

HAYNES RICE

In First Person: An Oral History

Lewis E. Weeks
Editor

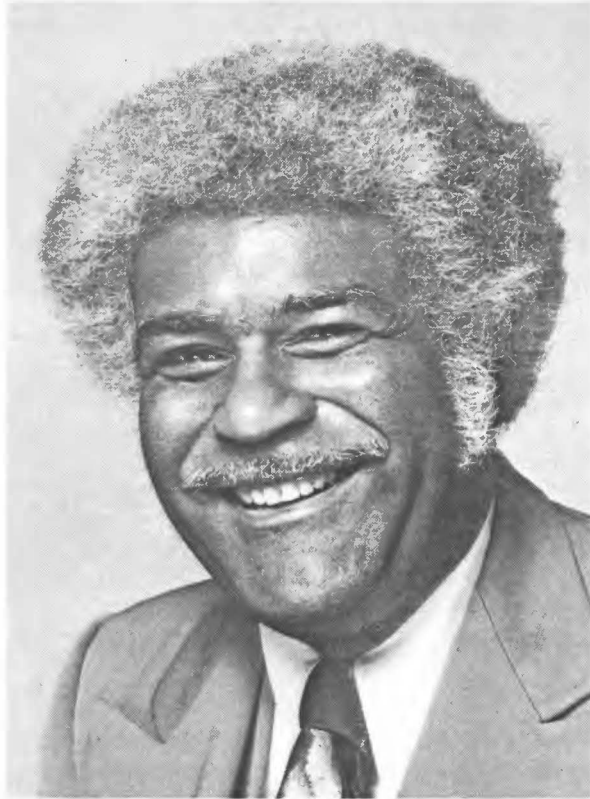
HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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Haynes Rice

CHRONOLOGY

- 1932 Born January 10, Knoxville Tennessee
- 1953 West Virginia State College, B.S.
- 1953-1955 Military Service
- 1955-1960 Kate Bitting Reynolds Memorial Hospital,
Winston-Salem, N.C., Accountant (1955-1956)
Acting Administrator (1956-1957),
Assistant Administrator (1957-1960)
- 1961-1964 Jubilee Hospital, Henderson, N.C.,
Administrator
- 1964 University of Chicago, M.B.A.
- 1964-1966 Florida A&M University Hospital,
Administrator
- 1966-1970 Norfolk (Va.) Community Hospital,
Administrator
- 1970-1972 New York City Health & Hospital
Corporation, Executive Assistant to the
Commissioner, Executive Assistant to the
President
- 1972-1973 Harlem Hospital Center, NYC, Acting
Executive Director
- 1974-1976 New York City Health Department, Deputy
Commissioner
- 1976-1979 Howard University Hospital, Deputy
Director
- 1979- Howard University Hospital, Director

AFFILIATION & MEMBERSHIPS

Alpha Kappa Mu Honor Society

American College of Hospital Administrators, Fellow,
Regent for the District of Columbia

American Hospital Association, Member, Chairman,
Council on Manpower and Education, Advisory
Committee for Conference on Urban Hospital Problems

Boy Scouts of America, Committeeman

Chi Beta Chi, Treasurer

University of Chicago Hospital Administrators
Alumni Association, Member

District of Columbia Hospital Association
President Elect 1982

Hunton YMCA, Finance Committee

Kappa Alpha Psi- Polemarch, Winston-Salem Alumni
Chapter Norfolk Alumni Chapter, Member Board of
Directors

National Association of Allied Health Professionals,
Member-Commission

National Association of Health Services Executives,
Member-President

National Presbyterian Health & Welfare Association,
Member

Norfolk (Va.) Chamber of Commerce Equal Opportunity
Committee, Vice Chairman

Norfolk (Va.) Model Cities Program Health, Consultant

Norfolk (Va.) Urban Coalition, Member of Board of
Directors

Tidewater Hospitals Council, Secretary-Treasurer

United Communities Fund, Norfolk, Va., Member Budget
Committee

Virginia Council on Alcoholism, Member Board of
Directors

Virginia Hospital Association, Member Nursing
Committee, Member Education Committee

Who's Who in American Colleges and Universities, 1953

Who's Who in Health, 1978

AWARDS

University of Chicago
Mary N. Bachmeyer Award, 1959

Kappa Alpha Psi
Achievement Award, 1952

WEEKS:

You started your career in North Carolina, didn't you?

RICE:

In 1955, after having spent two years in the army, I was offered a job as an accountant at the Kate Bitting Reynolds Hospital in Winston-Salem, North Carolina. Kate Bitting Reynolds Hospital is a city-owned and operated black hospital. The administrator was Everett Fox. I think that the aspect of this job that impressed me was it was the first black organization that I've ever seen where the doctors, the nurses, and the finance people were all black, and it seemed to be the beginning of a well-run institution to which I could make a contribution.

Prior to that time, my own exposure to hospitals had been limited to segregated institutions in my home town, Knoxville, Tennessee. There black people were treated in a wing that really was not a part of the hospital. The section for blacks was connected with a bridge to the larger institution and the black doctors did have admitting privileges. There were some black nurses but no administrators, no lab technicians--principally black people worked as orderlies and laundry workers.

So, I was really awed at this Kate Bitting Reynolds institution, and being

the first accountant I also was, I guess, an assistant administrator. I had worked for a year, when the administrator, Mr. Fox, decided to go away to the University of Chicago to get his degree in hospital administration.

So at twenty-four years of age, I was appointed Acting Administrator for this 177 bed hospital while Mr. Fox went away to school. I consider that experience perhaps one of my best experiences because as a young administrator I was then without training, only knew right and wrong, and was probably a little more idealistic than one is as he grows older. Mr. Fox stayed a year in Chicago and then returned. I was promoted to an assistant administrator, worked another year with him and then, during the year, applied to enter graduate school myself.

I applied to the University of Chicago and, as I was an honors student in college, I thought I would not have any problems. I tell this in terms of young people because of its significance. I was turned down for admission because of my low test scores on the graduate business exam. I say this in jest: They normally send you a form letter, but I got a personal letter saying, "Don't apply again." I know that there must have been some problems there in terms of my manner of application. I learned that I did not use a good political course.

City Hospital in Winston-Salem was the white hospital and the Kate Bitting Reynolds was the black. A person, B. Lee Mootz, was the director of hospitals with the administrator of the Kate Bitting Reynolds reporting to Mr. Mootz.

WEEKS:

What was his name again?

RICE:

B. Lee Mootz. He was a Chicago grad also. The town had a rich

relationship with the University of Chicago through the City Hospital, through Reed Holmes and his association with Ray Brown. I was told by Mr. Mootz to augment my curriculum by taking some extra courses, and I did. And I scored very well on those and went back to him this time before I applied and said, "I'd like to go to school, can you help me?" I didn't do that at first. He picked up the phone and called Ray Brown at his office and told him that he had this boy here that he felt was now ready to go to grad school, and I got in like that. I had also then made plans to try other schools. I got in at Chicago and surprisingly had little difficulty. I guess one of the most rewarding things for me is that I finished first in the class. Still, there had been this letter saying I wasn't good enough to enter.

So, the year at Chicago was very, very good. I was part of a very good class and in that class were persons who have been helpful to me and who have since shared similar interests with me. From my exposure at Chicago I was able to meet the leaders of the health field like Dr. Crosby, who throughout the years was sympathetic to problems of black people. I was able to turn to those sources in terms of working on some other things we got involved in later.

Unlike other members of my class, I returned to Winston-Salem, N.C., I did not do a residency. They allowed me to return to my work. That was very interesting in that Ray Brown was a task master and an autocrat, and he normally assigned residencies to complement the needs of the student. For example, he might assign a Baptist to a Catholic hospital, he might assign a Catholic to a Baptist hospital. Then he matched personalities. Students had no choice. He would go around the room and say, "Mr. Jones, you're going to Texas." When he got to me he said, "You are going back to Winston-Salem."

I challenged him by saying, "I'd like to talk to you about it, because I don't want to go back there." I knew I was going back to Winston-Salem because I was black and there was nowhere else for me to go. The conference with Ray Brown was the first time I'd ever seen him in private. It was difficult for him to tell me that I had to go back to Winston-Salem or go to Washington to Freedmen's Hospital where Dr. Burbridge was the director. He was also a Chicago graduate and I could have gone to Freedmen's or to Winston-Salem, or nowhere! Not that I didn't want to go back, I just wanted him to tell me that, you know, you don't have the choice.

I worked one more year and it was now 1960 and I was recruited by the Presbyterian Church USA to run a thirty-bed mission hospital in Henderson, North Carolina. Here in this tobacco town, about 20,000 population at that time, the hospital was built with church funds and Hill-Burton money and money from foundations. It had been administered by a black woman nurse who had worked at the hospital for forty-two years. She was a remarkable person. She was the director of nurses, director of the hospital, the accountant, the anesthesiologist, the dietitian, the housekeeper, and, in addition to all this, she maintained a magnificent garden of flowers on about three acres of land. When she left, we hired five people to take her place. And believe it or not, we worked hard fourteen to sixteen hours a day, upgrading the care in the hospital and keeping Mrs. Adams' garden growing and those kinds of things. I guess we could have probably made mistakes in care and gotten away with it, but if we allowed one of those pansies to die, we'd have been run out of town.

We had a medical staff of principally black doctors at that time. We had two black physicians who were our principal admissions persons. One, Dr.

James Green, still in the community, was a hard worker. The consultants and the other persons came from the white community. We worked very closely with Duke and Chapel Hill in terms of referring patients. I guess the real difference was in terms of being on my own. I had had a budget at Winston-Salem financed by the city--the city paid the bills--we had a budget that we stayed within but we never really were faced with some of the problems we experienced at Henderson's Jubilee Hospital. During the first two weeks that I was there, on the normal drug order--we were buying direct from the wholesaler--the drugs were sent C.O.D. for seven hundred and some dollars and I just have never experienced anything like that. I guess we must have had about \$800 in the bank and we had to pay for the drugs. I questioned why they would send them C.O.D. and the fellow said, "I knew Mrs. Adams, I don't know you, and the hospital's always had some problems paying its bills so anything you get you'll have to get C.O.D."

So, I made up my mind then that the first thing was to address the financing of the hospital. We got with the physicians and found that we could certainly do better if our census was kept up. I made an attempt to keep at least twenty-four people in this 30-bed hospital at all times. I worked out some arrangements with Duke whereby we would take their terminal cases and so we got to the point where we were not buying from the wholesaler, but we were buying direct, taking discounts and we installed a machine accounting system. The hospital, I guess, was at a turning point as was my own career, for it was at the height of the sixties with the sitins.

I attended a meeting in Durham where Roy Wilkins was speaking; there was a fourteen year old lad there with whom I chatted. I asked him had he been to jail during the demonstrations and he said he had been seven times, and asked

had I been? And, I hadn't. I had always been sort of aggressive, wanting to do something, but that struck me that, "Well, buddy, you'd better get out and do something!"

So I immediately went back and Dr. Green and I set out on the course to use the hospital as a base for change in that community. Our finances came from New York, I had no board, my board was an executive of the church in New York. I went to visit them, and they came sometimes to see us. We were encouraged to get involved in bringing about change in the community. So the hospital became the focal point for a voter registration drive; a campaign to integrate jobs in the community; integrate eating facilities and other public accommodations. I guess our best work was in the area of voter registration. We used this politics as an attempt to help the hospital. We were very active in making sure that tenant farmers came to the hospital; that the owner of the farm took care of the bills and if he didn't we'd move the family from that farm to somebody who would pay their bills. So we were very successful. We had demonstrations organized in the hospital, that literally closed the town down in an attempt to integrate the facilities. We were successful in every store in the town. After a period of about thirty days blacks were hired as clerks. I think there were about eight people hired on the same day. I am still in contact with the community; I still visit it. People came from miles around to watch a black policeman--they'd never seen one! These activities were really important in terms of outreach for the hospital and as an example of the impact the hospital can have. When I went there, employees of the hospital were making \$90 a month, that's nurses in 1960, and when I left there in four years this wage was up to about \$155, yet some of those then were on their way to sending their children to college. Their churches were helpful

in giving scholarships, and we were able to do that in the hospital.

We ran a black man for mayor. That scared me to death. He didn't want to win; he's an executive with the North Carolina Mutual Life Insurance Company. We did it in an attempt to get people registered. Taking an 85 year old lady to vote for the first time stands out as an accomplishment from which I still get some joy. As far as care in the hospital, we had, perhaps, the first Peace Corps in the country. During the summer, very wealthy white young people--college students--would come to the hospital and work and relieve our staff for vacations. We had, I can recall, the son of a judge in California coming to mop floors in our hospital and giving us \$1,000 when he left as opposed to receiving salary. This was new for this community.

We intended to obey the law. In all of the civil rights confrontations we only had one person go to jail and only two people who sustained injury. Through that Peace Corps experience, we would have nurses and sometimes some of our people go to other mission hospitals such as on an Indian reservation. They'd give up their vacation and receive a really rich experience.

I think as you trace the careers of black health workers back, most of them have worked in black hospitals or public hospitals. My whole career has been in that area. I think the racism that existed then still exists now and probably, since it's not as overt now, it's more difficult to deal with. I look upon how a school relates to the job market. Most of the jobs are gotten from the school. I have never really seriously been considered for any job that was not a "black job." I think we have contributed to the health field, and right now we can only account for one black person in the country running a hospital where less than 50% of his patients are black. So that I think enough persons have attempted to do a couple of things: try to be a

good administrator, try to run a hospital with doctors and nurses and to be a part of an organization where patients feel comfortable coming, and then develop some talented young minds. I'd had that in the back of my mind at Henderson in terms of bringing in young people from college to work in the hospital part-time and try to get them interested in health field.

Well, I stayed there four years and the opportunity to go to Florida as the administrator of the Florida A & M University Hospital became available. I guess the real reason that I went there was that this offered me growth. It was a hundred bed hospital, about a 50% occupancy, run by the State of Florida as part of the Florida A & M University. I felt it was a good upward mobility move. I went there in '64, stayed less than two years. This was probably the most difficult position I ever held. The hospital had an integrated board: five whites and two blacks appointed by the governor. The hospital had been previously managed by a black social worker who experienced personal problems, and the hospital was suffering for lack of leadership. I guess in terms of recalling experiences in that hospital, there were five black doctors in the community and about 150 white doctors who for some reason kept their eye on the hospital even though they wouldn't admit but one patient a month. They were there for the staff meetings and some were honest in their relationships but many of them not. I was there the first month and one of the board members actually slipped, or maybe not slipped, and called me a "nigger" at the board meeting. He was a very powerful man who had a dislike for black men in ties. Anybody who wore a tie was holding a job that he would mechanize and combine, and he was about to do that. He would leave the board meetings if he felt he was going to lose a vote. After about two months I was able to handle the majority votes, I had four votes and he had three. I went there in April

and by November he resigned from the board, a millionaire, but still a racist.

People in the hospital had not had a raise for three years. Although the hospital had a credit union, the employees were encouraged to borrow from a banker who was also a state senator. Their checks would go directly to the bank, instead of to them, for some loans that they could really have gotten from the credit union. I can say this in terms of politics and health that North Carolina, as I experienced through Winston-Salem, showed me that there are areas that are clean -- not graft, no offers. Florida was just the opposite and the two years there were very interesting but I was very happy to be able to leave.

I was offered a job as administrator of the Norfolk Community Hospital in Norfolk, Virginia in 1966. This was a hospital that had 192 beds, a black hospital, operating the building owned by the city, but the receipts of the hospital came from the patients. The hospital was in the process of expanding and had a very efficient administrator who died, a gentleman named Charles Green, who was a graduate of the Northwestern program. I guess the thing that I enjoyed about this new position was having come from Florida, the hospital, even though it had no endowment, was able to pay its bills and meet its obligations. Real good, honest people, both black and white on the board, interested in providing good care. Most significant was that the hospital had an affiliation with Howard University for the training of surgical and obstetrical residents. Thus care in the hospital, because of this affiliation, was good. I think that the thing I enjoyed most about that was the experience I got in building. It was again during many of the Great Society programs so that we could begin to introduce upward mobility into the health field where we could take a nurse aide and help her to go to practical

nursing school, send her to the two year program at Norfolk State to become a nurse, and later go to Hampton Institute to get an R.N., B.S. And that worked. We had all kinds of help by writing grants to augment the lifestyle of employees.

We started the credit union. In fact, that was, I think, the fourth organized credit union, because it helped us then to allow the employees to purchase their homes, purchase cars. We encouraged the physicians to participate and that's where we got the money. Everything was payroll deduction. I can recall in the five years I was there we had done over half million dollars worth of business and had only \$150 worth of bad debts. That meant that the hospital was accepted by the black community. It was the largest employer in the community of black people and that payroll meant a lot to them. We raised, in a building fund, \$100,000 in ninety days in the black community -- only \$5,000 came from outside of the black community. These were not pledges; this was money. Every fraternity, sorority, every church, put something into the hospital. Black people had been taught during that era that anything that was black was inferior, except in Norfolk. There for the most part, they did not accept that. There were board certified doctors in most medical areas and the hospital still was able to operate without substantial subsidy. Occasionally the city would help the hospital, but that was rare.

The time had come for me to increase the capacity and the hospital needed some money. A very interesting experiment was run there; in order to keep the hospital full, initially we did develop a plan I thought was unusual. We had a self care unit, an acute unit, and an extended care unit, all within a total of 190 beds. In the self care unit the patients wore their own clothes, had freedom of movement and it was priced structurally to accommodate the care we

were giving. We had the cost accounting system that allowed us to do that. The extended care unit was in one of the older wings of the hospital, a thirty bed unit. We operated the acute, self care and extended care units for about a year. I remember the cost on the acute side was about \$31 a day. The cost of extended care was about \$20 a day.

About that time, I think, a most significant thing happened in the health care field for workers in terms of bringing the workers under the minimum wage law. Medicare came in and the hospital worker came under the minimum wage law.

That, I think, is perhaps a part of the history of hospitals and change that's not been clearly articulated: the impact of paying the worker a minimum wage and what this had done to hospital policy. I don't really believe it's been technology and expansion and so forth as much as it has been that the worker who at that time was making 50¢ an hour, overnight made a \$1 an hour and progressively caught up with the rest of the workforce in terms of salary. The philanthropy of hospitals certainly was in the givers, but was also on the backs of those workers who weren't being paid a decent wage. When they started earning a decent wage and continually kept up to, and in fact, in some areas surpassed some of the hotel-type services in the community, there's no question it had an impact on costs and continues to have that. We were forced out of the extended care business because of government regulations. They expected that we'd have a separate board of directors as well as a separate accounting system for the extended care unit and that was a bit much. We were able to offer them the care at \$20 a day with the bureaucracy getting involved in it we just had to go out of business, take the extended care sign down, do the same thing and get \$30 instead.

At that point in my life I felt that government perhaps was the best

broker for poor people. In the South, cities and states took too much time to effect change. We were then operating probably one of the first PAP smear clinics in town and we did a lot in Virginia and North Carolina examining Head Start children. We had high school students paired with physicians' nurses. We always tried to move the hospital out into the community. Five years of that level of growth and it looked as if the second phase of the building plan was going to take longer than I wanted it to.

Running a hospital is not as challenging as doing things like building, so when I got the opportunity to go to New York I guess I jumped at it. I was interviewed for the job as Director of Harlem Hospital but there was another administrator in line for the job at the same time. After about four interviews he got the job. That was a loss in the sense that I had wanted the opportunity to try. On the other hand he got, I can't say "stuck" with Harlem Hospital, but it later turned out that way. I got the opportunity to go to work in a staff position as an executive assistant to Joe Terenzio, who was then Commissioner of Hospitals.

The first day on the job they invited me into a union management meeting and it was almost a terrifying experience because as a manager I've always felt that there was always room for negotiations and we just really didn't need unions. But, that one meeting altered my position completely on that issue and I realized I was in the big city. There were workers working for the city and workers working for the affiliation hospital, which was normally a teaching hospital. Both sets were working side-by-side and the worker on the affiliation was paid by the city but made \$20 a week more than the worker for the city.

The union was very adamant in saying "We have got to stop this!" The

spokesperson was Ms. Lillian Roberts, the vice president of District Council 37. Her conduct was superior in terms of management. Being able to negotiate out of that situation took unknown skills. I knew then that management of a hospital in the city was going to be much different from anything I had ever experienced.

In a staff job I did have time to think and reflect on what I could do to bring about change. There were a few blacks in the field, and apparently there were not going to be any more unless somebody did something about it. So the National Association of Health Services Executives, an organization of black health executives, really got off on a new track in 1968 at the annual meeting of the American Hospital Association in Atlantic City. The late Dr. Whitney Young gave an address that was pertinent to my thoughts. It stimulated me just as what that 14-year old kid said when he asked me "What have you done for me lately? What have you, as black people who have been successful, done for the rest of the folks lately?"

It forced a group of the younger of us to change the leadership of this group of black people to administrators who were really socially connected. At annual meetings we would get together and talk about each other's problems and share our ups-and-downs but not really in a constructive manner, in terms of having a new impact on the scene.

We organized in Atlantic City, selected officers, and began then to think about doing some things at the American Hospital Association and the American College of Hospital Administrators and the Association of University Programs of Health Administration. We had a strategy that we would play the "good guy", "bad guy" game. Normally I was the bad guy. We decided to try to get a work study program in health where we could force hospitals to give black

college students the opportunity to see what a hospital is all about. We met with the executive committee of AUPHA here in Washington in the early spring of 1970 with some statistics that showed there were three blacks graduating in '69 out of a total of 565 HA graduates. There were only eleven blacks enrolled in the programs out of some 1,600 students. We agreed that this was bad and we intended to help them do something about it. I think Professor Dornblaser was probably chairman of the executive committee. He was a decent man and gave us an audience. There was a young white fellow from Virginia, Robert Detore, who was working for AUPHA in promotional activities like health careers and so forth. Really a very decent person.

Very quickly we were able to get some money from Kellogg Foundation and some money from New York and Baltimore to start the pilot program. We started out with ten students in each city and ended up with twenty, I think, in New York, to work for twelve weeks in a hospital. We were able to pay them \$150 a week, which was non-taxable, and a good buck, so we were able to attract some of the best young black minds in the city from the workforce. We had a working advisory committee on programs in hospital administration. I can think of Miss Sally Knapp from Columbia who was extremely helpful. Many of the hospitals were reluctant to even participate in a program where they didn't have to put up a nickel. In fact, history shows that only one hospital out of 130 in New York City later was willing to pay \$150 a week when we got into trouble, and that was the Lutheran Hospital in Brooklyn; Mr. Adams was the director. We contacted placement offices in colleges to try to find their top students who really cared at that point. We were interested in junior and senior students. We had a good mixture; people from Harvard, Dartmouth, the Ivy League schools, Columbia, City College. I don't have the statistics

available with me now in terms of our success but we had a very good success rate of getting those young people involved in the programs. The schools were extremely cooperative. The graduate programs were all looking to improve their numbers, therefore, we were able to increase the number of blacks from less than 2% to close to 9%. It's slipping again because the emphasis has wandered. We were able to finally get up to, I think, twenty-eight cities in the mid-1970s, and it's down now to around ten or twelve cities. We watched the pendulum shift back in terms of numbers of students.

My job was really troubleshooter for the Corporation.* I came to work in the middle of January. Joe Terenzio was very instrumental in bringing a lot of talented administrators to the city system. This was still the Department of Hospitals, with the Corporation to start in July. He called us in on the first of February and informed us that he was not going to be a candidate for the presidency of the Corporation. So I'd been to work two weeks without knowledge of who the new boss was going to be so I worked closely with Bob Derzon who was the deputy. When Terenzio left I think Mayor Lindsay was looking for a name and was able to convince the board on Dr. Joseph English as the first president of the Corporation. That was a very interesting experience in terms of politics in health. This was a system that had no collection mechanism. They were reluctant to hire people with hospital knowledge. The first finance director had been the controller/vice president from Canada Dry. He was there four months and still did not know what Blue Cross reimbursement was all about. But I had my program money--that was my

*New York City Health & Hospitals Corporation which was replacing the Department of Hospitals.

major interest--and I was also in charge of the administrative residency program. We tried to bring into the city the best students that were willing to come, and from a variety of schools. One summer we had about twenty programs represented by real bright people. Believe it or not, it was the residents under our direction who found that the Corporation wasn't collecting any money. The Corporation started in July and we learned in August that they were supposed to be generating nineteen million dollars a month but that they'd only billed two. The billing system wasn't working. Problems like that existed because there was a five-part admissions card that had to be typed and the people who completed it couldn't type. The card was handwritten and the carbon only went down only one level so the card for billing never got completed. We called this shortcoming to their attention. Again one of the problems of administration change is you have to suspect the loyalties and there's always an attempt to take the Machiavellian approach, you know, the new guy sweeps out the old and brings in the new. It takes a long time for superiors to trust the fact that some of us knew about what was going on and so we could help them. So we played the role of staying out of the way, running the program, offering advice, sometimes getting frustrated when it wasn't accepted. The communities in New York were really alert to the politics of health. They were making great demands on the system. There were problems at Lincoln Hospital with the Young Lords; at Harlem Hospital with the drug fighters; and the Young Lords were in Metropolitan. So it was easy then to get the program started because we had black and Puerto Rican students, some of whom were members of the Young Lords after hours. We were able then to convince the administrators of all the hospitals that they should participate in the program. This didn't cost them anything. They were able

to get model cities' money and expand the number of students so we had a bright resident from one of the programs that was willing to take chances and make a contribution as well. So we got a lot of information back on what was going on in hospitals.

My job title changed from executive assistant to a commissioner, to executive assistant to the president. I was able to get responsibility for staff, and search committees for new directors of hospitals. It was then I was able to have influence on who got the job as executive director of hospitals. Joe English's career was rocky at best because communities just really didn't understand the slowness with which the system reacted to their needs and there was a reluctance to decentralize the operation of the hospitals. That same reluctance still exists and perhaps it is one of the reasons for the failure of the corporation. At that time though there was the opportunity to decentralize. I was asked to serve as the Acting Director of Harlem Hospital after Elliott Roberts left--must have been about 1972 to 1973. I was staffing a search committee then. This is very interesting because the search committee had 51% consumer membership and, in most instances, representative of minority ethnic backgrounds of people receiving the services. Some of these groups had never really worked together before and that, as a staff person, you are always suspect, no matter what your agenda is.

While at Harlem in the capacity of serving a search committee, I was asked to be Acting Director. I thought that probably I would be there thirty days at least, but they extended it to almost a year. They were developing community advisory boards at the same time. These boards saw themselves not as advisory, but as community boards. Failure of school boards in this

process has some carry-over to the hospitals. It was never the intent of the city to give community boards any resemblance of trusteeship. They wanted them to be advisory and the monies collected were always short. There was little accountability in terms of who was the cause of the problems because the decentralization process was so slow that hospital "A" could be doing a good job and hospital "B" could be doing a bad job and they were lumped together. One of the problems at Harlem was that they weren't collecting money. The union was aware of that and did attempt to try to address the issue. This is a very good example of why management and unions must really learn to work together for better in a system.

We had a job classification called Hospital Care Investigators. These were people that received information about financial status of the patients. Most of the people had bachelor's degrees and they were somewhere between a social worker and finance advisor. The output at Harlem was less than three cases a day when they processed it. I've always felt the one could process about fifteen to twenty a day in a real work day. The union was very powerful. Part of the fact was the person over the union later became a city council person there. I made a mistake of talking with the leadership of the union rather than with Ms. Pinkett. Ms. Mary Pinkett had aspirations with the union and political aspirations and I underestimated her power. We had agreement with vice president of the union to move these HCIs to another building where we could watch them, you know, and monitor their work flow and increase the productivity. But it was in a building away from the hospital and they decided they didn't want to go so they sat in the lobby of the hospital for two weeks. The person with whom we had the agreement forgot about us having an agreement because at that time Ms. Pinkett showed her

hand. So, we were able to move them back into the hospital in thirty days and while we had them moved they processed about 500% more work than they did when they had them in the hospital. But, that was a lesson for me in terms of learning that I had to cover all bases when dealing with the union.

It's easy to blame the union but it was poor management that caused the situation. At the Harlem Hospital they had the option of developing a subsidiary corporation. They could have moved away from the city, but there wasn't a leadership within the board structure at the community level to develop that and I didn't have the time to develop it. I guess I sensed the need to do so and that would have certainly helped the hospital because it had a good occupancy and it's in a good community. If one could have developed private practice and had a better mix of patients I could have made it a healthier hospital. Finally they held the city hostage because I had said that it's impossible to find an administrator to come to this hospital with all the things wrong with it. So we attempted to correct these deficiencies before we could even search for the administrator. That process took about a year and they were very helpful. In one case we got twenty-six nurses to keep the recovery room open, we got elevators fixed that weren't working. We achieved several goals that a new administrator probably never would have gotten. Finally they searched and found someone and he was able to come in and settle the hospital down, and he did a good job.

I moved back to the Corporation and by this time Dr. English's tenure was expired. I would also like to mention another mission had grabbed him. Gordon Derzon was the administrator of the Brooklyn Hospital of Kings County and perhaps he has contributed more to helping young blacks than any other person in the country in terms of making opportunities available, serving on

committees, and speaking out. Joe English tried to fire Gordon without checking with the local community board. The president of the local community board, a black minister, Reverend Jones, was a very powerful man, he didn't make mistakes like that. So, instead of Gordon Derzon getting fired, Joe English got fired. Well, at that time Dr. Holoman took over the corporation and again having gone through one change I wasn't anxious to do another. So, when Dr. Lowell Bellin, who was Commissioner of Health, asked me to join him as Deputy Commissioner, which only meant moving down two flights and not having to relocate, I took the opportunity because I could move my program, I could keep what I was doing and still influence change. Unfortunately the Bellin-Holoman relationship never really developed in anything other than war.

WEEKS:

Is that Haldeman?

RICE:

Holoman, John Holoman. He's a black physician who came out of the sixties believing that health care is a right. The politics of the city was changing, the financing was getting more suspect, and some tough decisions were going to be made. Bellin was not only Commissioner of Health, but Administrator of Health Services Administration, HSA, and also chairman of the board of Health & Hospitals Corporation. The opportunity to...it really meant that the two of them would have to cooperate and Bellin's allegiances probably were with the Mayor, and didn't understand much about the politics of communities and pressures that the corporation was under. So, I tried to play a role of mediator between two very decent people both trying to do the same thing but with different directions about how to do it. We weren't too successful because we were never able to keep them from getting into open war until one

day a letter was written from Bellin to Holomon that sort of outlined his thoughts about the director of the Corporation and questioned Holomon's ability to lead the operation.

I met Dr. Bellin through Bob Detore, formerly with AUPHA. We developed some slides and some films around the subject, " One Man Can Make a Difference," for a black audience, trying to get young people interested in hospital administration. It was a very successful film. Dr. Bellin and I were on the same program once for a career day. We made that film for \$600, the National Association of Health Executives did, but really it was Bob Detore's work. It turned a lot of people on.

During that same period the AUPHA and the American Hospital Association, through Dr. Crosby, were very helpful with the work study program. In fact, we were trying to find a financial base for the National Association of Health Services Executives because we were turning it out of our offices and we needed a paid executive. We were able to get a grant out of New York City and started with Bob Merritt, our first director. Once there was a meeting going on with five past presidents of the American Hospital Association and five members of NAHSE. We'd meet twice a year, and try to develop ways for the American system to be more responsive to the needs of the disadvantaged. At that time the disadvantaged were blacks. Very good meetings, good honest give-and-take. Dr. Crosby was able to do a lot of things. He had come under attack from the welfare rights organization at a meeting in Houston about what the American system was not doing for the poor. Dr. George Wiley was president of the organization and from that the AHA put consumer members on all their councils. I must say, that was a very good move but they've since gotten away from it. They also committed themselves to a committee on health

care for the disadvantaged. Joe Terenzio was the first chairperson of that committee. That committee was responsible for the patient's bill of rights in the American Hospital Association, and was able to keep the issue of access to health care as a right before the system by working on councils.

Dr. Crosby was at one of our meetings, between five AHA representatives and five NAHSE members. We met on a Friday and outlined a program which would take about \$400,000 a year to provide the staff and programs in terms of NAHSE staff moving into education and helping hospitals bridge some of their problems. Dr. Crosby committed himself to raise the money for us on that Friday. He died on Saturday morning. From his death, the relationships between the National Association of Health Services Executives, the relationship of black and poor people to the American Hospital Association started on a downward trend. Through small things we learned that things are changing. We used to meet in the board room of the American Hospital Association and we were treated as equals. After the appointment of Alex McMahon, the new president of the AHA, the meeting was moved from the board room to as close to the basement as we could get, and we were no longer equals. The opportunity turned into one of hostility and went to the point that eventually the National Association of Health Services Executives broke off relationships with the American Hospital Association, because they weren't getting anywhere. Meetings became one of intimidation threats and it dropped to a low end. They have since begun meeting again, and are not longer hostile, I'm told. It is much better, and there is hope. But the initiatives that were started got lost through the death of Dr. Crosby. One can look back and say, "If we had had another year, we probably could have had some impact on the hiring practices of hospitals."

The health department of New York, during Bellin's administration, went under--the fact is, the city was about to collapse--and I can remember one of the most trying periods was when we were faced with the decision, "Do you cut off health care to prisoners, or do you give health care to well children?" In other words, we had to either cut out prison health service or cut out child health stations. I learned a lot in terms of philosophies of give-and-take in that we decided to take care of prisoners, that perhaps the system would take care of children. So, the prison health system in New York right now is still in a lot better shape than some of the communities. We were able to force the opening of at least one health center that didn't have the money. With Bob Johnson as broker with Gordon Derzon, we did open a health center, the only one that did open during that period. Some of the others are still closed. There were new centers built to take care of 50-60,000 visits, but because of the finances of the city we weren't able to keep them going.

We were at that time, in terms of work study, as high as forty-five students one year in New York, normally about twenty students, going into hospital administration. In fact, some of our graduates went on to become AHA/Blue Cross Fellows, program officers within the major foundations. Our network was expanding to the point where one could pick up the phone and achieve some level of communications. The collapse of the city was due to its inability to meet its problems.

Dr. Charles Ireland, who was then the director at Howard University Hospital approached me about coming to work here as his deputy. I think that New York didn't have anything else going for me, I knew that the Bellin regime was at its end and perhaps my track then would have been back to a city hospital. That was a losing proposition and so the offer came at a good

time. I came here in a capacity of Assistant Administrator for Special Projects in February, holding on until Mr. Baker retired in July 1, and I then became Deputy Director. I was appointed Acting Director during Dr. Ireland's illness and assumed the responsibility as director of the hospital last July. This is, perhaps, the mecca for a career in health administration for a black person; probably the greatest challenge in terms of "us".

Left out is one of our other involvements with NAHSE in New York. We did come down to help Howard University write the grant. We did everything to get them started in the program in health administration, with the philosophy that the NAHSE members would be their alumni until such time that the program was established and it could develop its own base. That has been slow, I teach a course there and the hospitals here help, but the NAHSE members have been very supportive of that effort to the extent that they knew that if there was a retrenchment on the part of the major institutions in terms of selective black students, that perhaps we could fill this gap at Howard and perhaps that has proved to be prophecy because there has been retrenchment. If we are able to strengthen the program and the graduates do well, it will fill that void. I guess the most impressive thing one watches in terms of career development is to see initiative working, and then suddenly to see interest changing and then having to keep the people's interest to avoid their moving into other areas. I see a little bit of that already where young people are being turned off and rather than fight the problems of health care administration, they are finding it easier to be accepted, to have equal access in other management areas, private industry, law, or some other field.

In terms of making oneself available for national commissions, local commissions, it becomes almost a responsibility if one becomes successful in

the field of health administration. I think blacks really got a lot of support from Dr. Crosby in terms of appointments to councils.

Another man, Dan Schechter, has also been supportive of our efforts. He is a man-behind-the-scenes. A lot of his good work probably has gone unnoticed. While I knew Joe Terenzio, Dan was helpful on the Committee on Health Care of the Disadvantaged, he was also helpful in introducing us to some people in New York who helped us to advance the work study program to the zenith where we did get firm financing for about four years from the United Hospital Fund. That sort of help has gone unnoticed in terms of the person behind the scenes with a good heart with some resources who helped not only with the Chicago program but also with Wieboldt Foundation and in New York with Commonwealth Fund and the United Hospital Fund.

I think, more recently the Robert Wood Johnson Foundation and the AUPHA were very helpful along with AHA to keep the program going. The direction has somewhat changed in that I think the country accepts the fact that there is no more discrimination. That's not true. The outstanding student does have limited access. Financing of graduate education, however, is such that we perhaps will be producing a class system in those careers that require graduate education. Probably sons and daughters of the upper middle class that have been afforded the opportunity to go are the few who enjoy access. That was not true during the sixties. We were able to give opportunities to a broad spectrum of people who have proven that they can make a good contribution.

In terms of the American Hospital Association and Dan Schechter -- one of the other things that he did that was helpful was to introduce me to a gentleman by the name of Oscar Hemlich who was with the United Hospital Fund

in associate position.

WEEKS:

Is that Hamlin?

RICE:

Hemlich. He formerly was a Times writer and scholar who took to the idea of helping young people and knew most of the, in fact, all the directors of hospitals in New York and also knew how to bargain with them and most important knew how to make them take a student. I bring that up because I guess it shows how change is made. He later worked for Mr. Grant Adams and later worked for Joe Terenzio. I'm sure that even Joe doesn't know some of the things that we had to do to get students accepted in hospitals. One of the most difficult places was Columbia Presbyterian Hospital. I can recall sitting in an office when Oscar Hemlich called the director at Columbia and said, "We would like to put a good black student up there." The response was, "Oh, we are busy."

I think Oscar referred to how the director had received his own education. I think that Hemlich's father-in-law had loaned that director of Columbia money to go to school. So Oscar said, "This will be one opportunity for you to pay it back or allow a black student to spend the summer at Columbia at no cost." It's pretty hard to turn down an offer like that.

But then, when the student went to the hospital he was practically ignored. He did not have a good experience. They expected him to sit in the corner and if he hadn't been aggressive, his summer experience would have been a complete loss. In terms of placement of students in hospitals, we had to do a personality match; knowing the hospital, knowing the students who could put up with something like this and plan the counselling that went back and

forth. All this was just very demanding because the hospitals, for a large part weren't interested. They were somewhat hostile to this whole idea. But many places took a student and rehired him the next summer. In some successful instances the first job that the student had was back at that same hospital where he had done that residency. The personal relationships that one develops are of primary importance in the health care field, perhaps more important than even anything else in the industry because one has to develop a sponsor/prodigy relationship. The sponsor/prodigy relationship really isn't taught as much as it should be because there are identifiable sponsors who were prodigies. One has a difficult time when the sponsor is no longer influential and one must be Machiavellian and trade that sponsor off for another. While it's done subconsciously, it is real.

Meanwhile, several times when I went back to the American Hospital Association I have been tapped and told "Gee, we'd like you to come to work for us." Dr. Crosby did offer me a job as Vice President of the American Hospital Association but I was so involved with this work study program I couldn't leave it at that time. Furthermore, I would not have been very effective in that position without his influence.

I think we talked earlier about sponsor/prodigy relationship. My mentor was Everett Fox who was the administrator of the Kate Bitting Reynolds Hospital, and then went on to graduate school in Chicago. More recently he was the administrator of New York University Hospital and now is vice president for board affairs in New York University. At the time he was the administrator of the New York University Hospital he was the person who was the only black to be administrator of a hospital where less than 50% of his patients were black. So, if you're talking about a field that no matter what

talents you have you're of the over-the-hill gang, but not in terms of age. The opportunities probably will become less than they will in industry and education. I think that certainly in terms of having a mentor I was blessed, for mine had a sterling character and an undying quest for excellence. We had to work very hard to prove that we could run a hospital. The Duke Endowment in North Carolina was another mentor in terms of developing discipline for cost accounting. Their cost report that we had to fill out in order to get a dollar a day for our pay patients, free days for pay patients and a dollar a day for our free patients was an exercise in details. Our hospital in Winston-Salem managed something like \$47,000 a year and that was out of the Kate Bitting Reynolds trust; we also received other money. But in order to get it we had to participate in Duke Endowment. They would convene meetings twice a year for hospitals of similar size and activity and go right down the cost report and if you've spent a cent more per pound of laundry than a similar hospital, you had to justify the additional expense. Those sessions were certainly very helpful. In fact as an accountant I had to make up the report. This gave me an opportunity to learn the needs of the operating room and of the other places. The report was all-inclusive in terms of a hospital's operation.

I think that one tragedy of integration, in a sense, has been that the loss of black owned and operated institutions. We can identify up to 150 hospitals through 1950 that were black. Our latest figures show us to be down now to about twenty-two. Now, some of them were small and some of them were not worthy, perhaps, of continuance, but the tradeoff has not been an honest one where hospitals, like schools, merged. The fact is that far fewer black directors, and so forth, exist than did exist prior to the 1954 decision.

This loss is compounded in health because the role models in the black community just aren't there. You can trace the supply of black physicians and administrators and other persons from the fact that in their communities there did exist an institution with which one could identify, that participated in career days, and offered a summer job, and did many other things that are not quite existent now. Just in terms of my own experience, I was 23 years old before I saw or even knew that there was anything like a black anesthesiologist, pathologist, or radiologist. Those terms were just foreign to me because the hospital was a place that one went just to die, and other youngsters and myself just didn't related to it.

In terms of more recent relationships, shifting to organizational relationships, the American Hospital Association since Gail Warden's presence has certainly begun to take steps that point to the fact that they are aware that there does exist a problem in relationships to the poor in hospitals. That's going to be very important as the system retrenches. We, from where we sit now, are very fearful of rationing of health care services over the next decade and that the poor will pay a greater price in this tradeoff. Government is not armed with enough information or interest to ward off that tragedy. I think that the trouble lies already with hospitals which will probably not be funded. These at least address the problems of the inner city. But hospitals that attempt to take care of a broader responsibility in terms of delivering of health care to the poor are going to be in extreme difficulty in terms of doing this. In the absence of health care there's not much data known about who are the uninsured. If one traces the black hospital experience, one finds that in Winston-Salem we were able to collect 77%; Florida it was around 74%; in Norfolk it was 77%, and then it slipped. We now

have it down to about 65%. So, roughly 30% of black people, which represent, I think, the poor in this country, are uncovered. In order to meet their obligations, hospitals that dealt in this population had to charge the other patients more to take care of them. That's a mammoth problem when one starts talking about health care financing. The problem is how do you integrate that 30% into the system at somebody's expense. This integration is at state level, local level, or federal level. Somebody has got to pay. If there is any form of national health coverage, there certainly will be an increase in utilization because there are a lot of unmet health needs that people just don't bother to deal with because they don't have the financial ability to do it. The system in itself does not encourage preventive care and people who fall out probably come to the hospital only when they are really, really sick. Now, I think, the system's response to that is that there is access if one knows the system. The New York public hospitals serve as an example.

One of our thoughts on the matter is that there's a correlation in those communities that have had black hospitals and public hospitals and problems. Philadelphia, Pennsylvania, is perhaps a city that should be studied as to what is the long-range impact in terms of health indices on the community where a very large black hospital was closed, followed by the closing of the public general hospital, with no planning. So where do the people go? How many of them dropped out of the system? How many of them are alive? Do these hospitals have active clinics? The patients in the community looked upon these hospitals as their doctor. There has not yet been any of the kind of study done to find out what are the problems that arise from this. Certainly, we know that this situation does create financial problems for the rest of the hospitals in the area and maybe one or two hospitals feel that brunt more

acutely than others. Perhaps the problems of Temple could have well been associated with the problems of the Mercy Douglas closing as well as the Philadelphia General closing, but there ought to be a very serious study in terms of health indices to determine what happens ten years after a major health care institution closes. It could well be that nothing happens, you know, people are no more sick than they would have been. The opportunity for this government to shift now to what I think is growing responsibility could well be accomplished by addressing the health problems of the third world countries by using health care or our knowledge of health problems gained within the minority's communities. Rather than send tanks or bullets we could send hospitals or clinics. Herein lies an opportunity, I think. Probably the Cubans are doing this very effectively. Along with their propaganda, they're also sending medicine and physicians. If we are going to be oversupplied, and there is an excess of physician manpower, we could do this. We doubt that because of our own unmet health care needs. Perhaps one of our outreach programs could be putting more emphasis on health within programs of the state department and the investigative agencies like CIA, and other agencies. We could make an investment in terms of countries that we must get along with in order to survive. We try health instead of butter and guns. Here is where I think that institutions like some of ours could be more helpful for we have had to deal with problems like these. Such programs could offer our country a lot.

Upon reflection on the rewards of a career in health administration, I must confess that many times I was tempted to get out. These feelings always begin to stem from what I felt was a lack of opportunity.

The Florida experience particularly troubled me. It was not uncommon for

a board member to say, "I told you," to the rest of the board members, "that we should not hire a nigger, I mean a colored man, to do this job." Or to say, "You're no better than the other nigger that we ran away from here."

As a well-respected government-appointed person my responses were limited, of course, but my brashness of personality would make one response. "The only reason that I'm here is the fact that you felt that a colored man----nigger--- couldn't do this job and I'm going to prove you wrong."

Well, the fact that many of those hospitals are no longer open, and I know some of the tragedy that occurred at Henderson, the hospital in Henderson. At the time that I went there, a third of the babies delivered in the black community were delivered by untrained mid-wives--they were really grannies. They were doing a horrible job. The infant mortality rate was very high. We, with the help of many good church people throughout the country, black and white, were able to embark on a program to encourage these women to come to the hospital for prenatal care. The prenatal care was offered by the county and clinics and deliveries were offered in the hospital so we were able to give bassinets and other goodies at the time of the delivery to encourage mothers to come to the hospital. The newborn was given milk, two dozen diapers, knitted and crocheted booties and coats, things that sewing circles around the country would send to us. We would bundle that up with a blanket. We never put a dollar value on it but the deliveries by midwives experienced about a drop from 33% to 5% over a four year period.

When the hospital closed (and there had been some law suits to substantiate this--in terms of how they were solved I don't know), I don't know the exact number of black women delivered on the lawn of the integrated hospital because they didn't have the money to get in. This was not 1910,

this was 1968 and '69. So that by now perhaps some level of order has been restored to communities that have undergone change. I feel that there is still a role for ethnic institutions.

Our situation in health is parallel to the fight the black colleges are now undergoing for survival. The fact that they're doing a job that probably wouldn't be done, and certainly wouldn't be done by a majority education is not to be forgotten. So, as we strive for excellence we begin to force out the under achiever, the late achiever and the disenfranchised. We have worked so hard to get to excellence. Perhaps we are not a society for excellence and it takes a lot of all kinds of minds to make up a totality of...Somebody ought to give some time and study to ask what is the role of an institution in society? We here have been in some ways as negligent as the industry in the area of upward mobility.

I think that, for instance, the nursing shortage in this country could easily be solved through scholarship programs or helping people who are already in hospitals where they work at less than their capacities. We've begun a pilot program here at Howard with very limited financing, training our people or educating them to do well on high school equivalency examinations, to do SAT, and then provide them with scholarship assistance to nursing school. We've got four people now pledged in the program financed from receipts of our women's auxiliary of the hospital. We're paying them stipends and they're going to come back to work for us when they finish nursing school. Well, it seems to me that a program like that should have been very possible during the Great Society years. People look at model cities and all that as a complete waste. I don't see it that way. I think that a lot of good came out of that, in New York, especially. X-ray technology programs

that were established in cooperation between the union, hospital, model cities board afforded some type of upward mobility. Say, in Norfolk for example, where students are sent to med school, if they lived within model cities, they were expected to come back to their communities. Probably we need more monitoring to find out if they did in fact return. These things are possible. Regardless of a person's level or interest, the American system should offer him the opportunity for continuing education and upward mobility.

It's frightening to know that people do drop out and don't finish high school. In terms of promoting our interests, a high school education is minimal. We've only got a handful of jobs in the hospital that don't require high school education. What will the rest of the population do? As for perpetuating the welfare system, the prospect for avoiding it is dim, for there is no meaningful way that one who has not had advanced preparation to earn a salary, or hold a job, or earn a living can break those chains and free himself.

I talked earlier about experiences in North Carolina as to how a hospital can bring leadership to a community, not only in terms of political interest, but also in health care interests. The 30-bed hospital in Henderson was blessed with an excellent missionary, the director of the nursing school, who came from Walla Walla, Washington, with a master's degree, and some very, very, serious commitments about how people take care of patients. One area of her expertise was in the care of new born. Prior to our experiment, prematures were transferred to the premature center by way of State Highway Patrol in ambulances. We were able to get from one of the church groups, a deluxe bassinete, an isolette, and began to take care of our premies with success to the extent that the state changed its policy and began to encourage

the small hospitals to take on the responsibility because it had been proven there that if you give good nursing care, the baby would do all right. Such is the blessing of comprehensive health care. Our challenge was not so much getting them well and ready to go home, but to ensure that when they got home the care would continue. There were some lapses in that we did have some of them return ill because they couldn't continue the level of care in the home that the baby demanded. I think that the problems of the rural system are not articulated well in the national arenas. Few city hospitals can equal or better the feats performed in rural areas. For example, on several occasions we had to perform exchange transfusions on infants there in a 30-bed hospital where we needed fresh blood flown in from Tennessee to North Carolina, but we did not receive the blood until midnight, I had to be the person to meet it at the airport, drive 40 miles back to the hospital arriving at one o'clock in the morning so that the team could begin to work and do the exchange transfusion. The babies survived--two within a 30-day period. I don't think that those kinds of problems are understood by the system. What does it mean when a hospital does not have a blood bank? Or, in terms of a Red Cross blood bank, where the blood bank was your community roster? What happens when the patient needs Type A or B and you yourself happen to have that type? If someone's in shock, you become the blood bank, whether you know the person or not! The roster was a community roster and we, except for the use of the colleges for backup, depended on community input to keep it going. That, I think was a good place to learn. The combination of careers was something that stands out in my experience--combination of a lab technician and an x-ray technician--where one person is the same.

I recently sat on the commission which studied allied health education,

and it became apparent that as one moved toward the junior college and toward collegiate education for allied health, again, it is more difficult for a person to become an allied health worker. But there are lessons to be learned from the past. In this 30-bed hospital, there were three technicians; one worked days, one worked evenings and the other one was on call. They rotated around the off and on call. They had been trained, one on the job and the others commercially. In the commercial school they were taught to be x-ray technicians and lab technicians, in a couple years they were able to be certified in both. One with this background would probably have a hard time finding employment because of today's certification process. This kind of knowledge if transferred into the third world countries is certainly something that could bring us a lot more friends than some of the other type of policies.

WEEKS:

May I interject something here? I was wondering. Did you do anything in the health education as far as teaching these patients how to take care of the baby when they brought it home?

RICE:

We tried. In fact, we would visit the home and in many instances encourage the people to move if we thought the home was unsuitable. Public health in the rural areas leaves a lot to be desired. Physicians played a large role in that because they knew the family's situation, but that's what I meant in terms of rural health being so different. This wouldn't happen in the inner city; crowded conditions, or love itself won't sustain it.

WEEKS:

How about visiting nurses? I know they tried that at Tuskegee...

RICE:

Yes. On the newborns it was somewhat helpful since they did require them to bring them back to the clinics frequently and so one could keep up with it. But, no, there was not the type of programs that exists even in the inner city for visiting nurses. That's another point that we have here locally that troubles me: That is, you know, we certainly have problems in infant mortality.

The aged problem now is probably more bothersome in terms of the lack of clear courses to follow. How can you really do something about it? We have been pretty successful with our mandated in-and-out surgery program. It has had some negative influences on the hospital's operation in that the length of stay has gone up by about two days. So, you take that short stay out of the hospital and exchange it for an extended care problem. We have a real shortage of long-term care and skilled nursing care beds for the medically indigent and Medicaid. Even Washington has not been blessed with the overabundance of nursing homes for anybody.

WEEKS:

Would you care to talk about Medicaid and Howard University Hospital? You used the term a minute ago: your goals, your objectives.

RICE:

We have historically had an open door policy at Howard. We treat whomever comes to our doors. We are supported with a federal subsidy that allows us, or has allowed us up to this point, to do that. There is a city hospital in town and we're very much involved there, in terms of training the medical students at D.C. General and also in the operations of some of the services along with Georgetown University Hospital. I think that we're faced right now

with a cut of 50% on the Medicaid outpatient dollar for a visit and it's similar to what happened in New York that the ambulatory care issue is as grave as the extended care issue in that the only way government can control it is not to pay for it. Therefore, there's been very little planning about how nonemergency, or even emergency patients, get care. Who pays for it? The city has had a 1.7 million dollar allocation to all the hospitals on a contractual basis to treat outpatients that were not covered by Medicaid (\$12 for outpatients and \$72 for inpatients per visit). Both represent about a fourth of what it costs, but, at least, it was a program and it allowed hospitals something. The biggest issue that we have before us right now is that they're going to scrap that program. Outside of my experience in New York, poor people really don't have a constituency. There's nobody to speak up for them, so to turn that around is going to take a lot of doing.

For the outpatient ambulatory care in our facility, 40% of our admissions come from the emergency room. So, if you try to run a private practice and teach, in lieu of all that, you are left with strained admissions. There are no unnecessary admissions in that because there's a monitor for second opinion by the team that has to take care of the patients. One of our larger problems with the disposition of cases is that about forty of our beds are tied up with people that don't need to be in the hospital but really don't have anywhere to go. We're sending them to the health department that makes arrangements for transfer 190 miles away in Maryland. So that has been a problem in every community and is one to the whole country. I think government could find a cheaper way to deal with this problem than maybe in institutions. They could use shared homes. The law, in terms of the licensure of group homes and so forth, has made it almost impossible to approach it in the way it had been

approached. I suspect as the population gets older that this will become a larger problem. Home care is feared in a sense because many of the families have provided this responsibility and certainly if the government came up with anything, they would immediately relieve themselves of part of the responsibility and then make it financially prohibitive. So again, the government chooses not to deal with the problem. This problem crosses social classes too. This is not essentially a problem of the poor, but rates of extended care and long-term care being what they are, there are many retired formerly middle-class people who don't have any way to meet this problem.

It's been interesting to listen to the discussion on the increased number of physicians and the country's ability to absorb them and also on what the role of a foreign physician is. In the inner city many of them are in communities where they will stay. In New York there are more foreign physicians than there are American-trained, especially among minorities. You just can't cut off the flow of foreign physicians until such time as you've integrated or worked out some kind of system where the American-trained will have to do some duty in the underserved area.

Unfortunately the regulations have placed the health care system in a defensive posture. We're always fighting Medicaid cuts, trying to get a CAT scan, doing some other kinds of antiregulatory things so that it becomes very difficult to plan to take care of the very day-to-day business in an orderly fashion. I think that perhaps there has to be more understanding at the local level about health care problems. I don't see, and again, I've come three hundred and sixty degrees about the role of federal government, I don't see government producing too many solutions, except for saying "We're not going to pay for it." There has to develop, at the local level, a greater

understanding about what the health care problems within the community area are, what the resources are, and how we can best combine the two. This comes at a time when local governments for the most part have tried to get out of the health care responsibilities--a dramatic shift from private hospitals run by churches and other groups to government-run. It doesn't help by trying to address the problem. We have, I think, made that switch too fast. Perhaps groups like the church should have stayed around a little longer. The financing actually got easier for a while. The event of Medicare and Medicaid is tightening up now, it's no longer easy to make those kinds of changes.

WEEKS:

Do you have a relatively good Medicaid setup here compared to Alabama, which is now defaulting?

RICE:

We did, but now we are in the same boat as they are.

On the outpatient basis, I've planned and have not had to cut the ambulatory care, this is like the ghetto medicine in New York City and similar to many communities' poor fund. We will soon be faced here with a \$3 million deficit. That's something we never had to deal with in this area before. It's a dilemma in that you almost have to go back and agree with some of the people who said perhaps in the early seventies, late sixties, that we promised too much. Somebody has to come up with a solution and it's very difficult to withhold health care once you've given it. So I don't know. I used to think the answer was teaching the American public to take better care of themselves. I believe this for...Maybe it makes sense in sort of satirical way that the best vein finder in the community is the junkie. He can find a vein when the doctors can't. Why should a mother have to sit in a well baby

clinic all day in order to get a child some shots? Well, it's not that simple, I realize, but there are many parts of the medical knowledge not all in prevention. There are some security things that we ought to be able to find and handle by telephone calls without intervention of the system, so that one does not have to get in the system in order to get a cold or something like that taken care of.

WEEKS:

Well, do you think that people can be trained to take better care of themselves? I can remember when insulin came in. You can't remember that, but I can. People who were diabetics had to go to the physician to get an injection. I realize that's an intramuscular injection and patients had to be taught how to give themselves insulin injections. Physicians didn't think it would be possible that an ordinary patient could do this sort of thing.

RICE:

That's exactly what I'm saying. There are some studies with use of PAP smears and the taking of PAP smears in eastern Kentucky and the efficiency has been a lot better than we've been able to do in some clinics and offices. But, if we're not to get the complete rationing, you know, I don't want to be in a position where I have to say that "x" gets the treatment and "y" doesn't on the basis of his ability to pay. But, somehow, we're already there in terms of some of them, in sophisticated catheterization kinds of things and other things--it's not universally available. Even dialysis is a little better than others, but we're already rationing. The trend perhaps would be to more rationing with scarce resources.

WEEKS:

Well, this brings up a good point. Since, what was it, '72 when renal

dialysis was part of the '72 amendments? Then the question comes to my mind, who makes the decision, and where's the cutoff point and who should have these special and costly services available to them?

RICE:

Well, community involvement has been very unreliable in terms of health. Do you get the best decision? We have here a real live problem that's gotten national attention. We have all of our own three universities doing heart surgery and pediatrics with cath labs at less than the numbers you're supposed to get nationally. If health planning is to work, we have to change these situations through regional planning. I've always been for regional planning, because we're stuck here with all the resources and a dwindling population. The population is expanding in the suburbs. The first thing the suburbs want after they get a school is a hospital. The current system allows them to think like that, when really they're not twenty minutes away from existing facilities that have no equal in the world. The failure of regional planning in terms of someone looking over shoulders on boundaries to force integration of resources and the use of them is perhaps a larger problem in health planning than the unwillingness of institutions to cooperate with the process. So, unfortunately the Baumgartners and other people that were autocrats and said "x" shall be put to do "y" and "y" should not do what "x" is doing tends to make more sense than planning. We all can offer good examples to show we need to be competitive. For instance, to say that hospital "A" can't have a CAT scan because hospital "B" has one is not going to work. You know, it has been proven that in terms of defensive medicine, you've got to have it. If you don't, your malpractice issue is going to clearly make it needed rather quickly.

WEEKS:

I think you have a special problem here, don't you, with the District and Maryland and Virginia all having different kinds of laws and regulations and...

RICE:

Which brings me up to a point that I missed earlier in terms of New York experience. One of my responsibilities for Dr. Bellin was with two agencies, Health and Hospitals Corporation as his liaison, and the Comprehensive Health Planning Agency. The New York decision was that there should be one health system agency for five boroughs. That proved to be a good decision because all the resources are in Manhattan. There was a large number of medical schools and dental schools and everything but some of the boroughs, like Queens, were without a medical school, and are still clamoring for one. Had they ended up with five agencies you probably would have at the Corporation applications to build things that didn't exist in the Bronx, but were right across the river. Whereas in Washington, crossing the state boundaries, with northern Virginia, southern Maryland, the District of Columbia and Montgomery County we have four agencies. We've here got the population of resources, and they've got the population of people. So you end up with 7 1/2 or more beds per 1,000 in the District and 1 1/2 in southern Maryland. If you combine the two of them together you end up with 4 per 1,000. So, it's going to be a constant fight because we don't have the muscle--regional muscle--or support from the Secretaries.

So there could well be expansion of un-needed facilities in the areas that don't have them because you're trying to attract industry and one of the first things industry is going to ask is, "Do you have a hospital?"

"No, we don't have one but there's one five minutes across the state line."

Well, that won't sell as well as, "Yes, here's one on the drawing board and we've gotten an approval from our Health Systems Agency to construct it."

So, to me, the planning regulations leave a lot to be desired because I'm not convinced there's going to be that much of a savings out of it.

WEEKS:

Some people have suggested that maybe the answer is to have a health corporation that provides all health services for inpatient, outpatient down through mental health, home nursing, everything you can think of, and nursing homes. I realize this is just a conceptual model and maybe it never can be put into use, but, I was thinking in a particular area like this where you have so many conflicting laws and regulations, if there could be an agreement on one health corporation, this would mean a lot of merging, but...

RICE:

It's a dream almost, because the interest of the constituencies seems to me to be part of the American fiber in knowing that what makes it run is competition, but the competition ought to be made to address the unmet needs. As I've said, I've come 360 degrees in terms of what the role of government is and I guess I say the same thing about corporations. Perhaps there's some merit to competition so that even though we've extended our resources at a faster rate than we should have, we need to consider whether we would have gotten to where we are with this one big conglomerate without prior planning. I don't think so, I think that the strength of the system, up to this point, is that the free-enterprise system has been pumped with federal initiatives. But then there has to be a ceiling, the six digit amount in terms of earning, and so forth, is necessary, but that is probably better monitored through the private enterprise system.

WEEKS:

Many of the hospitals out in Michigan, for an example, are beginning to put out satellites. Would that be an answer to the suburban problem here?

RICE:

Yes, it might help D.C. but there are some racial connotations to it as far as we're concerned and history hasn't proven this to be an honest marriage that...

WEEKS:

Mathematically it might work, but from the standpoint of the social problems it might not work? It probably wouldn't work?

RICE:

Right. Unless we dramatically came up with the cure for cancer or something like that...

WEEKS:

Yes, you get an exclusive on something...

RICE:

Right, right.

WEEKS:

I've heard a lot about the problems of running big university hospitals and medical centers because of the relationships with medical schools. Do you care to make any comments on your experience here?

RICE:

Well, I think that it's still very young so I don't want to go out on a limb. I think that the hospitals that are run best that I've been associated with have been those that work for the best interest of the patient and physician. In other words, there is a set of tasks to be performed, there's a

way to get them done and get them done properly so you can get the patient in and out. The Norfolk Hospital, in terms of my experience, does this best. It does it best because they need to turn the bed over. In the large teaching institution that's one of our philosophies, is to try to become like the nonteaching institutions wherever possible in order to serve both the patient and the man or woman who spends most of the time here. The large teaching institutions, in a sense, are impersonal and that in some ways makes them inefficient. I have some idea about size as to what's best. The larger the institution, the more difficult it is for it to do the job very well. If you have all efficient submanagers it's all right, but unfortunately you won't always have those. You can run the best lab and yet have a lousy x-ray or a poor way of operating some other areas. We have begun to force ourselves to look at national trends. We're participating in Monitrend. We're the only teaching hospital in the area doing that. We did do the dry run of individual effectiveness, a review program, ourselves, but not to the extent that it wouldn't have been done had it been done by outsiders. Those kinds of things, need to be done more often but there is a demand, you know. If you're going to change the patient mix, we've got to offer the hotel services in a more efficient manner. It has forced us to at least examine why we aren't more efficient. I would think that that's being accepted, that we are trying to address those matters in an effective and efficient manner. The accreditation process could focus more on effectiveness and efficiency as opposed to some of the housekeeping and structural problems. Unfortunately, though, when I said you try to make the life of physicians easier, that's one of the tragedies of it. If you get forty-nine people on your staff, you might run forty-nine different ways on the individual issue. So, I'm half-way contradictory in

that, but if people use your service and they have the ability not to use it, then it makes good sense if you try to...

WEEKS:

In listening to you I was wondering. In working with medical staff it seems to me that you're approaching this from the standpoint of first you satisfy the physician that you're going to give him good service, and then, I would assume, when you go to him with a request he's much more likely to cooperate with you. Is that your approach?

RICE:

Yes. In fact, where you've got paid chiefs-of-service, it's clear that they need help. So, we're experimenting with assigning an administrator to that paid chief-of-service, but we've not been in it long enough yet to say that this is a model, but Johns Hopkins has done it on a larger scale. I can see behavioral change already when the problems are in. We involve them now in all our decisions. In other words, we try to share with them as much information about our strengths and weaknesses as we can.

WEEKS:

I was interested in the preposition you used there when you said you assigned an administrator "to" the chief-of-service. Just what is that relationship?

RICE:

Well, he's in charge, that chief-of-service is in charge. The administrator is working for him. For instance, take the department of medicine, we've close to 200 beds. He's got a hospital and he can't look after students, interns, and residents and look after care, recruitment, and meet our obligations as a hospital and do that well without administrative

training in it to start with. The other advantage is that, you're not wasting a lot of time by trying to put somebody on top of it. So you strengthen and hopefully augment his effectiveness by some of the short courses they have for chiefs-of-service. But you've got a leg and arm and mind that knows how to get it done, because you'll have to get it done through him.

WEEKS:

How do you maintain your line of authority to this administrator that's assigned to the chief-of-service.

RICE:

Take a gamble. I pick and purr with it and we have a collaborative selection process.

WEEKS:

There's a great lesson in diplomacy in that for the man or the administrator you put in there.

RICE:

They're really in the hot seat. I've lost some friends that way. In one instance it wasn't working, you know, but it's not the cohesiveness so that it's gamble...you give up a lot. I've given up our top young assistants to go into the trenches because I can't from here get down there. It's a good learning experience for them and I can say problems don't get swept under the rug that way.

WEEKS:

What kind of reporting system and staff-meeting system do you have with your administrators and your department heads?

RICE:

Well, we have weekly ones, and this is something that's probably different

from many institutions; the medical staff is intricately involved in the operation of the hospital. The president of the general medical staff as well as the chairman-elect meet weekly at a meeting that I chair with the deputy director, the medical director, the director of nurses, and one other administrator, and the finance director. That meeting is supposed to last from 9 to 11 and it's a "no-holds barred" meeting where we have an agenda of goals, concerns, and develop strategies on how we collectively go about solving them.

WEEKS:

There's a sense of shared responsibility.

RICE:

Have to, have to. It's no longer possible for the administrator of the hospital to attend to all details personally otherwise he would get bogged down in parking and space and things that have nothing to do with care.

WEEKS:

So the people in there aren't talking about their own particular interests, they are talking about hospital interest, hospital concerns?

RICE:

Right. If we can't do it, they know why we can't do it, because the finance man is there. It gets harried at times but it's useful. Then, in addition to that, every department in the hospital reports to one of those individuals so that there's nobody left out of it. There's the administrative staff meeting on a monthly basis. It's really educational and informational. Then there is the meeting of the executive committee of the general medical staff. That's decision making. I think there's a fear on the part of some of the administrative people that part of the decision-making process has been

taken away from them, and they really don't understand. For instance, when we purchase equipment, everybody gets a crack at "x" dollars and this group makes the decision as to what we recommend for the board to buy. So as administrators you're giving away a lot of what was felt to be power but you also are honing the process to make it more representative and equitable.

WEEKS:

As a matter of interest, has this group made a decision which we'll say, the majority of the medical staff thought was wrong, and if so, did the medical people in this group back the group up, group decision up?

RICE:

Can't say whether it was wrong or not, but, I can say this that the executive committee of the general medical staff meetings are certainly easier for the administrator to sit through and explain what's going on. Certainly there is more trust because there are more people involved and it's very interesting to watch another's behavior change once he is brought into the process. The real antagonist is sometimes sooner or later brought into the process and once he gets a part of the process it becomes his job and his responsibility to help solve those problems that might not have had his support before. We see daily evidence of behavior change. Lack of broad involvement is perhaps one of the weakness of some current programs in health administration, in that there's too much analytical and too little on the behavioral sciences. Perhaps many of the dropouts and things that we talked about earlier come from the inability of people to deal with stress and conflict. No matter how analytical and pure your answer is, if you aren't able to sell it, it's not any good. For example, take something simple like the question: "Do the residents have to have a license?" For my benefit

"yes", we need people who are licensed. Eventually they will all have a license because they will have passed a board before they get here. Or there could be a lot of reluctance there, you know. Is a chief really concerned about, "Do you have someone here to do something?"

WEEKS:

But you have to look at the legal aspect too?

RICE:

Right. They can help you do that. That's again one of the trends that we see. In terms of offering advice and counsel to young people, if they are young and smart enough, they ought to combine the careers. I don't see the health administrator, who's just a health administrator, being able to cope with problems in the next decade. He's either got to combine a career in law or be a certified public accountant. This duality gives him more currency at the bargaining table. I can look back to New York. It seemed a lot more complicated there, and a little further down the line with regulations. It used to amuse me at the meeting of the Greater New York Hospital Association, when John Conaughton had his lawyer on one side and his accountant on the other. While he was there chairing a meeting, as he was going from right to left, he would ask, "Can I legally do it, and can I afford it?" It seems to me, you should possess the paper or degree in one of those other areas that you wouldn't have to have just to legally or professionally be an administrator.

WEEKS:

Would you like to elaborate a little more about what you see down the road in the next decade?

RICE:

Well, I think that the planning process will probably undergo a lot of trouble once they get into real issues. If they're dependent on federal financing, the process will probably slow down some, because you can't plan overnight a whole system that was unplanned. Trying to right the wrongs is what priorities have been. They're going to have to learn to slow down in terms of that, and the regulatories will probably become more active.

There perhaps will be many hospitals that will experience grave financial problems and probably will close. Now, in many instances, these are not going to be the hospitals that ought to close and it's not going to mean that they're inefficient but this will happen because of the patient mix. They are not going to be able to spread the cost of caring for people who can't pay to the people who can because there are going to be fewer of those who can and more of those who can't. If in the political process, mayors and councilmen, state legislators and so forth, do not become more involved in the financing of hospitals then you're going to have many non-public hospitals in trouble also. I think that the New York experience is something indicative of what's in store for the rest of the country. The poor are going to get shafted. They're going to have more difficulty in keeping what they've got and perhaps many of the good programs that have been working will be lost for a while in terms of some of the home care, some of the people that have day care, people coming into the homes. I see a contraction of services. I guess the one that comes to my attention more is in the ambulatory care area because its the one that's easier to turn your back on. I think one of the real problems would be in nurse shortage and ought to be solved on the local level, but it's going to take a national initiative to pump interest into it. We're recruiting, and

have been successful in the foreign market. I don't brag about it. I detest to have to admit that I do it, because there are so many people who are underemployed and we shouldn't have to. If other countries can produce nurses for the world then we ought to be able to produce nurses for our own communities. I don't see the opportunity existing. The financing structure, the mobility prevents it. I think over 45% of the sophomore class in medicine are women, so that they, to me, had to come from a very limited pool of people with science preparation and interests. So, therefore, that's going to have a negative impact on nursing. The fact is that no matter what you pay, it's a very difficult job. Nursing is an extremely, extremely taxing program and perhaps maybe we need to develop more programs that would give better sexual balance in the nursing profession. You can't do that unless the idea is primed. It has to be primed with retraining. New York did take some firemen and policemen and made nurses out of them. This pattern didn't catch on nationally so that has to be addressed. As we invest more in the military and less in the domestic, there's probably going to be a great deal of rationing of what resources we have, as I would like to see problems solved on the local level. Historically, government has run away from health. They've been able to get away with it and close hospitals. I don't see anything that would stop that. The churches and the other institutions can turn that around. It would be helpful, but I think we had 75% church or non-profit ownership of hospitals in Carolina in 1950 and I figure it switched from 75% to 25% in ten years. So can you encourage them to come back? Not with today's problems. I think that the nurse shortage is probably one of the acute national problems. If we dry up the foreign supply of nurses the way we have doctors, we will have a crisis. There is some inkling that it's more difficult now to get the

foreign nurse than it was two years ago. Not by the conduct of the foreign governments but because of our own state department tightening up and trying to ensure that the person who comes is going back home. And, hell, when we've got ten jobs for them why should we be worried about that?

WEEKS:

Well, I've noticed, for instance, in English nursing journals, there'll be ads there from American hospitals for nurses, and I know that we've had a lot of nurses hired from the Philippines, for example. There have been active recruitment programs going on but, as you say, if they make it more difficult to bring these people in...

RICE:

It's much more difficult to obtain nurses from overseas but if it ever gets as bad as it's going to get in medicine then many of our urban areas and rural areas will not have people to take care of them.

I think that technology is another aspect of change that will come. We hear of things that are going on in Japan now that could revolutionize some of our treatment and modalities. So, perhaps, we'll always exist because there will be institutions that can afford it and there will be people who will need it, therefore, in time, everybody's going to want it. So you can't stop technology. You really, really can't.

The thing that we would like to see, I guess, is a return, in our educational system, to the basics. I am very distressed about cost, for people who are not upper-middle class, to get into the system; that means the minority, especially the black people. We will experience some difficulties with the growing number of minorities in the country and the fact that they, perhaps, will have a more difficult time integrating into the system than the

previous generations because of their language and their refusal to solve their problems as well as because of their color. We're approaching a larger percentage of Spanish population within our communities and we're not doing much now currently to absorb it. I can see some real problems.

WEEKS:

Then it looks like a real problem with the Latin Americans with as an example, 800,000 Cubans coming in within the recent period. As you say, the absorption of these people should be implemented some way, but we're not doing it.

RICE:

Not planning at all.

WEEKS:

Not planning, no. I shudder when I read the birthrates, the statistics of Latin America. What's going to happen to these people that are going to have to get out of their own countries eventually and this is the most likely place for them to come? Are we prepared?

RICE:

Well, I think that, unfortunately, we know the problems. It takes bold measures to solve them. New York, I know, more honestly tries to deal with it than anywhere else. It's not understood in Iowa and other parts of the country, but it is a problem for this country. The immigrant, whether he's illegal or legal, he has to get health care and somebody's got to pay for it. We're not really paying for native Americans of second and third generations, so that I think that medicine is going to have to get a little better organized and strengthen its ability to speak for the profession. Hopefully, this will be done through the people, but that's going to be rather difficult

because we've got an entirely different ball game.

WEEKS:

Well, unfortunately, AMA hasn't a very good reputation for being a representative and that's going to take time to overcome that. It's the picture we had of them in the sixties.

RICE:

What the American Hospital Association is doing is putting that responsibility more with the trustees. That makes sense.

WEEKS:

Do you have a board here?

RICE:

We have two boards, we have a regular university board. That's a national board in scope. It does not fit the description of a local board. Also we have an advisory board that is perhaps going to have to assume more responsibility for some of the local things. But here again is part of the problem of the American health system. The boards of trustees of hospitals in this country are certainly not representative of the population or the problems. I say that 11 o'clock on Sunday morning, if you use race and class as to what happens in American churches, our boards of trustees resemble that. The two most segregated bodies to appear in this country are boards of trustees of hospitals and people in church at 11 o'clock on Sunday morning. There's a parallel and somehow they're going to have to develop some type of communication with the broader issues. I think that unions will have more influence on what goes on in hospitals as they purchase care, as they work in hospitals. So as union has gained a seat on a board of a large corporation it will probably be in their interest and the hospital's interest that they seek

representation there. It's going to be difficult but, you know, he who pays the fiddler....

WEEKS:

Yes. Well, of course, I'm from the automobile country and Ford and General Motors both, I understand, are now taking steps to look into social situations which might affect health care and in turn affect the premiums they pay, which may be the wave of the future. For instance, I know they're going at things such as alcoholism and I suppose there are other things that...

RICE:

Suppose they pulled out though and began their own systems. The miners went broke doing it, and that's probably why they...

WEEKS:

That's an interesting thing because Karl Klicka said that--you're talking about the Presbyterian church--when he went to work in the miners' hospitals they were taken over by the Presbyterian church, but even they didn't have enough money to really bankroll that the way it should have been. I don't know how many years he was there, eight or ten years, he had headaches all the way. Not only from that standpoint but he had problems with medical staff in the hospital and with town medical people.

RICE:

How do you in a very young medical school in West Virginia--that's one of the things developed in the fifties--how do you attract and keep the flow of competition among the new doctors coming into the system? But, the automobile industries probably could do it. It could have done it, but now it's going to be more difficult.

WEEKS:

Well, I was looking at Ford and General Motors Annual Reports the other day, and they have an item there where they show how much it costs to pay hourly workers for wages and benefits and I know their wages are about \$8 an hour but their total is about \$16 an hour.

RICE:

They make a statement that they're paying more for health care than they are for steel. Of course, that's disputed in the health industry. But, you see, I go back to the problem of the minimum wage and the fact that was certainly misrepresentative of what the problem is. The large portion of that is the fact that years ago that figure was probably...

WEEKS:

Yes. If I may suggest another thing, the ratio of employees to patients shows double in the last twenty years. I can remember when we did our Progressive Patient Care study back in '62 that we thought that if a registered nurse made \$100 a week and a practical nurse made \$75, an aide \$50, that was the ratio we looked at, on a two to one employee to patient ratio, giving four hours of nursing care per patient day...

RICE:

You had the large open ward, patients tended to...you had students too...to augment...

WEEKS:

This little hospital...well, later they started their own practical nurse school.

RICE:

Well, I can remember the head nurses for the spring semester were always

students. You could always give vacations because there were students about to graduate.

WEEKS:

But the hospitals can't run that kind of school anymore. They can't get students to come and...

RICE:

Even if they could do it it's anti everything, see, so...

WEEKS:

And when people start talking about a year of slave labor there that last year of nursing school was just...Well, the unpleasant thing is that some day we're going to have to make our priorities then we're going to have to say, "Well, we're going to have to pay for them." If we have to sacrifice to do it...

RICE:

I think that as you get older you begin to think more about it. The tragedy right now is the fact that older citizens in this country deserve a better life than many of them have. If we have to go to communes or whatever we have to, we ought to be able to afford adequate and effective health care. It does not have to be fancy. Whether that's best done in the acute hospital, I don't know. I don't think so. The nursing home, certainly on a proprietary basis, can't do that adequately. So that we're busy in this community. Infant mortality is one of our big problems. Also we have a problem with tuberculosis.

WEEKS:

Is this still a problem?

RICE:

A mammoth problem. You don't have the controls. You don't have the power, the authority; you can't make people get treatment; and you actually have grandparents untreated giving the disease to grandchildren, undetected. It's not only a sleeping problem...it was a problem in Harlem, but it wasn't a problem in New York. It's a problem in DC in some communities, but it's not a problem for the metropolitan area. I'm always reminded of the chapter in Flexner that was dealing with the health care of the Negro and he said that, at that time we had seven medical schools--black--and he said that only two of them were worth keeping. They were Howard and Meharry. It would be so interesting to see what would have happened if he'd said we kept five, you know. Those two were probably not much that better than the other three. His idea was that the Negro had communicable diseases and he named them, tuberculosis, venereal diseases, and so forth, and it's foolish to think they'll stay within their own community. So therefore, you should not expect that black patients will be entirely taken care of by black doctors and, therefore, some benevolent white doctors will look after them, but we should train some black physicians to do it. We're not too far removed, in a sense, from that philosophy. We've got Howard as a medical school and we have got Meharry struggling, we have got Morehouse just struggling to get its feet off the ground. Of course, there is California. We were at one time training 65% to 70% of the black physicians in black medical schools. It's down now, I think, to 20% to 29%. Sooner or later the problems of the masses will explode and cause problems to the political interest of the country and you will then be forced to give attention to it. Unfortunately, we don't do this well on a national basis.

WEEKS:

No. The most indirect and the best way I've seen so far to combat some of these problems has been the food stamp. At least there is some possibility of people eating better. As we all know, good nutrition sometimes is a good doctor and, hopefully, that won't be...

RICE:

I've seen in many communities now they're running out. I think it's very difficult for the system to understand the gravity of any kind of problem from the start and it's always going to cost a lot more than they ever anticipated. That's why people say national health insurance and I don't even turn my head because if you try to consider the cost of it, you can't afford it.

WEEKS:

It's just inconceivable. Well, on this whole Social Security thing, I started at the very beginning, started paying in, but I'm sure--I draw it now--I'm sure that if it were on an actuarial basis I would be getting paid too much. I could afford to get along without it probably because I still work and still earn a little money and have saved a little and so forth. The people who are getting the minimum are not getting enough, if that's all they have. But it would seem to me that it would be better if they had an insurance plan that when I, or anybody, got to be 65 and retired that he could get what he had coming on an actuarial basis and then if it weren't enough and he needed more he could get it. Maybe that is what Nixon meant by his minimum income plan.

RICE:

The problem that you mention, the fact this year there are people who just

don't have enough; Social Security is not enough, and the minimum levels required for one to get on Medicaid rules that you almost have to be really destitute to get the assistance. They will keep you out of the hospital.

WEEKS:

What is minimum Medicaid level here in D.C.?

RICE:

I think \$4,500, but that doesn't mean that you can afford a homemaker that will come in and spend two hours a day, which would be a lot cheaper than coming into the hospital. We had some very good programs on that. Unfortunately, due to the new cuts, there will be no more intake into that program after May 1. So that they won't be taking on any additional people.

WEEKS:

Well, I imagine many Medicaid programs are trying to plan ways they can cut back. Cut it back to the basic anyway, to the required services, but, some of the states have very little in the way of services. The northern industrial metropolitan areas usually have had fairly decent...

RICE:

When they put limitations on, you know, the one in Virginia and limitations on fourteen day stay, augmented to twenty-one days is not practical. Those are very strict limitations and, again, no one can keep the people out if they need to come.

WEEKS:

That's right.

RICE:

I think there is a brighter side, certainly. Although this is sort of looked at as a "me" generation among young people, where they tend to look

more after "What's in it for me?" they are certainly very bright and with some good human relations indoctrination they perhaps can make it, if they don't get started off with greed. There's going to be a leveling off of income, and, if they don't expect to make the six digits, you perhaps can bring more control to health care costs because you'll have control on the salary side.

WEEKS:

I think another thing enters into it too. It is that most of us live in a pretty small world. I consider myself an average middle class person. When we were talking, I started to think, what were my contacts? My contacts are with just a few friends that are in the same situation. I have a church-connection, I have places that I go; maybe a couple of nights a week we eat out at certain restaurants or we go to the university restaurant. We see university people. We don't see this problem. I think most of us are well-meaning people, let us say, but we don't see the problems.

RICE:

Then, you see, you're pressed also in terms of having a distorted view of what being poor is about. You know, poor has always been equated to being lazy or dumb, and it really isn't that. You have to call yourself to heart and say that, just like what's happening in the auto industry now, unless something changes some of those well-meaning people are going to have to experience something they never dreamed of, poverty. So, one of the joys of having worked in that small community in North Carolina was to learn the ability of the community during the sixties to rise together, work together, play together, pray together; it worked. We had close to 400 children every morning. Some of them were young, nine to twenty-one years old out to demonstrate against the system. In fact, many of the parents sent them

because each church was given the responsibility of feeding them once a week. The ladies from the church (it couldn't be our teachers, who would get fired if they were identified) would come in and do the cooking. The stores went so far as selling shoes at the regular price for the first pair and for a nickel you got another pair. So the people would slip in and try to get them and the kids would think, "We ought to go an hour earlier today." It can work. It will be very difficult, though, to turn around. when you say back to basics.

WEEKS:

I'm of a different generation from you but a lot of my contemporaries talk about the Depression. I was a young married person then. We had troubles and worked for almost nothing, but I think that the point you brought out about these people working together and being interested applied there also. We had that same community feeling. We're all in the same boat, and we could understand each other. Nobody had more than the other fellow and...

RICE:

But everybody had something.

WEEKS:

Everybody had something. We had one neighbor, he was a struggling young attorney. He and his wife lived on the Boulevard, we lived the first street off the Boulevard to give you an idea--she would come down the alley with a can of something and my wife would meet her and they would talk about what they could put together to serve a meal for all of us, because he was working on fees and sometimes he'd wouldn't get a fee for a month, you know. This was pretty bad. He turned out to be a judge and now he's retired, but when we get together occasionally, once a year or so, and talk, we always talk about those days during the Depression. They were good days because we felt close to each

other...Now it is time for your meeting, I see.

Interview in Washington, D.C.

April 17, 1980

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