HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

John M. Stagl

JOHN M. STAGL

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298

John M. Stagl, F.A.C.H.E.

CHRONOLOGY

1915	Born in Chicago, August 1
1936-1942	Commercial Investment Trust, Office worker
1936-1941	Northwestern University, Student
1943-1946	U.S. Military service
1946	DePrato Statuary Co., Bookkeeper
1946	Commercial Discount Corporation, Auditor
1947	Emerson-Comstock Co., Accountant
1947	Passavant Memorial Hospital, Credit and Collection Manager
1948-1952	Passavant Memorial Hospital, Office Manager
1953-1961	Passavant Memorial Hospital, Assistant Director
1961-1969	Passavant Memorial Hospital, Director
1968-1972	Passavant Memorial Hospital, Project Coordinator with Woman's Hospital
1970-1972	Passavant Memorial Hospital, Executive Vice President
1972	Passavant and Wesley Hospital merge into Northwestern Memorial Hospital
1972-1976	Northwestern Memorial Hospital, President
1973-1976	Northwestern Memorial Hospital, CEO in addition to President
1974-1976	McGaw Medical Center, Executive Vice President
1974-1975	Northwestern Memorial Hospital, President; McGaw Medical Center, Executive Vice President
1975	Woman's Hospital and Maternity Center of Chicago merged into Northwestern Memorial Hospital
1977-1980	McGaw Medical Center, President
1979-1983	Stagl and Associates, President
1980-1981	Joint Commission on Accreditation of Hospitals, Director of Finance and Administration

MEMBERSHIPS AND AFFILIATIONS

American College of Hospital Administrators

Fellow, 1964

American Hospital Association

Ad Hoc Committee for Implementation Statement of Financial Requirements, 1969

Board of Trustees, Member 1972-1975

Chairman Elect, 1976

Chairman of the Board, 1977

Committee on Accounting and Business Practices, Member 1955-1956

Committee on Accounting and Statistics, Member, 1952

Committee on Approval of Blue Cross Plans, Member 1971-1972

Committee on Financing Hospital and Health Care Programs, Member 1966

Committee on Legislation on Funding of Depreciation, Member 1967

Committee on Nominations, Member 1980-1981

Committee on Reimbursement, Member 1955

Committee to Review Financial Standards, Member 1967-1968

Congressional Presentation to House Ways and Means Committee, 1966

Congressional Presentation to the U.S. Senate Finance Committee, 1967/1970

Council on Blue Cross and Finance, Member 1967; Vice Chairman, 1968

Council on Financing, Chairman 1969

Executive Committee, Member 1976-1978

General Council, Member 1976-1977

Hospital Research and Educational Trust, 1976-1977

Joint Committee with Blue Cross Association, Member 1973-1979

Joint Committee with the Health Insurance Association of America, 1979

Joint Committee for Promotion of Voluntary Prepayment Health Plans, 1967-1969

Liaison Committee with the Health Insurance Council, Member 1967-1969

Speaker of the House of Delegates, 1978

Special Committee to Study Leadership Role of AHA, Member 1972-1973

American Management Association, Member 1960-1975

Association of American Medical Colleges

Executive Council, Member 1975-1976

National Health Insurance Task Force, Member 1974

Task Force for Implementation of Health Plan Legislation, Member 1975-1978

V.A. Liaison Committee, Member 1971-1975

Blue Cross Health Care Service Corporation, Corporate Member 1977

Chicago Hospital Council

Member Board of Directors 1964-1973

President, 1966

Community Fund of Chicago

Board Member 1966-1968

Health Reviewing Committee, Member 1962-1966

Comprehensive Health Planning (local)

Short-term Inpatient Tertiary Care Subcommittee, Chairman 1974-1975

Task Force on Health Services and Facilities, Co-chairman 1969-1972

Council of Teaching Hospitals

Administrative Board Member 1973-1976

Representative to AAMC Assembly 1973-1976

Executive Club of Chicago, member 1966-1977

Greater North Michigan Avenue Association, Director 1972-1979

Hospital Financial Management Association

Member Board of Directors 1950-1951

President 1952-1953

Past President 1954

Illinois Cost of Living Council, Member, State Advisory Board 1973

Illinois Health Facilities Planning Board, Member 1974-1979

Illinois Hospital Association

Board Member 1965-1968

Subcommittee to Revise Blue Cross-Hospital Contract, Member 1951

Task Force on Reimbursement, Member 1970; Chairman 1971-1973

Trustee Development 1979-1980

Illinois Regional Medical Program, Executive Committee, 1967-1974

Institute of Medicine, Chicago, Member 1962-1977

Joint Commission on Accreditation of Hospitals, Commissioner 1979

National Center for Health Services Research and Development

Ad Hoc Advisory Group: Consortia, Mergers, Joint Ventures and Services Member 1969-1972

Norby-Hatfield Consultants, 1962

North Shore Country Club, Member 1973-1979

Northwestern Memorial Hospital, Passavant and Wesley Hospitals merge into Northwestern Memorial Hospital, 1972. Woman's Hospital and Maternity Center of Chicago likewise merge into Northwestern Hospital (1975) as does the Institute of Psychiatry of Northwestern University in 1975.

Northwestern University

Graduate School of Management, Advisory Council, Member 1972-1978

Lecturer on hospital administration, 1951-1960

Preceptorships

University of Chicago 1963-1969

University of Minnesota 1971-1974

Northwestern University 1961-1976

HONORS AND AWARDS

Hospital Financial Management Association

Frederick C. Morgan Individual Achievement Award, 1960

Illinois Hospital Association

Distinguished Service Award (first recipient), 1977

Northwestern University

Delivered MacEachern Commemorative Lecture, 1976

Northwestern University

Program in Health Services Management, Alumni Association

Honorary Membership, 1978

Northwestern Memorial Hospital, Chicago

Honorary Trustee, 1983-

WEEKS:

I would like to begin this as a sketch of your life, and then come back and look at details of different aspects of your work. I have you as being born in Chicago on August 1, 1915. Did you grow up there?

STAGL:

Yes. I have lived in Chicago or its suburbs all my life.

WEEKS:

One thing that I noticed early on in your career you seemed to show an interest for business and financial affairs. This seemed to be a natural trend in your life.

STAGL:

But not due to any psychological testing. When you tried to get a job in 1934 you took what you could get. That happened for me to be in an office, so I took up accounting at night school.

WEEKS:

I have one of your first jobs at Commercial Investment Trust as an office clerk. That was in 1936.

STAGL:

Right. I went there a year or two after high school and worked there until I went into the service.

WEEKS:

You were in the military service from 1943 to 1946?

STAGL:

Right.

WEEKS:

Did you have any particular duties there that fitted your talents?

STAGL:

I was assigned to a Tank Destroyer battalion while in Italy. When I joined this outfit they had a battalion adjutant who was relieved, and they made me battalion adjutant because I had worked in an office. It was very interesting to me. It was the closest thing, I think, in the army to office management, coordinating different activities for the different battalion companies and for the colonel. By the time I was discharged, I had sort of set my sights on managing an office. I had some accounting, so that is what I shot for.

WEEKS:

I have you down for three different jobs shortly after the war. Is that DePrado Statuary?

STAGL:

DePrado Statuary Company as a bookkeeper.

WEEKS:

Then I have Commercial Discount. Is that different from the other?

STAGL:

I went into that because I felt for my accounting I needed to get some auditing under my belt. What they did was to loan money to different concerns on the basis of their receivables. It was my job to go out and make sure that the receivables were actually there. Subsequently, I went to work for Emerson Comstock as their accountant.

WEEKS:

You seem to have found your life's work in about 1947. How did you happen to go to Passavant?

STAGL:

The story there is that while I was at Emerson Comstock, an electrical contractor, I was doing only straight accounting. In fact, it was myself and a girl, that's all. I was still thinking of an office management type of career. I left to go to Passavant Hospital. There was a lady there who ran the office and kept the books -- she had been there since 1929 or so, a long, long time. It was decided they would hire me to do collection work, be collection manager, until I could get a year of hospital experience under my belt. Then I would take over her job when she retired and I would become office manager.

The funny part about that story is that I had been born at Passavant Hospital. I used to claim that I had more seniority than anybody at the hospital. I had been born there in 1915. One day we had a young administrative resident and we told him to clean out one of the storerooms down in the basement. He did so and later told me about some old, old records down there. I went down and took a look at them, and sure enough they included my own birth record in one of the big thick books that they had in those days. They used to keep the medical record and the financial record all on one piece of paper, bound in a big thick book. I saw how many days my mother had been in the hospital and I think she paid something like $34 for fourteen days, which was amazing to me.

WEEKS:

At least you saw it. That is the nice part about it. How large a hospital was Passavant in those days?

STAGL:

In those days it was around 200 beds. When we merged we were about 350.

We had put on some additions.

WEEKS:

You had a hospital nursing school, didn't you?

STAGL:

Not when I first started at Passavant. Dick Vanderwarker came as administrator about a year after I did and he started a nursing school.

It's hard to describe Passavant, you had to be into the guts of it to really know the institution, but in many ways it was outstanding. It was only 200 beds but had the president of United Airlines, the president of Standard Oil, the president of Beatrice Foods on the board; not to mention others equally as prestigous. It was a tremendous board of recognized people. An equally distinguished medical staff had -- within a few years of one another -- had the president of the American College of Surgeons, the president of the American College of OB/GYN, and the president of the American Heart Association all on the staff. Its woman's board was also distinguished. It had Swifts and the Armours and other noted Chicago families. So within the institution nothing was done unless in their eyes it was done properly. Standards were high and one couldn't cut corners.

The present building was built in 1929. The first administrator was Dr. Irving S. Cutter who was also dean of the Northwestern Medical School. He wrote, in fact, a medical column for the Tribune in addition to running the medical school and the hospital. He was there until about 1945 or so. Subsequently the board recruited Dick Vanderwarker from the hotel field. Dick was there five years. He went on to Memorial Center in Cancer and Allied Disease in New York City, one of the prime administrative positions. He was followed by John Hatfield who had just a few years before finished the

presidency of the AHA. What leads me on this course is when you mentioned our nursing school. Edison Dick who was chairman of the hospital was a great believer in the philosophy of the hospital as a charitable institution. By that I mean that he believed that the patient shouldn't have to pay for anything but his care. For a couple of years we held up establishing a nursing school until Edison Dick could raise enough money from industry and businesses and so forth to meet the cost of nursing education and not pass it on to the patient. He did that in many things. I know because I was keeping the books when operations one year resulted in a large black figure. That year we had an unusually high occupancy and we did come out with a substantial black figure. Mr. Dick's idea was that you must always come out with a little deficit if you were really a charitable institution.

To me, those were the great days of the hospitals. To see it, to live with it, as it changed into a business operation and then into a government involvement -- cost plus and all of that sort of thing -- to come from then to now and to see it and to know how it reacted on some of these people as we went along was, I thought, very interesting. It was hard for me when we were getting to the point of Medicare and I was somewhat involved nationally with the negotiations, it was a whole different world. I guess today it is even more different.

WEEKS:

I'm sure it is.

The reason I asked about the nursing school, I happened to meet a nurse in Howell, Michigan. John Griffith and I were doing a study up there of progressive patient care, and she said she had gotten her training at Passavant in Chicago. She spoke so highly of it and was so proud to be a

graduate.

STAGL:

It was like the Marshall Fields of hospitals.

WEEKS:

Or in our area here if you are a nurse graduate of Henry Ford Nursing School.

STAGL:

This hospital was the first in Chicago. It was formed by Reverend Passavant in 1865, I think. He built the first one. Its legal title for years was the Institution of Protestant Deaconesses. It was staffed by deaconesses of the Protestant Church. He came from Germany, and I guess the order did. It ran that way for years. They finally eliminated that corporation and it became Passavant Hospital. They had a nursing school way back, at least in the early 1900s. It ran for a number of years before they cut it out because there was a surplus of nurses, believe it or not. They were graduating girls who couldn't get jobs. Then when Dick Vanderwarker came the opposite thing was happening and we were getting short of nurses. He wanted to start a school for two reasons. He wanted to start it because of the need for nurses, but he also wanted to start it because he knew it would upgrade the care to have these students in the institution. He finally did get it going.

But the general philosophy of the board was that you didn't get into these things unless the institution and not the patient could pay for them. That was possible back in 1947. A man couldn't run a hospital that way today.

WEEKS:

I have heard stories of hospital boards, especially during the depression

days, if you were a member of a hospital board you were expected to chip in and pay off the deficits. There would be people who would not take a board position because they had had financial losses and were not able to live up to that responsibility.

STAGL:

I had a great admiration for those board members as I began to know them. I didn't have much contact with them really until I had been there for a number of years, but I used to admire the man who would accept the leadership of fund-raising for a major hospital project knowing that when he did this he was going to have five hundred people ringing his own doorbell for contributions in their particular areas.

WEEKS:

In reviewing the data on your life I began wondering if there was a master plan back in the early days. You were credit collection manager in 1947. From 1948 to 1952 you were office manager. From 1953 to 1961 you were assistant director.

STAGL:

That is about the time that John Hatfield came.

WEEKS:

Then it was about eight years later that you became director, 1969?

STAGL:

Yes. To answer your question: there was no career master plan. About the extent of the plan after I got out of the service was that I knew I would like to manage an office. That appealed to me to be able to have people doing things in a coordinated way. After I became the office manager I was wrapped up for the first couple or three years. I spent those years getting things

caught up. My predecessor was there every evening -- the hospital mail would go out and she would put the postage on or either one of the girls in the office would put postage on and she would give them the exact amount of postage. That is why I say you have to go back in the old days when these things were important in the hospital, the cost of postage and all that sort of thing. I am surprised they didn't have a parade for me when I brought in a Pitney-Bowes postage machine to let it all be done mechanically.

I had been there a while and Van started using me and the personnel manager in administrative matters. There was no personnel manager when he came, there was no public relations, accounting was absolutely nothing but keeping track of patients' accounts and processing the pay checks. He moved to these sorts of things because he had come from a hotel background. When he left and John Hatfield came in I was at least privy to meetings with him, an assistant director and the personnel manager. That was our management team. Mr. Hatfield gave me certain administrative projects in addition to the other duties. I remember having to buy 350 electric beds and refurnish all of the patients' rooms. This led into a whole new world for me. I began to think 'this is kind of fun.' Finally he got another accountant to run the office and he assigned three or four departments, the laundry and housekeeping and so on. I really began to enjoy what I was doing.

Subsequently, I received an offer of a position in Detroit. I came back and told John Hatfield, who knew I was being interviewed. By then I was assigned most of the service departments. He went to the chairman of the board, still Mr. Edison Dick, and some others on the board and they made a commitment to me. Through their executive committee they promised that when Hatfield would retire in three or four years the job would be mine. By then I

had had enough exposure to them that they knew who I was and what I was doing. I owe John Hatfield a great, great deal. It was three or four years later when he retired. I took over. It was during that I became serious about wanting to be in administration.

WEEKS:

You were beginning to do some committee work with AHA by that time?

STAGL:

That kind of gets into the story of the HFMA.

WEEKS:

I have a note to talk about that.

I guess what I was interested in was not only your own master plan, but I was also interested in the possibility of a master plan at Passavant Hospital, in light of all the mergers that came later.

STAGL:

We had master plans. It seems we had them growing out of our ears, but then it was fashionable at that time to have master plans. We were across the street from Wesley Memorial Hospital. Wesley was a big place. At one time it was 800 beds. Over the years, when one of us had had one consultant or another in, they all said that we should be working more closely together. But we really never did. There was a lot of competition -- the different units of the medical staff. About the only thing I can remember was that we took on the renal dialysis service and they kept their hands off. They took on the cardiac surgery and we kept our hands off. In other things we were duplicating all over the place. This went on for years. Along the way, Ray Brown came to the medical center as its president. One of the projects that he undertook was to form a committee for the medical center of the

administration, doctors, board members, from each institution to plan for the campus area. On that campus was the medical school, Passavant, the VA, Wesley and the Rehabilitation Institute, all very close together. Ray ran this whole thing. The committee came up with a plan of things you did do and you didn't do, not the traditional master plan in the sense that at a certain date we would initiate this or that program. They laid some ground rules or guiding principles. They said, for example, we will never use this important high-priced land area for a nursing facility or a nursing home, of any kind. That was an issue at that time.

One of the things they said was that Wesley and Passavant ought to merge. This was years before it happened. One of the truly remarkable things about this "plan" was that years later in reviewing the 30 principles or so, we found that all but one or two had been followed.

WEEKS:

I was going to ask you what the McGaw Medical Center really did.

STAGL:

It probably served for the most part as a communications mechanism. But one thing where the institution really did work together was on the matter of house staff coordination. Before the Medical Center there was a lot of frustration; everyone doing their own thing in relationship to house staff. Finally the chairman of opthalmology agreed to have Wesley and Passavant pay the residents in the two institutions from one bank account and get one Blue Cross coverage plan and so on. It eliminated a lot of separate negotiating that was going on. The chief had less problem thereafter because this was set the same at Wesley as at Passavant. Other chiefs became interested. Finally, at the medical center level it was agreed that the chairman of the service at

the medical school would be responsible for the training in each of the institutions. In most cases he would recruit them. If he decided a young man needed more experience in a community-type hospital like Evanston, or needed it in VA or whatever, he was free to move these men around. From a program with average success, I would say, in recruiting, we suddenly found ourselves with more residents than we could assign. And they still recruit beautifully. I see the other day that they matched everything and they had more than they needed. It developed into one of the country's fine house staff programs simply because the medical center started on some minor steps like coordinating payroll and benefits.

There were some other things that they worked on together, but so many things that we couldn't. We never did get a single computer center which would have been another great thing in terms of saving, but more important what you could do when you had that kind of volume. You could go out and get one of the best computer men in the country to come in and run the unit.

That is the same thing we found out in the merger of Wesley and Passavant. We were no longer looking at only our two department heads that had been running our food services, for example. We settled on the president of one of the biggest catering companies in the Chicago area. Here was a man with all kind of degrees after his name, tremendous experience, and a real pro. That went on through all the departments. That was the toughest part of all, to take people with whom you had been on a very intimate basis, but knew that while they could run 350 beds at Passavant to run 1200 beds or more was simply too much. One time we checked I think we were the sixth biggest of the private hospitals in the country, not counting the public or the big VA institutions, but the private hospitals. It was particularly tough when a

department head at Passavant, who had been a very close friend over the years dating back to my own department head days had to be passed over. That was true in several areas. I think one thing we learned, and it would be a good point for people thinking mergers, you don't draw a plan that says in March we are going to merge these units and in June we are going to merge that department and so on. You have to take targets of opportunity. In some cases the person left. He was close to retirement anyway and he didn't want to experience all of this change and so away he went. You either had to appoint the other person or you had to get somebody new. You had to fill the position, so you did that one right then, not because it should have been done a year later. We didn't go in and have a master plan that said here is who we are going to replace and here is who we are not going to replace, and we are going to do this all in the next four or five months. Some units we ran separately. The toughest one, originally, was nursing. We had two ladies, the one at Passavant who had literally saved my skin by recruiting and keeping a full staff of nurses. The one at Wesley seemed to have some problems with the medical staff. The thing that was the most difficult of all was as soon as the nursing union saw these two separate nursing services to be merged, they moved in hard on us. They petitioned and finally got us to a point of an election. It was a battle for five or six months. Sensing the need for leadership that was not tied to one or the other of the two services, we recruited the nursing director from the University of Chicago. Her pitch with the girls was to give her a chance first. We beat the election on about a two to one basis. That was a blow for the Illinois Nurses Association but I think now that is all over.

Another one on the merger was that Wesley about three or four years

before had been unionized in the service departments. Passavant was not unionized since we had a big advantage, we were smaller and therefore a closer knit group. Most employees knew me and I knew them, whereas Wesley was so big. According to the law, in a merger the new combined unit has to take whatever contracts are in existence on both parts. Well, there was a union contract at Wesley, so the Passavant people -- the new people hired after that had to go into the union -- the people who were still at Passavant after we negotiated and threatened to go to court, they agreed to let them make their own decisions. They wouldn't have to join the union if they didn't want to. That led to some unrest for quite a while because the Passavant people weren't paying any dues to the unions. As turnover took these employees away, I would guess most everybody by now is a union member, but to my knowledge the hospital doesn't have much problem with the unions.

The merger was made in 1972. I found the most difficult part from my personal standpoint, in picking department heads was to tell them that in a few years I would be leaving. Newly recruited department heads were making a major change in their careers on the basis of somebody who was to be around only a short time. I had that problem with two or three people including an assistant. By the time we hired the assistant I had told the chairman of the board that this wasn't going to work and that I had come to the conclusion that this wasn't fair for me to make these choices a few years before retirement and to begin laying all kinds of new procedures and merging units together and then have somebody new walk in. If he was going to walk in at all, this was the time for him to walk in.

I went to the chairman of the board and explained that to him. He got together the executive committee and they approved based on another year's

service. They would institute a search in the latter part of that time. They did go out and recruited Dave Everhart.

I had made the commitment on the department of nursing, which, after I talked to him years later, he said was working fine. I had made a commitment to a man in finance that didn't work out. That was a tough thing for Dave coming in.

Mostly the changes I made I tried to stay with the smaller things and not commit to any major departments.

I got the first piece of advice on mergers long before that time. I went out to Wilmington, Delaware, to talk to a doctor who was merging three hospitals down there. He was the one who put me on to not to try to lay it all out in a neat plan. All he knew was that among other things he had to get one fellow to head all of radiology and if the radiologist happened to be leaving, that was the first thing he was going to put on his agenda. Never mind at the moment the director of nursing if he had three powerhouses in there. He could take care of that later. Don't face the tough ones right away. Just take them as the opportunity presents itself. That's what we were doing in our merger.

If somebody was going to leave anyway or if somebody was so obviously out of place, that received priority.

WEEKS:

What did you handle in your data processing -- clinical as well as business information?

STAGL:

No, not at that time. At Passavant we had gotten mostly into statistics and some medical records data. We were into payroll. It was done pretty

quick. We were moving into patients' accounts receivable. They are the two big things and the easiest things really. The dream when I left, and since then I have heard them talking about hooking up the patients' floors to the doctors' offices so that a doctor could check on a patient from his office. He had a monitor there. All kinds of wonderful possibilities. How far they have gone, I don't really know. I know bills I get as a patient now and then all look to me they are about as modern as they could be.

WEEKS:

I still don't quite understand what the McGaw Medical Center was.

STAGL:

Finally these five institutions got together and they agreed there would be a medical center and they would elect a president. Each institution would have an equal vote in the medical center. That was about it. The first thing they did was hire Ray Brown. He got into a number of programs, getting the hospitals to voluntarily come together on some kind of service. We ran a bus service from our place out to Children's. I can't think of the others now, but there were quite a few. Ray made a point of writing an agreement on each service that we decided to get together on. The big one was the house staff. There were a number of things which we did do together, which nobody objected to. It was fine. We put direction signs all over the medical center. He did that. He arranged for security on that campus.

WEEKS:

Sort of a coordinated...

STAGL:

One man handled all of the security. He tried to put all of the telephones together. That was a tough one. I think they are now all

together. That sort of thing. For each one of those things he would get into he would write -- almost a contract -- but he would write a document that gave everybody's intent and how they would do it. They all had to sign it. These documents, to a bunch of administrators, what a wonderful opportunity to nit-pick! This wasn't done just like that. It had to be carefully worked on. He did all of that sort of thing.

Along the way Mr. Foster McGaw made a big contribution to the university. In turn, they named our medical center the McGaw Medical Center.

Ray, just before he died, was planning to go back to Duke. His thought expressed to me, and we did get rather close in the last year or two, was that with Wesley and Passavant now one, literally half the beds or more of the medical center group of hospitals were already under one entity. In other words, the merger cut the medical center about in half.

WEEKS:

So the medical center coordinated all of these?

STAGL:

I followed Ray in that job, followed him because by then I had made my arrangements to leave Northwestern Memorial Hospital. That worked out fine for the Center, worked out fine for me because at that time I became chairman of the AHA and I had about half time available for the medical center. It all came together very nicely except there was that year I had promised to stay at Northwestern Hospital. So for about a year I was administering both the hospital and the Medical Center. The Center board also knew that I was going to end up with the AHA. since by then it was already pretty clear. So that was going to work out fine for everybody, because there was no way the medical center could be a full-time job given the way it operated.

I was there several years before I went over to the Joint Commission. The Medical Center had to get somebody else. No career administrator was going to come into a half-time job. So the dean of the medical school took it over along with his other duties.

WEEKS:

As I picture it you were a commissioner to the Joint Commission for AHA first for a year. Then you went to work for them?

STAGL:

Yes. The Joint Commission was having problems, the staff of the Joint Commission, with a number of operating details. I was coming to the end of AHA and the end of McGaw. I didn't have the guts to retire outright. So, I said to myself this is right down my alley, running an office. It'll give me something to do. I agreed to work there four days a week running the office functions. I went in not as an employee but as a consultant. I ran the office there for about a year and a half. It was obvious that whoever was running the Joint Commission, meaning John Affeldt and before him Ken Babcock, were so interested in the medical, professional kind of things that the business of getting the surveyors out and paying them and collecting from institutions was not down their alley. I was hearing this at board meetings as a commissioner. About the time the thing with McGaw ended they let the office manager go and I said I would do it. It was really cowardice because I was afraid to retire, go home and sit all day long.

When I got in there it was like the old days in a hospital where a doctor, with no management experience or no tendency towards management, would try to run the hospital. It was obvious that the Joint Commission, and I still believe this is true, does a great job on setting standards, I sat on

one of those committees with some doctors and they really work at it. They have staff who know what they are doing in deciding how you measure different standards. That part was fine. What I thought they really needed was an administrative-type guy -- I don't care whether in John Affeldt's job or where, but somebody who would do just as an administrator did in the hospital, let the medical people set all the standards, and he would get down to the nitty-gritty business of operations. When I first walked in there were some hospitals who had had three accreditations and never paid. It was a simple matter, pretty quick. I found out when they were going to be reviewed again and after they scheduled them I called the administrator and said I want you to know that they are not coming out and you are not going to be accredited unless you pay the Commission for the last three surveys. Of course, they had the check in the mail the next day. They had storage of broken furniture and so forth in a big area they had rented in the John Hancock Building which was a god-awful mess. I think within six months we got rid of the broken furniture; we either fixed it or we got rid of it and had the space.

I finally ended up at odds with the powers that be on the basis that you don't absolutely need a doctor to run the thing. Now if you can find a doctor who has a management ability, like an Al Snoke or some of those fellows, that's fine. But you've got a mess here and you aren't going to clean it up this way. Let the professional people look at the standards; let them work on that. Let them decide if a hospital is accredited or not. So I left, not too happy. That was my consulting.

WEEKS:

Stagl and Associates was it?

STAGL:

I just worked there and did a couple of other things.

WEEKS:

Didn't they hire Larry Hill later on?

STAGL:

Yes.

WEEKS:

Possibly we could talk about AHA. There are a lot of things about AHA. I was thinking when I looked at your CV and the fact that you spent those three years at AHA towards the end of your career. That is quite different from some of these younger men who go into it at an earlier age. I have even heard of some men who have had trouble with their hospitals because of all the time they were taking for the three years in AHA activities. You were near the end of your career at the hospital.

STAGL:

Also, I think it makes a difference who you work for, in that several of our board members at the hospital and at the medical center were on sort of a national scale. Leadership of the medical staff was too. I think if you had asked them, "Do you think Stagl should participate in these national associations?" I think they would have said by all means. They would know the benefits. If you get to somebody in a hospital where the board is not so attuned, when he went off to a meeting in Dubuque or somewhere I am sure there would be some kind of resentment about wasted time because they didn't know what that would do for the institution.

WEEKS:

I think that does take place sometimes.

You did a lot of traveling, I suppose, and speech making.

STAGL:

A great deal of it. My wife and I used to say it was fun and we were glad to have had the opportunity to do it, but we wouldn't want any more of it.

WEEKS:

In those years that you were chairman elect, chairman, and speaker of the house -- 1976 through 1978, I believe -- I was looking at the committee assignments that you have had at AHA. If I read the names of some of them could you tell me if there was any particular significance as far as you were concerned with what happened? I noticed that here again you were heavy on finance.

STAGL:

You have to understand, Lew, that a lot of people like a Russ Nelson and some of those fellows get into leadership positions in AHA because they are leaders before they even get there. For whatever reason, I knew about Russ Nelson while I was running the business office.

What happened in my case was that in 1965 they passed Medicare. The hospital controller was the man who until then issued the paychecks and took care of the receivables and a few things like that. He might render a few statistics to the boss on what the nursing hours per patient day were or a few things like that. Nothing really very exciting. There wasn't any big financing of hospitals. You had an accounting committee on the AHA. At one time the committee was six Blue Cross people and six hospital controllers. This committee met and decided policy for the AHA in finance. There never was a great deal of policy to decide to begin with. The AHA board didn't pay much

attention to finance.

My first entry into some attention at the AHA was that I was one of the people on this committee. Really the reason I was on is because I had been involved in the Hospital Financial Management Association, so I had been on an AHA committee on accounting before. Now hospitals were starting to get into heavier negotiations with Blue Cross all across the country. Here we are six Blue Cross, six controllers debating policy issues and then referring them to the AHA board. We were both walking on opposite sides of the street. I felt AHA officially should take a position on what ought to be involved in financing. Then from the board level, the president and officers negotiations would proceed with Blue Cross. Not six hospital controllers and six men from the Blue Cross Plans across the country. So I wrote a letter. Dick Cannon happened to be chairman of the committee and I got his approval to do what I was suggesting which was to say that there shouldn't be a joint committee to begin with. Policy ought to be initiated here by the AHA with their boards and their councils and so forth and then they ought to sit down and negotiate with Blue Cross. That is exactly what they ended up doing but probably not because of my letter. At the highest level of AHA and Blue Cross I understand they decided they had to start going separate routes. So this fitted in.

It ended up with me being on the council on finance, then the chairman on the council on finance. About this time Medicare was coming along. Now AHA was getting down to serious negotiating -- is the U.S. government going to pay for depreciation, and if so on what basis are they going to pay? Outside of me sitting there as chairman of the council on finance at the board meeting there wasn't a board member with any career financial background. The only

person who would be sitting there would be a Dr. Dave Drake. He was staff. Dave Hitt came along later on and some of the other fellows with real financial "know-how." But at board meetings as we discussed the Talmadge bill and other legislation, I must have been doing most of the talking, because they would have to look to an accountant when they would wonder, 'can you charge nursing education to so and so?' They just didn't know. So, I was getting a lot of attention.

As it got heavier and heavier financially on the board, I ended up with the chairmanship of the board. I have always said that my being chairman was the result of a quirk in time. I happened to be sitting there when Medicare was passed. I participated in Congressional presentation about three times to talk because I knew finance. The rest of these men, even a Russ Nelson although he wasn't on the board then, wouldn't have been able to handle this sort of thing. It was a specialty kind of thing. That was really my role at the AHA. Most of those committees that you see will be finance. There are a few other ones.

WEEKS:

I have one on accounting and statistics. It would be about the earliest one, about 1952. George Bugbee was still at the AHA then, wasn't he?

STAGL:

Yes. That is an interesting story. A lot of this I got by hearsay, so I don't know whether it is all really true. On a parallel track with Mr. Bugbee and the AHA was a group of accountants who were trying to get together as an accounting association. They did. Some of them worked in Rochester, New York. They used to meet at Indiana University once a year to have an institute. Maybe they attracted fifty people in attendance. They wanted AHA

to support them. I understand George Bugbee wouldn't do so. I don't know the reasons, but I can guess. I can see the AHA not being too happy with every position in the institution wanting some such kind of recognition from the AHA.

I went to the Institute to talk one time and thereafter became involved in the HFMA. At that time it was the AAHA, American Association of Hospital Accountants, and later I ended up on their board and ended up being president. We did a lot in terms of trying to upgrade hospital accounting. We got some good people to give us advice. Bill Markey was George Bugbee's AHA specialist in accounting. So, of course we invited Bill to come down to the institute at Indiana University. Then he arranged for AHA to put the president of the AAHA on their committee on accounting and statistics. That was me. We put Bill Markey on our board in the AAHA. So I was kind of an ice-breaker at their meeting. Way, way over my head with the group the AHA had. They had Charlie Roswell as chairman who was the greatest ever, from the United Hospital Fund in New York. They had the man from Johns Hopkins. All sitting there and I'm there just five years into the field with little Passavant Hospital. That was the first AHA committee for me.

WEEKS:

It's strange that George didn't want to cooperate because he had an accounting background himself.

STAGL:

He came around very nicely later on. We had no problem. All I know is I heard the fellows saying Bugbee wouldn't have it. I don't know what the whole story was.

WEEKS:

At the time of this accounting and statistics committee, were you working on uniform reporting?

STAGL:

That sort of thing. What we really got into was cost analysis, cost accounting. Charlie Roswell had put that into effect in New York City. I don't think people realize this is really a cornerstone of hospital financial management today. He had to do it because the money raised for the United Hospital Fund had to be distributed among the hospitals. The way to distribute it was based on their costs. Now he had to determine their cost. That got into a really revolutionary thing in those days. If you had to spread the laundry costs, for example, over surgery and over all of these different departments, that was unheard of. All I did when I first began presenting statements to our hospital board was to give them a total of salaries, supplies and so forth. That was my accounting to my board. Then after I heard Charlie at these meetings, and with the help of our auditor, Robert Penn, I started to develop a cost analysis. We had never weighed laundry. We didn't know how much laundry we did. I had to get the laundry manager to start counting pounds by departments. Little by little -- it must have taken five years -- I was able to present a decent cost analysis. Even then it was a long way from what an accountant would call sophisticated accounting. But that eventually led to modern day hospital accounting.

WEEKS:

Looking at the dates of the middle 1950s, I was wondering if any of that work had any affect on Hill Burton?

STAGL:

I don't know. If it did I didn't have any part of that.

WEEKS:

There was another committee during George's tenure, the committee on the cost of hospital care, sort of a national committee.

STAGL:

The Perloff Committee was one.

WEEKS:

This would be before Perloff. I'll have to look that up.

You also had membership on the committee on accounting and business practices.

STAGL:

That may have been the one with the Blue Cross members on it.

I think that may have been the committee where we developed criteria for reimbursement for hospitals. That was probably the most controversial one that I have been on, with two states threatening to leave the AHA. If that is the one I am thinking of we wrote a manual on what the hospital needed to be reimbursed. We had all sorts of things in there. It faced certain issues, but the one that really got everyone excited was on the issue of depreciation. If you want to go back far enough in history there were university professors who said that hospitals should not be paid for depreciation because depreciation is the recovery of costs and the hospital didn't cost you anything because it was built by community funds. We made a lot of arguments that said, "We are reporting to the community and the community has the right to recover its costs, depreciation." Finally we started getting down to the line of argument that said, "If I buy an operating table for $10,000 today, I

have to replace it ten years from now so therefore it is the cost of replacement that we want you to pay for. You've got to give us this money because you don't allow us to make a profit. The only way we are going to keep this institution viable is by using replacement costs."

I remember I was on a committee negotiating a new Blue Cross contract in Chicago. We used the same argument. That was my first exposure to it. Robert Evans, who was president of Blue Cross, finally after several meetings said, "All right, if we agree with you how do I know that Blue Cross money is going to be put aside and used only for that purpose in the future? How do I know you are going to buy an operating table? The only way that I know is for you to fund it until needed."

This went over like a lead balloon because the truth of the matter was that most of us were using the depreciation funds either to cover deficits or for other things. If I would have had to show money for all that I had depreciated and not yet spent, I couldn't have done it. Most of the others couldn't. In fact, under Medicare legislation a Senator Anderson proposed that in the formula the government keep the money it paid for depreciation. Instead of paying the hospital it would fund the monies and then pay hospitals for major projects out of these funds. That went over dismally because Illinois for example wasn't about to have its money for depreciation go to build a hospital in Missouri. That lasted a couple of weeks and then he was out of the picture. This was the argument on depreciation.

In this manual we went through this same argument that I went through with Bob Evans. It either got funded or you've got to have somebody approve the fact that you are going to spend some of that money a certain way.

But by now we are far away from just operating room tables; we want a

hundred more beds. We need a million dollars to do that. That was the argument with Evans. He said, "All right, but then you have to have some kind of planning body."

Now we in Chicago were on virgin territory for sure. We didn't know what to do about it. A little later AHA in preparing the manual was in the same boat. We were writing these needs that hospitals have to have and the powers that be are saying, "All right. But now you have to have planning groups that will approve it. Because in some areas you have about twice as many hospitals as you ought to have and we don't want to pay for expanding any of those or renewing them."

To make a long story short, in that manual we, the committee, agreed to the concept of planning controls. That is the first time that I know of that AHA took the position of supporting planning -- I mean supporting it where it meant something, not individual institutions but the whole field. You would have to have a plan for the hospitals in an area. The field had simply not been exposed to having to justify to outside bodies the expenditures of funds. When the manual was presented to the House of Delegates for approval, I believe it was Wisconsin and Utah who indicated they would no longer be members of the AHA if this manual was approved. That's how intense this whole subject became.

Finally, and I'm sure there were a lot of phone calls, it was passed. That's when AHA was in a position of supporting planning, areawide planning. That was really a tiger.

WEEKS:

What about the committee to review financial standards?

STAGL:

That followed after the leadership committee report, and really didn't have anything to do with finance. It was one of my best experiences. The leadership report, which we can get to later, said that AHA would be a lobbying organization in Washington and that the state associations would let AHA do this business. The AHA then convened a group of state execs. There were twelve or fifteen of them and I was much impressed by them. We discussed at great length what AHA would do and what the state associations would do. The only people representing AHA were Bill Robinson, who himself had been a former state exec, and myself. Bill was testing the water to see whether these fellows would buy federation. Federation being that all hospitals would be bound to support AHA positions. This goes back to the framing of the Constitution of the United States. They had the same problem. Some of the little states didn't want to get tied up with whatever Virginia might decide. All of us had to read a book which Bill gave us on the history of writing the Constitution. But federation for the AHA didn't fly.

What they did decide was that the state association would keep hands off. Nothing in writing or nothing formal, but they would keep hands off of Washington. That was a big help to AHA because at that time when they were arguing formulas for Medicare, a controller from Mass General in Boston who believed in a different formula than the AHA's official position, had more access, it seemed, into Washington than the AHA did. On the other hand AHA agreed to back off and let the state associations run the institute part of the educational program. I think that has worked out pretty well. AHA, to my knowledge, doesn't run very many now. Then these fellows convinced other state associations I found out later that this was rather an exclusive group.

I never knew it existed. You could tell the way they talked that they had had a lot of doings together and had been off different places together. It was kind of fun to be with them. I got a terrific admiration out of those individuals of the role a strong state exec could play.

The reason I had an admiration for a number of these particular state execs was that if they thought something was right, they tried to get it accomplished. There were other state execs, I suppose, like other administrators who often waffled and played the safe course.

WEEKS:

Actually the state association didn't become generally prominent around the country until, when, the middle 1950s, when Crosby came in and Kenny Williamson was trying to set up state associations?

STAGL:

I don't know.

WEEKS:

I got the impression that there were several states that didn't have associations as late as the middle '50s.

STAGL:

It could very well have been. I don't know.

WEEKS:

The ones who started associations probably tried to get some dynamic character to head the association and build it.

The council on finance. You were chairman of that too. Is that what you were referring to before?

STAGL:

Yes. That came about when we were a committee. There were different

committees, the one with Blue Cross and then we went to another one. Finally, I think this was the result of a Hamilton report, they formed a council on finance. At the same time they formed other councils. I think I was the first chairman of that council on finance. It may have been under some other name like a committee before that. We had some good people, and I'm sure we had a lot of big issues, but I don't remember under that group whether there was anything specific.

WEEKS:

What was your connection with HRET?

STAGL:

Hospital Research Educational Trust? Only that while you are chairman of the AHA, you automatically become a member.

WEEKS:

I see.

STAGL:

I did my turn there. I never got too involved, mostly because it was pretty much run by staff and some people who were specifically interested in research.

WEEKS:

Was Colin Churchill there?

STAGL:

Yes.

WEEKS:

I've never been able to find out exactly when this started. I know it was set up as a 501(C)(3) organization in order to get research money, but I ran across a name, Alan Treloar. That must have been in the early days of

HRET.

The committee that I think you referred to previously and one which you place great importance on was the committee to study leadership role of AHA. Would you like to talk about that?

STAGL:

I had gone on the board of AHA replacing Jack Kauffman who became chairman of AHA. I was doing my share of talking because of the financial atmosphere that existed at the time. Jack asked me to chair a committee to look at the leadership role of the AHA. What was the AHA going to do in the future? He gave me some very good committee members. Jim Hague secretaried that committee.

There was a great deal of concern at that time about the AHA role in Washington. AHA had been pretty much educational and that sort of thing if you go way back in history. It hadn't really done too much in the field of negotiation. Oh, it was called to come in before committees and so forth. Kenny Williamson was in Washington at the time. I understand that at the AHA board level there had been some concern with some of the positions that Kenny took. Some of the board members felt they were not the position of the board. I think that may have been part of the background for forming this leadership committee. But there were also issues with the state execs. Some of the states were going directly to Washington. Also the AHA was getting a reputation as an administrators' club. They were all administrators on the board and in the House of Delegates. Also the AHA was trying to get closer to the AMA and the medical people, among others. They were also trying to get closer to the trustees of their member hospitals who were sort of shut out from the AHA too because they weren't administrators. With these things in

mind I think they decided to have this leadership committee.

The committee was formed and divded into four or five different groups. One to study the staff and committee relationships of the AHA. Part of this problem was that if you looked at the AHA manual at the beginning of the year when they appointed the committees there were three or four pages of them. Some of them never met. And some of them, if they did meet, only met once a year. They really weren't doing anything. There were a number who felt that it was a good thing because it gave more members recognition. It gave the member a chance to be on a committee of the AHA even though the committee didn't do much. It fanned out the AHA among its membership. Others said that was hypocritical and that that wasn't the way to go and you shouldn't have a committee unless it was actually going to do something. That was one of the groups that came out of this to study the AHA staff and committee relationship.

Another one was to study the entire Washington situation. Another one was to do something about this "administrators' club" reputation. There are a couple that I am forgetting. There must have been four or five. Each sub-committee wrote special reports.

The Washington committee which I was on and chaired talked to a lot of people in Washington. We talked to some Congressmen. We mostly talked to their staff people. We were trying to get a feel for whether the AHA, representing the hospital field should get into the guts of politics or were above this sort of thing because we were a humanitarian organization. We found, to our surprise, that some of the staff men for some of these Congressmen were saying, "That doesn't cut any ice with us. We don't hold in contempt the lobbyists. They've got a purpose to serve." They thought that a

weakness of the AHA was that we didn't lobby heavier than we did. That would include things like convening a whole group of administrators in Washington in February and have them go see their Congressman. Everybody speaking the same tune, a major lobbying effort. We dealt with this other issue of the Washington office getting too much power as far as the board was concerned. The Washington office had some special name which I don't recall, but it was no longer to be that. It was to simply be called the Washington office of the American Hospital Association. The leadership was to come from the president of the association who headquartered in Chicago but who was expected to be in Washington a good deal of the time. Remember, Alex McMahon wasn't on board yet. He came a little bit after that. When they interviewed him for the presidency it was on the basis that he would spend time in Washington.

WEEKS:

He loved that.

STAGL:

Yes. He would have an apartment there. A big issue that came up along with the lobbying whether they should move the AHA office to Washington. The board felt no because in Washington you "couldn't see the forest because of the trees." In fact, Walt McNerney, one of the fellows we interviewed, told us that too. You don't want to be there because there are fifteen rumors a day and you are running off fifteen different ways as president tracking them all down. It's better if you're back here in Chicago and when information finally comes to you it is really of some importance. We did recommend these particular changes. We waffled on the issue of saying that we were an out-and-out lobbying agency. So if you read that report you will find out that it says that we have a responsibility, in effect, in Washington but we also have

a responsibility to be a humanitarian outfit and we reconcile the two by saying that if all the hospitals were humanitarian then what was sent to Washington was humanitarian.

The other issue of the thrust on the "administrators' club": we enlarged the House of Delegates to include trustees, one from each RAB, and a doctor from each RAB. I think that wasn't a big hair-raising issue at the time. I think that has had quite a nice impact over the time, because when I became chairman I used to have to visit the RABs and you could tell the doctors had an effect -- even though only one would be sitting on an RAB. I think it made a good contribution.

The other one they decided was on the matter of so many committees. They conceded that it did have some beneficial impact, having a lot of them. But too many of them, and ones without anything to do, had a negative impact -- If you were put on a committee and then never met. So they said we've got to look at the way we approach problems. One thing they did was to use the ad hoc committee or a committee for a special issue or a special purpose. Then later they went carefully over all the committees and junked a number of them. There is still quite a long list of them.

WEEKS:

You mentioned McNerney a moment ago. Did you sit on the search committee?

STAGL:

No. I was there as a board member but my memory is bad on the details. The search committee came up with Walt as their recommendation. Some felt that the Blue Cross image would be bad, particularly in view of all the heavy negotiations going on at that time with them trying so hard to be the outfit

for Medicare. I don't think the board actually turned down Walt. I think the committee made its recommendation and it was a tie or something. In any event, their recommendation was not accepted at that time. I believe there was a special board meeting called then, after this committee had made its recommendation. At this subsequent meeting for three or four ballots it was exactly tied, for Walt and against Walt. I don't know whether you have heard this but one of the board members, Jack Rivall from Minneapolis, was in town at the time but didn't come to the board meeting because he thought it was scheduled the next day. The story I got was that he was a supporter of McNerney, but he wasn't there to vote. After going on and on and on, the board remained tied on McNerney. On this I am really vague. Some way they decided that they would call McMahon to ask him some questions. They did. They came back and somebody changed their vote. It was all on a secret ballot. Finally McMahon was then elected.

WEEKS:

I've heard that. Just a little twist of fate and strange things happen. I heard another follow-up to that. I have an idea that Walt was fairly confident that he would be selected in the beginning and that he had decided that McMahon would be a good successor to him at Blue Cross.

STAGL:

I'll bet that's the way it would have worked too.

WEEKS:

That's another twist of fate. McMahon, I guess, is happy now back at Duke.

STAGL:

I haven't talked to Alex but I assume he is. That's his territory.

WEEKS:

The name of the Washington office was the Washington Bureau, wasn't it?

STAGL:

Something like that. They wanted to tie it closer to the AHA.

WEEKS:

This idea of representation in Washington by the AHA has many facets to it because there are a lot of splinter groups now, the Voluntary Hospitals of America and the different multi-hospital groups, and many of them feel that they don't need AHA any more and that they can go on their own, that they are strong enough, I think is causing a problem in the AHA as to the dues structure because they are not considered as individual members but as a group at a lower rate.

Kenny Williamson, I believe, developed a lot of close relationships in Washington. I think he did some lobbying. The story I heard -- maybe it isn't true -- that Jack Kauffman and Steve Morris and some of the others didn't like Kenny's attitude about President Nixon. He apparently made some outspoken remarks in public and they felt that this was unfair for his position on the AHA. I think Morris or Kauffman, I'm not sure which, was president at that time.

STAGL:

Morris was. I think you are right. Nixon had a secretary of health, education and welfare and I think his name was Finch, from California. The story as I heard it was that Finch wouldn't see Kenny Williamson, or at least he kept him waiting for two or three months or something like that. Kenny got mad. So, Kenny would not have anything to do with Finch. In my own opinion, it was probably that Steve and Jack Kauffman and Jack Hahn said we don't care

what they do to you, your job is to get in there and to get something done for the AHA. We've got to have access to the Secretary of Health, Education and Welfare. Kenny did, I am told, get his dander up when he was mad. He hadn't been treated that way before. I think that may have been behind it. My only personal experience was at a board meeting at AHA, when I was sitting there as chairman of the Council of Finance. I heard Jack Kauffman as chairman of the government relations committee and Kenny bitterly arguing in the meeting about some issue, something to do in Washington. I felt this should have been settled back at their government relations committee.

WEEKS:

That's stepping out of bounds a bit. Kenny, I think, was proud of what he thought was his ability to get into government offices and do things. So he probably resented some of the so-called outsiders coming to Washington. I tried to find out the different methods of representation. It seems that Kenny didn't like to use local administrators on a national scene. I know that an official of the association could step in at times, make himself available to appear before a committee, or the president of the association, like McMahon, but there are different theories about how it should come about. Some feel that the top man should just step in at the crucial moment, not be there routinely talking to these people. I think Jack Owen, today, seems to have organized it a little differently from what Kenny did. I think he is trying to get in all these fringe organizations that are existing and are trying to come into the national scene and have their own man in Washington. I think he is trying to get those people to meet together every month or every week at occasions so that AHA can be the strong influence and the advisor and maybe offer to take over certain kinds of representation.

STAGL:

I can see where this would be a big problem for Jack Owen because there are so many groups now and they probably all have the ear of somebody up there. The reason I went before the committees, in those days -- I don't know whether we did it in areas other than finance -- but I remember we went before Ways and Means with about twelve people, myself included. We went into Washington the day or two before and we went over the documentation and the presentation to be made. Then we all marched to that committee meeting, all of us sitting there. Only one or two did the talking. I think the idea was to impress the committee with the fact that here was somebody from Chicago, here was somebody from somewhere else. One of the recommendations of the committee on leadership was that McMahon or staff should do the presenting, should be there. Only on rare occasions did you need a member there.

The other two times I participated, we went into Washington and the staff had their position documented, but somebody says he doesn't like the word would instead of could and on and on. It took all kind of time. I always thought if they wanted me to come and they wanted to sit me back there somewhere so they could say here's somebody from Chicago or here's the chairman of the council on finance or something like that, okay. But Alex, who probably testified a couple of dozen times a year, could handle this thing so much better than I could.

I would object to me as an amateur sitting there when somebody like Alex or Jack or even Kenny or anybody else who does this all of the time and knows how to sense when to say certain things. I would always be conciliatory, you know.

WEEKS:

Yes. Unless they invited you as an expert. According to my notes you were before the Ways and Means Committee in 1966 and the Senate Finance Committee in 1967 and 1970. You must have been talking about Medicare then?

STAGL:

Yes. I was always there on something to do with Medicare and reimbursement for Medicare.

WEEKS:

Back in those days they were just beginning to find out, I believe, at the end of the first year or certainly at the end of the second that they had underestimated what the cost of all of this would be. It must have been very embarrassing for actuaries who worked on that to have this happen.

Was Mills there the day you were?

STAGL:

Mills was there part of the time. He got called out. At another time, we went to see Mills himself and one of his staff men. Ed Crosby went; Tekolste and myself. Tek used to work for AHA and then was the state exec in Indiana.

WEEKS:

Oh, yes. He is now dead, isn't he?

STAGL:

Yes. He and Ed Crosby and I went to see Mills. I was there -- I was on the board at that time. We went to talk to him strictly about depreciation and their position that they weren't going to pay anything but historical depreciation. I guess we were there about an hour. I don't know whether we made any dent on Mills or not. It's hard to say. He treated us nicely, and

listened.

WEEKS:

I was very impressed with him. I talked with him in Washington about four or five years ago, about the same trip I went to see Kenny Williamson. He was running his own consulting business.

STAGL:

Is Kenny still active?

WEEKS:

Well, he retired, so to speak, and went to California and built a home out there. He told me he was going. I saw him just before he left. He sold his business. He wasn't going to have anything to do with those "damn" hospitals anymore. Somebody said he had been doing some consulting with the business. I really haven't been in touch with him in three or four years.

You mentioned the Perloff Committee. Were you familiar with their workings at the time they were working on it?

STAGL:

At the time I was very familiar. That was the hot topic in the field, but looking back I don't think they got into finance too much and I guess my interest was like any other administrator.

WEEKS:

I couldn't quite understand how they reached their conclusions that this system they were talking about would be successful. It seemed to me that they were leaving a lot to wishful thinking.

STAGL:

I remember it was hotly debated and argued. I can't remember what system they proposed.

WEEKS:

Setting up corporations, not to be limited, to have competition. It's probably a good thing it didn't get started because of the way things have turned out.

I had a telephone call yesterday from a young woman in Philadelphia who wanted some information on Earl Perloff. She had read his oral history and she had one or two questions. Apparently they are planning some kind of a memorial service to him in Philadelphia. It's been nice that of the sixty-three oral histories that we have published and of the others that we have in the works, several of them have asked for the right to use the oral histories in the memorial services. Like Ig Falk, they called from Yale and wanted to know if they could use it.

I just finished Al Snoke's before he died.

STAGL:

Al died? When did he die?

WEEKS:

Oh, about a month or two ago.

STAGL:

Sorry to hear that.

WEEKS:

I met him here at the airport six or seven months ago.

STAGL:

I had a lot to do with him because he came to Illinois at the Governor's request. He did a lot of work in Illinois. I happened to know him through the AHA, so he came around pretty often. We talked a good deal about what he was doing. He sure missed Parnie when she passed away.

WEEKS:

Oh, yes. That was quite a partnership, wasn't it?

STAGL:

It sure was. They were a great pair together.

WEEKS:

They worked together on that Chicago deal, too, didn't they?

STAGL:

Yes, she was in town with him.

WEEKS:

He was a very lonely man, I could tell that.

I was going to ask you about some other of your Blue Cross connections. You mentioned the council on Blue Cross and Finance. I have another one down here about the committee on the approval of Blue Cross Plans.

STAGL:

Even when I put it down I couldn't really remember. It must have been one of those committees that met once a year or something. I have nothing in my files on them other than the name of the committee.

WEEKS:

I was thinking about that too, thinking that actually there were no new Blue Cross Plans during that period from '71 to '72. There might have been some mergers or consolidations, but I don't think there were any new ones started up.

STAGL:

The only thing that sticks in my mind is about some of the Plans that were doing badly came up as a discussion. Perhaps the job of the committee was also to satisfy for the AHA membership the fact that the Plan was healthy.

Hospitals, at least in the Illinois Plan as I remember, contracted with the Plan to cover for sixty days if the Plan went out of business. I suppose we guaranteed if we got a Blue Cross member that for sixty days we would take care of them if the Plan were out of existence.

WEEKS:

There were a number of Plans, a handful, that were in bad shape and had been in bad shape. In this past year many of them had not had revenues equal to their disbursements. What do they call their fund?

STAGL:

The reserve fund.

WEEKS:

Their reserve fund is in many cases millions of dollars lower because of this. In some states I understand, New York State as an example, a Blue Cross Plan can show that it has been losing some of its reserves and is therefore entitled to a raise in premium. They can't get a raise in premium until they can show that. I suppose this differs from state to state. Lately I have heard rumors that some of the Blue Cross Plans are saying that they should be able to operate anywhere they want to. For instance, we have one Blue Cross Plan in Michigan. I can see where they could say that they should be able to sell in Toledo too; it's closer to Detroit than it is to Columbus. Or somebody could say that all of the southern states should be able to band together and have a stronger organization, because they might have to be competing with Sun Health or a regional organization.

STAGL:

I always sensed there was more to this alliance of the Blue Cross Plans than met the eye. I always looked at the national Blue Cross and the cohesive

kind of thing. Then I got in to some of these meetings, I don't know whether it was just the one or not, but I remember some of the men saying, "Maybe we don't care what they think." I remember thinking to myself they are not much different than hospitals. I know they had some powerful men. The man in Michigan before Ben McCarthy was a powerhouse, and the fellow in New York was another one. I suppose those were the biggest Plans.

WEEKS:

Michigan is having plenty of trouble. They came up with what they think are financial irregularities. I don't know what they mean by that. There has been a lot of trouble between the Blue Cross Plan and the legislature. The national Blue Cross Association should be able to step in and help out and be a trouble-shooter in things like this. I understand, although you don't hear it publicized very much, BCA can step into a Plan that is doing badly or has poor management and finally say to the board of that Plan, "You had better do something or we will go public on this and bring in somebody." So they can use pressure like that. The fiscal intermediaryship; is Blue Cross as strong in that now as they were five years ago. Are any of them slipping away?

STAGL:

Blue Cross in Illinois lost it for a while. I think Mutual of Omaha. I am pretty sure now that they have it back. That always bothered me. I knew they had a heck of a decision to make when Medicare came along and that the fiscal intermediary role was bound to change their relationship with hospitals. I don't know about the other Plans around the country, but way back in history in Illinois we were hand in glove with Blue Cross. In fact, this Dr. Cutter I talked about who ran Passavant originally and the medical school, he was instrumental -- in some of the old documents in our archives I

found this -- he was instrumental in calling meetings setting up what was at that time the Chicago Blue Cross Plan.

It was the hospitals that set it up. For years, up until the last ten years or so after Medicare came along, they were brothers.

When I first started, the contract with Blue Cross was very simple, you just sent the bill into Blue Cross, they took three percent off, and paid it. They needed the three percent to get started. That was fine. Finally they came along, almost apologetically, and said something had to be done about this contract because their big subscribers had been sold on the basis that by working through Blue Cross they would pay costs. Of course some of our colleagues in administration were making far more than costs, and there was no plan or safeguard that Blue Cross was really able to say honestly that you are not paying any more than cost for your hospital care to these big subscribers.

So we sat down and we started to negotiate. It was tough. A few years after that we again had to redo the contract -- unbelievable the assumptions that were made that first go-round. We had to have a contract, so we had to have a cost formula, so what you do at Passavant is you add up all your expenses and divide by the patient days and that tells you what the cost per day is. Immediately Blue Cross said, "No, no, no, you've got outpatient costs in there and we don't pay for outpatient costs." Well, how much do we take out for outpatient costs? Try two dollars a visit. So the hospital took the number of outpatient visits and subtracted it from the total expense. What was left was what they owed us per day for Blue Cross patients.

Then we went on for a while. Subsequently we have to sit down and redo it because hospitals have their full OB costs included but Blue Cross only paid $75 and we were getting credit for the full cost. The same thing is true

in x-ray. They only paid certain x-rays. We had the full x-ray department cost in the formula.

When I think back -- you know, negotiations today are cutting every corner, every dime is analyzed -- in those days we said $2, okay, $2. They said all right leave your x-ray costs in, because you can't break them out. You didn't know how to do cost accounting in those days. Our relationship with Blue Cross was really very much on a friendly basis. They came to hospitals and said help us out because the big subscribers are saying they are not getting their care at cost. So, we did.

By the time we were doing the last negotiations with Blue Cross it was pretty tense. It was no longer so friendly. A whole different world even among hospitals. I used to be able to call up fellow administrators when I was at Passavant and ask what salaries they were paying. They tell me now that you don't call another administrator and get information about that institution the way you used to. It's apparently pretty competitive now.

WEEKS:

Then came the term "allowable costs."

STAGL:

Yes. When I think back on the Medicare negotiations, the regulations involved such big money that everybody had to be super careful and you argued and argued about different things. I can remember when the government finally said they would give hospitals two percent on to their costs to take care of the fact that historical depreciation wasn't going to buy the new operating table when needed. That was finally the concession. Before that, we had sat in Baltimore -- in fact, at Russ Nelson's club -- about ten or twelve of us, Sam Tibbits and some others and Ed Crosby, had gone to see Bob Ball and Art

Hess to discuss these matters. They were adamant. They were not going to pay more than historical depreciation. At dinner afterwards, a group of us had a long talk about what our position should be.

It was noted that we could tell SSA that they might not have the support of the hospitals in the Medicare program.

Some of those present said we should pull out of the program. When I went back to Chicago I talked to the chairman of our board, Edison Dick. I asked him if Passavant would refuse to participate in Medicare.

His reaction was that our job was to give health service to these people. He wouldn't have supported the negative position. I suppose that was true elsewhere in the country. So the AHA didn't. SSA finally agreed to two percent as a legitimate allowable cost. About three or four months later I heard Tom Tierney, who was with Medicare -- Art Hess' deputy I guess -- on a platform talking about Medicare and referring to the two percent as a "bonus" that hospitals were getting. We felt it was a legitimate item in the cost; he was treating it as though it was something they had handed out as a bonus. After a while they dropped even the two percent.

WEEKS:

Wasn't there an allowance on nurses?

STAGL:

Oh, yes. Part of it had to do with the Catholic nurse, the nun.

WEEKS:

There was that. They had to allow a cost comparable to a lay person.

STAGL:

Your right. There was something else on nursing.

WEEKS:

I have forgotten the reasoning behind it but it was something like a two percent overwrite on nurses. I'll have to look it up.

The trend on Blue Cross Plans seems to be to merge now. There are less every year when I see the total. I think New York has had a couple of mergers, one with Blue Shield of Buffalo. They combined with somebody quite a distance from them. I think there have been a couple there, and think there are some going on in Ohio.

You were speaking about your experience at Oakwood Hospital. You undoubtedly knew Karl Klicka when he was alive, didn't you?

STAGL:

Oh, yes.

WEEKS:

You know he ended up being president of the Peoples' Hospital System of Michigan. Before that he had been to Appalachia.

STAGL:

Yes, I remember that.

WEEKS:

I understand now that the Peoples' Hospitals -- there must be seven or eight of them in suburban Detroit -- are running into a little trouble. I understand there is going to be an association with Oakwood and they are going to, not have a financial arrangement of any kind nor an administrative arrangement, but just work together for shared services and things of this sort. It seems a little bit strange. The Peoples' Hospital Authority is a group of hospitals in blue-collar suburbs. They were formed by an act of the legislature so they get some milage from each of these twenty-five or twenty-

six communities that they serve. It would seem that they should be able to get by, but apparently they have run into trouble since Karl left. I think when he left they were in good financial condition.

I wanted to ask you about the Blue Cross Health Care Service Corporation. Is that the corporation that carries their insurance?

STAGL:

That is the legal name for the Chicago Blue Cross Plan. I was appointed to their board. I went to a couple of meetings and became pretty discouraged. I wrote the chairman of their board who at that time was Bill Swartchild, chairman of the McGaw Medical Center. I expressed my concern to him. Also to the president of Blue Cross in Chicago, and finally went off because the meetings were so orchestrated. They had to have by law a representative kind of board. It's as though I walked into the board meeting at the hospital and presented a lot of high-powered statistics and data knowing that the board members probably didn't follow half of it. These men would give all sorts of statistics and things they were going to do and give us an opportunity to comment on it. Well, you know, if I'm going to participate I have to have this material a week before. Especially if I am talking about insurance which I know so little about and I've got to do a lot of checking. It was bing, bing, bing. So I finally told them I thought I was really being a lightning rod because they needed to have a number of administrators and a number of community people and so forth. I wasn't really contributing anything at all. I was kind of glad to get out of it.

WEEKS:

I didn't know. I know Blue Cross Association had some subsidiaries.

I was thinking particularly about since the passage of Medicare and

Medicaid. You did serve on a liaison committee with a health insurance company, didn't you?

STAGL:

Yes. The health insurance industry. That particular committee, I don't think, did a great deal. What the AHA officers used to do once or twice a year, the officers and Alex, was sit down with a group from the health insurance industry consisting of company presidents and top brass. One of the things that they would propose is that they received the same kind of reimbursement contract as hospitals had with Blue Cross. We weren't ready for that, plus the fact that they would have only given us a historical depreciation and a couple of other sticking points. We met with them and, in addition to the bigger issues, there were a lot of little things that would come up, things we could do to help them and things they could do to help us. That was about the size of it.

WEEKS:

You might have met Dan Pettengill.

STAGL:

I met Dan Pettengill. The man who really did all the argument was one of their staff men who was trying to promote the reimbursement change.

WEEKS:

A committee that sounds intriguing, maybe you have already covered it, is a joint committee for the promotion of voluntary prepayment health plans. I don't know with whom that was a joint committee. Maybe it was one of those things that passed in the night.

STAGL:

I think so.

WEEKS:

I was trying to lead you into AAMC. You did serve on a task force, didn't you, on national health insurance? I was wondering what their conclusions or their attitude was.

STAGL:

I don't remember that we finished that job. Ray Brown was on the committee and a fellow from UCLA and some other people, trying to develop a position on national health insurance and particularly what it would do to the educational process. The teaching hospital had to have more reimbursement, it had more expenses, and it had a great deal to do with the medical schools that they were really representing. I don't recall the final positions taken by that committee.

WEEKS:

I'm sure it wouldn't be very much in favor, probably..

STAGL:

No, I think this was one of those things that you prepare to have something to draw from if you are called upon.

WEEKS:

You did serve on the executive council of the AAMC, didn't you?

STAGL:

Yes. I became involved in the AAMC principally through the area of reimbursement because when they started to get into that area they were about as bad off as the AHA. I found their meetings very capable, especially their meetings for the general membership. Their talks were good, and in their committee meetings and so on, the Council of Teaching Hospitals, they had some very knowledgeable people. I think when you go to hire a controller for Johns

Hopkins as against a controller for a 200 bed hospital in Chicago, you are going to get much more capability at Johns Hopkins. First of all because you have a lot more dollars to pay to begin with. Secondly, because you've got more of a challenge. I think that is true of administration too. When you sit at the Council of Teaching Hospitals and at their executive committees, you are sitting there with people -- few from hospitals under 500 beds to begin with. Secondly, with a much broader aspect than the fellow who runs a hospital that delivers just medical care.

So, I used to find their thinking in the committee meetings on a very high plane. I'm not being critical about the fellows at the RABs. Maybe if they were running a teaching hospital they would be thinking in different terms too. I used to look forward to the AAMC committee meetings because of the level of discussion even though I was running to catch up most of the time. Our hospital was a little teaching hospital compared to these institutions. I wouldn't want to be misunderstood, but I think the caliber was different.

WEEKS:

You were handling different problems.

STAGL:

Well, at a much different level.

WEEKS:

You also were on a VA liaison committee for AAMC.

STAGL:

We met with the VA people and talked about how our teaching hospitals could cooperate more with the VA. I met some nice people, but it was really an exchange of information.

WEEKS:

I met Al Gavazzi. He probably came after this period, although he has just retired. As I understand it, the VA is divided into two parts, the medical side and the other the administrative side. He was at the top of the administrative side when I talked with him. I was very impressed. He talked about relationships with community hospitals too.

I wanted to ask you about the Chicago Hospital Council. I have been impressed with some of the things I have read about them doing. I met Howard Cook one time, just casually.

STAGL:

I was on their board twice and was their president for a while. Their efforts were more toward a joint purchasing arrangement. It became that way. It used to be, years ago, that they were more involved with things with the board of health and equally involved in the issue of whether County Hospital, the big one, should go out of business and private hospitals take over -- big issues of that kind.

As time went on, their emphasis moved into questions of a central laundry, group purchasing, group systems engineering, things of that nature.

It always bothered me some that in our town a man like Dr. Rocky Miller, running Northwestern University representing a terribly powerful board, could call up Mayor Daley and get an appointment. We had, among the hospitals, ten times the power in boards, but we'd have a hard time getting to see the head of the Board of Health. I kept thinking, "There is something we are not doing right. There must be some way we ought to be able to use this clout." While I was president I tried to get a committee formed to look at that sort of thing. I didn't get very far. Howard Cook wasn't enthused about it. I

guess some of the others weren't either, so we never did do anything.

It seems to be that particularly these large urban councils have more of a role to play than just joint services. I think that's fine, if you want to say you saved three million dollars. If you put the three million against the total supplies used in Chicago you've got a minimal percentage there. I thought their role should be bigger. I'm not quite sure to this day why it isn't. I don't know of many other cities in the country where the hospital council has that kind of clout either, so maybe its got something to do with the whole issue of councils and associations. Or maybe we can't rely on our own board members being willing to step into the political process. I don't know, but we shouldn't be tenth in line when somebody wants to start talking about health care. The first place they ought to go to is the council or the IHA (Illinois Hospital Association) for information and opinions. It doesn't happen, that I can see.

WEEKS:

I had no idea what they were doing there. I haven't seen any publications from them in several years.

You do mention the Chicago Community Fund. Are they related to health care? Do they contribute?

STAGL:

The Chicago Community Fund collects from, hopefully, people in the city and they put their money to those particular types of endeavors that they feel are the most worthy. They collect I don't know how many millions a year. Then it goes to several reviewing committees of the community fund and they will decide that so much goes towards education, so much towards health care and so forth. When their budget is fixed on how many dollars they have

available to give the health field that goes to the health reviewing committee. I sat on that. We established a formula for certain hospitals, but not every hospital was eligible. We had a formula that divided up the amount that was available for hospitals. In addition, there were things like ear testing and eye testing in the schools. All kinds of health programs. They were all required to submit a detailed budget, each of these applying institutions. We of the health reviewing committee would go over that budget and would try to determine whether there were activities included in which they shouldn't be involved. These agencies all come to the Community Fund for assistance but there are only so many dollars to go around. After a couple of years or so on that health reviewing committee I went on to the board which is the one that decides the broad distributions of where the money goes.

WEEKS:

Is that the comprehensive health planning board?

STAGL:

No. The comprehensive health planning board was another activity. When planning came on the horizon, national legislation provided for the health planning boards.

WEEKS:

There are so many changes in the planning picture. So many things have come in and gone out I wasn't sure.

STAGL:

I'm not even sure what is in existence today. I know the state health facilities planning board is still in existence.

WEEKS:

I'm sure there is something in existence because it is a bureaucratic

sort of thing.

We were talking about Blue Cross previously but I wanted to ask you about the Illinois Hospital Association subcommittee to revise the Blue Cross hospital contract. That was an early one back in 1951, wasn't it?

STAGL:

That's one of those two times that we sat down with the contract and Blue Cross.

WEEKS:

I have never had a very clear picture about how regional medical programs operated.

STAGL:

And I don't think you'll ever have a very clear one. I don't think even they had a clear one. That hit the scene nationally and funds were available. The idea was that the state of Illinois, for example, would set up criteria and guidelines for the development of certain regional programs. This got very close to public health-type of endeavors. I remember that we spent a lot of time talking about cardiac surgery. In other words, that we ought to develop some program that could have some teeth into it so that only certain institutions could provide the service. You had to do twenty-five a month or some such figure. You couldn't qualify, for example, if you only did a few each month. They had some funds which they could make available for these different projects. That was about the size of the Regional Medical Program. That was in existence for several years. I can't ever remember having a feeling that I was really contributing something or that this program was producing anything of consequence.

WEEKS:

I got that impression that it was a little vague.

Just in passing, the Institute of Medicine in Chicago, is that a local medical society?

STAGL:

No, that was originally meant, way back before my time, to honor men who had done good things in medicine. Finally they started recognizing some of the administrative types and hospital board members. By the time they got around to the years I was there, what it really took it seemed to me was simply some member to write a letter on your behalf and you were elected. That's about all.

WEEKS:

It was really an honorary society.

STAGL:

Yes.

WEEKS:

I notice that you were on the National Center for Health Services Research and Development advisory group for mergers, consortia, and so forth.

STAGL:

I felt that was really a lot of nothing. That was one of Paul Sanazaro's groups. I don't know which one.

WEEKS:

He was the head of the center when I first met him. Now he is out in California. I don't know what he is doing out there.

STAGL:

We came to meetings and we had a lot of reading material and we explored

issues. I don't recall that we ever really created much of a stir.

WEEKS:

Among your notes you have listed as consultants Norby and Hatfield. I suppose that was Joseph Norby and John Hatfield.

STAGL:

Yes, John Hatfield had come to Passavant Hospital; he had been in Philadelphia at Philadelphia Hospital and served as chairman of the AHA. The interesting coincidence was that his assistant at Philadelphia Hospital, Bob Cathcart, later became chairman of the AHA. Then John Hatfield came to Chicago and I was his assistant there. After Bob was through as chairman of the AHA, I followed as chairman. That is real training of two assistants.

Joe Norby and John Hatfield were long time friends and the two of them were working together as consultants. When John Hatfield came from Philadelphia to Passavant, part of the arrangement was the right with the board's knowledge, to develop his consulting work. He did a little of it and he just loved it, because the part that he always did was the planning, the blueprint part. I spent hours with him in his office reviewing plans.

He was involved in this with the full knowledge of our board. Now and then they would involve me as a "leg-man" type. I would seek out all kinds of information on the hospital and its environs which they were consulting on. Proper number of beds for the area, growth of the area, hospital reputation, etc.

They were nice enough to call me in and say, "This is what we are going to recommend." It was more fun arguing about this since I had been out there and seen it and knew the people involved. It was beautiful to see Joe Norby in operation. I was with him specifically on two projects, one in Butte and

another one, a Chicago hospital. They had commissioned a study at the Chicago hospital as to what they should be doing, expanding or remodeling or relocating. Joe was good enough to invite me to attend his presentation on their recommendations. They recommended remodeling and renovating. There were three or four doctors at the meeting. I remember one doctor who noted that if the report was worth anything at all it would be recommending that we move out to the suburbs instead of spending money here. He really went after Joe. I can remember Norby turning to the Sister and saying, "Maybe we've got this all wrong, Sister, I thought you were here for the benefit of these people, not the medical staff." Then he went on, of course, to say they would make a lot more money in the suburbs but here was an area that would be without health care.

WEEKS:

That was a good point.

STAGL:

I enjoyed working with those fellows. It was a tremendous learning experience for me. They were nice enough when they got down to making their decisions to ask me to sit in and answer questions they had. They did this with a number of fellows who helped them on various projects.

WEEKS:

I knew Maurice Norby, the son. I have heard of Hatfield many times, beginning with George Bugbee talking about him.

You were a lecturer in hospital administration at Northwestern and you sat on the advisory council for the Graduate School of Management at Northwestern?

STAGL:

Yes. They had me on there, I think, because Northwestern had a school of hospital administration under Dr. MacEachern on the Chicago campus. Finally they moved out to the Evanston campus. Because it was one of their schools, I think they wanted some representation from the hospitals. They invited me to sit on the advisory council. I was completely lost in that world of high finance and academia.

WEEKS:

The point about all of this that interests me is the preceptorships. I notice you have three different universities that you have accepted men from. Did you have a pattern set up for preceptorship, like rotating them?

STAGL:

We had changes in our own thinking as we went along. We started taking the resident first from Northwestern University. With that one we felt very strongly that he must be exposed to all of the different departments. We actually had them put on uniforms and go work in the laundry for a couple of weeks. We would have them cleaning floors, working in the admitting office, everything.

In time we got to the University of Chicago and we began to wonder whether we weren't indeed exposing him so that when he walked into his own hospital he would know what a flatwork ironer was or something like that, but we didn't know whether we were giving him the opportunity to manage, to say to somebody that this is the way I want it done and then to wonder why it didn't get done that way. We finally tried exposing them, still going through the departments, but we were less concerned about whether they were actually lifting soiled clothing or not.

In addition to that we gave them a couple of small departments. One was our mailroom and messenger service, three or four people. Pretty tough people, because they were old-timers. We always gave them that one, because we knew he would have trouble managing Sophie down in the mailroom. That, I think, was valuable to them. At least a couple of them said so, because they had to learn pretty quick that just because he said she was to do it that way was no sign that it was going to be done that way. They learned.

Near the end we gave them less exposure to departments -- this is by the time we were getting the Minnesota grads -- less exposure to the departments on the theory that when they got to where they were going it isn't going to take them very long to find out what is in the departments. We gave them more of the management, we never gave up the management. In fact, we added a couple of other small units. And projects, hopefully with the medical staff involved. Believe me, I had some rough goes with some of these men. One young man wanted to talk to our medical staff as to why they weren't doing more preventive medicine. If I had let him go and he got as far as the chief of staff, I think that would have been the end of his residency.

In addition to the residents, we always had four, five, six of the students from Northwestern over on part-time jobs of one kind or another, the office or working in the mailroom. They were funny, some of them. I can remember one fellow who today is a state exec, and a good one -- if he hasn't retired -- who was to relieve our cashier for two weeks. He came to me the day before the cashier was to leave, he had been there working with him for a week now, and said, "I can't handle this."

I prevailed upon him and he finally said he would do it. So he worked it for about a week and began to feel pretty confident. He was now a

sophisticated cashier. I remember standing there next to him while he was waiting on somebody checking out, very professional, totally comfortable with the job and everything. He had a roll of nickels. We had a marble-topped ledge. Our regular cashier would always crack the roll across the corner of the thing and it would break and he would have them in his hand. I can still see this fellow, real sophisticated, cracking them and having them go all over the counter. I have seen him and we kidded about this quite often while I was still active. He said he certainly learned a lot just those two weeks in the cashier's cage; a humbling experience.

WEEKS:

He learned how to crack a roll of nickels anyway.

The reason I asked you about the preceptorship is that I have found some graduates who have told me they were sent somewhere as a resident and sort of ignored, not much direction.

STAGL:

Oh, yes.

WEEKS:

Jim Hamilton told me that he used to call preceptors in to Minneapolis -- I don't know whether it was more than once or not -- to talk about the profession and about residents becoming administrators and what they could learn and what they should look out for. He was telling the preceptors what they should do for these residents, what kind of records they should keep, what they should do for the students, that they should advise them, be available to them. In other words, he tried to make a vital experience out of this preceptorship.

STAGL:

I think that's right. He used to hold a meeting once a year. I went up a couple of times. That's the kind of thing they lectured us. If you had accepted one of our students simply to say that you had a resident, or to have a pair of hands to do the fire alarm code or whatever, that wasn't what they were interested in. They wanted a meaningful residency. I think they were right. We did, I think, pretty well with the fellows over the years. We had some very good ones; and some not so good. What you had to watch out for in the institution were our own department heads. You found the poor resident not learning a darned thing but just sitting around for the two weeks or so. It bothered us. There were some departments we just wouldn't put them through, where I knew darn well it was a waste of time. We tried to get them to the ones that were really concerned.

WEEKS:

I would like to mention some of the awards that you have received. You have the Fred C. Morgan Award from the HFMA.

STAGL:

Fred was really the founder. He was really the backbone, so they named an award after him. The first person they gave it to was Charlie Roswell from New York. He really was the pioneer of the cost accounting that has made so much difference. Then I was pleased to get the second one. The HFMA is really kind of a story in itself because they started with an institute at Indiana University and grew to their present membership.

I went to Indiana Universtiy the first time to substitute for a man I worked for and I was to speak on fund accounting for him. I had only been in the field for three years or so. So the only way I could come up with

something to give a decent talk on was through Charlie Roswell's book. He had a chapter in there on fund accounting. I went there and I met some of their officers, really highly motivated individuals about bringing more recognition and prestige to the controllers.

We ran that institute down there for years. In addition we started to provide for our membership a monthly magazine. But the only way you had anything for publication was for the officers to write articles. That was another job you had as an officer, to write an article every now and then.

I go off track on this because it reminds me of a funny incident. I wrote an article for Modern Hospital sometime after that on internal control. I worked pretty hard on it. Modern Hospital agreed to publish it. A few weeks before the magazine was to be published we found that our cashier had embezzled $3,000, just sort of found it out by accident to tell the truth. Then we called in the bonding company and sure enough he had gotten away with $3,000, and for all I know they are still trying to find him. Anyway, here is this article coming out about how to do good internal control in a hospital.

These officers of AAHA worked very hard but the big problem in the early days was the Association only had about 300 members. What could be done with the little dues available? They worked hard. One of the fellows wrote letters to all of the accountants, every one of the hospitals, asking them to join. Little by little it built. If ever there is a success story, that was HFMA. Today I don't know what they have in members. I may be way off base, but they must have more than 5,000 members. More than that. There are over 7,000 hospitals in the country. I was invited back to one of their institutes in Boulder about three years before I retired.

At the one in Indiana, out of the fifty people there I would swear thirty

of them were nuns in habits. I went to the one in Boulder with at least 500 people in the room -- I was just there to be acknowledged -- but, as I looked around and then walked among them afterwards, there were many sharp, young, individuals, really on the ball. If ever a group has progressed, it's that group. When I talk to any of them now at all about some of the financing they have to do and the borrowing and the cash flow, they lose me.

WEEKS:

If you had stayed in it, you would have gone with it.

On these awards I see you have received the Distinguished Service Award from the Illinois Hospital Association. That was their first award, wasn't it?

STAGL:

Yes, it was the first time they gave it. I had just been into the chairmanship of the AHA. They were very nice.

WEEKS:

The Northwestern University MacEachern Commemorative Lecturer. That was a first too, wasn't it?

STAGL:

Yes. That was from the program in Hospital Administration and Health Services Management. They have an alumni association which gave me that award. I had not gone to any hospital administration courses at all, hadn't gone to anything but night school for accounting. When it became time to try to become a fellow in the ACHE, I had two or three of these fellows nice enough to give me tutoring on the kind of thing they were getting in the hospital administration course and also letting me see some old exams that they had in the College. I took the exam and passed it. Then when the

chairmanship of the AHA came along this alumi group made me an honorary alumnus.

WEEKS:

That's nice to have. The Northwestern Hospital also made you an honorary trustee?

STAGL:

Yes. I think that was Dave Everhart's doing.

WEEKS:

Now I am to your philosophy section. The basic question is: What lies ahead? What is going to happen to the health care system?

STAGL:

From the base and time from which I started, it is nothing but downhill. I shouldn't really say that, because I have to concede that the so-called voluntary, the old, old voluntary approach couldn't carry it today, in my opinion, in view of the need for business practices. It is so big. The dollars are so immense now that they couldn't operate without sophisticated career managers.

In other words, I am not of the philosophy that everything that has happened is all one big mistake. The fact is that you had to get care to the older people, and in my opinion you couldn't have done it any other way except by government funds. Once that started, then hospitals were competing with all the other obligations of government. To think that hospitals will get the same kind of awe and help from government that they used to get in the old days when they were doing so much charitable work and were so highly respected -- the government doesn't work that way. They have too many other irons in the fire.

I think what is happening is something that we could have foreseen way back then, bound to. I think the mistakes that were made, if any, is that improvement in good management didn't keep pace with hospital growth. There were legitimate concerns about the way the cost of care was increasing, back when it was reaching such a large share of the gross national product. Our answer was to fight the government and not let them put in any restraining legislation. Part of the cause, I think we have to face the fact, is that we were still administering with people from the old system. Imagine Passavant as late as 1947 with no personnel department, no budgeting against which to measure operations, no awareness of the pricing structure or the departmental relationships of charges to costs. There were all sorts of tools missing that are necessary to run a business. I think Passavant saw that fairly fast and they got a Vanderwerker in and then a John Hatfield and so forth. Across the city of Chicago that wasn't so. Into the sixties you had, I can remember, a nurse running one of the big hospitals. There were others like that whose concern may have been very genuine as far as taking care of patients and the professional end, but the answer to a shortage of nurses was to pay more to get more nurses. The answer to problems seemed to be more money or more people not the elimination of a problem or at least an objective evaluation or measurement of the problem.

What Ray Brown used to talk about, and I know there is a magazine article on it, was that the hospital is accountable to the community not only in care rendered but in its expenditures and so on. Just like the banks, Ray would have had them publish once a year, in a newspaper, their financial statement complying with certain informational requirements. We felt very strongly about productivity at the hospital, partly because we had a business board but

more because it was a challenge. We tried very hard -- we didn't make it but we tried very hard -- to convert our monthly financial statement dollars into units. In other words, it didn't do much good for me to tell you, the board member, that we spent $62,300 in medical records. You don't know that $62,000 is the best figure in the country or the worst. So, what we tried to do, and did in the salary end was to report by hours. We said that this year we were going to budget 4.0 hours of nursing care per patient day. We estimated there would be a hundred thousand patient days. Therefore, our budget showed the number of hours that nursing would need. On another sheet that was translated into dollars. We were trying for the unit type of reporting. Every month our statements reported the number of hours paid by department. If the figure was off from projections we analyzed it and tried to get the reason to give it to the board. We did that on all the hours, and it was very well accepted by the board. Our whole salary budget was on the basis of hours. We tried to do the same thing with another big item which was supplies. It was easy enough to conclude that if needed 30,000 films and to justify any variance, but it was a lot harder to keep the records on gauze, on cotton balls, on housekeeping supplies, etc. We tried it for a while, but it got to be such a chore trying to inventory these items and keep track of how much we used during a month and why that usage was more or less than the norm, that we finally gave up on it.

I bet you General Motors could tell you years ago exactly how many production hours they used. The board was very much with us. This made sense to them. If we said we needed four hours of nursing care, we at least could tell them that that was one of the standards that the AHA or the NLN set up or wherever we got our background. At least they knew this much, it was

legitimate forecasting. We worked on a lot of things like that. In management, we were especially strong in personnel procedures. The first personnel manager was Mort Zimmerman who left us after four or five years to administer Weiss Memorial in Chicago. He was followed in personnel by Henry Kutsch who then left after five years or so to administer Ravenswood Hospital in Chicago.

I supported -- Alex and I differ entirely on this thing -- I supported rate review. This is the system that was being used in Maryland where a hospital, once a year, had to go before a board. The hospital couldn't get an increase unless the rate review board approved. Alex was very much opposed to this. I guess I ended up being the only one supporting it. He saw immediately some political problems. If the politicians in Illinois didn't like hospitals, you might have trouble getting any money approved for rate increases. I suppose he also saw that that would be forty-eight or fifty bodies sitting in judgment on hospital costs each in their own areas and that there would be sure to be some that would belabor hospitals. He would prefer, I think this was his thinking, would prefer to deal just with a group in Washington and not get into this individual state thing. I saw rate review as a means for contributing at least partially to the need for improving management in hospitals. The exposure to comparisons between hospitals of not only financial figures but also employee utilization statistics would surely highlight the inadequacies of management in institutions that badly needed improvement. While I am certain that poor management was not the only or even major factor contributing to rising costs, I do believe it was one that could be dealt with.

Obviously there was little support from the weaker state associations in

view of the implied criticism of their dues paying membership or from the administrators who hesitated placing their operations in public comparisons.

I am amazed at some of the things I hear about the way physician rates are set now by government. I suppose the government bases its case on the fact that a patient doesn't have to use the physician who won't accept the government rate. But this is out-and-out rate setting. Its as though I were in business for myself and the government told me what I could charge for a pound of coffee. I obviously have not been into the thing in depth, but I have a feeling they are already controlling too much. I don't know how they can justify this business of if the average rate for a gallbladder in Chicago is $700, that is what they are going to pay and it doesn't matter. This DRG, I guess it is. They are doing it and they are getting away with it. I suppose what they are doing is dictating what the government will pay, but the patient doesn't have to have them pay. That philosophy bothers me. I can see that they had to do something about costs and abuses but I feel pessimistic about where it is going to go from here because hospitals are in competition with all the other needs of government. Hospitals aren't as glamorous, I suppose, as something like defense.

WEEKS:

There has been a lot of agitation, or at least talk, about physicians accepting fee schedules. There has been quite a movement, I think, toward salaried physicians. Many of our big organizations are -- Henry Ford Hospital, for example, is salaried -- Mayo, I guess, has a partnership, but their board sets prices. I don't know about Cleveland Clinic, what they do about fee schedules, but I assume that they have something comparable within their own group. This is getting to be a very serious problem. We are

getting to a point now where we are becoming emotional about many of these things. For instance, you listen to Claude Pepper and you think all old people are poor people. I think everyone should have good medical care available to them whether they can pay or not, but I think there is another factor that we are possibly overlooking and that is what Jim Hamilton called rising expectations. I think a lot of our retired people go for medical care because it is available, not because they think they need it particularly.

STAGL:

Yes. They feel it's their right.

WEEKS:

Another thing that may be getting out of hand is our pill culture. We are taking too much medicine. I think doctors are, many times, prescribing too much. I once worked on a study where we looked at medical records. When I found a medical audit that hadn't been brought up to date, where a patient was getting seventeen doses of medicine a day, I know that the doctor didn't want that, but it was there. I think that a lot of people time their lives either by television programs or the pills they take, or both.

STAGL:

I think that's right. That hits it on the head, the rising expectations. In other words, I am sure I expect a great deal more in the way of health than my folks did. Maybe they didn't expect enough, I don't know. I know that it was an occasion when I was sent to the doctor. I had to be really sick before I went to see the doctor. Now, you expect it, and the doctor better cure you. This is s whole different philosophy. I think we are expecting too much. It is not only true in medicine, but all sorts of other things. The number of people who are suing about anything and everything is clear evidence of this

problem.

WEEKS:

They think all doctors are rich and insurance companies have deep pockets, so they are not hurting anybody if they get this money, because they are taking it either from a rich man or a rich insurance company.

With our aging population, and I am aging myself so I begin to think in terms of what I would like to do for retirement living. Will there be a day come when I can afford to buy a life care insurance policy that really extends over more than three or four years? Most of the benefits run on limited basis. Will catastrophic insurance take care of a great need? I don't know. Have you formed any ideas about catastrophic insurance?

STAGL:

If I need it, I want something in effect; if I don't need it, I don't want to pay the money for it. This bill that is under consideration now, I guess it passed the House or the Senate, I can see what they are trying to do. In other words, for the person who runs into something catastrophic, he obviously needs help. But they didn't want the cost added to the general tax dollar so they moved it onto the shoulders of Medicare recipients. Now the premium B will be dependent on how much is reported in income tax. All right, but, there has to be a limit somewhere. I do owe my share of worthwhile programs whether it goes for education or whether it goes for housing or whether it goes for health. There are people who need help.

At some point along the line I get selfish though. I'd like to do a certain amount, but I don't want to take on all the cares of the world myself. I don't have trouble with how much they are going to do. Are you going to take care of every social ill that comes along in this world and say that the

person who has any misfortune has a right to have it taken care of for him? The world doesn't come to an end if a person doesn't have a television set, or even a care. I know that if I talk to a social worker in Chicago and they do a needs study, I know that I am going to be told that you can't ask a person to do without a television set, because this is now a manner of communication. I think you hit the word before when you talked about expectations. There is just too much.

WEEKS:

I know we can't refuse care to people who don't have any money. Have you, in Chicago, had television ads on chairs that elevate? If you qualify under Medicare you may not have to pay a cent for it. I wonder how many people are going to get somebody to say they need a chair like that because they have arthritis or some other ailment?

STAGL:

If we ever get to the point where all the cares are taken care of and it costs me a reasonable amount okay, they can have their chair. But nobody ever puts the priorities down. Even in Congress. I suppose the problem in establishing priorities comes from the fact that today they are arguing about defense, they are going to increase it or decrease it. Then tomorrow they will argue about another issue. Nobody ever puts it all together and says, "Now Congressmen, you vote on one sheet of paper where you want the money to go to. Then we will take it all over here -- mind you, your constituents are going to see whether you have education ahead of housing or whatever, we'll take it over here and face some hard facts. We are going to add it up and say this is what people want the most, this is the next and the next. There is no room down below here." But they never have to. Every Congressman can get up

and say I'm for defense, I'm for housing; they are for everything.

WEEKS:

After all, Congress should be responsible. One man can't make all decisions or all policy. These people are supposed to be representing the people, the Senators and Representatives. We haven't had a strong Congress -- even during the Depression it was all rubber stamp. It was necessary at that time to do drastic things I realize. But never since then has congress seemed to have said we'll take the reins in our hands and really do something.

STAGL:

It is a fallacy in our system. I have no quarrel with our system, but the Congressman doesn't ever have to vote the items in priority. The number of times that a Congressman comes back to Chicago and announces that Congress was wrong in doing something! If he speaks to another group tomorrow night, he is for their interest. No legislator has to ever say, "This is my first priority, this is my second, this is my third. If you can't go down any further then I stop here."

WEEKS:

I think he was responsible for Claude Pepper's bill not passing, not because of financing or anything, but because it didn't go through the Ways and Means Committee.

STAGL:

I'm sure there is a lot of that.

WEEKS:

I think Mr. Pepper was put in his place by his colleagues just for that reason. I believe in home care. I've seen it operate. If we can afford it. I don't know how we can do it, but probably we can afford to keep a person at

home cheaper than we can in the hospital. At least that is what most of us believe.

One thing I would like to ask you: How do you picture the hospital system of tomorrow? Are we going to have multi-hospitals? Are we going to have so-called systems? Are the individual tertiary care hospitals, or maybe the head of a group, are they going to be in clusters? Lately I hear the word campus used a great deal in respect to hospitals, particularly hospitals with cluster groups -- that's a word I picked up from the Seventh Day Adventists -- that have maybe a general hospital, a psychiatric hospital, maybe combined with drug control or abuse systems. Maybe a children's hospital, maybe a women's hospital, or maybe a technology center. I have often wondered if we can't have technology centers in clusters like that where we could take patients by tunnel to the center and have them go through and use this highly expensive technological material, different imaging systems. What do you see?
STAGL:

Up to a point I was very deeply involved in that systems approach, not for our hospitals so much but -- another man in Chicago you may have heard of was Dr. Jim Campbell. He is dead now, but he was at Presbyterian Hospital. He felt strongly, and I sort of supported him, that with six teaching medical schools in the Chicago area there should be about six systems in the Chicago area, with there being one medical school in each system, not necessarily the kingpin of the system, but chances are they would end up being that way. All the seventy other hospitals could have a preference as to what system they went into but not necessarily with the final say. There would have to be a decision body. You couldn't have one system have fifty of the hospitals.

He and I used to discuss that if his Rush-Presbyterian was one of them,

Northwestern was another, which hospitals would we expect to be in our system? Obviously, you hope for a lot of suburban hospitals. In his eyes, each one of these systems would have to take and perhaps support some of the inner city hospitals. This was as far as I have, in my experience, gone with the systems approach. Yes, I supported it a great deal. I support merger even more than the system approach although I appreciate that that is maybe a dream.

When we merged our hospitals into one board things really moved. The philosophy or the policy was determined; there was no endless argument. Once you have one board, things happen and they happen a heck of a lot faster than when you've got to deal with an entire system. I can see this system idea developing into some mergers.

I think there is maybe still too much protection of turf. I think I have seen instances where the adoption of a system becomes a lightning rod, doesn't really do too much for you but you can say that you are doing all you can do to help your patients and to cut your costs. That sort of thinking goes on when you allow the individual institution the right to step away. That is what bothers me about the systems approach. I don't know too much about how far they have gone, whether they have started to put some teeth into the thing, whether any system provides that if you are going to be a member of this outfit you will have to comply.

WEEKS:

I suppose they differ. Some of them, such as the Carolina group, are strong on industrial engineering or management engineering, as they call it. That is their big service that they sell to everybody. They may have purchasing too. Another thing they are getting into is technology, into some

of this intricate medical technology apparatus repair service, even dealership in some cases, to sell it to a lot of hospitals who are part of their network but maybe not of their system. There are so many variations that it is confusing. I can't get them all clear.

STAGL:

You hit on a part of it that is my problem. When we merged, everything was together, I mean everything. Just one board and they ran the hospital. Now the discussions I used to hear among system advocates when they would get together on repair of professional instrumentation and so forth or systems engineering -- I'm saying okay that is motherhood, nobody is against it, but you boys aren't really talking about where the big benefits of the system are. The big benefits are if some hospitals plan together and they agree that certain costly services will be allocated between them. They agree to get out of the business of one institution doing a half dozen cardiac surgical procedures a month.

We are talking not only about improvements in patient care, but the savings in dollars are, to my mind, substantial. When you use heart transplant as an example it is dramatic. But there are, I am sure, a good many procedures, surgery and medical, that are very expensive procedures; terribly expensive because they are only done a minimal number of times per month. If such a procedure is done in one place you see what a difference it makes in the quality of care in the first place; secondly in the cost of care. I saw this because when we started to put services together after the merger, and you suddenly had thirty urology cases in one place instead of fifteen here and fifteen there, there was better house staff coverage, more qualified people, you had all sorts of things, plus the fact that you saved money

because you didn't need to duplicate equipment in two places and so on. This, to me, is the ultimate. If somebody were to say, "Have you achieved a system?" I would say, "When you have been able to move in on the medical end."

Now, I have no illusions about how difficult it is to do this, because the hospitals are not all located on corners across the street from each other. They are spread around the city of Chicago. How you assign patients to these tertiary units is difficult. The tertiary care institutions are probably going to need support from the bread and butter dollars here to pay for those high cost procedures which they can't possibly charge the patient the full amount for.

WEEKS:

Your first job would be to sell the physicians on the idea, I would think. I told you about our study on progressive patient care that I was in for three years. Our biggest difficulty was to sell the physician on the idea of moving patients to areas commensurate with the amount of care they needed. They agreed in principle, but they didn't do it. The only thing that took over well was home care. It was a small hospital in a small town and it covered the whole county with home care. It was wonderful. Everybody talked about it. The doctors loved it and so on. Most things they don't want to change. Do doctors feel threatened?

STAGL:

I think they not only feel threatened maybe, but if you really did nothing but routine kind of work at this institution and all tertiary care was referred to one place that is the first problem. The other problem is then he is dealing with a whole group with a level of medical practice which, I

suspect, becomes fairly routine.

I can see that change can only be accomplished in small steps. First of all, for example, all cardiac surgery or cardiac transplant is only going to be done in designated hospitals in the city of Chicago. That's all. Nobody else can legally do them. The way that is done is by denying the patient reimbursement from any insurance. The patient pays the whole bill if it is done in an unauthorized hospital. That was the principle behind comprehensive planning. First thing we were going to do when I was on the planning board was there were only going to be so many CAT scan places. That went out the window. We started it that way, we had certain criteria, but nobody wanted to sit down and designate the chosen hospitals. So, what was done was to rule on each case as it came in. Now, of course, it is such a common kind of thing that I suppose most everybody is going to end up having them. It must cost a fortune to provide that service to Chicago.

WEEKS:

We did the same thing in southeastern Michigan with the lithotripters. Everybody wanted one. Two of them, including the University of Michigan, went ahead and bought them before they had a certificate of need. With all of their prestige, they got away with it. What are you going to do after somebody spent a million or two million dollars to put one in?

What do you think of satellites and surgery centers and all those sort of places?

STAGL:

I think they are here to stay. Apparently they are successful. I read somewhere not so long ago where some surgical outpatient outfit's stock had gone way up. They were doing very well. A satellite, in terms as I see

satellite, is acceptable as long as it is under quality medical control. I don't like the thought of a satellite which is opened and doesn't really have responsibility for compliance with either medical or financial standards.

WEEKS:

They shouldn't be independent profit centers.

STAGL:

No. If I can't control them governmentally, then at least I would like to see them under the control of some of the good institutions in town in the hope that there would be good standards.

WEEKS:

What are we going to do about AIDS? How is that going to affect us?

STAGL:

I don't know. From the standpoint of medical care, something is going to have to be done. Whether they can do something about controlling AIDS... I'm not one who says, "You, Mr. Weeks, have a right as a citizen to privacy therefore you never have to take a test." Sorry, I think the rest of the citizens have a right that you do take a test. Whether you take that test when you are getting married or whether you take it as part of your job or whatever, I don't know. I wouldn't get all concerned when somebody says to me, "Look, if you want to work here you have to take an AIDS test." Okay. If I've got something to hide, then I won't work there. Just that simple. Always this business of the Civil Liberties Union coming in and everybody saying you can't make people take the test. The only thing that scares me about mandatory testing is that a lot of them will go underground, but they will go underground anyway.

And if AIDS goes the way some of the really bad predictions say, I think

it will come away from the hospitals. In other words, it will be a medical service, but I have suspicion that unless there are a lot of vacant hospital beds that need to be filled that it will go somewhere else like the old TB sanitarium or some such facility.

WEEKS:

An isolation place.

STAGL:

Yes, something like that. That is where you will go for AIDS. My friends tell me in Chicago that they all seem to have closed beds, they have closed the floor, they've closed the unit or whatever, because the occupancy has gone down. Well, if there is a lot of that, I can see some enterprising hospital administrators and boards opening AIDS units just to fill beds. I don't know what will happen on that.

WEEKS:

I have really enjoyed this. I am sorry our time is up.

Interview with John R. Stagl

Detroit Metropolitan Airport

June 30, 1988

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