When they haven't had any hardships in their lives, they really don't know what that means. They think more of the worldly things. That certainly is one of the factors.

I think another factor is the women's movement. When I entered the order in 1941, I didn't have too many options. I could get married, and a lot of girls did right out of high school. I could be a nurse, I could be a secretary, or I could be a nun. That's about what your choices were. Now look at the choices women have. The opportunities are there for just about everything. Then there is the mentality of wanting to prove that a woman can do what a man does. I think it has hurt the religious orders. Whether this is a period when people are trying to find themselves, and will reverse itself, I don't know. I have an idea, it might be right or it might be wrong, that there may be a reason for this drop other than what I mentioned. The Catholic Church, at least up until the recent years was a church that looked to the priest and the nuns to direct the people. The people, although considering themselves good practicing Catholics, were never brought into the mainstream of church administration because they never did anything for the Church. It was the priest and the Sister who did.

"We will come to church on Sunday. We will give you money to support yourself. You run the church, you run the schools, the colleges, the universities. You run the hospitals. You are our people out there on the front. We will come to church, and that's the extent of it."

That's fine, and that was all right for its time and place. Today's

individuals, if they are good church-going people want to feel it's my church. What has happened because of the decline in the number of religious is that the lay people are coming in and doing the jobs; they are teaching in our schools where our nuns used to. In hospitals, in our order alone, in the 38 to 40 hospitals, over 50 percent of them have a Catholic layman or woman running the hospital, and doing a very fine job of it. They are very committed to the cause. So, part of my belief is that possibly this is providential, maybe this is a deliberate movement to bring the laity into their rightful role in their church to see that the work of the church goes on -- not just leave it to the priests and nuns to do it.

WEEKS:

In a sense it would be stronger.

SISTER IRENE:

Absolutely. This is just my theory. Maybe this is why it has occurred, to allow the age of the laity to come to full blossom.

WEEKS:

Within all this we have the nursing problem.

SISTER IRENE:

Yes. The nursing shortage. It has the same basic problem as the nuns. A girl has so many ways she can go today.

WEEKS:

Better working hours.

SISTER IRENE:

Better working hours. Better pay. Better everything. There were plenty of nurses when you had the three year diploma programs, and they were all free. I could have entered nursing in 1941 and not have paid one red cent. I

would have been given my room, board, and uniforms, books and everything for my education. I would have come out with my R.N. and not have paid a penny for it.

WEEKS:

But you would have contributed quite a lot of work.

SISTER IRENE:

Yes. No question. Service and education elements were the basis for the problem.

WEEKS:

Do you have many hospital schools now?

SISTER IRENE:

We have, I think, two left. DePaul Hospital in Norfolk and Sisters Hospital in Buffalo still have diploma nursing programs. Carney Hospital in Boston has a two-year associate degree. I think they are the only ones left that are directly under our control.

WEEKS:

I know the influential persons in the nursing associations would like to see a bachelor's degree mandatory for an R.N. I doubt if they can get enough candidates to do that.

SISTER IRENE:

I think that is a long way off. You would like to think you could do that, but I think the shortage of nurses is so great. The two-year associate programs are producing a lot of girls. It's a serious problem. The AHA just asked me to serve on a task force for them regarding the nursing shortage. It will be interesting to see what happens on that.

WEEKS:

For two or three years I served on a board of a practical nursing school (LPN) in Howell, Michigan at McPherson Community Health Center. I was quite impressed with their program. They had a good faculty. They had an outstanding record in state examinations. Here was a little hospital in a small community, facing a nursing shortage. When they started training LPNs it helped fill some of that void. I realize that they cannot do everything an RN can do but it is certainly better than depending on aides.

SISTER IRENE:

I would like to see personally some mixture of a practical type of nurse that doesn't have to have that bachelor's degree, and then the bachelor's degree. Whether you call it a practical nurse or vocational nurse doesn't matter. There are a lot of activities that someone with a little bit of knowledge could do who would not need a degree. I think there are ways to develop a compromise between the two. They could sell the bachelor's degree proposal much faster if a compromise could be worked out.

WEEKS:

I think so too. Now it seems to me that most of the bachelor's degree graduates are going into supervision.

SISTER IRENE:

Yes. They are, there is no question about it. That's where the money is. If they get into bedside nursing now, outside of bedside nursing in a nursing home, it is in the critical care and high technology areas. So many of the patients now go in in the morning and out in afternoon. For those that stay, the intensity of illness is likely to be much greater now. These nurses burn out very quickly because of the strain of watching monitors and other

technology, plus the strain of dealing with the patient's family. It's much greater than it was years ago.

WEEKS:

And now we have AIDS.

I was never conscious of the problem until the last couple of years.

SISTER IRENE:

I don't think anybody else was either.

WEEKS:

I was never conscious of the mode of living of many of these people. The numbers surprised me. I knew there were people who were different, but I always thought they were e very small minority.

SISTER IRENE:

You never heard the word "gay." Now you can't even use the word in the good sense.

WEEKS:

I had a very good friend who recently died whose name was Gaylord. Up until this came along we called him Gay. It was perfectly fine but it became a very embarrassing thing after a bit.

What is your policy on taking care of AIDS patients?

SISTER IRENE:

We have a very strong policy: we take care of them. All of our hospitals have them. We are looking into some special programs for AIDS patients.

WEEKS:

If this becomes an epidemic it is going to be a great strain on the finances.

SISTER IRENE:

There is no question about it. I just can't believe that a cure or a vaccine is not going to be made available. I saw a news item just the other day that the Food and Drug Administration just approved a new vaccine for testing. I think it is just a matter of time. It's going to be like polio. It has become so widespread that pressure is on the research people to come up with a solution to the problem.

WEEKS:

I get a little bit disturbed by some of the people who get frantic, who say, "Why are we spending only fifty million dollars (or whatever the number of millions was)." They are assuming that all you have to do is throw money after it. It is a very serious problem, there is no question about it.

You did move to Jacksonville to St. Vincent's Medical Center, didn't you?

SISTER IRENE:

Yes, in 1983. I said to myself, "Isn't it nice? This will probably be my last move. They never will move me again. I'm in Florida. Our hospital is a beautiful hospital. It's right on the water. It's an administrator's dream in every sense of the word. Financially they were strong. Medical staff A++. People great. This is my dream." Look what happened! I didn't stay there long.

WEEKS:

To paraphrase slang, "You ain't seen nothing yet."

While you were there you probably were acquainted with Donald Welch of the Seventh Day Adventist group. Their principal hospital in Florida was in Orlando, The Florida Hospital. He is a delightful person. I hope you meet him some day. They have quite a few hospitals too.

SISTER IRENE:

Seventy some. They have more hospitals than we have, but we have more beds than they have. That's why we can say we are the largest not-for-profit system. They are number two. If you go purely by institutions, they would be number one. We have some four or five thousand beds more than they do. They must tend to have smaller hospitals.

WEEKS:

They have a few big ones. Florida Hospital is about a thousand beds. They have a lot of smaller beds. Because of their history they grew up as sanitarium types, or health spas. I guess they have discontinued those, if not all of them.

Before we leave your chronology, I think we should say something about the awards you have received. You are a Fellow of the American College of Healthcare Executives. I have you as being chosen as one of the top ten women in Detroit in 1968.

SISTER IRENE:

Do they still have that annual award in Detroit?

WEEKS:

I am not sure about that.

SISTER IRENE:

It was a civic program. Every year they picked ten women who in some way were outstanding. I have no idea how many nominations they receive. They advertised in the newspaper for nominations and from them selected the "Top Ten Women Who Work." They were on a TV talk show in the morning; then breakfast, then all through the city for luncheons and other affairs, then the big banquet in the evening.

WEEKS:

I imagine since you have been in many cities that you have noticed the differences in the way communities support local projects. I think Detroit has been outstanding in money raising. Of course, there is big money there in big industries.

SISTER IRENE:

Yes. Here in Detroit, of course, you have General Motors, Ford, and a few others.

WEEKS:

In Nashville you received the Zonta Club Award. Niagara University gave you an Honorary Doctor of Letters.

SISTER IRENE:

That was the year I was Chairman of AHA.

WEEKS:

The AHA gave you their Distinguished Service Medal, which is their top award. Not many people have had that.

When you were in Nashville, you probably became acquainted with Dr. Frist?

SISTER IRENE:

Yes, I did.

WEEKS:

I am speaking of Dr. Frist, Sr.

SISTER IRENE:

Yes, he was on our staff. Dr. Frist, Junior had not even finished training yet. His father was on our medical staff. Even though he was involved in HCA at that time, he was still practicing. He would occasionally

admit patients to our hospital when they wanted to come there. He was not a regular admitter. We very seldom saw him.

Then his son came along with his special training in cardiac work. St. Thomas Hospital is a stronghold for cardiac work in Tennessee, so he practiced at St. Thomas. At that time HCA's hospital in Nashville, Park View Hospital, was not doing any heart work, did not even have a cath lab. So young Tommy came in our direction. I don't know whether he is practicing at all now after his father retired. I believe Dr. Frist, Junior became quite involved in HCA.

WEEKS:

I found Dr. Frist, Sr. a very interesting person and a very engaging man. His early life reads like Horatio Alger. He worked his way through school and supported a widowed mother. I went to see him at his home after he had an automobile accident. He had been in traction, and he had a hospital bed in the living room. By the time I got there he was able to sit up in a chair. His wife was there, very gracious. I happened to think: Here is a multimillionaire, probably many times over and they lived so plainly that I felt right at home. When I left, he got up and walked out the front door with me where my car was parked. He looked at my Ford, and said that they had a Chevrolet and a Pontiac. I didn't see any imported cars there or any other evidence of great wealth. I was very impressed.

SISTER IRENE:

He is a very dedicated man. He has been very involved in HCA almost since its inception. There were a lot of people who were critical of him for getting involved in the for-profit hospitals. When I was there in the 1960s in the early days of HCA, doctors in Nashville were buying stock in it. When you would say, "Why are you buying stock in that?" They would say, "This may

be the wave of the future. We want to be sure to have a piece of the action."

WEEKS:

Anybody who invested in that stock early made a fortune, no question.

SISTER IRENE:

If they sold it.

WEEKS:

I don't know what it is doing now.

SISTER IRENE:

It dropped after the October 1987 crash.

WEEKS:

That raises a point: Did the stock market drop in October have any effect on the financial condition of the Daughters of Charity Health System?

SISTER IRENE:

No, it did not. We do pool all our investments. We have a cash management program. Each day the hospitals wire into a central bank excess cash so we can pool it together. we have a system by which we pool not only the cash, but put all of our investments, debt, etc., into one big financial package. We have an extremely conservative policy for investments. It includes very little, if any, stocks. Our policies require very secure types of instruments -- CDs, bonds, etc. So, the event in October really did not affect us.

WEEKS:

I read some expert -- and I was thinking the same thing so I feel kind of an expert -- I read an expert who pointed out that the value of stocks today is about what it was a year or two ago. We thought it was good a year ago.

SISTER IRENE:

It went so high during the past year so that's what made October so dramatic.

WEEKS:

The people who are trading day by day, and using the computer to buy and sell may be affected but the average person who keeps his investment and has it paid for...

SISTER IRENE:

That's right, and I think that's why the advice you heard was: Don't run and sell that stock, because if you panic and sell you might not get just paper losses but actual losses. If they will just stick it out, particularly if they have good stocks, they will come back.

WEEKS:

Can we spend the rest of the time talking about the Daughters of Charity National Health System? I think we can find enough to say about it. In our earlier conversation you said the order started in France. Would you like to give me a little history of the Order?

SISTER IRENE:

Our Order started in 1633 by St. Vincent DePaul who saw a need for taking care of the sick, the poor, infants, and many of the social ills of his time. The social environment in France was terrible. Babies were just left on doorsteps or left out in the snow to die. The sick were in hospitals with three or four in a bed. The poor were not being taken care of by the government or anybody else.

St. Vincent DePaul had the idea of interesting women to do something about this situation. He started by trying to get the wealthy women of France

to help. Of course, they were very happy to help financially, which they did. They actually did some of the work but pretty soon the wealthy ladies didn't want to do that kind of work. They were sending their maids to do it. They were still willing to support the work financially. That led St. Vincent to find someone -- he called them "country girls" -- French girls -- whom he invited to Paris who were willing to do this kind of work with a sense of dedication, to consecrate their lives to God.

At that time in the Catholic church no religious order of women was allowed to do that kind of work. Any nuns in those days were what we called "cloistered," and they had to stay within their convent and their life was a life of prayer. They never left their convent. St. Vincent did not want to call our order a religious order because it was too revolutionary. He therefore, set up his order in an entirely different way. They did not establish convents. The Sisters just rented rooms and lived in rented rooms. They did not wear habits and veils as the orders did. You probably have seen pictures of us before 1964 when we wore the great big white hat. That was the dress of the French peasant of St. Vincent's time. He said, "We are not going to give you a habit, just wear that kind of dress, and that will be your habit. You will not take what the religious in those days called "final vows," vows for life, you are just going to take them a year at a time." We still do that. We never take final vows. He did not want to give them any kind of an appearance which would look like a religious order. He said, "You are not going to have any chapel. You are going to the parish church. You are not going to wear a ring as most religious orders do, because you are not a religious order. You are just a group of women dedicated to work for the church, for the poor and the sick."

It was many years after St. Vincent died before the Church actually recognized us as a religious order. The wisdom of that now, in retrospect, was that it was the wisest thing St. Vincent could have done. In those days if he had said he was forming a religious order, the Catholic people would have been up in arms. A nun was never allowed outside the cloister. It was very revolutionary for its time. So that is how our Order started.

In St. Vincent's lifetime it spread into Madagascar, into Poland, into many European countries. Our central Mother House is still in Paris. We are a worldwide community. We are in practically every country in the world except Norway and Sweden. We have Sisters in the Communist countries. They don't have too regular contact with the Mother House but they still are in Communist countries carrying on the work in whatever way the Communists will allow them.

In some of the countries they allow them to take care of the elderly or the mentally ill -- as they say, the lunatics, people the Sisters can't influence. They don't take care of the children because they might influence the children.

The whole world of the Daughters of Charity is divided into regions. The United States has five regions. There are about 67 regions the world over, with the Central Mother House in Paris.

WEEKS:

Does the Central Mother House have a line of authority?

SISTER IRENE:

Yes, a definite line of authority for certain things. Once every six years they have a congress or an assembly where all 67 provinces send representatives and vote on the critical issues of the Order. That's when

they look at the rules again and decide if they want to change them -- to change the habits, or any other important business. those kinds of controls are exercised in that body.

They came to the United States in 1850.

WEEKS:

How did that happen?

SISTER IRENE:

We say here in the United States that our Order was founded here in 1809 by Sister Elizabeth Ann Seton. She was the first American-born canonized saint in the Catholic Church. She started an order in Maryland in 1809. During her lifetime she was advised that her little American order should unite with the French Daughters of Charity. She requested that of France and they said they would accept the American community but they would have to send the rule and some Sisters over to be sure that everything was done properly. Napoleon would not allow the French Sisters to leave France. They sent the rule over, but the Sisters were not allowed to come. It was not until 1850 that this little order that was started in 1809, which had grown considerably by that time, joined the French order.

WEEKS:

Their goals are about the same?

SISTER IRENE:

Exactly. It's an interesting story. If it happened today, it would be on TV. From 1809 to 1850 is a long span of years, 41 years. In the meantime the American founder, St. Elizabeth Ann Seton had died. She died in 1821, 30 years before this union with France took place. In all this interim time the order spread as far north as Nova Scotia, through New England, west into Ohio.

By the time the union with France was ready to take place some of the Sisters didn't want to join the French Order. They said, "We don't need to join France now. It was all right back in 1809 when we were a small, little group, but we don't need it now." There was a real scandal, but nobody knew it because it was kept internally. As a result the Sisters were all given their liberty. They were told, "If you want to join the French community, come to Maryland, March 25, 1850 and we will join the French community. The rest can do whatever they want." As a result there were five religious orders that flourished from that group. There are some right here in the Detroit area. St. Joseph's Hospital in Mt. Clemens is run by the Cincinnati Sisters of Charity, one of the breakoffs that formed their own.

WEEKS:

They call themselves the Sisters of Charity?

SISTER IRENE:

Yes, Sisters of Charity to distinguish from Daughters of Charity. You have a group in New York City, you have a group in Nova Scotia, Convent Station, New Jersey; Greensburg, Pennsylvania; and Cincinnati, Ohio. They all broke off and formed their own religious orders and are doing well today.

WEEKS:

Are most of them operating in the health field or the educational field?

SISTER IRENE:

A mixture, but about the same. It is interesting that Napoleon allowed the rule to come over in 1809 so all of them had the same rules as the daughters of Charity of the French community. Most people don't know that story, but there is nothing secret about it.

WEEKS:

You mentioned that communication was not as good as now, and these groups could begin springing up in different spots and could be quite cut off from larger groups.

SISTER IRENE:

I always say that God must have wanted it. If he didn't, they would have failed and disappeared in time. However, every one of them has flourished into a large, well-managed, well-run, religious order in the United States today. Many of them have missions in foreign lands, South America and Central America.

WEEKS:

Speaking of your regions, Larry Prybil was my neighbor for three or four years in Ann Arbor.

SISTER IRENE:

He is the Regional Executive of one of our regions.

WEEKS:

It would seem that your interests and goals have been the same all along.

SISTER IRENE:

The poor and the sick — that is our "reason for being."

WEEKS:

You have done a wonderful job. If we could just turn the problem of Medicaid over to your order maybe you could find a way out of it.

Have you gone into many specialized hospitals? I noticed there are some long-term care hospitals listed in your order. Have you gone into psychiatric care or rehab?

SISTER IRENE:

We had quite a number of psychiatric hospitals in the United States up until the 1950s - 1960s. We had one right here in Dearborn, Michigan, St. Joseph's Retreat. We ran that for a hundred or more years. We had mental hospitals. You name the city, we had a hospital there: Baltimore, Buffalo, New Orleans, St. Louis -- all across the country. We opened many mental hospitals over the years. Again, responding to a need, but that need changed as the treatment for the mentally ill started to be taken care of by medication, and within general hospitals. We have none today. We have put units in our acute care hospitals. When St. Joseph's Retreat in Dearborn was closed, it was closed with the specific idea that when the new Providence was built in Southfield they would open a psychiatric unit for the care of the mentally ill. When we closed that in the 1960s we were building a new St. Agnes' Hospital in Baltimore. It was with the intent that there would be a psychiatric unit in that. It was the trend of the time. That was the compelling reason for closing that mental hospital.

WEEKS:

The reason I asked about the specialized hospital was that I had noticed that some of the for-profit hospital chains are going into the psychiatric hospitals now, and rehab.

SISTER IRENE:

Comp Care, on the West Coast particularly, is doing a lot of that. The compelling reason I think they are doing that is that the payment is still good for that type of care.

WEEKS:

This is what I think. There is a profit to be made there.

SISTER IRENE:

That will soon be cut out, little by little. The government hasn't done that yet, but they will.

In the early 1960s, as Medicare was coming along there was a big movement in the for-profit chain to run nursing homes. The Medi-Centers of America and the Beverly Enterprises, and such like groups started building as they saw a need as well as a good reimbursement system. Look and see how many of those are left today. One by one they have pulled out of it because payments, particularly Medicaid, became impossible. The for-profits got out of that. I think you are going to see the same in psychiatry when the governmental system of payment comes in and affects it. Now we get good payment for psychiatry.

WEEKS:

There is a small market, I suppose, for the people who can afford it.

SISTER IRENE:

Yes, of course. You may have noticed that a lot of these for-profit groups are getting into drug addict care, alcoholic care, eating disorders, etc. Again, I think, for the money. That's their motivation particularly with the drug addicts and alcoholics. So many employers will pay to put their people into these programs in the hope of returning them to be productive employees. They are paying patients for the most part.

WEEKS:

I think you put your finger on the motivation of the for-profit institutions.

We are taking care of the alcoholics and drug people, I agree that may be where the profit is.

SISTER IRENE:

I recently had a call from a large for-profit chain that I have worked with over the years in various ways. They wanted to know if I would be interested as a system to be in a joint venture with them for AIDS. I think they are seeing dollars in the care for AIDS. I think they realize the government is going to have to do something about this major problem. They see that the Feds are going to pour some money into it. They want to capitalize on it. The individual who called me compared it with what had been done with alcoholism. He said, "You know, for a while nobody was doing anything for the alcoholic, but when it was something that was being paid for, we jumped in and established our alcoholism treatment center. We see the same thing is going to happen with AIDS and we want to be in the forefront and get in there."

WEEKS:

Is there any typical description you can give of an AIDS patient? I am thinking now of how long the incubation period is.

SISTER IRENE:

I don't know all those details.

WEEKS:

How long is an AIDS victim hospitalized before he dies?

SISTER IRENE:

Most of those I have known have been in and out of a hospital over a period of a year or so. It's usually with side effects. People seldom die of AIDS itself. They die of pneumonia or something else, because their immune system is not able to fight the disease. It really fluctuates depending on the disease they get, and how much resistance they can keep up in some of

these conditions. I think on record they have had patients who have lived for years. I guess it depends how frail their health was before they got AIDS.

WEEKS:

And what they become exposed to.

SISTER IRENE:

That's right. It may not be a fair comparison, but if you have ever had a patient on intensive chemotherapy for cancer, you know that chemotherapy reduces your white count dramatically, and it is your white count which helps fight disease. When a person is put on intensive chemotherapy, he is told not to go out in public, not to go any place where there is a big meeting. If somebody in your family has a cold, keep away from them. If there are children in school do not let them get near the patient. With AIDS patients it would be the same sort of thing. If they could be kept away from environments where they might pick up germs, they could go on indefinitely. It depends on the environment.

WEEKS:

Do you segregate these AIDS patients in the hospital?

SISTER IRENE:

To the best of my knowledge I don't know of any general hospital that is doing that. However, there is a lot of talk about it. Nurses are getting afraid, other patients are getting afraid. In Jacksonville we had a unit there which we called "infectious disease unit," which was not just for AIDS. Anybody with an infection was automatically put on that unit. There were 58 patients. That whole staff was geared up, because that was the only kind of patient they took care of. They had to have sterile precautions for the patients, for themselves, for the families.

Not too many hospitals have an infectious disease unit. Ours in Jacksonville is very successful. It is successful because the nursing staff is dealing with this all the time where you must place a patient with an infection in a regular unit, with regular nurse staffing. You find that that might be the only infection case in six months. So the staff are not skilled in the techniques. People were not so afraid in the Jacksonville Hospital relative to the AIDS patient because they were used to the kind of surveillance required for this condition.

This sort of situation might force hospitals to at least start to segregate not just AIDS patients but anybody with a staph infection or other infection, and put them on a special unit.

WEEKS:

When you were in Detroit was Herman Kiefer Hospital still in operation?

SISTER IRENE:

Yes.

WEEKS:

Sort of a pest house.

SISTER IRENE:

Yes. Does that still exist?

WEEKS:

I don't know, but I don't think so.

I can remember in 1941 on this particular day, December 7, Pearl Harbor day, I was in bed with typhoid. At that time there were about one or two cases a month reported in Detroit. I don't know how I got it but I remember being taken to Cottage Hospital in Grosse Pointe. When they did the lab tests and discovered what I had, the administrator couldn't get me out of there fast

enough. I was supposed to go to Herman Kiefer. My wife, who is a very loyal person to me, protective, said, "I'll take him home." That was rather than take me to Herman Kiefer, which many thought was a pest house.

Maybe we are coming back to infectious disease hospitals and units.

SISTER IRENE:

It could be.

When I was at Providence here we used to send our nursing students down to Kiefer for TB and other infectious diseases experience.

WEEKS:

That was a fairly large hospital, wasn't it?

SISTER IRENE:

Oh, yes. When you think of what TB was at one time in this country, in the 1940s, it was like AIDS.

WEEKS:

That brings up an interesting point. I talked with Haynes Rice, of Howard University in Washington, DC. We were talking about some of the diseases that have almost passed away. Foolishly, I mentioned TB. He said that in the inner cities of the metropolitan areas, it is still a big problem.

SISTER IRENE:

They still get the disease, but it can be treated with medication. That's the difference.

When I trained as a nurse in Washington we went to what is now DC General Hospital. They had one building as large as Providence Hospital in Washington just for the TB patients. They had two buildings just as big as Providence for polio, scarlet fever, whooping cough, and all communicable disease.

For the treatment of tuberculosis then there was no medication. There

was nothing you could do for those people except to try to keep them healthy, give them plenty of rest and fresh air, or there was surgery. If their TB lesion was small enough, the surgeon could remove a lobe of the lung which resulted usually in a very good cure.

It was a matter of keeping them there with rest. Rest did cure some of them. In fact, they used to say it would be good for the women to get pregnant because as their uterus enlarged it pushed the lung up and made the lung almost inactive. If the TB was in the right spot that portion of the lung became inactive and by the time the pregnancy was over the TB was gone. Now they have medication and can clear it up like they do any other infection. We have that much of a difference.

WEEKS:

A good difference.

SISTER IRENE:

Yes. Definitely. With polio you just never hear of it anymore. Smallpox... I think it still exists in other countries, although I read some literature not too long ago that smallpox was pretty well done away with world-wide. I don't know whether that is true or not.

WEEKS:

I don't know either but almost anything can come out of Africa because they have so much disease there.

I have been wondering about the administration of your Daughters of Charity National Health System. Did you move your general offices to St. Louis because it is centrally located?

SISTER IRENE:

We started out in St. Louis because we had some existing office space

available to us there from one of our regional offices. There was room there that we could set up business right away. The board agreed to that. They then asked us to do a study of where would be the best place to locate. We did a very detailed study of 10 different cities throughout the United States. We studied everything within those 10 cities: the cost of living, the school system, etc. To attract people we had to be sure of the cultural opportunities in those cities, what the airline schedules were between our cities, and what was the on-time and departure record of the airports. We got it from the FAA. That was over a year ago. That study was the first one we did when I arrived in the summer of 1986. Believe it or not, O'Hare had the best on-time arrival and departure record.

WEEKS:

Is that right?

SISTER IRENE:

You don't think it when you go in and out of Chicago but it was true. What happened was we had two choices: Chicago and St. Louis. So we focused on those two. Basically, Chicago was more expensive, but how could we put a value on wasted time? St. Louis airport was the worst for on-time arrivals and departures. How could we put a value on executive time being wasted in an airport? So, we ended up recommending Chicago because of the airline record, even though it was clearly identified that it would cost us more salary-wise because the cost of living was higher in Chicago. We actually went to the board in October of 1986 and recommended that we move to Chicago. The board did not accept it. They said it is going to cost too much more and you can't prove to us how much money you are going to save in executive time. So the board made the decision that St. Louis would be the headquarters. We looked

at Dallas, Denver, Washington, Atlanta, New York, Detroit among the 10. We have moved to a new headquarters. We are no longer in that little space where we first were.

WEEKS:

I noticed the new address.

SISTER IRENE:

We have about 25,000 square feet. We have the whole third floor of a brand new office building. It's not completely occupied yet. It's 12 miles from the other address and it is near the airport.

WEEKS:

How do you choose your lay administrators? We were saying the movement is in that direction. Do you select from graduates of any particular hospital administration school, or select from the field?

SISTER IRENE:

In most any instance where we now have a lay administrator, that administrator was working in that hospital or one of our hospitals as an assistant administrator. In fact, that is one of the things we have said is of value in having such a large system -- that there is the beautiful career ladder opportunity for employees, and not just for top administration. For instance, today we have a girl who is starting in St. Louis as our director of planning who had been working here at Providence in Southfield. She was director of planning there. To come from the local level to the national level is a nice promotion. When we were setting up our organization in St. Louis and were looking for a vice president for human resources, a senior vice president for legal affairs and a vice president for planning, we first gave the opportunity of applying to our own. All three eventually came from our

hospitals.

WEEKS:

That must be a great boost to the rest of the staff.

SISTER IRENE:

One danger to it that I see, Mr. Weeks, and we have to be careful, is not to have everybody brought from the inside. Then you are not bringing new ideas and new life blood into the system.

WEEKS:

New ideas coming in...

SISTER IRENE:

We hired our Director of Quality Management, who actually came from AHA, Marcia Ladenburger. She applied for the job and even though a lot of people applied internally, she was just head and shoulders above those within our system. We say to our people, "If you work for us you are going to get priority on the career ladder." With very few exceptions, the people who are running our hospitals now have worked for us previously.

WEEKS:

They at least know that there is the possibility of moving up.

SISTER IRENE:

You know what happened in years past. If you worked here as an assistant to me in Southfield, your chances of going any further were quite slim. You would say, "Sister is in that job; they always have Sisters in that job. I want to be an administrator so I will start looking around. I will find something some place else so I will say goodbye to Sister Irene and go off." Now, we circularize all our openings in all our hospitals and post them on the personnel bulletin boards. All they have to do is go and look and they will

see any management openings from the Atlantic to the Pacific. They may come up with something.

WEEKS:

They know they will at least be considered.

SISTER IRENE:

They know that with all things being equal, they will get it. If there are two people as front-runners, one is ours and one is not, the one with our system will get it. If someone outside the system is better qualified and there also is one within the system, but less qualified, the one from outside the system will get it.

WEEKS:

I can see where the lady from the AHA might have a broader view from working in the AHA, might have a broad view of all hospitals in the country.

SISTER IRENE:

She was head and shoulders over anyone who applied so that is why she got it.

WEEKS:

How about your boards? Does each hospital have its own board?

SISTER IRENE:

Each hospital is a separate corporation with its own board.

WEEKS:

The regional offices, what do they...

SISTER IRENE:

The regional offices, up to the time National was formed each was a system to itself.

WEEKS:

Each one?

SISTER IRENE:

Each one was a separate system. We had four separate systems, throughout the United States. In putting the National together we planned to have regional offices. So, we took each existing system office and made it a regional office of the National. The Larry Prybils of the world answer to me where they had answered at a regional level previous to that. It has been a hard adjustment for all of them because the same four regional executives, up until I moved to St. Louis, actually were presidents of their individual systems. Now they are regional executives and I am president. So they had to change their titles.

WEEKS:

I suppose there was the feeling that they no longer were autonomous.

SISTER IRENE:

Yes. What I have tried to do with them is to bring them in to St. Louis every month. We spend a day as a group as we are trying to formulate our policies, etc. They all have a say in what we are doing so we will have a commitment when it passes our board.

WEEKS:

Your central office has a board also?

SISTER IRENE:

Yes.

WEEKS:

How are those persons chosen?

SISTER IRENE:

The thing you have to understand is that when we decided that maybe we ought to have a system that we had five Provinces or regions in the United States, each of them with a board or provincial council, as we call it, that was responsible for the hospitals, the schools and everything else within the region.

WEEKS:

The regional board is for health, education, and welfare.

SISTER IRENE:

Yes, everything under that jurisdiction. When we realized as hospital people that we really ought to have a system, we went to the heads of those five boards and said, "The Daughters of Charity ought to have a health system here in the United States, a national one where our unity would be stronger and more effective than as regional systems.

I guess we went to them early in 1980, but there was no interest expressed. We started again around 1983 or 1984. We went to those five Provincials again and said they really ought to do something. In January 1985, those regional bosses did. They appointed a task force, drawn from the Atlantic to the Pacific, to study if we should have a system throughout the United States. In addition, the Provincials said, "If you recommend a system, tell us how it should be governed and managed."

I was on that task force, so was Larry Prybil. There were fifteen members, three from each of the five regions across the United States. We met every month for two days from January of 1985 to June of 1986. You can imagine the man hours that were put into that, besides subcommittees that did their work back home. We studied, over that period of time, all the reasons

why we ought to have a system. We drew up a definition of the system, we drew up a mission statement for the system, we drew up the goals and objectives of the system, we drew up the governance and management structure for the system. We put the whole thing together in a report and presented it in June of 1986 to the five regional boards. We stated in that report that we recommended that we start right away, because we felt we had already lost years in the process.

It was accepted in June of 1986 and I was appointed by the end of June. I was asked some months prior to that when it looked like the national system was to be formed if I had an interest. My own Provincial Superior in Maryland talked to me and was willing that I be appointed to my present position. So, as soon as the report was accepted and the decision made to go ahead with the system I was immediately contacted. That is how the system was formed.

We tried to base as much as possible on what already existed. We tried to avoid any unnecessary reinventing of the wheel. We had four regional offices already set up, people already there.

WEEKS:

What happened to the educational part of the Order? The system is all for health, isn't it? There is nothing in the way of education in the national system, is there?

SISTER IRENE:

That has to stay with the regional boards. That is their work of the Church for the Order. They, by the Canon law of the Catholic Church, have responsibility for any work in their Province, not just one section of it. When we formed our national board we said we wanted the head of each Province to be on our board, and we wanted the Sisters responsible for the health

ministry of each region to be on the board. Then, hopefully we would have a number of lay people. That was one portion of the task force report that the Provincials accepted but they said they were not going to implement it yet. They didn't want to have any lay people on the board until we had our system structured and in operation. Our board right now is composed of the five heads of the five regions and the Sister from each of the regions who is in charge of health. It so happened that three out of five of the heads of the five Provinces had been in hospital administration previous to their assuming their present positions. So out of the ten board people, eight have been hospital administrators. There is no problem of explaining what is going on. They all know.

That's how the system got started.

WEEKS:

Do you have plans for expansion?

SISTER IRENE:

Our expansion is more of a method of merging. For instance, in the Eastern Region, they had their own risk management program, professional liability program, trust fund, etc. Three of the areas in the West had merged and had that same thing. That is the first thing we started to look at. Wherever we had programs that were spread over the five areas but were separate, we decided to merge them. The first one that was merged was risk management and professional liability. After March 1 of this year (1987) it was merged into one total program.

WEEKS:

Is that a subsidiary corporation?

SISTER IRENE:

No, just a service of National. Those employees are pulled in from the regional offices and moved into our national office so now everything is done in the national office for risk management and professional liability.

The next one we started to look at was pension, because we had the exact same thing. We had a pension trust fund in the East and about five different ones in the West and conglomerates of all kinds. We are now in the process of merging all of that into one. We had a very detailed study of our pension funds and our pension designs. As of January of 1989 they will all be merged into one. We had to have a much longer lead time to be sure that in merging we were conforming to the law. It's a much more complicated thing. In fact, we have a special committee doing it. They are meeting in St. Louis today. I will go home and sit in on their meeting. I will be a part of their meeting while they are finding ways of doing this because they have three trust funds in the West and one trust fund in the East. You are talking about hundreds of millions of dollars.

WEEKS:

Will these pension benefits be uniform?

SISTER IRENE:

They will be uniform throughout the system.

WEEKS:

There will be some adjustments?

SISTER IRENE:

Yes. The value to this is that as you move from one Daughters of Charity hospital to another your pension plan can go with you. A lot of people who have moved in the past have run into problems. They have not been able to

carry a program with them, which is not fair.

We have a benefits task force working now to see if we can get a commonality on that. We have done it on several benefits, for example, life insurance.

Our people said to us, "You know, all our hospitals have their own life insurance program, probably enrolling 1,000 to 2,000 lives. If we could take the 60,000 or 70,000 lives we have across the United States and take them to insurance companies we ought to be able to save something." We did. We save over $500,000 in premiums.

WEEKS:

Is that right?

When you were talking about professional liability insurance, I was wondering: Are you insuring the hospital and its employees, but not offering it to the physicians on the staff?

SISTER IRENE:

That varies, depending on the situation. In some places, obviously, the doctors are on our payroll and they are covered. Because we have certain problems that are different, depending on where the hospital is, we have had to make adjustments. Right here at Providence in Southfield, because of the situation here in Michigan, Southfield requested of the region they were in if something could be done to create a captive insurance company through which selected doctors could get their insurance because some of them were really having a hard time getting it here in the state. As a result, a captive insurance company, domiciled in the Grand Caymans, was established for our Michigan doctors in Saginaw and for Providence in Southfield. The doctors have to individually apply, and some are accepted and some are not. So we do

have a captive company for our doctors here in Michigan.

We had an unusual situation down in Jacksonville, Florida after I left there. Some of the physicians were in something of the same kind of situation as the doctors were here in Michigan. We said that we didn't want to start a lot of different captive insurance companies. Our insurance people went down to Jacksonville. They set up with the medical society there special conditions with our physicians there. They are in the process of doing the same thing in Washington, DC.

We react to a need as we see it, and settle it the best way possible, whatever that may be.

WEEKS:

You are bound to run into state laws and regulations.

SISTER IRENE:

We have other places, like Alabama, that practically don't have any malpractice problems at all. Then we say why should we form a great, big company that would cover us from the Atlantic to the Pacific? We have a fair number of hospitals that don't need that kind of coverage. So, we are reacting on a local or statewide basis.

WEEKS:

Do you know what the secret is about Alabama?

SISTER IRENE:

My guess would be: They don't have any real large cities, they are mostly a rural population. You look where your problems are, they are in the Miamis of the world, the Los Angeles. It is where you have states with large cities where you have aggressive people. In Alabama you have Montgomery, Mobile, and Birmingham. They are the state's large cities. We have hospitals

in all three of them. The people have a very strong allegiance to their hospitals and to their doctors.

WEEKS:

I am showing my ignorance. Are all the medical specialties well represented in Alabama?

SISTER IRENE:

Yes. As an example, our hospital in Montgomery does open heart surgery.

WEEKS:

They do high risk procedures.

SISTER IRENE:

Yes, high risk but their claims are low. So it does vary from state to state.

WEEKS:

I was talking with someone, I think it was Jim Hague...

SISTER IRENE:

Is he in California?

WEEKS:

I haven't heard from him in about six months, but the last I heard he was in California. I think that is a permanent retirement for him. Jim was telling me about the Catholic bishops and their influence. What is the national association of bishops?

SISTER IRENE:

The United States Catholic Conference.

WEEKS:

Do they set policy? Where is policy set within the American Church?

SISTER IRENE:

The policy within the American Church is with that group, the USCC, and that is a conference of all the bishops, archbishops, and cardinals in the United States. They meet twice a year. Their policy, as it affects hospitals, has to do basically with what we refer to as ethical and religious directives. They do issue those periodically and we must conform to them. Other than that, for the most part, the bishops do not get involved in our hospitals.

It is so different from the schools. The bishops are very involved with the Catholic schools. The difference is the parishes own the schools. Very, very few Catholic hospitals in this country are owned by a diocese. They are usually owned by a religious order, that might not even have its headquarters in that diocese. For instance, with us, since we are in so many different cities, and our headquarters might be in Maryland or Indiana (the clergy) do not get involved with hospitals unless they are owned by the diocese. Of all of the hospitals we have, two of them are owned by the diocese, and both are in Boston. They don't even belong to our system now, because the cardinal in Boston decided to start a system of his own. Boston is quite a Catholic town and they have quite a number of Catholic hospitals of various kinds, so they decided to form a system. St. Margaret's Hospital of Dorchester and St. John of God Hospital of Brighton have Daughters of Charity operating those hospitals, but they are owned by the diocese and the cardinal is chairman of the board. So, for the most part the bishops throughout the United States do not get involved in the running of the hospitals except where it is a matter of faith and canon law. They have the right to give us policy which we must follow to assure them that we are conforming to the teaching of the Catholic

Church. That's where they have authority over us. That's why they can come in and say to us that we can't do abortions, we can't do sterilizations for the sake of sterilization. We can't do anything against the moral teachings of the Church. They will draw policy from those and give them to us. We must conform to them if we want to be called a Catholic institution. If we would not be a Catholic institution the bishops would take our name out of the Kennedy Directory, and that would be it. That is the obligation that we have to the Church. I wouldn't be so naive as to let you think that is the only influence the Church has on our Catholic hospitals. That is not true. In Jacksonville, Florida we are in the Diocese of St. Augustine. That bishop is a very good example of a bishop who is interested in health care. That is part of the ministry of the Catholic Church. He knows he has no authority over how we run St. Vincent's Hospital, but he also knows that we are the image of the Catholic Church in health care. We are the only Catholic hospital in the diocese. He could have a strong moral persuasion over us, if necessary.

For instance, if we were going to start a fund drive, and he felt that a fund drive right now for St. Vincent's would hurt his planned fund drive for the diocese, I am sure he would come to us and say we should talk this over. Neither of us would be well-served. The bishops certainly have the power for moral persuasion and they exercise that for the most part in a good, healthy way. Most of the bishops will visit the hospitals on a very regular basis several times a year, if not more often. They will meet with administration or come over for a dedication or special event. They clearly identify with the hospital.

The bishops could come to us and say that we should have an open heart

program. We could ask them if they would furnish the money for it. I can say that I don't know of any instance in recent years where a bishop tried to interfere with the plans or management of our hospitals.

WEEKS:

I was going to remark that some of the priests have had great influence on Catholic health affairs. I was thinking of Father Schwitalla, and Father Flannigan.

SISTER IRENE:

And Father Casey after him.

WEEKS:

I suppose their influence and their example of... Were they all Jesuits?

SISTER IRENE:

Yes. All three of them were.

WEEKS:

They were interested in hospital administration courses. I am sure they had their influence in the associations.

SISTER IRENE:

They certainly did a fine job. You do not see many priests involved in health today at all. It is not a ministry that appeals to them. Again there is a shortage of priests as there is a shortage of nuns. The priests concentrate more now on their ministry, direct ministry, the liturgy, and so on.

WEEKS:

About 40 years ago, the priests I mentioned were pretty strong characters.

SISTER IRENE:

They did a lot of good.

WEEKS:

Yes, they did.

SISTER IRENE:

I didn't know Father Schwitalla, but Father Flannigan and Father Casey I knew very well.

WEEKS:

Some of the people with whom I have talked have mentioned these priests and all that they did and how influential they were. I have been trying to think of the priest from Cleveland who was so influential in AHA. It was Monsignor Maurice Griffin.

SISTER IRENE:

He is dead now.

WEEKS:

He and John Mannix were great friends.

SISTER IRENE:

Monsignor Timothy O'Brien from out on the West Coast has been influential in AHA. He was on the AHA board. He still serves on the AHA insurance company board.

WEEKS:

Does he?

SISTER IRENE:

I chair that insurance company board. Monsignor O'Brien has been active on that board since it was formed in 1976.

WEEKS:

There was some connection there with Jim Hague. Didn't Jim's daughter marry into the Catholic faith, and didn't Father O'Brien perform the marriage ceremony?

SISTER IRENE:

I think I remember hearing that.

WEEKS:

I didn't ask you the big question. Why did you consolidate and form the national health system? What was the prime cause of it?

SISTER IRENE:

We identified four or five reasons. Number one, and the predominant one, was for the continuation of our mission. There is a decline in the number of nuns. We realized more and more lay people would have to come into our operation. By consolidating we would be able to spread the Sisters' influence further and get a stronger commitment of the laity to our mission of the care of the sick poor. That was the predominant reason.

There were a lot of other reasons: economies of scale, which I have already mentioned; career ladder opportunity, and others. Predominantly it was the continuation of our mission.

WEEKS:

That certainly was a legitimate reason for a church. I am a non-Catholic and I wish our churches had more of a sense of mission.

You mentioned the risk, the insurance, the pensions, and so forth. Were there any other shared services?

SISTER IRENE:

Yes. Purchasing. We set up what was called Central Purchasing. There

was an office in Baltimore and an office in St. Louis. That goes back to the 1940s. That has been folded into our national operation. There has been a separate corporation but that is in the process of being dismantled. It will be coming in as a service. When we moved into our new headquarters, purchasing came in with us.

We have engineering services. We have engineers in several of our regional offices that we will send out for that kind of activity. Planning is another. We are establishing a national planning office as well as regional ones to help the local planners strategically so they know where they are going to go. Our general philosophy since we started this over a year and a half ago has been that if the local doesn't benefit we should not be in existence. Care is delivered on a local level, not delivered our of St. Louis. Our emphasis must be on the local level. Everything we do must be focused on that. That is our overall philosophy.

WEEKS:

It has often been said that in today's modern hospital the patient is often forgotten.

Have you done anything in the way of satellites?

SISTER IRENE:

Yes. Again, this differs by location.

WEEKS:

I understand.

SISTER IRENE:

In Jacksonville, Florida they very systematically planned satellites to ring the entire city. At the time I left there, we had 14 of them. They were walkin centers where we delivered care on an in and out basis with referral to

the main hospital. At Pensacola, Florida they probably have three or four satellites doing the same thing. Providence in Southfield, Michigan has satellites in Novi and in four or five other locations. The whole idea was to establish a mechanism for referrals to the tertiary care operation. That, I think, is a good thing to do.

WEEKS:

Are the referrals worthwhile in volume?

SISTER IRENE:

Here, very definitely. Novi is very active because there is no acute hospital nearby. In Jacksonville, Florida those 14 satellites see something like 150,000 patients a year. About 10 percent of them come into the hospital.

WEEKS:

I think Henry Ford Hospital in Detroit had the same sort of experience in Bloomfield, Dearborn and other locations.

SISTER IRENE:

We see them now as a source of patients for the hospital.

WEEKS:

Are there any regionalization plans where you have a network of hospitals? Where you have small primary care hospitals feeding into larger hospitals?

SISTER IRENE:

We have a few of those right now. Again it is what the local need might be. In Milwaukee we have a large hospital, St. Mary's Hospital. They have St. Mary's in Osaki. Satellites are usually 40 or 50 beds. In Indianapolis, Indiana we have a small 60 bed hospital that is a satellite of St. Vincent's

in Indianapolis. It actually is in Carmel, Indiana. Down in Indiana near Evansville, there is a town called Boonville. We have a satellite hospital there, Warrick Hospital, which feeds into St. Mary's Hospital in Evansville, Indiana. We were getting referrals from those hospitals. To protect the referrals, we went in and bought the hospital, or signed a contract with the hospital -- something of that nature.

WEEKS:

In the broader sense of representation, say in Washington or the state capital, how does this work? Does your organization have a man in Washington?

SISTER IRENE:

We do not, and I don't think we intend to. The task force, in setting the system up, talked about that. We felt in putting such a large system together we would have a lot of power, and we should make proper use of the power. So, what we did was set up on a national level a vice president for governmental and legal affairs. For activity of that nature where we want to influence Washington in whatever way is right, it is through his office. we have done several things the short time we have been in business. You may or may not be familiar with the new HCFA regulations about cardiac transplants; they came out October 1. Any hospitals that were doing transplants that did not meet those regulations, would not get Medicare payments for that procedure. The regulations were based completely on the requirements of an organization that certifies cardiac surgeons for doing their work. It's a regular association like the AMA or others, UNOS, United Network for Organ Sharing. UNOS has this whole set of regulations. One of them is that to be certified by them you had to have gone through an official training program for heart transplants. We have four hospitals that do transplants. Not one

of their physicians had ever gone to one of those programs purely because the programs didn't exist at the time these doctors began their work. It was impossible for our physicians to meet those qualifications. These hospitals were notified that after November 1 they could no longer do heart transplants. They had been doing them for years, almost from the time transplants had begun, and had a wonderful record. They called us, what were we going to do!

Our governmental affairs people got on the phone and put together a really concerted effort to Congress, to Secretary Bowen, etc. There was a letter from me saying I represented the largest not-for-profit hospital system in the United States, and what they were trying to make effective was unfair, and that these physicians should at least be grandfathered in, if they could demonstrate that they had the proper experience and the results of their work had been good. As a result all four hospitals doing transplants were grandfathered in.

WEEKS:

You did this on your own without the Catholic Healthcare Association?

SISTER IRENE:

We did it on our own. We did inform CHA that we were going to do it. We informed the Washington office of AHA, Jack Owen. We could not see those programs into which we had put millions of dollars go down the drain because of some capricious regulation. That was just not right.

WEEKS:

Have you found that any of these other organizations will join you?

SISTER IRENE:

St. Thomas Hospital of Nashville, our premier cardiac program, was so upset about the potential of losing their transplant program that they already

had gone to an attorney and they were ready to file a restraining order. I am sure that if we had reached a point where we would have had to take legal action, we would have asked AHA and CHA to come in with us. That was not necessary. Our four hospitals that were involved all went after their congressmen. We had a very well organized plan. I think HCFA got so much pressure that they pulled back.

WEEKS:

The next question comes naturally in sequence. With certain of your hospitals being specialists, like St. Thomas specializing in cardiac, do you have any plan under which you send specialists to other hospitals to explain what you are doing in the special unit?

SISTER IRENE:

We have several things. We have put together in St. Louis a listing of all the special kinds of services, programs, anything that could be of help to one of our other hospitals. For instance, if Southfield decides that they want to start a home nursing program, they just have to look under "home nursing" and they will see a listing of every home nursing program and the person to contact. There is a lot of that interchange. That is one system we have.

There is another thing that, like Topsy, just grew. I had hardly moved to St. Louis when I had a request from one of the regions where they had a hospital that had some problems. They called me and said, "Do you have a SWAT team that you could send over? It's a good hospital and we have got to get to the bottom of our problem."

I said, "I am it. I have a secretary, otherwise, I am it."

I said, "I don't have a SWAT team." I kind of brushed them off.

After I hung up, I thought about this and said to myself, I am here for service to our hospitals. I can't go our and be a SWAT team, but we have expertise from the Atlantic to the Pacific. We can put together a SWAT team, which is what we did. We got an administrator, a financial person, a planner, and a physician from our hospitals across the country. We put that SWAT team together and sent it to the hospital. They did a beautiful job; they got right to the core of the problem, wrote a beautiful report. That hospital is getting its act together now. We did it all internally. I think we are going to get more and more of that, particularly as the hospitals get to know each other.

We had our second annual symposium a month or so ago. There were trustees, administration, and medical staff in attendance. We had 856, almost as many as the Catholic Healthcare Association has at their convention. They usually run around 900.

WEEKS:

You are doing a marvelous job from all appearances here.

I wanted to ask you a little more about representation. I wondered if you joined any other groups like the Voluntary Hospitals? Do you join regional associations, or metro groups?

SISTER IRENE:

We belong to state hospital associations, local and regional hospital groups. I think it is important that we stay very active in those kind of organizations, for they can help us and we can help them. We have not joined any of the other groups, like Voluntary Hospitals, for we could get nothing out of it. It is the same in the Catholic system. I am sure you have heard of the CCHC (Consolidated Catholic Health Care), which is a group of Catholic

systems. They have formed an association. That was in process of being formed at the same time that we were looking into forming our system. We were part of the original task force to form this CCHC. After they had drawn up their whole plan and had asked all of the systems to contribute capital to it, we would have had to contribute millions of dollars because of our size. We had nothing to gain, so we did not enter. I still get calls asking if the Daughters will not reconsider.

We might mention some of the other organizations: Academy of Medical Administrators, the Academy of Catholic Healthcare Executives. We did not encourage our people to join them because we did not want to exercise that kind of control over them. We said they should not join any of these where it is an unnecessary duplication and they can't justify the expense.

WEEKS:

One of the questions addressed, not publicly but at least privately, is: How are all these new organizations affecting the AHA and the CHA? There are too many splinter groups.

SISTER IRENE:

Absolutely.

I was in San Antonio Saturday with some of the Catholic health systems' chief executive officers. That was one of our discussions at the meeting. There are just too many splinter groups. We cannot support them all, and we are not going to support them.

WEEKS:

Then you take in all the multihospital systems.

SISTER IRENE:

It just kind of blows your mind.

WEEKS:

It blows your mind is right.

I wanted to ask you about education. Do you have any medical colleges? You are affiliated...

SISTER IRENE:

Many of the church hospitals are affiliated with a university.

WEEKS:

You do offer residencies?

SISTER IRENE:

Yes.

WEEKS:

What about paramedical training of various sorts?

SISTER IRENE:

That differs by hospital. In Nashville, when I was there, we teamed up with the University of Tennessee to create a very large, comprehensive paramedical program, a critical care program, for the training of those personnel. I know quite a number of hospitals were involved in that sort of thing.

WEEKS:

Do you take what we sometimes call residents or fellows in hospital administration?

SISTER IRENE:

Yes, but not all of our hospitals do that. I personally have always taken them. I had them in Nashville, I had them in Washington, I had them in Jacksonville. Carney in Boston has always taken them. I have noted that the regulated states -- four or five hospitals in New York -- are not taking them

anymore. It's because of the cost. The regulations are so terrible on what kind of money you can spend and how you can spend it. They just cut off their residencies. That's up to the individual hospital.

WEEKS:

There are so many hospital administration course graduates. There must be 2,000 or 3,000 each year.

SISTER IRENE:

They ought to cut it off. The field is flooded. I had a resident in Jacksonville who finished a couple of years ago. He still doesn't have a job. He is living in St. Louis now because his wife was from St. Louis. She thought at least she could get a job out there. He calls me or she calls me every month to ask if I know of anything yet. She has had a baby, so she isn't working either. He is black. If you are black or a woman, you have a hard time getting a job. They have just flooded that field. The numbers keep rising.

WEEKS:

Not only the master's degrees but also the bachelor's in hospital administration. They can't be expected to run a hospital with their training.

We talked some about your subsidiaries. I wanted to ask you, do you have office buildings?

SISTER IRENE:

Every one of our hospitals except the little satellites has at least one office building on their campus and usually two or three. They would have one building and that was not enough and then they would build another or a third. And the land is there to build them on.

WEEKS:

I was interested to hear you use the word "campus." It is coming into use in the hospital business.

SISTER IRENE:

It has to, there are so many different things on the hospital ground.

WEEKS:

St. Joseph Hospital in Ann Arbor went out and bought a farm. They are rapidly building a campus. They soon will have everything there.

Do you have your own ambulance system anywhere?

SISTER IRENE:

We have helicopter service in some of our hospitals. In fact, ours in Saginaw crashed not long ago.

WEEKS:

I read about that. That was not long ago.

SISTER IRENE:

It was in the spring. It was not on an emergency call.

WEEKS:

It was a demonstration, wasn't it?

SISTER IRENE:

Very unfortunate.

WEEKS:

Hospitals are going into many things, but I don't think that ambulance service is generally profitable.

SISTER IRENE:

No, and I am not sure they are practical. As the cities have tried to develop their own disaster plan and have tried to be sure they have ambulance

service to meet the entire need of the city, it is more practical that they function as a city government service. This ambulance covers this area and that ambulance covers that area. It is so much more logical than sending ambulances all across the city. If you were doing it yourself you might send ambulances across the city. For service to the community it is better to do it in an organized way. I don't know of any regular ambulance service that any one of our hospitals has but several have helicopter ambulance service.

WEEKS:

We have talked about one of the big areas of care, to AIDS patients. Another great area of care is care of the aged, and the disabled. You have five long term...

SISTER IRENE:

Every one of them started out as an arm of the hospital. I speak of Jacksonville because I was located there. It is much easier to use an example you have lived with because you have more current information. There was a proprietary nursing home built across the street from the hospital. It may have been ten or twelve years ago. They eventually got out of it when the money was no longer there. It was bought up by another proprietary that again withdrew, all this within a couple of years. It was a terrible situation. About six years ago it was up for sale again. The hospital decided to acquire it, which they did, and made it a part of the hospital. It was a large one, 232 beds. They brought it in as part of the hospital complex, so it was not identified as a separate unit. About three years ago when it became popular to restructure and form holding companies, they made it a separate corporation called St. Catherine's Nursing Home. That is what it is today, an entirely separate corporation, run by a separate board. St. Vincent's doesn't really

have anything to do with it. St. Vincent's belongs to the same parent that St. Catherine's does.

That's how most of them evolved. We have one in Evansville that was the same way. There was a building built on property right next to the hospital, built by a different order of nuns. They decided to withdraw. They turned to St. Mary's because it was right next to them. They asked if St. Mary's would like it. St. Mary's took the nursing home and made it part of St. Mary's Hospital. Since then they have made it a separate corporation and have given it another name. Pensacola is going through the same thing now. There was a nursing home run by another order of nuns on property adjacent to theirs. That order of nuns has left and the Pensacola hospital is in the process of acquiring it.

WEEKS:

Isn't there any intermediate between nursing homes and hospitals?

SISTER IRENE:

We have a couple but they are actually located within the hospital. For example, in Buffalo we have a large hospital, 600 beds. It goes back 16 years at least when they built a wing of the hospital for intermediate care. That was thinking which was ahead of its time. It was specifically used for that, and identified as intermediate care, but separately accredited by the Joint Commission.

I hate to keep repeating but you won't see any set pattern evolving. We try to see what is the local need.

WEEKS:

I am interested in home care, among other things. I am wondering how a person at retirement age might best live. I realize there are different

stages of health which may govern what you do. It would seem to me you would have to have a suitable place to live. I can visualize a one floor ranch type, connected to some kind of food service, and connected to some kind of medical service, so that you could live in some kind of security.

In talking with people of retirement age about this idea, many of them say, "That's fine, but we are not ready for it yet." There seems no proper time to be ready for it.

I did visit Burcham Hills, HCA's retirement place in East Lansing, Michigan. They had three levels of care: ambulatory, wheelchair, and bedridden. They are separate.

There are people who want to live at home. Home care comes in here. Do you have home care service in your hospitals?

SISTER IRENE:

Yes. In fact, we have a couple of interesting things. We have a number of hospitals in Texas, so we have formed a Texas Home Health Program that all of our hospitals there belong to. We have done the same in Alabama. We have hospitals in each of the three large cities in Alabama. We have the Alabama Home Health Services run by the Daughters of Charity in each of the separate units. I cannot think of any of our hospitals now, any of our large hospitals, that do not have a home health service.

WEEKS:

Do you usually staff these home health services from your hospitals? Some places will hire or contract services.

SISTER IRENE:

If I am not mistaken, Mr. Weeks, the program in Alabama is a joint venture with the Upjohn people.

WEEKS:

We talked about community links. What do you do in the way of health education for the community? Do you have days when you take blood pressure, or that kind of program?

SISTER IRENE:

Because our hospitals are in large cities and very much committed to the community, we have a tremendous number of educational programs. St. Thomas in Nashville or St. Vincent's in Jacksonville almost every night of the week has a lecture being given some place sponsored by St. Vincent's Hospital or St. Thomas Hospital or Providence Hospital. Southfield has a tremendous educational program. In fact, in Indianapolis they call it St. Vincent's Good Health School.

I was down in Austin, Texas in the middle of September giving a talk. When I was driving by a building I saw the sign "Seton Hospital Good Health School." It looks like a regular school and they have regular classes in it for people. It is amazing the amount of education our hospitals are furnishing for the community, healthwise.

St. Thomas Hospital in Nashville a couple of years ago built an indoor running track in the hospital. One whole wing of the hospital on one floor instead of being partitioned off as rooms is now a running track. In the center of that track are exercise cycles and other exercise apparatus, then off to the side are classes. That goes all day long. They have programs for the elderly all morning. The elderly from the apartments in the neighborhood come in for their exercise and educational opportunities. It is just amazing to see how hospitals so quickly have gravitated to health education and promotion.

WEEKS:

How is your feeling about advertising? Harper and many of the other hospitals in Detroit will have a television commercial...

SISTER IRENE:

I have mixed emotions about it. I think it depends on what you call advertising. If the advertising says, "Come to us, we are number one," that turns me off. I think if we can use our advertising money to sponsor an educational program, and at the breaks in the television show some of the works of the hospital and the services they have that is very acceptable. Some of our hospitals run two different kinds of programs. One of them is called "Health Matters." Have you ever seen that?

WEEKS:

No, I haven't.

SISTER IRENE:

It's a canned program out of a company in Pennsylvania that might take, for instance, geriatrics. They will put a part of the program together that can be used in Southfield, or Ann Arbor, or Denver, or Florida, or any place and they sell it to the hospitals. It is a pre-taped program educating the public on geriatrics. They allow one segment of that to be spliced in for your particular situation. You pay them for that. Then you go to the local TV station and ask them to run "Health Matters." I seldom pick up a TV Guide now that I don't see "Health Matters" listed. It's a half hour program. Many of our hospitals subscribe to it now. They have it run on the local TV with a segment of their own.

The other thing that is now becoming popular -- and we have three or four hospitals doing it is a live "call in" health show. A health topic is chosen

and some segments are filmed in the hospital on that particular health subject. They then have a panel of doctors from that hospital to talk about that subject on the live show, then field the questions called in by the viewers at home. They are usually two-hour programs. This started in Jacksonville. St. Thomas in Nashville heard about it and asked Jacksonville to come up and help them start it. Jacksonville went up for a couple of programs. Now St. Thomas is on its own, and there are a couple of other hospitals thinking of starting such a program. So we are helping each other. It is a marvelous tool designed for educational programs for the public where they can call in and have their questions answered and it is also good advertising for the hospital, and excellent advertising for the physicians. The physicians used to tell us in Jacksonville that after they had appeared on the program they would get calls to their offices saying, "I may have what you talked about on the TV program. May I have an appointment?" It was a method of getting patients to physicians. When we first started in Jacksonville, doctors were not too keen about being on the program. By the time I left Jacksonville, they would be insulted if they were not invited to the panel if the program was on their specialty. "Why wasn't I on?" they would say. It made the doctors feel good about the hospital because we helped them get patients.

WEEKS:

For financial support, do you do any community drives?

SISTER IRENE:

For individual hospitals they will do it as the need arises.

WEEKS:

I noticed that in Battle Creek there is a Catholic hospital and a

community hospital. They have a joint effort in fund raising.

SISTER IRENE:

A smaller town can do that. In the large cities it is not so practical.

WEEKS:

Maybe we can talk about HMOs. Does your central or national office advise on the signing of contracts with HMOs by the Daughters of Charity hospitals? Or any other kind of managed care?

SISTER IRENE:

We have a director of managed care in our national office. We do not dictate to the local institution what they should do relative to managed care because we have found it varies all over the market. Some of our hospitals are not involved in any because there are none in their city. Jacksonville, Florida belongs to 14 of them. So that is a local decision. Whether they go to HMOs, PPOs, or IPA, or whatever, again is a local thing. Whether they go in as a partner and put capital in, again is a local decision. Where our office comes into play depends on several things: number one, if they need capital for it, they have to come to our finance arm. They have to give us a good feasibility study for why they want to, what the return on the investment would be because they are going to take money out of our investment pool. The managed care people in our office will take the contract that is going to be signed on the local level. The local people will send it to us to ask us to review and advise them. The locals are not expert on that. All those contracts come to us for comment, review, and advice, which is very practical.

One thing we have done a little of and plan to do more is to get a national contract that can apply to any of our hospitals. We have just finished one for a CHAMPUS supplement. We have just finished it with a

company based just outside of Washington in Arlington, Virginia. We signed the contract. Any of our hospitals can join up with them if they want. We negotiated a pretty good deal. We negotiated one with Maxicare. They have HMOs and PPOs. This was an HMO. We have negotiated a national contract for any of our hospitals who want to use it. We just sent out word to our hospitals that we have signed this contract, making it available, with a list of benefits that will come through the national contract rather than signing an individual contract. Use it if you want. That's our involvement right now.

Our initial plan, when we started our national office, was to go after some big insurance company and do a joint venture with them for an HMO or PPO across the United States. We did talk with several large insurance companies. In fact, we were almost at the point of signing a contract with one of them when we started hearing about Humana's problems, and a few others. We thought maybe this was not what we ought to do, that possibly we ought to handle it on the local level. The hospitals locally could contract but we should not try to put together a national contract.

WEEKS:

There is a great state of confusion over this. As we both know, there are many mergers, failures, bankruptcies. There is a variety of benefits.

Do you think there is ever going to be an HMO on a national scale?

SISTER IRENE:

There are too many differences on local and state levels.

The Voluntary Hospitals of America are trying to work with, I think, Aetna. When we first heard that I thought if they are doing it, maybe we should be doing it. But, I get rumbles now that that was not what people

expected.

Down in San Antonio last Saturday -- I don't know how correct it is -- they were showing that some things are best done on a national basis, there are certain things best on a regional basis, as there are certain things done best on a local basis. The smart system is going to be able to identify which is the best place to take care of some of these things. I think HMOs involve your local doctors, and you can't get along without your doctors. They have got to buy into it. If you have to go through all the red tape and bureaucracy that you have at a national level it is just not practical. We thought it was ill-advised.

To get back to your question: Will there ever be an HMO on a national scale? Probably not unless there is national health insurance or service. There are possibilities of that. If we do come to a national HMO, one or two big groups will carry the whole United States. As long as the element of competition and diversity is in play, as it certainly is now, I can't see more than one or two, any more than the prediction you heard a few years ago that within 1Ø years there would be only five super-med systems in the United States. I don't believe that. I think it sounded right when it was first said, but it does not appear to be getting that direction now.

WEEKS:

There are so many things that are questioned now about health systems. When we think about the federal government coming in to the health business more and more we come up against the question: Can we really afford it? Can the federal government do it? It doesn't seem very likely that they will.

The catastrophic insurance bill is now in a conference committee in Congress, isn't it?

SISTER IRENE:

Some form of it will pass. I am not sure how good it is.

WEEKS:

It isn't taking care of long-term care, I don't think. I don't mean just nursing care, I mean other kinds of long-term care. You mentioned Jacksonville had 14 satellites. It would be interesting to know how many are showing a profit. I am sure there must be systems of satellites where some are profitable and some are not.

SISTER IRENE:

I am not certain of the figures. When I left Jacksonville, some of them were showing a profit and some were not. Overall they were not making a profit. The hospital gets so many referrals as a result of those satellites, that we would be hurt if we closed them. So, the parent holding company gives money to support the satellites, because of referrals. It is a loss leader, as the business world would call it.

WEEKS:

Now that many of the HMOs are canceling Medicare or Medicaid contracts, it doesn't seem as though they are making any profit or they wouldn't be doing that.

What do you see for the future? You mentioned national health insurance or national health service. What do you see down the road? Do you see any changes coming up? Some people are already saying: "What comes after HMOs? They have been here. What comes next?"

SISTER IRENE:

I don't think HMOs are going to succeed in their present form. I think like everything else in health care what went in the funnel is not coming out

at the bottom. All kinds of things have been thrown into the hopper. I would think that within five or ten years something good will come out, that most people can buy into. The form it will take, I think, will depend very heavily on physician agreement. Frankly the physician can make or break anything you want to do. They control it. Right now they are so upset with any of these HMOs. All they do is contend with discount, discount, discount. They see their income eroding. I think the smart group will be the ones watching what comes out of the funnel so the physicians can enter into the shaping of it, and buy into it. Our greatest problem when we have started HMOs or PPOs on the local level has been physician resistance. The physician has been against the hospital getting involved at all. When I was at Jacksonville I think they belonged to 13 or 14 HMOs, etc. I was there during the beginning of getting into some of them. I can remember sitting at many doctors' meetings where the doctors didn't want to sign a contract, and didn't want the hospital to sign.

WEEKS:

They can be very threatened.

SISTER IRENE:

They are very threatened. To me the future success is tied to doctors. It's going to be the physician who is taking the patient to the hospital. As there are less and less inpatients, we are going to depend more and more on the doctors.

WEEKS:

I want to ask you one more question and that is about the physician.

Do you have them on your board? Do they enter into management? In any way other than serving on committees?

SISTER IRENE:

I think that in one or two hospitals we do not have a vice president for medical affairs, a medical director. I would say 30 to 35 of our hospitals have physicians in top management as vice presidents of medical affairs -- or whatever title they want to give them. They are full-time, and for the most part have come from the ranks, somebody in the medical staff who has been promoted. That started here in Providence in Southfield. In fact when I was still at the the old Providence Hospital on West Grand Boulevard in Detroit I hired the first medical director. We put in Dr. Briggs. He was our first medical director. I saw him when I was here last week.

As to physician members of the board, that is completely a local situation. Some of the hospitals have put physicians on the board, others have the Director of Medical Affairs go to the board meetings as a non-voting member. We consider the physicians as very primary to the operation of the hospital. We are in the process right now of finding a vice president for clinical effectiveness for our national office. He will be a physician.

WEEKS:

I want to ask you about your information system. What kind of information have you put into that system?

SISTER IRENE:

At the time we started the national health system we had four regions. Each region was doing something different relative to information systems. The task force, in setting up the design of the national health system, realized that those four regions had millions and millions and millions of dollars invested in information systems in their regions. Seventy or eighty million dollars across the United States by the four regional systems. They

hadn't even gotten fully started. Some just had the basic design of it. Some had just gotten equipment on board or programs operational. If we said that we were going to do that nationally, and that there would be one system nationally there would be equipment not needed and we could not afford to see that money go down the drain. We made a very distinct decision. We would not touch any of the information systems until 1992. Most of them would have lived out their usefulness by that time. In the meantime we would have a task force that would continually monitor what those four regions were doing. The new things that we would want to think about we would naturally do in 1992. We also started working on a common data base. Our regions were with different programs, one with SMS, two with Intermountain, and so on. So that is the status of where we are now. Each of the four regions is in a different level of sophistication. The West Central region, which is St. Louis, is the most sophisticated. They are direct, on-line to a central office in Dallas, Texas. They have computers at the nursing units. They have gotten far beyond the financial data, the personnel data. Theirs is a clinical operation. I think if I would poll our hospitals only about 30 or 40 percent are into clinical operations. All of them are in the personnel and financial aspects of MIS. The Eastern Region and the Far West Region are just going into Intermountain. That's the Mormon program. We will be up on clinical systems very shortly, within a year. Intermountain has a very, very good program on that. That is one of the reasons they were selected. There are seventy some hospitals using Intermountain. Some of Ed Connor's are. I am not sure how many. We will be bringing 20 or more into the Intermountain system. Hopefully by 1992 it will all be together.

WEEKS:

I can ask you one more quick question. What do you do about technology? How do you decide to spend a million dollars for new state-of-the-art equipment?

SISTER IRENE:

The original request has to come locally. We have restrictions as to the amount of money for any new technology they can approve on a local level. I think that is around $100,000. They can do that on the local level and we don't even get involved. The regional office can approve items up to two million dollars. They never would come to me at the national level unless it were going to cost over two million. They take care of all that on the local and regional levels. That works out quite well. That means that there is very little that comes up to us unless it is a new wing or building, a new hospital, or another major investment of some kind. I think that is fair, I really do. We do have certain requirements even though it can be approved on the regional level, because it is two million and less. We would ask for a feasibility study, etc. This is done so that a hospital couldn't buy a lithotripter without a good study to show that there would be a good return on the investment, and what kind of use would be expected from that particular piece of equipment.

WEEKS:

Speaking of lithotripters, we had an incident in Michigan in the Detroit area where four hospitals bought them before they got certificate of need for approval. The hospitals were clustered. It was very embarrassing, it seemed to me.

SISTER IRENE:

Several of our hospitals went in on joint ventures with four or five other hospitals. Another group did this on magnetic resonance. They set up a mobile unit.

WEEKS:

There should be a technology center wherever possible. As you say, it could be mobile, or the patient could be brought to the center. It would depend on conditions, I suppose.

You also do transplants?

SISTER IRENE:

Yes, particularly heart transplants. We have a number of hospitals doing them.

WEEKS:

Unfortunately you have a plane to catch, which forces us to bring this interview to a close. I want to thank you for a very informative conversation.

SISTER IRENE:

Thank you for this opportunity to talk together.

Interview at Detroit Metro Airport

December 7, 1987

INDEX

Abortions 56
Academy of Catholic Healthcare Executives 66
Academy of Medical Administrators 66
Aetna Life & Casualty 77
Africa 42
Aged 70
AIDS 24-25,39,40,70
    for profit care 38
Alabama 72
    lack of malpractice problem 53
Alabama Home Health Service
    Daughters of Charity 72
Ambulance service 69-70
American College of Healthcare Executives 26
American Hospital Association 46,66
    Distinguished Service Award 27
    ethics committee 11
    insurance board 58
    nominating committee 11
    Task Force on Nursing 22
    Washington office 63
American Medical Association 62
Ann Arbor, MI 35
Ann Arbor Airport 8
Architects 9
Arlington, VA 77
Atlanta, GA 44
Austin, TX
Baltimore, MD 36
Battle Creek, MI 75
Binghamton, NY 3,5,12
Binghamton State Hospital
    School of Nursing 4

Birmingham, AL 53
Bishops
interest in health services 55-57
Blue Cross/Blue Shield
Iowa 8
Michigan 7
Boards of trustees 46
Boston, MA 3,55
Broome Community Technical College 4
Buffalo, NY 36,71
Burcham Hills, East Lansing, MI 72
California 54
Cardinal Bernardin 13
Cardinal Dearden 18
Career ladder 44
Carney Hospital, Boston 3,67
Catastrophic insurance bill 78
Cathcart, H. Robert 16
Catholic charities 2
Catholic Church 20-21
canon law 49
Catholic Healthcare Association 10,63,65,66
Catholic University of America 2
Central America 32
Central purchasing 60
Central Regional Hospital Council of New York 3
CHAMPUS 76
Chemical dependency 37
Chicago 13,43
China 1
CompCare 36
Connecticut 3
Connors, Edward J. 82
Consolidated Catholic Health Care (CCHC) 65-66

Cottage Hospital, Grosse Pointe, MI 40
"Country Girls" 31
Dallas, TX 44,82
Daughters of Charity 1,3,10-11,14,15,33
Central Mother House, Paris 32
France 33-34
merging of health services 50-51
pension benefits 51-52
Provincia; Council 12
regions 15-16
regional boards 48
regional offices 46
task force 48-49
Daughters of Charity National Health System 42-43,48,59
annual symposium 65
board of trustees 46
central purchasing 59
corporation 46
Director of Managed Care 76
Director of Services 64
engineering services 60
financial condition 29,30
information system 81-82
national contract 76
office buildings 68
representation 62,65
residencies 67
Denver, CO 44
DePaul Hospital, Norfolk, VA 22
Des Moines, IA 8
Detroit, MI 3,7,15,74,83
Diocese of St. Augustine, Jacksonville, FL 56
District of Columbia General Hospital 41
El Paso, TX 14

Farmington, MI 18
Father Casey 57,58
Father Flannigan 57,58
Father Schwitalla 57,58
Federal Aviation Administration (FAA) 43
Florida 15
Florida Atlantic University 12
Florida Hospital, Orlando 25
Ford Motor Company 27
France 16,30
Franklin, Benjamin 16
Frist, Thomas, Jr. 21,28
Frist, Thomas, Sr. 27-28
Fund raising 75-76
Gavazzi,Aladino 16-17
General Motors Corporation 27
Grand Cayman Island 52
Greater Detroit Area Hospital Council 8
Hague, James 54,69
Harper Hospital, Detroit 74
HCFA (Health Care Financing Administration) 62
"Health Matters" 74
Heart transplants 84 See also: Transplants
Herman Kiefer Hospital, Detroit 40,41
HMO (Health Managemnt Organization) 76,77
    future 79
    national scale 78
Home health care 71,72
Hospital administration
    graduates 68
    residencies 67
Hospital Corporation of America (HCA) 27,28
Hospitals
    advertising 74,75

Hospitals
Catholic 7
long-term care 15
psychiatric 36
specialized 35
Howard University 41
Humana Corporation 13,77
Indiana 15
Indianapolis, IN 61
Infectious disease unit 39
Insurance
captive 52 See also: Liability insurance
Intermediate care 71
Intermountain information system 82
Investor-owned hospitals 36
IPA (Individual Practice Association) 76
Jacksonville, FL 38,40,53,56,60,70,75
HMOs 76
satellites 79 Also see: St. Vincent's Medical Center, Jacksonville.
Jesuits 57
JCAH (Joint Commission on the Accreditation of Hospitals) 71
Ladenburger, Marcia 45,46
Liability insurance 52-53
Lipson, Stephen 14
Lithotripters 83
Long-term care 79
Los Angeles, CA 53
LPN (licensed practical nurse) school, Howell, MI 23
McCabe, John 7-8
McNary, William 8
McPherson Community Health Center, Howell, MI 23
Magnetic Resonance Imaging 84
Maine 4,15
Management information systems (MIS) 82

Mannix, John Robert 58
Maryland 15,34
Medicaid 35
Medical colleges 67
Medicare 37,77
Medi-Centers of America 37
Metropolitan Detroit Council 3 See also: Greater Detroit Area Hospital Council
Miami, FL 53
Michigan 83
Michigan Catholic Hospital Conference 7-8
Michigan Society for Mental Health 7
Mobile, AL 53
Mobile units 84
Monsignor Maurice Griffin 58
Monsignor Timothy O'Brien 58
Montgomery, AL 53
    open heart surgery 54
Mormons 82
Napoleon 33
Nashville, TN 8-10,14,28,75
National health insurance or service 78,79
New England 33
New Orleans, LA 36
New York City 8,34
New York State 67-68
Niagara University 27
Nova Scotia 33
Nuns 19,57
Nursing
    operating room course 2-3
    shortage 21-22
Nursing homes 70
Nursing schools 22
O'Hare Airport, Chicago 43

Owen, Jack 63
Ownership
    Catholic hospitals 55
    Catholic schools 55
Pearl Harbor 40
Pennsylvania 4
Pennsylvania Hospital, Philadelphia 16
Philadelphia 1,16
Physicians
    control of health care 80
    hospital board members 80-81
poliomyelitis 41,42
Port Huron, MI 3
PPO (preferred provider organization) 76,77
Providence Hospital, Detroit, MI 5-6,41
    medical director 81
Providence Hospital, Southfield,MI 6,7,9,52,73
    psychiatric unit 36
Providence Hospital, Washington,DC 16,17,41,67
Provincial Councils 48,50
Prybil, Lawrence 35,47,48
Regionalization 61
Retirement living 71-72
Rice, Haynes 41
Ryan, Jack 10
Ryan Advisors 10
Saginaw, MI 3,52,69
St. Agnes Hospital, Baltimore 36
St. Ann's Infant Home, Hyattsville, MD 17-18,19
St. Catherine Nursing Home 70
St. John of God, Brighton, MA 55
St. Joseph's Hospital, Ann Arbor, MI 69
St. Joseph's Hospital, Mt. Clemens,MI 34
St. Joseph's Retreat, Dearborn, MI 36

St. Louis, MO 15,36,42,44,47,64,82
St. Louis University 12
St. Margaret's Hospital, Dorchester, MA 55
St. Mary's Hospital, Milwauke,WI 61
St. Mary's Hospital, Saginaw,MI 3
St. Thomas Hospital, Nashville,TN 8-10,14,16,67,73,75
transplant program 63-64
St. Vincent "Good Health School," Indianapolis 73
St. Vincent Hospital, Indianapolis 62
St. Vincent's Medical Center, Jacksonville, FL 17,56,67,71,73
St. Vincent De Paul 30-32
San Antonio, TX 66,78
Satellites 60
Seton Hospital Good Health School, Austin, TX 73
Seventh Day Adventists 25-26
Shared services 59
Sibery, Eugene 8
Sick poor 16,35
Sister Elizabeth Ann Seton 33
Sister Maurita Sengelaub 10
Sisters of Charity
Cincinnati 34
Sisters Hospital, Buffalo, NY 22
Sisters of Mercy 10
SMS 82
South America 35
Southfield, MI 6,7
State hospital associations 65
Sterilizations 56
Stull, Richard 11-12
Sun City, Arizona 8
SWAT team 64-65
Syracuse, NY 3-4
Technology
decisions on acquisitions 83

Tennessee, University of 67
Texas Home Health Program 72
Transplants 62-64,84
Tuberculosis 41-42
TV Guide 24
United Network for Organ Sharing (UNOS) 62-63
U.S. Catholic Conference 54-55
U.S. Congress 63,78
United Way 18
Upjohn Company
Home Health Care 72
Vatican 13
Virginia 15
Voluntary Hospitals of America 65,77
Vows 31
Walkin centers 60
Washington,DC 2,14-15,16,41,44,77
Waterville, ME 4-5
Welch, Donald 25-26
Wesbury, Stuart A.,Jr. 12
West Coast 15,36,58
Women
career choices 20-22
World War II 19
Zonta Club 27