

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

Paul J. Sanazaro

PAUL J. SANAZARO

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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Paul J. Sanazaro, M.D.

CHRONOLOGY

1922 Born Sanger, CA, September 27

1944 University of California, Berkeley, A.B.

1946 University of California, San Francisco, M.D.

1946-1947 San Francisco City and County Hospital, Intern

1947-1951 University of California Hospital, and VA Hospital,
Resident in Medicine

1950-1962 University of California, San Francisco, School of
Medicine, Faculty Member

1951-1953 U. S. Army, Medical Corps

1953-1955 Berkeley, CA, private practice

1955-1962 University of California, San Francisco, School of
Medicine, Chief, General Medicine Clinic

1959-1962 University of California, San Francisco, School of
Medicine, Associate Professor of Medicine

1962-1967 University of Illinois College of Medicine,
Clinical Professor of Medicine

1962-1968 Association of American Medical Colleges,
Division of Education, Director

1963-1966 National Commission on Community Health Services,
Consultant

1966-1968 DHEW Health Services Research Study Section,
Chairman

1968-1972 National Center for Health Services Research &
Development, Director

1972-1973 DHEW, Associate Department Administrator

1973 Private Consultant, Health Services Research &
Development

1973-1976 Private Initiative in PSRO, Director

1974-1975 George Washington University School of Medicine,
Professor

1975- University of California, San Francisco, Clinical
Professor of Medicine

1978-1983 Private Initiative in Quality Assurance,
Director

MEMBERSHIPS & AFFILIATIONS

Alpha Omega Alpha

Member

American Board of Internal Medicine

Diplomate

American College of Physicians

Fellow

American Public Health Association

Fellow

AWARDS & HONORS

Phi Beta Kappa

Who's Who in America

BOOKS

Health Services Research and R&D in Perspective (with E. Evelyn Flook, Editors).

Ann Arbor: Health Administration Press, 1973.

WEEKS:

Dr. Sanazaro, we are sitting here today talking about your life. This oral history is really an autobiography and the usual way we begin is to ask some sort of question about how did you get into the health care field, and particularly, how did you choose to become a physician. You might want to begin talking from that.

SANAZARO:

I always wanted to become a physician. My parents were both immigrants and, as you know, the first generation is always impelled by a variety of forces to do something above what has been characteristic of the family.

At any rate, with that, all throughout school there was never any question that I was going to end up in medicine. Fortunately, I turned out to be qualified to study medicine. I went to medical school with the intent to become a general practitioner, having a very broad interest in taking care of families, people of all ages, all kinds of problems.

But this was just at the time of World War II, when specialization was coming to the fore and I realized that it was not possible to be expert, as a general practitioner, in all the fields that were required. I switched to internal medicine and became certified. I was in the Korean episode, on stateside duty. Practiced in Berkeley and became interested in teaching. Went on the full-time faculty of the department of medicine at the University of California at San Francisco and functioned primarily as a teacher. That was my primary interest.

WEEKS:

Some of your colleagues who have worked with you in the past have said that they believe that you have such a love for teaching, particularly

clinical teaching, that you would never give it up, no matter what kind of job you have otherwise, you would like to keep your finger in, keep up-to-date, and...

SANAZARO:

That's true. I'm now clinical professor at the University of California at San Francisco--I work with medical students and house staff. When I was in the government, my one regret was that I had to give up teaching. The other regret, which I haven't been able to recoup and probably will not be able to, is giving up the direct care of my own patients. Those have been the two most satisfying experiences in my life. So at least I have one of them.

WEEKS:

You are a graduate of the University of California at San Francisco and you did your residency at the university hospital and at the VA hospital?

SANAZARO:

Right.

WEEKS:

You have been in private practice and you are a teacher at heart, you say.

One of the things I wondered about, looking at your chronology of your life, was...how did you happen to move to Illinois? You seem to be a California-born and so forth.

SANAZARO:

Well, I mentioned that I was primarily a teacher and became interested in educational process, curriculum, and inevitably was asked to do a study of the curriculum there for the school.

About 1959, I had the notion that a lot of what was going on in curriculum, in form, was nothing more than 'shaking the box', as they say in

management. Or that it was having a placebo effect. So almost tongue-in-cheek, I wrote an abstract of a paper and sent it to the Association of American Medical Colleges for their annual meeting. Ward Darley picked the paper and so I met him at the annual meeting in '59.

Then the following year, the Commonwealth Fund asked me to do a survey of medical education, to make a projection of the trends, what factors should be influencing medical education, and what really was happening.

In early 1962, Ward Darley invited me to come back to the AAMC, which then was in Evanston, saying that he had obtained a grant from the Carnegie Corporation for a long-term program of studies in medical education and would I head up that activity. I found myself saying yes, giving up a tenured position and all of that. That is how that happened.

WEEKS:

Would you like to say a few words about Darley? I have heard so many...I have never had the opportunity of meeting him in the past.

SANAZARO:

Yes. He was a remarkable individual. He was a native of Colorado, trained in internal medicine. He was in private practice there. By all accounts, a beloved practitioner.

He had this amazing capacity to absorb new ideas and new perspectives. He did some clinical research which was in line with what later became Nobel Prize winning research on the use of steroids in arthritis. And because of this unique ability to grasp concepts and see trends, he moved into the medical school and became the dean. Again, because he saw the relationship clearly between the medical school and the university and the fruitful and the non-fruitful interactions, he became the President of the University of

Colorado. And very active in AAMC activities. With his contacts with all the fellow deans, it became very clear that when medical education was going to move to the fore, in the mid-'50s, that he was the outstanding candidate to be the Director of the Association.

If you look at his writings, you will see there a mirror of the advancement of medical education, the appropriate politicization of medical education, and you will see all the seminal ideas that have been carried forward. Just a remarkable person. I don't think I have ever met anyone like him with the scope of abilities and interests.

WEEKS:

Is he still living?

SANAZARO:

Oh, no. He died several years ago. His widow, Pauline, still lives in Denver and his son is there, an administrator in a hospital.

WEEKS:

At the time that you were doing this work for AAMC, this must have been about the time that there were many new medical schools being founded with the clinical experience in community hospitals, which was quite a change from what it had been.

SANAZARO:

The two early ones were, of course, at Michigan State in Lansing and the Kansas experiment with Grey Dimond. Yes, there were about 72 medical schools in operation in 1960 and the number has grown enormously since then to over 120. Despite all the educational experiments the surprising finding is that the different curricula haven't made much difference.

Ward Darley was responsible for pushing the button. He instigated the

action that led to government subsidy of medical school construction to make this expansion possible. Everyone thought, of course, that it would take decades to overcome the physician deficit and the miracle is that we are now talking about over-supply though it is less than twenty years since the deliberate effort to expand capacity began.

WEEKS:

I attended the meeting of the schools--how do they characterize themselves--the medical schools founded since 1960, which was this group, on the Michigan State campus about four or five years ago. These men were very much concerned about their income as to whether when this great over-supply became a fact, would their incomes be affected...What would they do? We heard examples of other countries where physicians are in heavy ratio, like Argentina or Italy or Israel, these other countries where physicians have to take second jobs in order to get by and feed their families and so forth. So there is a lot of concern about this but, as you say, maybe it won't make as much difference as we think.

SANAZARO:

No. The needs of the American people have never been adequately met, neither in range of services nor geographic distribution. And I don't see the supersaturation here.

WEEKS:

How do you think these physicians will be employed? Will we get into a situation with the salaried physician sponsored through the government some way, or HMOs?

SANAZARO:

An absolutely unique change is occurring in the delivery of medical care

in this country, historically unprecedented and representing a true deviation from all tradition, embracing the principle of competition and organization, simultaneously, although the two are antithetical in personal medical care. It is the uniquely American way of trying to achieve what is achieved by the countries with so-called socialized medicine where the medical services are organized and funded by the government and where there is budgeting of total medical costs, as in Britain, Sweden and so forth. Up to the present time, that has been the only means of controlling the cost of medical care in those countries. They simply budget a certain level.

Well, we are not going to have socialized medicine here. But, for a variety of reasons and the physician over-supply, so-called--I say so-called over-supply because it is not yet evident that that is true. Bob Sparks at the Kellogg Foundation has some interesting data on the projected growth of the physician population vis-a-vis the projected population growth in this country which raises serious questions about the doomsayers' wisdom. At any rate, because of the concern that there might be an over-supply of physicians and the political saliency of cost overruns in all the public programs, there has been a remarkable willingness on the part of organized medicine, individuals and hospitals, to enter into these new arrangements, the preferred provider organizations, prudent buyer plans, the independent practice associations. The notion of HMOs has been greatly boosted by this. Out of all of this will come a higher proportion of salaried physicians, salaried by hospitals, and new kinds of practice arrangements.

Even those that are not salaried will increasingly have to function as though they were, because their income will really have a ceiling except for those that are true entrepreneurs and they'll, of course, remain

individualistic. But that clearly is the trend and there are benefits of such an arrangement in terms of efficiency. But the available evidence suggests that that efficiency is not an automatic accompaniment of a higher degree of organization. These could become bureaucracies.

The other hazard is routinization. If you remove the sense of individual responsibility and increasingly the perception is of being a cog in the great machine, there is no way of knowing what effect that will have on physician/patient relationships, ethical concerns, and all the rest. So this is a remarkable period for someone who would like to do a prospective study of the fundamental socializing change.

WEEKS:

There is no question about that. I had an interesting interview with Dr. Crile at the Cleveland Clinic. I went to see him because I wanted to know more about his ideas about no fee-for-service on surgery. I am quite impressed with the fact that he says that they have no trouble with their salaried physicians. All of their physicians are salaried in the clinic.

I said, "What do you do about PSRO? Or what do you do about peer review?"

He said, "Well, we just naturally watch each other anyway. We always have help available and everybody responds that way, so we have no trouble."

And it seemed, of course, from his viewpoint that it was a very perfect situation.

SANAZARO:

Yes, what you are seeing there, of course, is the influence of that rare key ingredient, whenever you have excellence in quality; and that is great leadership. A clear commitment to high standards, the exemplification of ideal care is so that it is inspirational, but it is also, if you will, a

controlling influence in that no one is allowed to fall below the standard.

WEEKS:

It was a remarkable experience to talk with him and to hear him talk about his father, one of the founders, of course, of it. They must have been remarkable people.

SANAZARO:

Yes, there are a whole series of sagas and I hope you can capture some of those. That is one of them.

WEEKS:

Before we leave this physician population--what do you think the effect is going to be of the large increase of women students of medicine? Most of the newer schools have about fifty percent or more of women enrolled.

SANAZARO:

I am not sure that a projection can be made. On the basis of past experience you would predict pretty much the same cycle: a large proportion would drop out of active practice to have a family or would simply find not enough in practice to challenge them and that, therefore, the retention rate in full-time practice would be considerably lower than for the male physicians.

The reason that you can't make that projection is the simultaneous change of the work force where at all levels you now have women carrying out the jobs that men used to have. So it is likely that the profile of the patient population of women practitioners will also change. And the fact that women are now going into all the specialties and not just pediatrics, OB/GYN, is another factor. I would guess that the retention rate will be much higher; that you will find a clustering of working women patients around the female

physicians for a variety of reasons. My prediction is that the retention rate will be better and the quality of care will be unaffected.

WEEKS:

It seems that all the professions, law,--nursing is suffering because of women going into other professions where the hours and working conditions may be better.

Today I received, from your old Center, a leaflet which was really for book reviews--this is the first I have seen of this sort of thing--in which some author has said there is no shortage of nurses.

SANAZARO:

True.

WEEKS:

And if hospitals would pay better salaries, they would have no trouble keeping their nurses. I don't know whether it is that simple or not.

SANAZARO:

No, it isn't. It is one of the factors. There are some hospitals that are remarkably successful in maintaining a very low turnover and a number of things go into it: not changing the shift, an escort service, simply the professional climate in the hospital and for the nursing staff. All of these things enter into it.

But I agree that there is an over-supply of nurses in numbers.

WEEKS:

I was wondering when you were talking about the female physicians, if they might not go through the same pattern--drop out and raise a family, as you mentioned--and then many of them go back working at times convenient to them or hours, days, convenient to them?

SANAZARO:

That's right. And there are retraining programs at certain medical schools specifically for that purpose.

WEEKS:

You mentioned women coming back to nursing and then the hospital is faced with in-service training to bring them up-to-date. In fact, I have noticed that in many hospitals hiring nurses who have worked in another hospital somewhere where they are allowed to do certain procedures and in the new hospital they have other procedures so they have to teach them. There isn't a uniform level of practice that nurses...

SANAZARO:

No. Each hospital tends to pride itself on its own procedures. In fact, as you know, some hospitals will not accept technicians that are trained by the standard schools because they feel that perhaps the training has been wasteful in not properly imprinting the technicians with respect for costs, such as materials and all the rest.

Most hospitals want their own training programs. It is a legitimate cost of doing business. I think the patient ends up with better service.

WEEKS:

Yes, I think so, too.

I had quite a long talk with Faye Abdellah about the problems of nursing. She's an interesting person, isn't she?

SANAZARO:

Wonderful.

WEEKS:

I want you to talk about her when we come to it later, if you will.

I also have a note here that you did consulting with the National Commission on Community Health Services.

SANAZARO:

Oh, yes. In the mid-'60s, the National Commission on Community Health Services had a series of task forces that looked at all aspects of health services and I was on the manpower group. Steve Guerke, who was then the Dean of the School of Public Health at UCLA, was chairman of that and convened us out there in California. It was welcome to go there from a Chicago winter to the sunshine and bougainvilleas blooming. That was still a time when the concept of community health services was thought to be the forerunner of the progressive reorganization of health services.

But, of course, their report came along at a time when funding was beginning to dry up. The peak year was '67 and in subsequent years there was the politicization of the federal bureaucracy. And although the words community health services persisted, there was progressively less emphasis on it. Public Health Service people had progressively less influence on policy and programs. So it simply disappeared. Just another report on the shelf.

WEEKS:

In looking at my notes, I'm wondering first how you happened to become chairman of the Health Services Research Study Section? This is under the Public Health Service, isn't it?

SANAZARO:

Yes, that was originally in the Bureau of State Services before the reorganization of 1967, I suppose it was, and I forget all the labels that were attached to it.

Well, I was working in Evanston and my studies in medical education stimulated my interest in the relationship of medical education to medical practice. Also, the Association had conducted this longitudinal study of all the students entering some twenty-six medical schools in 1956. They were followed through their four years of medical education and the original plan was to follow them prospectively for the rest of their careers.

If you are going to try to relate their medical education to their practice, you are going to have to have some criteria of their performance. I became interested in the criterion problem and discovered, of course, that there were none, that the techniques did not exist. So I proposed a series of studies, some of which were funded by the Public Health Service through the Health Services Research Study Section.

One day about 1965, Duncan Clark brought some people out to Evanston--it was in the dead of winter, one of those bitter, cold days. I think he was wearing his earmuffs, and they were freezing, and it was a terrible day. We had a nice conversation and it was subsequent to that that I was invited to join the Study Section.

I didn't know much about the Study Section. Kerr White was then the chairman. What a dominant figure! If there is anyone who has had an imprint on health services research, that has put it in its mold for this country, it is Kerr White. I was just so very fortunate to learn so much from him. Chairmanship rotated, it was not permanent. I just happened to be the next one on rotation.

WEEKS:

Is this where you met Ed Connors first? He was on that, wasn't he?

SANAZARO:

Yes, that's right.

SANAZARO:

He is one of the individuals who startles you with the naturalness with which he puts out wisdom. He's always talking about sports and you would think that he is an Irishman interested in fun and a good time, which he is. In addition, he is a very wise person and just knows so much. We would have these interminable discussions at the Study Section going round and round and round. Ed would sit there with this bland expression on his face and finally there would be the lull and he would say, "Why don't we..." and there would be the solution.

And then subsequently, as you know, he came back to Washington at the behest of Bob Marston, who was the head of the Health Services and Mental Health Administration, as an advisor to the administration on the whole range of problems centering on the hospital, health services and financing. And we were able to get together then. He was very helpful to us in the Center in many of our key programs. We used him heavily for that.

WEEKS:

I've had about thirty-five of these interviews and every time your name has come up in any of them--and it had come up in several--you'd be very pleased to hear how well you are thought of. And Ed, of course, has a great affection for you, and great respect for your ability.

From this Study Section then, I assume this is how you worked into the National Center. Was this a natural move?

SANAZARO:

Well, yes and no. I suppose more yes. The AAMC was in transition at that time. Ward Darley had retired. He had serious health problems. There were the discussions of the move to Washington. There were many internal difficulties. The question was whether to continue working with studies in medical education there or to move directly into studies of medical care.

It turned out that the American Medical Association was also interested in problems of medical care, at that time, and after discussions with Bert Howard, I was about to sign a contract with them to organize a program in the quality of medical care--a central resource unit at headquarters that would gradually serve a function comparable to that of continuing medical education. Bill Ruhe was very interested in this.

I then got a call from Washington saying, "How would you like to head up the Center?" I had to tell Bert Howard that another opportunity had come up that I felt I was more suited for and was more motivated to undertake.

WEEKS:

Who set the goals and objectives for this new center?

SANAZARO:

Remember that it was an outgrowth of the Commission on the Costs of Medical Care of 1967. Its narrow recommendation was that the Center concern itself with the costs of medical care. But, there were other commissions like that on health manpower, with its recommendations for research on quality. It was very evident that any center that focused narrowly on the costs of medical care would almost certainly fail, because the costs are only one aspect of the whole picture.

The strategy for arriving at the formal statement of objectives was to involve the most knowledgeable people in the country. We set up the various task forces with only a very rough original idea as to what the component programs would be of the Center. We must have involved over several hundred individuals to develop a statement of priorities, rationales for dealing with those priorities, suggested approaches to them, funding that would be required, the kinds of projects that should be supported. Quite truthfully, that Center began with a high degree of chaos, rather than any predetermined ideas.

WEEKS:

One thing that has impressed me over the years and you can tell me whether I am right or wrong, when you were there, there was the National Center for Health Services Research and Development. Today the development has been dropped. Did you--I think you did--envisage the idea of the Center as being the place of not only doing research but would also do demonstrations?

SANAZARO:

Oh, yes. That was the precise point: health services research had gone on before for quite some time--and Evelyn Flook is the best historian on that. There was already at that time concern that so much more that was known than was being applied. The apprehension was that if the center just did research, it would not build adequately on what was already available. That is why it was "research and development." The range of programs was from pure detached health services research all the way through demonstration and evaluation and application. That was always the strategy. What we didn't know is what the substance should be for that. That is why we used all the advisory groups.

After the inputs were obtained and the decisions made, the review panels were set up. We still had the HSR Study Sections, the granddaddy, but then we had a demonstration grants review study section to handle that part of it. And we then had special panels for the large scale R&D as well as the training grant review groups.

But, yes, development and application were a priority.

WEEKS:

It stays in my memory that the first time I visited the Center was in respect to what we called the Mid-Career Program. I think Faye was trying to get that developed. Michigan was one of the schools. Do you remember the first time I met you we brought our fellows down and sat down and you talked with us awhile. But we also were addressed by other members of your staff. At that time I can remember, there was a demonstration program going on somewhere in the East where you were trying to again establish the fact or investigate the situation of a set daily rate of reimbursement which is an idea that hasn't died and I hope it never does.

By the way, have you noticed AHA's new idea, "new" in quotes, of not considering it from a daily basis but from a patient's stay in hospital? I think this is coming out, isn't it? Medicare is going to try it out I think.

SANAZARO:

That's right.

Yes, I remember that very well--the all inclusive rate--and then the prospective reimbursement experiment in Rhode Island which was ruined by the cap that President Nixon imposed.

Yes, I hope that that idea never dies because again if it goes beyond that as a way of controlling costs it will do damage.

WEEKS:

I hope that something can be worked out because if we in the health business can't control our costs, we are in for a lot of trouble. Either we are going to have to cut services or we are going to have the federal government saying that they should look more closely at what we are doing and this might not be good either.

SANAZARO:

No. And that is one of the pressures that is bringing about this unprecedented move towards competition and different degrees of organization.

WEEKS:

You mentioned Evelyn Flook. I've known her over the telephone, basically. I think I met her one time when I was there. But, of course, I had many conversations when we were publishing this book, but would you tell me something about her?

SANAZARO:

Oh, my. Well, E. Evelyn Flook is the grand lady and the unsung scholar of the Public Health Service. She was a teacher and joined the Public Health Service in the early '30s and worked with Joe Mountin who, in the 1930s, had all the ideas that subsequently have been expressed regarding almost anything you would care to mention regarding data systems, manpower...

WEEKS:

I think of him for regionalization; primary up to tertiary care...

SANAZARO:

That's right. And Evelyn worked with him in that and had some good publications. Then, because of her remarkable organization and personal skills in dealing with difficult situations when there was reorganization of

major programs, she became one of the key people in the successive reorganizations of the Public Health Service. And quite apart from her administrative contributions there, she became the historian, the keeper of the history, of the changes in the Public Health Service, the rationales for them and all of the ins and outs of why certain things did or didn't happen.

She has a remarkable circle of friends and acquaintances going back to members of the Commission on the Costs of Medical Care--had a delightful meeting with them. I first met her when she was one of the staff people for the Health Services Research Study Section. I very quickly saw what a rare person she was. Her absolute integrity; her grasp of the situation and her perspectives; her humanism.

So when the Center was set up, she was one of my priority people to recruit because she was absolutely indispensable for knowing how things should operate properly. A loyal trooper and just a great person.

WEEKS:

I imagine she is a rather modest person, too, isn't she?

SANAZARO:

Yes, she will never volunteer anything about herself. You would have to drag it out of her.

WEEKS:

It was in the beginning, I think, I called her and asked her if she would do an oral history. I told her that I had wanted to talk with you and maybe Tom McCarthy.

SANAZARO:

You must get her because she will give you an insight...

WEEKS:

May I use you as a reference then?

SANAZARO:

Oh, sure, by all means. I'll be glad to arm-twist on that. She will not volunteer. It won't be out of false modesty. She just feels that way. But it would be a shame to miss her.

WEEKS:

I'll do my best to see her.

I mentioned Tom McCarthy. I've met him and know him slightly but I've heard that he is a very able Irishman...

SANAZARO:

Yes, he's a political animal. He's proud of that eponym. He has in a sense suffered for being that way because he ended up with the wrong alliances at various times. Because he is very aggressive and did alienate himself from some people there, he had to leave and go on detached service to the State of New York, where he is now.

But I chose him because I realized the enormity of organizing the Center. And if it was going to do anything, it had to get organized in a hurry and we needed to short-cut bureaucracy. Otherwise nothing was going to happen. Tom, when I first met him, was the Exec for the Study Section and he was the one who organized the health services survey in Britain and got a great many other things going which otherwise would have taken years. That is why I got him there. And there was a price for that year.

I paid a price for having Tom as my deputy. But, overall, I have never had a regret. He did what I expected him to do.

WEEKS:

But you needed a political person.

SANAZARO:

I needed that. He supplied it. We had a polyglot team. Evelyn Flook was a complete lady and Tom McCarthy was a complete political animal. But they each served an indispensable function.

WEEKS:

This year that he spent in Britain, somebody said that they thought that there was pressure, so he left for a year.

SANAZARO:

That's true. Because of his political affiliation--and remember that the Nixon team cleaned house, or wanted to clean house--he had enough allies that he was able to resist that. But he couldn't be given a prominent position in a Republican administration. So he had to leave. The year in England was a stepping stone. He is hoping, obviously, that things will change in Washington. But he is on the outs until then.

WEEKS:

Let's see, he is a Ph.D. from Iowa?

SANAZARO:

Yes, in hospital administration. Again, from his background, you wouldn't expect it but he could sense the importance of new ideas and new developments. That was his Ph.D. thesis. You just wonder how it is that some individuals can do this--it is somehow a built-in, intuitive talent. He's had that and that is why he has been politically astute. But also he has helped many things come to fruition that were important.

Like the series of papers on health services research, the Milbank series, Tom was the one that supplied the muscle, the energy and the know-how to get that done, despite all kinds of hurdles. He was, in a sense, Kerr White's point man. Kerr provided the intellectual direction and Tom did the hard, dirty work to get it through. Or it would never have happened. And that is one of the best state-of-the-art publications that has ever appeared in any aspect of the Public Health Service as far as I am concerned.

WEEKS:

When you stop to think about it, I know Gary Hartman had been criticized many times for thinking he should have a Ph.D. program but there have been quite a few of those men come out of there that have made their mark, haven't they? I think maybe that proves that he was right.

SANAZARO:

Yes.

WEEKS:

I didn't get to know Dr. Eichhorn either. I, of course, talked to him on the phone several times.

SANAZARO:

There again, he had the unusual characteristic for a social scientist of not being a prisoner of his discipline. The chapter that he and Tom Bice wrote for this book, I think now is considered a model statement of the perspective that a health services researcher needs to have if in fact he is interested in health services. It is the old tension between an academic discipline that is advancing itself academically and a discipline rooted in academia that is directed to improving health service.

Bob is a sociologist and he is at the school that the people in Berkeley refer to as the outhouse counters because he is quantitative in his orientation. Bob was on the Study Section and demonstrated his ability to see what social science disciplines had to do if they were going to help improve health services, which wasn't to refine theory but to improve practice. That is why, when we set up the key team, the question was who would be the key social scientist? It had to be Bob Eichhorn because he understood the disciplines and all that they represented and also understood their application.

During a meeting of the Study Section Tom McCarthy and I decided that this was the time to put the bite on him. So we went up to his motel room, and after all the pleasantries we told him where we were in our thinking about the nucleus for the Center. I think he was so taken aback that he blinked and said, "All right, yes."

And then he said, "Of course I'll have to talk to my wife."

And I never regretted that. A very strong person, good person, knowledgeable and selfless, hardworking and took a lot of punishment from what many of his colleagues in the university were saying about him. He had to do a lot of translating but he organized programs for us; he set up the training programs and when we finally got to the R&D unit, we asked him to set it up because we felt that he had the best view of how research applies to demonstration and development.

Afterwards he returned to Purdue instead of going other places. I think he is an invaluable resource.

WEEKS:

He served for a long time on our editorial committee on Inquiry. We still value him as a good referee.

SANAZARO:

Yes, he is very fair but critical.

WEEKS:

And probably he and Odin Anderson are the two outstanding medical sociologists, if that is the title they'd choose, in the country, I would think.

SANAZARO:

I think so.

WEEKS:

I was going to ask you about Faye Abdellah, too. How did she enter into the Center? Was she a part of the staff or did she have a connection through the Public Health Service?

SANAZARO:

Yes, she was in the old bureau--I'm forgetting some names there have been so many--and I had met her there and again just had been impressed with her remarkable career line. She began with hospital training in nursing, then went the academic route to get a doctorate, and then continued to see more broadly and deeply the issues in nursing and, in essence, committed herself to dealing with those. Anyone that can do that has extraordinary talent.

So she joined the list of people who had extraordinary talent, which is what we needed in the Center. When we talked with her about this she was very pleased. It required sacrifices on her part. This was a deviation in her

career line and career interests. I was hoping that it would be helpful to her eventually.

WEEKS:

I think she has done pretty well in her new appointment and...

SANAZARO:

Yes, isn't that fine. We were so pleased to read that.

WEEKS:

I talked to her secretary just this past week and she said, "Dr. Abdellah is in Australia for the month."

She'll get back I think this next week, and that will be a nice experience for her.

SANAZARO:

I think she is just right for the responsibilities that she has. She is so committed. Just one of the fine, fine people.

WEEKS:

The young man we met on our trip--is it John Marshall? He came in sort of on a horizontal shift, didn't he?

SANAZARO:

From NIH, Faye brought him over and I was very impressed with him. He did a good job for us and I don't know where he went after I left.

WEEKS:

I never discovered where he went either. I think he was there for awhile after you left.

SANAZARO:

There was general turmoil and turnover after that.

WEEKS:

I can remember one of the things that I thought was the greatest weakness in your Center, not your fault, but I think it was a human weakness, was that--I came across this when I was editing Abstracts of Hospital Management Studies and I was looking for publications. I was getting lists of your grants and I was trying to follow-up. I would contact the grantees and say, "Now when you write your report, we would like a copy for possible inclusion in Abstracts."

I discovered that in many cases those reports were not written, certainly not promptly, sometimes I guess, not at all. It seemed to me that the Center was rather helpless in that they had no club to hold over the heads.

SANAZARO:

After the money is spent, what have you got?

WEEKS:

I was wondering if there might not be some way of withholding part of the money until the report was written.

SANAZARO:

Unfortunately the money was often all spent. Sometimes there was a good reason for not writing a report; most of the time there wasn't. The people who were conscientious about their public trust and had received public money, provided that report. And that is how you could tell the good troopers. It became a matter of discussion at the Study Section. If we had never gotten his final report, then how did we know what he actually did?

But you are right, we were basically powerless if somebody says I'm too busy, or so-and-so has left my staff, or the money is all gone.

WEEKS:

I can see your point.

We were talking about the fact that it wasn't always possible to get a publication at the end of a research study and the effect this might have had on the grantee receiving another grant.

SANAZARO:

The acceptable excuse was, of course, that they had spent their time and effort in preparing a publication for a scholarly journal. We always accepted that. Those that did that for real could, of course, demonstrate it, because there would be the publication. We thought that that was a better use of their time, than writing a pro forma report.

WEEKS:

I've been talking with some persons at AHA Library and some of the vice-presidents under whom the library serves about this very fact. That there should be some--AHA library being the best repository in our field in the country, maybe in the world--should make a greater attempt to get some of these unpublished reports so they could be made available. I realize that many of them have very limited distribution but could be very valuable.

SANAZARO:

Well, there is a tremendous bulk problem, as you know. The National Technical Information Service in Springfield, Virginia, is, I think, a partial resolution of these difficulties.

WEEKS:

But even they haven't been able to do it.

SANAZARO:

No, the report has to be available. I don't know what you could do about that. I've generally found that when the unpublished report is meritorious, there usually is a published report. I'm thinking of a series of studies. If someone has gone to the trouble to write up a project but then there is no formal publication in a refereed journal, that almost is a judgment about the content. But, again, someone else with an entirely different interest may find information that's helpful to them that is almost peripheral to what the original project was.

WEEKS:

We felt that that was our field at Abstracts of Hospital Management Studies because we could take a paper even if it were not of a quality for a refereed journal, but if it did have data that might be valuable even if it were not stated elegantly. If it were there, if there was some substance there even in the rough, we figured that it would be better to index it and make it available to someone.

These are the ideal situations that you can never quite attain.

My first interview in this series was with George Bugbee. George Bugbee told me about the--was it one or two years that he spent with you? He was very much interested. Incidentally, I think that George Bugbee came to Michigan while he was working on your staff and was inquiring about publications. Because he came to see me and wanted to know what my ideas were. Of course, my ideas have always been very strong on this. That they should be available.

I talked with George for two or three hours, I know, and he finally went away with some notes. What did George do besides that kind of thing?

SANAZARO:

George was there on a contract basis for one year and then a continuing basis. He was there one, then two years and even beyond that.

We relied upon George because of his direct involvement with, literally, the evaluation of the modern hospital field. Going back to the early studies and then, of course, to Hill-Burton. Because of his familiarity with what really happened, the behind the scenes events as well as what was generally known, and had traced that up to the present time. We felt that we needed his guidance whenever we were deciding on a major project that could have an impact on hospital functions, broader organization of health services, from the standpoint that we wanted to be absolutely certain that we were not overlooking anything fundamental.

George, as you know better than I, is an absolute stickler for detail. I think if there is anything that characterizes him it is to make sure that each "i" is dotted and there is a period at the end of each sentence. But not frivolously. With very good reason, great care, because he usually only takes up important tasks. He has that uncommon knack of assigning priority in proportion to importance. The importance is defined not by his being involved in it but by the relevance of the task to what happens in the field.

So George was there as, really, our mentor, in working through our problems. Now the implications of our program for the hospital field--were we making the best use of what was in the pipeline? Were there some things that were missing in our advisory function? What should we do to bring the information that was emerging to the attention of certain groups? What about the liaison with the decision-makers on Capitol Hill?

So it was the whole range, if you will, of policy and procedure to make certain that the right questions were being addressed correctly and that important issues were not overlooked, that important people were properly kept apprised. He was also a kind of a radar for us: because of his contacts in the field George would hear things that no one else would hear.

So that is what he did.

WEEKS:

You know I think there was really one of those "old-boy" networks back in those days, back in the '40s. Take George and Jim Hamilton and Basil MacLean and Bob Buerki and a few of those men who could get on the phone and settle questions, or shift people around, or find jobs. It was remarkable, the influence they had. And all for the good, I think.

SANAZARO:

We just happened to hear that George would be available for something like this. If the Center was to be more than a paper enterprise, it would have been a shame to miss that opportunity. He was very helpful, very helpful. Just wise.

WEEKS:

He still is busy. He was in Ann Arbor not long ago with his Veterans' Administration Forum. He keeps very busy at that.

SANAZARO:

Yes. I was with him on some of those.

WEEKS:

Yes. He mentioned that he had you whenever he could.

SANAZARO:

He is still very forward-looking. Someone was telling me that there was some retrospective affair on his behalf and he was regretting that he was always so busy with the present and future, that some of the past was slipping away from him. That's characteristic.

WEEKS:

The loss of his wife must have been a severe blow to him. And possibly he kept busy because of that. I think he enjoys being busy anyway.

You were set up under LBJ, weren't you?

SANAZARO:

Yes, just about the time he was drowning in the Vietnamese area.

WEEKS:

Along towards the end of his time?

SANAZARO:

The center was commissioned basically in the late '67, formally established April 1, 1968, just about the time of the riots and the burnings in Washington. Terrible times.

WEEKS:

I was up near Howard University a few months ago. There are still houses up there that are boarded up. Some of those beautiful old row houses. Some of them are beautifully renovated and others would be boarded up just like...

SANAZARO:

They have never covered over those scars. Maybe it is just as well.

WEEKS:

You left the Center in '72, wasn't it?

SANAZARO:

Well, I was elevated, as they say, through some title upstairs. But basically it was a disagreement in policy. It was the fact that administrators were put in every agency in HEW to compare the awards of grants and contracts with the political affiliation of the applicant. So we had a number of very large scale projects--we had a very substantial budget--and a man who was put there to oversee the distribution of these, regardless of the review process. There was a fundamental difference of opinion, so I was given a non-title and then shortly after that I left the government.

That was the time that I started working on the book with Evelyn.

WEEKS:

Yes, that came out in '73, wasn't it? Publishing date at least.

SANAZARO:

Right. I stayed there basically to finish the book because everything was there. But, in essence, had left the government in spirit.

WEEKS:

Before we talk about the book, I do want to ask you some questions about that and about the people.

I have you listed for the Private Initiative and PSRO. Was that a Kellogg project?

SANAZARO:

Yes.

WEEKS:

There was also one on quality of care. That came later, didn't it?

SANAZARO:

Private Initiative and Quality Assurance. That is still going on but being wrapped up. In the Center we had started one of the R&D projects, the Experimental Medical Care Review Organization (EMCRO), and we knew that Bennett's amendment was in the hopper in the Senate. Everyone agreed that there was no adequate prototype. If the thing passed, what would happen? So we started that program. Talked about it in 1970, started it in 1971 and developed what we hoped would become models for the PSRO.

But then the bill passed unexpectedly and mysteriously. To this day, no one knows quite how that happened. And all of a sudden it was law. Some of the experience from EMCRO was used in the guidelines that were put out for that. But everyone in the field recognized that there would be a great waste of effort and money if there were any attempt to achieve uniformity in what was done.

So a group of people who were interested in quality and utilization review and were leaders in the medical community, were asked if they would be interested in working on the development of some models for PSRO, in cooperation with the government. Here we had the past president of the AMA and the past president of the American College of Physicians and people who were active in state politics, medical politics in good way, technical people. We had people from the Foundations for Medical Care.

They agreed that if this could be done, it would be very worthwhile. Because otherwise, it would be a tremendous waste of opportunity. So we talked with the people who were in charge of the PSRO program, Charlie Edwards, Henry Simmons and they said that would be a great idea. On that basis this group went to Kellogg and said what we would like to do.

We wanted to create four or five model PSROs, in different parts of the country, building on existing resources, and make them generally available. Their primary function would be quality, but in relation to the cost concerns and utilization review. Kellogg said fine. We started doing that and soon learned what I guess veterans know, that there really is no such thing as a true partnership with a federal program. There is an inertia built into whatever federal activities there are. There are different rationales. We entered into agreements with seven new PSROs that they would develop these alternate models. That was with the understanding that Washington would permit them to do it.

We had this steering group that I mentioned, the most informed people in the country on the state-of-the-art--what you could and couldn't do. In consultation with these PSROs, they began to sketch out these models, bold programs which were very exciting.

At that same time, the PSRO program was going through its first phase of requiring a plan--there was a deadline for the plan--and we were looking forward to these plans that we developed coming forward and being approved and then we would be on our way. Lo-and-behold, in every single instance, the PSROs working with us on the private initiative were told that their plans were unacceptable.

So we went to the people in Washington and said, "Hey, what is going on?"

They said, "What do you mean?"

And we said that our agreement was such and such.

"Oh, that is still the agreement."

I said, "But your project officers in the regions aren't approving these."

They said, "We'll look into it."

That is the last conversation I had with the people in Washington. Project officers never did accept the plans. All PSROs were forced into a mold. We had to radically revise the whole concept of our projects. That was a terrible period. Our advisory group threw up its hands and the old-timers in organized medicine said, "See! What did you expect? We told you it wouldn't work."

I said, "Forgive me, I guess I'm just young."

That is when we changed the whole concept and decided that within the framework of what they had to do as PSROs, we would try to install a quality assurance mechanism. That became the project, which was quite different than it was originally intended.

But it did grow. It is a method that has been adopted now fairly widely, seems to work, and is useful.

WEEKS:

Did Dr. Beverly Payne work with you at all?

SANAZARO:

Yes. Beverly Payne is the one who introduced me to his audit approach. I think just after his Nassau study. I was still at the AAMC. I was collecting this information on what was being done and his paper came out in the JAMA--"The Continued Evolution of Medical Audit."

I went up to see him and he was very generous in orienting me to all the things that he was doing. He was on our advisory committee--very helpful.

WEEKS:

Walter McNerney regrets that about the time Payne was working on these things, he (McNerney) left Michigan to go to Blue Cross. He regrets that he

wasn't there to help Payne from the political angle and to help him get this off its feet from an organizational standpoint.

I think it was out in front of other ideas at the time. Some of the things we accept as new now look something like Bev Payne's.

SANAZARO:

The interesting thing is, that in talking to Bev about this, I said, "Well, when you were working on the Michigan Blue Cross study, which was with Walt and Riedel and Fitzpatrick, did you consciously decide to adapt Paul Lembcke's work?"

He said, sort of sheepishly, "You know, when we did that we had never read about Paul Lembcke. We didn't know about his papers in JAMA. We just independently arrived at it."

I said, "I guess that's the way all good ideas emerge finally."

WEEKS:

Lembcke died quite young, didn't he? Or relatively young?

SANAZARO:

Yes. Again, I was still at the AAMC and I mentioned the idea to compile, bring together, usable information on medical care that would enable medical educators to see the relationship of what they were doing to what physicians would do. So with Kerr White, in 1965, we planned a seminar on medical care. Paul Lembcke was on the planning committee with Sam Shapiro, Paul Densen, Kerr White, and one other person. We had two meetings. That was when I met Paul Lembcke. Just an amazing person.

WEEKS:

Was he in Rochester at that time?

SANAZARO:

No. He was at UCLA. He had gone west and was on the staff at the School of Public Health and was doing his multi-university hospital study. Remember that his basic principle of audit was that you used specific, valid criteria, arrived at scientifically, but as a standard of reference you had to use the best practice, which to him was a teaching hospital. So he was doing this to establish his baseline for the standards.

It was after the second meeting that he came down with a brain tumor. He died within a matter of months in 1965.

WEEKS:

The first study of his that I saw was one he did at Barnes in St. Louis. I have forgotten the name of it now. I was impressed.

SANAZARO:

I'm not familiar with that. The first paper I saw was when he went to Rochester and worked on the data system that the Commonwealth staff had set up there. They were working on the data system that was the forerunner of CPHA. The first paper that I saw was on the use of uniform hospital data on a regional basis. Then the subsequent studies that he did.

WEEKS:

His name pops up quite frequently. Of course Vergil Slee spoke about him.

SANAZARO:

Evelyn Flook can tell you the origins of that data system in Rochester. She can trace that back. There is a lot of history there that has never been brought out regarding the uses and the shortcomings of such a data system, long before it was imported into Michigan. Paul Lembcke was the key person in that. In my view he and Mindel Sheps, Cecil's wife, really were the two

intellectual architects of quality assessment. Within a year of each other, they published two papers. Mindel Sheps in 1955, I think in Public Health Reports, which really was the foundation of Donabedian's later formulations. Of course, Lembcke's classic report in 1956 was on the scientific audit of female pelvic surgery. Those two pieces together really defined the state-of-the-art at that time.

I have often wondered how the history of quality assurance in the 1960s and 1970s would have been different if Mindel Sheps and Paul Lembcke had lived and remained active professionals. I think it would have been different. Because their influence and their knowledge was missing, quality assurance went off in the wrong direction.

WEEKS:

Just to mention, you were a short time at George Washington.

SANAZARO:

That was only a clinical faculty title.

WEEKS:

Oh, I see. We still have some time left. I would like to talk about the book, Health Services Research and R&D in Perspective, how it came about, and how you acquired all this knowledge of the literature.

SANAZARO:

I mentioned the unusual group of people that we assembled there as the key staff of the Center and the fact that we still had close relations with the people who established the field of health services research.

Periodically, when we would meet to review where we were and where we were going in the Center, somehow someone would say, isn't there any way that we can make a benchmark out of this? People would say, yes, that's a good idea.

Of course, we were overwhelmed by everything that needed to be done. Later when Evelyn Flook said that she was getting ready to retire, it just seemed that that was the opportune time to compile much of the material that we had in files, along with the collective knowledge of our staff people and also other people that we knew outside, on the assumption that health services research was going to persist.

I guess Cecil Sheps was responsible for coining the term health services research. Before, it had been called medical care studies and all the rest. At a North Carolina seminar, he used the term "health services research." There were no real publications on that.

So I talked to Evelyn and asked her if she would be interested in heading up this beginning effort to compile a first description of the state of this field because, otherwise, people who would come along later would always have to go through the individual task of trying to assemble a perspective. And that is how the title surfaced. We knew it couldn't be a definitive description--it was impossible--but the intent was to bring together a collection of the salient work to date and provide an entree for people into the field. We decided to do it in such a way that no one could confuse it with a definitive statement of the capabilities of the field or the disciplines or a definitive interpretation of published work but simply an overview as a point of departure. That is how it began.

She said, "Yes, I'd be very interested in that."

WEEKS:

You were saying that you talked to dozens of people and got their ideas.

SANAZARO:

Yes, on how to approach this. Out of that came the rough outline of the book, then the beginning compilation. Evelyn did the hard work of examining our files, her personal files, and various non-confidential files in the Center about the various subject categories. She began to distill and trace out the historical evolution of the field leading up to a reasonable representation of contemporary work.

She had an office there, and there were these towering stacks because she tried to get reprints and copies together of every single article that was eventually cited in that book. When you would walk into that room you would always make certain that you stayed near the center because if those stacks fell... Of course she was undaunted. She worked long hours. It is really owing to her dedication and skill that that book exists. Because otherwise it was just an impossible task. Most people said, "Why try to do that? It has gotten out of hand already."

I said, "I don't think so. I think Evelyn will do it."

WEEKS:

I judge people many times on the way they read their proofs. She was meticulous about it. We had a standing joke around the office. We had a telephone conversation with her one time between Ann Arbor and Washington that lasted over three hours. We were wondering what kind of bill it was going to be.

SANAZARO:

You know, all the time she was in the PHS her name was Evelyn Flook. When we were getting towards the end of the book, I said one day, "Evelyn, is there anything about this book that you would like to change? Anything at all?"

We had settled the business of the alphabetical order, that her name would be there first. She paused for a long time and looked at me and she said, "You know, I'm on the official records here as Evelyn Flook but my true name is E. Evelyn Flook."

I said, "You mean you would like to add the E?"

"Yes, that's the only thing I would like to change in the book," she said.

A lot of people didn't know.

WEEKS:

Is she a maiden lady?

SANAZARO:

Yes, her work has always been her first love. Really, you will have to talk to her. It would be a shame not to.

WEEKS:

Would you care to talk about some of these persons who are in the book? We talked about Faye Abdellah. Tom Bice, I know only slightly.

SANAZARO:

Tom Bice was a student of Bob Eichhorn's at Purdue. Eichhorn has produced a remarkable number of productive sociologists. When I say productive, that means they pick important topics, subjects, and are able to grapple with them successfully and produce worthwhile results. We asked Eichhorn one time: How do you do it?

He said, "I look at their graduate record exam and at their quantitative score and I always pick the ones who have the highest quantitative score."

That is why he turns out quantitative sociologists.

Tom Bice is of that school. Nominally a sociologist, he is not bound by the narrow principles of that and applies good quantitative statistical

techniques and has done a number of seminal studies. He and Salkever, an economist at Hopkins, did that study of certificate of need legislation which has had great influence. They showed that in states with certificates of need, the various hospitals and special interest groups are able to circumvent the intent with the net result that, although the certificate of need program is in place, there is actually an accelerated rate of increase of medical care costs.

Tom was very helpful, because of his ability to see through the designs of studies in relation to the problem that was being addressed. That was the Eichhorn knack and then Bice had it. Just an enormous talent. Some unfortunate personal circumstances intervened in that. He is now out in Seattle and working with the Health Services Research Group there. A very good person.

WEEKS:

He is a relatively young man, yet, isn't he?

SANAZARO:

Yes.

WEEKS:

I guess these are alphabetic. Duncan Clark...

SANAZARO:

Duncan finally retired as chairman of community medicine at Downstate. As I say, he was the first one who came out to Evanston to talk about our project. A rare individual. Duncan would set aside a week of time to thoroughly digest a massive proposal that came to the study section. All of his administrative, teaching and other responsibilities, he would do the bare minimum, so that all of his spare time was available to master that proposal.

When he came to the study section with a critique and recommendation, it was a performance. He would check previous references; he would read prior reports that were available. Again, a detail person. That was almost his failing because in his book on preventive medicine, he could never meet a deadline because he was waiting for this next thing to happen so that he could have the latest thing in his book. And, of course, the latest thing never does happen.

He was the chairman of one of our advisory groups of the training program. Again, just a rare resource. And also knowledgeable about the history of events in this country.

WEEKS:

You really were able to assemble some very talented people, weren't you?

SANAZARO:

I was fortunate in being exposed to them, yes.

WEEKS:

How about Bob Haggerty?

SANAZARO:

Bob, at that time was at Rochester, chairman of the department, had been on the study section. He was wrestling with the issue of how you can have a practical enterprise called health services research and reconcile it with academic requirements for rigor. Bob arrived at a perspective on that and that is the perspective he brought to the Institute of Medicine report on quality assessment, when he chaired that group. He was one of our good strong right arms. We often disagreed but it was always with respect. He always gave full measure.

WEEKS:

Looking at the dates, I knew that your Center was set up under Cohen and then Finch was Nixon's first secretary of HEW, wasn't he?

SANAZARO:

That's right. He brought in Roger Egeberg. Roger and I were old friends. That was the Nixon administration.

WEEKS:

Someone has made the statement that HEW or DHHS cannot be managed.

SANAZARO:

And that is true. And God help us if it could be because if you think of the sums of money that go through that and what those monies are directed to, and you think of central management, you could have a serious conflict of philosophy and purpose.

Now, if they are referring to the size of the bureaucracy, then that is just part of the general governmental problem. My education in bureaucracy was too painful. I had intellectually known the ramifications of it, but I had never experienced it. It's frightening. It's disheartening to see the waste of money, public money, by the hordes of employees who have no motivation, no interest, whose only purpose is self-interest. This is not a blanket statement. But it is true that only a very small minority of the people in a very large organization make that organization work and the rest are simply hangers-on.

So from that standpoint, the statement is absolutely correct. It's a large, wasteful enterprise except for a handful of people.

If they were talking programmatically, in terms of what the programs are supposed to achieve in the country, the concept of management is immaterial.

That money is supposed to be used for designated purposes. There is accountability, that is true. But to speak of management in the way that President Nixon set it up with Ash--in 1970, the Ash report--that accelerated the beginning of the end of professionalism in DHEW and now DHHS. Because that politicized the entire enterprise--the whole government.

The Ash report simply stated that the White House and the White House staff should be the central managers of the total federal enterprise. It was on that basis that events happened that I recounted earlier where administrators were placed in agencies to make awards on the basis of political affiliation. That was called management--political management. There has been a progressive diminution of, and really downgrading of professional expertise in what used to be HEW.

The rise of this concept of management is totally contrary to the fundamental purpose of federal subsidy of essential health services, because the responsibility for their management is at the local and state level. That's where management occurs. What should occur in Washington is the exacting of appropriate accountability and, of course, the proper safeguards for preventing abuse.

But the Ash-Nixon management mentality somehow viewed this money as a political tool, and that is what that word means to most of the current administration. That is why I say that I'm not glad that they can't succeed in that, totally, or it would be a catastrophe.

In terms of the other parts, there is no answer except that you run the tightest ship that you can. In the Center, we had a small staff and a handful of people did most of the work. Perhaps half of the people there were giving

less than half of their time and effort to the task. I don't know how you improve on that.

WEEKS:

You had the advantage of being a new agency, in a sense, and a new group. You were all enthused and working hard toward making the most of it. Where, if you had been an established agency, you probably would have had--maybe you wouldn't have had--but the agency might have had a different attitude.

SANAZARO:

That's right. Yes.

WEEKS:

I was wondering if you want to talk about your present work. I assume you are doing some consulting work, or you wouldn't be here.

SANAZARO:

Yes. Well, there are a number of projects. When I left the government in '73, I headed up the Kellogg project on Private Initiative in PSRO. Then, as I indicated, the original purpose was changed to a form of quality assurance--a narrow method of quality assurance.

As an outgrowth of that project, our advisory group of physicians began to consider the possibility of working on a method of evaluating individual physician's performance. All of the audits that had been done in the past were based on group evaluation. In fact, Bev Payne always stresses the point that audit should never focus on the individual physician. I always felt that there was a contradiction there because the aggregate of medical care is composed of individual efforts, its individual physicians, individual nurses, individual orderlies, technicians, and so forth. How can you ever arrive at an accurate aggregate description without knowing the individual?

This is a philosophical difference. But until recently, it had been thought that you can't evaluate individual physicians because methods are so crude that you can only evaluate group data. I didn't feel that that was true.

But anyway, we had this kind of discussion. The decision was made that we would attempt to develop a technique for measuring performance of individual internists. We couldn't operate across the whole field. The people that were most interested were internists representing the American College of Physicians, and the American Society of Internal Medicine. Because hospitals would be involved, AHA became a natural cosponsor. They were also cosponsors of the previous project.

So we designed that and obtained funding again by Kellogg. That project has been running now for several years and is winding up. I think we can say that we demonstrated the technical feasibility of objectively evaluating what the internists do in the office and the hospital. The product of this will be that technique that can be used generally to measure physicians' performance. Perhaps some time in the future, specialty boards will want to actually measure performance as the basis of recertification.

When a man is fresh out of training, a written examination may be adequate as a measure of his competence. The program director has evaluated him for three or four or five years and that provides good information. But down the road, after he has been in practice for more than ten years, a written examination may not accurately reflect his performance.

So that is one activity. I've been the technical director lately for that.

I consult with various hospital groups, mainly on quality assurance. That has a history in itself. The use of that term, as popularized by Donabedian, has spawned a whole generation of new workers in this field. A surprising

number of people out there who are in charge of quality assurance activities in hospitals believe that they are measuring quality and have forgotten the fundamental principle that quality can only be judged, can only be inferred, from some information, some data which must itself have some validity. And only if the data were accurate and valid can you then apply a judgment regarding the degree of quality that it represents.

So, my work with hospitals partly consists with helping people to come back to first principles. I was mentioning before the Sheps/Lembcke principles that you can only have individual indicators of quality. And to the extent that they are reliable and valid and representative you can make a judgment about quality of care. But you don't ever measure quality. There is no thermometer for quality.

I have been asked by the Joint Commission to do a number of things with them. I developed their reorganization plan in 1978 because that had grown like Topsy since its beginnings and it just seemed that there was need for reformulation of its directions and its organization to achieve its objectives. I also work with them on their quality assurance standard.

So I worked with them on that issue. I have worked with state associations on regulation of medical practice, the issue of relicensure. What can a state do in relicensure? Well, as you know, about half of them have a requirement for continuing education. I think that is necessary, very important. Without that knowledge, nothing can be done. I think that should stay in place.

A more fundamental issue is how that physician is taking care of his patients. I feel very strongly that a method must be developed in the near

future for tying relicensure in some way to the evaluation of actual performance.

All the studies which enable comparison of levels of performance against valid standards show a very great degree of variation of what individual physicians do, surgeons do, hospital do. If you approach quality assurance from the standpoint of the patient, that patient is being assured that care is what it should be.

The conclusion is inescapable: simply reissuing licenses or simply accepting CME credit does not assure the patient of anything.

WEEKS:

This is what I was going to ask you about. I have been very concerned about continuing education. I think there are very few professions today that either do not require or at least have not considered it. As you say, many of these CE credits seem to be rather... I can remember years ago, I had a friend who was an osteopath in Michigan, as you know, is quite strong on osteopathic physicians. He would go up to Grand Rapids, he and his friends would go up there for three days, twice a year, to get their CE credits. That would consist of attending meetings and hearing speeches. And if the speech was a little bit dreary, they would get up and go out and play golf. But as long as they checked in, they got credits.

Now, I think if it had been interesting he would have stayed, or did stay. But it was sort of a farce.

SANAZARO:

Yes. Well, there is a lot of that. Continuing education is that whole spectrum from going to formal meetings, reading, to contact with colleagues.

And contact with colleagues is probably the most important source of continuing education.

I think the states are correct in having that requirement because it shows that the state is expecting continued satisfactory performance. And although CME doesn't guarantee it, at least it shows that expectation. The states that don't have that are laissez faire. I don't think they are exacting sufficient accountability. I'm all for continuing education. I think it is indispensable. It is a necessary but not sufficient condition.

My personal interest is in advancing the evaluation of the individual physician, especially in the delineation of privileges. This is still done mainly by the seat of the pants where the head of the department says, "If Paul hasn't been in any trouble lately, we'll sign off on his privileges."

It can't be that way.

WEEKS:

You hear some pretty gruesome stories occasionally. Some of these classic cases of malpractice that are grown out of someone who is, by record, a risk or a danger and yet is given privileges.

SANAZARO:

Yes, there is a lot there. I worked with the American Dental Association. It has formally endorsed and is actively involved in a project supported by Kellogg where they will develop a survey method for going into individual dentist's offices to evaluate the quality of care. The acronym is DEMCAD. I don't know what it all stands for.

The American Dental Association and the American Fund for Dental Health have actively joined in this project which is directed to evaluating the quality of dental care given by individual dentists in their offices. I find

this heartening because at the same time, the AMA and even the AHS seem to have diminished interest in the quality.

At a time when the competition approach and the emphasis on cost control is almost certain to cause some providers to cut corners in a way that jeopardizes patient well-being, you would think that there would be greater concern for quality because it now has a greater rationale--to protect patients from unwarranted shortcuts. But the AMS's statement of professional responsibility makes only passing reference to quality. It is not one of its primary concerns.

And the AHA doesn't seem to be out front in it. So I thought it heartening that the American Dental Association takes a leadership position, puts it up front. I'm very pleased to be associated with that kind of a project.

WEEKS:

Don't you think that the professional associations are the medium through which this should come? I mean this help for the formulation of programs of continuing education. I've talked with AHA about this. I think they should take the responsibility because ACHA is really not representative of all the hospitals. It is representative of a group of administrators.

SANAZARO:

Of course it must be the leadership but you see the same trend towards populism in your national organization as you see in your politicians.

WEEKS:

Bur how can they represent so many diverse groups and keep everybody happy?

SANAZARO:

You can't. But that is the point. You are supposed to represent the interest of the professions and not the particular interests of individuals and factions. But that's what we are in populism. We are losing our leaders in Congress who refuse to operate that way and are left with those who "lead" by putting together coalitions of small factions. I would think that our major national professional organizations would not fall into that pit. And I am afraid that they have.

WEEKS:

Well, they talk this way. I've had this statement made to me by officials. What can we do? We can't represent the South and the North and the Northeast, they have different standards, different problems, different social and economic conditions.

SANAZARO:

That's not true. That's not true. The point is that regional solutions are no general solution and the only general solution comes from leadership that is dedicated to finding an acceptable, proper, professional solution, in the public interest. That is what has disappeared. Now what you see is satisficing--remember Herbert Simon's term, satisficing--doing the minimum that will keep the critics quiet and yet not rock the boat? That's not leadership.

WEEKS:

In other words, they should look at principle and not people.

SANAZARO:

When there is forward momentum towards an important goal, that everyone agrees is important, they will contribute to it, then the factionalism

diminishes. But when that forward movement stops, then people say: What about me? That is the antithesis of acting in the public interest.

I think if you look at the cycles in American history that when you had populism, you had a lack of leadership. When you have leadership, that sets a responsible goal, people orient towards that and their whole perspective changes. They want to be part of that forward movement. If there is no forward movement then obviously self-interest runs paramount. That is what I think we are seeing in medicine and hospital care. That's unfortunate.

WEEKS:

You made a statement earlier that we would not have socialized medicine. Were you referring to the British model?

SANAZARO:

Yes, government control and government employment of physicians. I feel that very keenly. That that would be the second American revolution.

WEEKS:

Do you anticipate some sort of voluntary insurance coverage with options to the type of provider and so forth?

SANAZARO:

Yes, I think that what you have seen through Blue Cross/Blue Shield in the master contract with the government for Medicare is the model. It is very clear since 1964 that the increasing amounts of public money will flow in private channels. That is where the new demands for accountability came from to begin with. But the public will only be served so long as the private sector has the ultimate decision as to the deployment, the expenditure of that money.

Once the government gets to the point where it dictates the expenditure of that money, you will have the equivalent of socialized medicine which will paralyze local initiative, private initiative. That is why we call our projects "private initiative" because so long as that survives, it really doesn't matter what the form is. But once medical and hospital care is under the dead hand of government, then we are all through.

I don't think it would be acceptable to the American people.

WEEKS:

I don't think so either, although we are being lulled into it.

SANAZARO:

As I say these remarkable new arrangements that are coming into being are symptomatic of the threat that is posed politically to organized medicine and hospital care. They would not take these steps if they did not even feel that threat, as you say.

Of course, the fact that they are responding and something new is going to come out of this, I think may be the salvation of the preservation of our private system. I think so.

WEEKS:

If we can retain pluralism, many approaches?

SANAZARO:

Yes. So long as several things are true. One is that, in the broadest terms, the public interest is kept front and center. Now there is the merging of the professional self-interest and the public interest, obviously, but there is a balance. You cannot say that serving the professional interest will best serve the public interest. To a varying extent that is true.

Secondly, somehow if our leaders at whatever level can be kept continually reminded that at the end of everything that we do in health services, medical care, there is a single patient. An individual is at the end of everything that happens. Sometimes I think people forget that. I don't know what the answer is. But if we remember that everything that is being done is being done for their benefit as patients, as well as the collective public, then pluralism and all these new forms are helpful.

But if it just becomes a fight over dollars, then I think something fundamental has gone out of our medical care system.

WEEKS:

The Wall Street Journal, yesterday, carried a story which described what was happening in several industries where companies were revising their benefit structure. Many of the things that they had been giving before such as dental care or eye glasses or whatever might be somewhat curtailed, not entirely, but there would be limits placed on it.

As an example, I was in Detroit a few months ago when the optometrists were negotiating with insurance companies for optometric service to the subscribers. I looked at what they were offering, or what they wanted, and that was two examinations a year. I said to this optometrist, "How many of your patients normally come in twice a year for an examination."

"Well, almost none, but it would be good, you know."

I suppose it is like the twice a year to the dentist, the same.

SANAZARO:

Oh, yes. That is long overdue. The cutbacks. The change in the tax benefits to the employers, long overdue. Marty Feldstein, who now has risen to enormous heights, was the one that tutored me in this. Because I never

really thought about it and he gave us a lecture one day. I've always remembered. That's good.

You see, these are unwarranted expectations that were put into practice when no one was thinking about the compounding of the future costs of all of this.

So, yes, there has to be that cutback.

WEEKS:

I have heard the term "rising expectations" used too as something we would have to address, which is the same idea.

SANAZARO:

That's right. It must be curbed.

WEEKS:

Is there anything you would like to say voluntarily for the record?

SANAZARO:

I thank you for this unexpected opportunity to look back on some very important associations and wonderful people and the fortunate vicissitudes of opportunity in a career like medicine. I thank you very much.

Interview in Farmington Hills, MI

August 26, 1982

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