HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Richard J. Stull

RICHARD J. STULL

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Richard J. Stull

CHRONOLOGY

1916	Born September 17, Washington, PA
1940	Duke University B.A.
1942	Duke University, assistant purchasing agent
1942	Duke University, Certificate of Hospital Administration
1942-1944	Phoenixville (PA) Hospital, Administrator
1944-1946	Norfolk General Hospital, Administrator
1946-1947	California State Department of Public Health, Hospital Consultant
1947-1948	James A. Hamilton Associates, Western Representative
1947	Vancouver (BC) General Hospital
1948-1960	University of California Director of Hospitals and Infirmaries Director of Course in Hospital Administration Clinical Professor in Hospital Administration Executive Faculty, School of Public Health University Health & Medical Sciences, Coordinating Council Vice President and Full Professor (1955-1960)
1949-1959	AUPHA, Long-range Program Committee, Chairman
1949-1959	California Department of Mental Health, Advisory Board to Director of the Department of Mental Hygiene, Member
1950-1953	California Senate Commission to Study Nursing Problem, Member
1950-1954	American Hospital Association, Committee on Organization, Member

1951 W.K. Kellogg Foundation, Advisory Committee of Education in Nursing Service Administration, Member

1951-1952 American Hospital Association, Committee on Personnel Relations, Member

1951-1959 California State Nurses Association, Citizens Advisory Committee (Study of Nursing Functions), Member

1952 Australia, Study of five Teaching Hospitals in Sydney and Melbourne and Integrated Education Program, Member

1952 American University, Beirut, Medical, Nursing and Paramedical Education, Consultant

1953-1959 University of California, Coordinating Committee on Building and Campus Development, Member, Chairman, 1957-1958

1953 Contra Costa Medical Association, Indigent Medical Care Committee for Alameda-Contra Costa, Member

1953-1954 American Hospital Association, Committee on Organization, Chairman

1953-1959 California Department of Mental Health, Governor's Council, Advisory Committee on Mental Health, Member

1956-1957 University of California, President's Special Committee on Peacetime Use of Nuclear Energy, Chairman

1956-1958 University of California, President's Administrative Advisory Conference, Member

1956-1960 University of California, Academic Senate, North Section, Member

1957-1960 University of California, President's Cabinet, Member

1957-1958	Association of University Programs in Hospital Administration, Bylaws and Constitution Committee, Chairman
1957-1959	Western Interstate Commission for Higher Education, Medical Education Advisory Committee, Member
1959-1960	American Hospital Association, Committee on Research, Member
1960-1961	Booz, Allen & Hamilton, Director of Health and Medical Administrative Division
1961-1965	Aloe Medical Division of Brunswick Corporation, Professional Affairs for the Health and Science Division, Vice President
1962-1964	Health Industries Association, Board of Directors, President-elect 1963, President 1964
1965-1978	American College of Hospital Administrators, Vice President 1965-1972, President 1972-1978
1965-1969	White House Conference on the Aging, Participant
1965-1969	White House Conference on Nutrition, Participant
1965-1969	White House Conference on Health, Participant
1965-1971	American Hospital Association-Health Industries Association Liaison Committee, Member
1967	London, England Educational Seminar, Director
1967-1971	American Medical Association, Committee on Community Health Care, Consultant
1969	Stockholm, Sweden Educational Seminar, Director
1970	Sydney, Australia Educational Seminar, Director
1970-1971	National Advisory Committee for Health Services Research, Member
1971	Veterans Administration, Consultant

1972	W. K. Kellogg Foundation, Advisory Committee for the Establishment of a Commission on Education for Health Services Administration, Member
1972	Tokyo, Japan Educational Seminar, Director
1973	National Commission on Productivity, Panel on Administration for Hospital Productivity Study, Chairman
1975	Belgium, Analysis of Programs for Health Services in Nine EEC Countries
1977	University of Wisconsin, Advisory Board of Center for Health Care Fiscal Management, Member
1977	U.S. Department of Health Education and Welfare, Health Resources Administration, Consultant
1979-1982	American College of Hospital Administrators, President Emeritus

AFFILIATIONS

American Association of Hospital Consultants (Honorary)

American College of Hospital Administrators, Fellow

American Hospital Association, Member

American Public Health Association, Member

Association of American Medical Colleges, Member

Association of University Programs in Health Administration

Australian Institution of Health Administration (Honorary)

California Hospital Association (Honorary)

Committee on Hospitals & Health Facilities, San Francisco

Delta Omega (Honorary)

Duke University Medical Center, Board of Visitors

Health Industries Association

Illinois Hospital Association (Honorary)

Indonesia Department of State, Consultant

National League for Nursing, Member

Sigma Xi (Honorary)

Virginia Hospital Association (Honorary)

Western Hospital Association (Honorary)

Who's Who in the West

Who's Who in Education

Who's Who on the Pacific Coast

Who's Who in the United States

AWARDS & HONORS

American College of Hospital Administrators

Silver Medal, 1977

American Hospital Association

Honorary Member, 1971

American Hospital Association

Distinguished Service Award, 1978

Cornell University

Annual Sloan Lecturer

Golden Gate University

Richard Y. Bibbero Distinguished Lectureship

National Association of Health Services Executives

Humanitarian of the Year Award

WEEKS:

How did you happen to get into hospital work?

STULL:

My career in hospital administration probably started by a coincidence, because of a high school football injury reactivated in sports at Duke University. I was hospitalized at Duke University Medical Center for an extended period. During that time I became acquainted with my nurse. She was the girl friend of Ross Porter, the assistant superintendent of the hospital. Following my return to school and through social relations with these individuals, I found out that Porter was involved along with Harold Mickey the other assistant superintendent and Vernon Altwater, superintendent of the university hospital, with support from the Dean of the School of Medicine, Wilbur C. Davison, in a program in training in hospital administration. Recognizing that my chances for pursuing a medical career, which was my original idea, were pretty dim, I began to explore the program.

From the way the program was structured I believed it would give me an outlook of public service, which was an interest of mine from other

experiences. I ran a public park in my home town when I was 16 so I was involved in public service. Also the program would give me exposure to all kinds of business; legal, financial, purchasing, hotel-type services, all kinds of things. Maybe if I went into the program I could decide what kind of career I wanted to enter. So, after more conversation with Harold Mickey, Ross Porter, and Vernon Altwater on what the program offered, I applied and was accepted in September of 1940.

The Duke program at that time was in the form of what they called a "residency type" or "preceptor type" program which took the individual into the hospital setting. It started out with a rotation, with your working in every department of the hospital. In addition to rotation to the various divisions and departments of the hospital, the medical center, you were allowed to take some courses on campus, but that was purely by your own personal election. Periodically, at least once a week, the superintendent and the assistant superintendents would lecture or they would bring in people from the outside such as from the hospital care program in Durham, which was a counterpart of Blue Cross, to talk to the students about other things that related to hospital care.

During the work period I was fortunate in the sense that halfway through the course the purchasing agent at Duke University was called up to the War Production Board and they needed an assistant. So as part of my experience I was sent to work in the central purchasing department of the university. I spent six months working there.

Also in the preceptor program, at times, if they had particular problem areas in the operation of the Duke Hospital, they would give specific assignments to students. There were two of us in the process at any one

time. At the time of my experience there they were having extreme difficulties in the outpatient department in two areas. One was handling and scheduling appointments, the other was in financing. I was given the assignment to try to do something about the outpatient department. I concentrated my efforts on that department for a while. I am happy to say we turned it around by improving the scheduling of the clinic appointments and in arranging for financial screening. After a period of time the department was in the black. For that effort I was recognized by the university treasurer and was given a magnificent bonus of $150 for employee contribution -- the first for a student in the hospital administration program -- for what I did for the department. In those days that sum was more than two months salary in the residency program.

What I am trying to point out is in the environment of Duke Medical Center you were given every opportunity to be intimately involved, to play a role in and participate in the operations of the institution. Therefore, you became knowledgeable about the purposes and functions of each department, about their interrelationships, and a great deal about the people relationships in a complex environment of that kind. So, despite the fact there wasn't the emphasis on the basic management skills which currently is the point of focus in graduate education, you learned a whole lot about the environment in which you were going to apply the skills. This was an essential thing.

WEEKS:

When did you get a chance to test those skills?

STULL:

I was to finish my program at Duke in June. At that time there was a small hospital in Phoenixville, PA that had a real problem. The community was

alive with defense industries. It also was a center of social activities of some of the Mainliners of Philadelphia at a local fox hunting club. So, with the industries' concern about good health and hospital care for the employees and the hunt club's interest in taking care of their members after falling off their horses, they wanted to do something about the hospital.

One of the industrialists heard about the Duke graduate program and came down to the university and asked about candidates for administrator of the hospital. Mr. Porter, Harold Mickey, and Dr. Altwater suggested he interview me. I was interviewed. I thought it would be a challenge. I went up and visited with them. I was well entertained but pretty disappointed with the facilities that I saw. But I figured it might be a challenge and, if anything I might do would be an improvement, that might be something worthwhile.

So I agreed. In July, after graduating in June, I took off on my first hospital, one of 100 beds. The local situation at the hospital was an old nurse superintendent, no accounting person, no financial manager, I was practically a one man band. In fact, as I will unfold here, when I went into it, the hospital was not approved by the Joint Commission, there was some question about the medical practice in the institution, it was in financial difficulties and, as I said, the facilities were miserable.

With that confronting me, I went to work, working most days, most nights. Within two years we had the hospital approved by the Joint Commission, got the medical staff in order, got community support, and completed a major hospital renovation program with an addition for obstetrics and newborns. I personally did all the functional programming and worked directly with the contractor on all the construction work. In fact, one night I went over and ran an air hammer to tear up the basement floor in the dietary department because we

couldn't get workers to do it when the department could be shut down. (I had had experience in construction work.) I did such mundane tasks as helping out in the laundry running sheets through the mangle when we were short of employees, and learning the insides of the total operation of the institution. Also I learned the importance of community relationships: generating funds for capital, getting public confidence in the institution and getting the medical staff organized and disciplined. It was a great experience, and I met wonderful people.

My first encounter with the board might be interesting to talk about. I had to give a presentation to the total board on the proposed building program and funding requirements. Sitting in the front row was Justice Owen Roberts of the Supreme Court. Also there were: Mrs. Marin who was one of the Pughs of Sun Oil and Sunship Co., Mrs. Packard of Strawbridge & Clothier Department Store, and others of the elite of Philadelphia. As my wife said, I nervously picked my nose and got them all convinced to support the hospital. That was an interesting exposure. Here was a young man, I think I was 25 years of age, standing there before this powerful group. Needless to say, I was shaking and practically in spasm but secured the board's support and started the program out with a productive two years. When I left the hospital there was a Mrs. Phoebe Gilkyson, wife of the owner and a reporter of the local newspaper who wrote of the boy wonder who came and did something. I was perfectly content.

WEEKS:

You weren't called into the military service were you?

STULL:

I had tried specifically to get into the armed services but, because of my football injuries and loss of partial vision in one eye, I was turned down. I took the examination and was at the point of getting approved for involvement with the FBI but it was in counterespionage where I would have to leave my family and at times they would not be able to know where I was. My wife wouldn't sign the papers.

Needless to say, I stayed working at the hospital in Phoenixville. However, about that time a good friend and former Duke classmate, Willard Earngey who was the administrator of Norfolk General Hospital in Norfolk, VA, which was 400 beds, a much larger hospital than my hospital, was called into service. He suggested to his board that they look at me to take on the job. After an interview I was given the appointment. Here again I ran into a major building program because Norfolk General was pretty much an old facility. We were at the center of wartime activities with the naval shipyards. Population growth and all of the other problems in an areawide emergency service were fantastic. They needed interns and residents. They needed a new building, new facilities, so I spent those years building up whole new facilities, replacing the old plant, establishing an areawide emergency service, building a house staff program that I worked out with Washington University of St. Louis and a couple of other institutions to get interns and residents. With the support of the medical staff and of the board we moved ahead and developed that institution up to a successful enterprise.

Interestingly, up to this point I had undertaken two major development projects. It is probably typical in my life that most things I have taken on have been down at the bottom, in bad shape physically, organizationally, and financially, needing to be built up. I took these two projects on and when I

got them up and running smoothly I became uneasy. Surprisingly, it became a bit boring when they were operating smoothly. The building was done. I could see the results. They were financially sound. They were operating. There wasn't the same challenge.

At that time I had a close relationship with Graham Davis who had been at the Duke Endowment when I took my program at Duke University. In the program you took a rotating experience in the field visiting Carolina hospitals (Duke Endowment supported) and helped fill out all the annual reports of the hospitals to Duke Endowment. You learned about small hospitals this way.

Graham Davis left the Duke Endowment to go to work for the W. K. Kellogg Foundation. There Graham was approached by a Dr. Phillip Gilman, retired chief of surgery at Stanford Medical School in San Francisco, California. Gilman had just been appointed to head up the Hill-Burton program for the state of California in 1946 when the Hill-Burton legislation came through. He asked Graham about getting somebody to do the state-wide planning for the program. They couldn't find anybody; they didn't know anybody. Graham told them they should contact me. I got a letter from Gilman. I had never planned a major state program. I didn't know anything about it, but on the other hand as I had looked at the hospitals before I went there, I said, "Well, it seems to me..." This, of course, was the confident youth.

If I were to lead a Hill-Burton program, I would learn something more about public service, public health needs, health services to be provided by the hospital, and the environment in which the hospital works. I figured this was a year's project and that, if I took it on, I would broaden my experience by getting beyond the walls of an institution and understanding what the environments of health services and hospital services and their interactions

were. Maybe in the long run this would broaden my knowledge of the field and make ne a more productive person in the future.

So I took the gamble and the job, much to my wife's dismay because she thought there were still Indians west of the Mississippi. Nevertheless, I took on the assignment and went to the California State Department of Public Health. My first responsibility was to develop the survey approach, direct the study, and write the plan to be adopted by the state and subsequently by the Secretary of HEW for approving Hill-Burton programs in California. This is what I did.

I recruited a staff. A lot of them were ex-military people. We trained them in the application of the survey forms and then initiated the survey, learning all about the state and all about the health facilities in the state, and what had to be done. Then we began the process of developing a state plan. I put together a Hill-Burton plan, which was ultimately adopted by the state and by the Secretary of HEW. This made California eligible for Hill-Burton funds. Concurrently with that I worked with the legislature to pass enabling legislation in the state of California so that the state would then match federal and local funds. So the funds were one-third national, one-third state, and one-third local, which was quite important for California.

One has to recognize that in the period of about 1949 on up to the 1960s California had a history of the greatest voluntary mass migration that was ever known. I can remember sitting on the Governor's Advisory Committee on Planning for Higher Education when the figures were given that we were growing at the rate of one new city of 25,000 people per week. Needless to say, there were tremendous problems of developing health facilities to keep pace with that kind of growth.

The situation in California at that time was that most of the big hospitals were located in metropolitan areas. There was a strong two class system. There was the county system. You had the huge 3,000 bed county hospital in Los Angeles, the San Francisco County Hospital, the San Joaquin County Hospital, a few other big county hospitals and small, inadequate facilities in the more rural counties. Also there were church or other not-for-profit, voluntary hospitals for private patients mostly concentrated in major metropolitan areas. There were also a number of small for-profit hospitals scattered in metropolitan areas and rural sections. One system for public supported patients and one for those who paid personally or by insurance. Interestingly many of the not-for-profits started out, like Peralta Hospital in Oakland, as proprietary hospitals. Because of tax matters and medical staff concerns they began to be converted to not-for-profit hospitals. This happened in a number of the big voluntary hospitals except for the religiously-sponsored ones like those of the Lutheran Hospital Society and the Catholic hospitals. The religious sponsored groups were not originally for-profit hospitals. (I am rambling here but there is a lot of history in this.)

In doing the Hill-Burton plan it became necessary to consider the magnitude of the needs to be filled. Tremendous population growth was occurring in suburban and peripheral areas and in concentrations in the north, central, and southern valley areas and in other coastal population centers. A mechanism had to be found to provide the capital for hospitals. You have to understand that in the mass migration of people, a lot of them were young people just getting started, their first house, their first car, their first big job, post-World War II and low on financial potential for giving. A lot

of the ties of those who could give, and the big industries, with at that time only branches in California, were with communities and institutions of the East and the Mid-West. There wasn't a history of the traditional community hospital type in California like there was in the East where you had well-established community hospitals getting philanthropy and other support. There was not the potential of generating the capital needed in California. You couldn't expect that new population to contribute financially and substantially. As mentioned, in California most of industry parent corporations were in the Mid-West and the East. They had distribution centers on the West Coast. Industrial growth occurred along with population growth so you didn't have established industry to provide funds for hospitals.

Because of this situation -- described for capital funding potential--we worked with the legislature and focused on development of the hospital district law which was passed in California and became effective in 1947. This was, in a sense, somewhat like the school district where you have authority to tax up to a certain amount of the assessed value of property to amortize bonds used to capitalize the hospital system. Also there was the possibility of using such assessments to support indigent care. We also wanted to look at something that would be sort of like a community hospital because the real lesson that was learned from the Depression was that county hospitals were overloaded in those years and the private hospitals were suffering. The county hospitals had developed some of the sophisticated and needed services because of their affiliations with medical schools as teaching centers and provided some tertiary care and contagious programs which were not in private hospitals. So in many cases taxpayers were denied access to such services and the indigent had access to them. As I said, the private

hospitals were just emerging from the financial crisis of the pre-war depression because Blue Cross/Blue Shield and third party payment hadn't really taken off then. From the standpoint of sound planning we had to think of a way to develop a hospital that would avoid the duplication of the county vs. the community hospital situation. The district hospital was that kind of mechanism. It was a not-for-profit quasi-political subdivision. It could take both private and public patients which put it into a one type, one class system. That does not mean that the big county hospitals in the metropolitan areas were ever done away with. Perhaps some of them would have been over time. There had been many recommendations that they should be in some counties but they weren't. It did close up a number of the antiquated and unacceptable county hospitals, saved other counties from undertaking needless building programs and some from getting into the business of owning and operating a hospital.

So California started, for the first time, on a community hospital concept in which people had a voice. When one stops to think about it, and you talk about consumer representation, it was a mechanism where people could say how much health care they wanted because they had to pass the bond issue, and how much they were willing to support the indigent because they had to pay the assessment.

Interestingly though--this is a sidelight--as I got later on in my career in the university, I conducted some surveys and studies of local hospital needs. In these endeavors it became apparent to me that the hospital district had a potential for something which I've always thought about, and that is not just a hospital district but a health district--a health services district. We could see the extensions of public health services from the city into

suburbia. We could see developments of long-term care tied with the hospitals as opposed to fragmented nursing homes, and the development of clinics, mental health services, etc., all matters I had proposed for accommodation of changes in the Hospital District Law. Such approaches were objected to by organized medicine and other vested interests which wanted the law confined to hospitals. It could have been called a health district in which the district would be free to develop and operate all kinds of health service facilities and programs.

Needless to say, in those days the California Medical Association was very touchy and considered an extension of the district law as suggested to be socialization. They were concerned that the state Hill-Burton plan just for hospitals was enough socialization.

Regardless of what was dreamed about, without the Hospital District Law the success that was achieved and the hospitals developed in California -- I think 25,000 or 30,000 beds in twelve years, and three major medical centers -- would never have come about.

That health services district concept--I still look back and think today--if that had been extended we could have applied that around the country. We could have had local input, local consumer control over financing with the government just participating with support where needed. This one corporation could have operated a public health activity. It could have operated long-term care facilities, mental health, and vertically integrated hospital systems with others for maximum efficiency and effectiveness. At that time it was killed (the health district idea) and the plan was confined to hospitals. It has been kept that way purposely, I think, for many years. That is an aside but it's a part of history of the development out there.

More recent history would indicate that the confinement of the law to hospitals within strict political boundaries may have served as a deterrent to voluntary hospital systems or to improved interhospital relationships in California.

While I was with the State Department of Public Health, Jim Hamilton was requested to do a survey and a report and recommendations. He was in some difficulties because he had a lot of other big projects going on that kept his staff busy. He came to me, knowing my work with the state health department in planning for the statewide project. He asked me if I would be interested in joining him on the metropolitan survey. I talked with people in the State Department of Public Health. We had finished our survey, submitted our plan, had it approved, so it was a matter of implementation from this point on. We had set up a division in the state health department to do this, a bureau of hospitals within the State Department of Public Health--I forget the exact name we called it at that time--and things were going pretty well. The state department said I had fulfilled my commitment to them, which I had promised, but that they hoped that if I went with Hamilton I could help them out for the next couple of years if they got into difficulties.

That was agreed and I went with Jim Hamilton in 1947 as his western representative to do the metropolitan survey for Los Angeles. I worked with Jim for that next year. We completed the survey; it was accepted; it was included as part of the state's Hill-Burton plan as being an acceptable plan for a metropolitan area and one of the first major medical metropolitan plans which the Public Health Service included in a total Hill-Burton report. It's still a valid report and many recommendations have been fulfilled. I was called in later, when I had moved into the university, to go back and help

some of those institutions for which I had identified their future in the metropolitan plan for Los Angeles. I helped them fulfill what was suggested for them. As an illustration, there was an old Methodist hospital in the deteriorating downtown area of Los Angeles which was becoming an area for patients eligible for county help. The hospital's purpose was not being fulfilled. Their medical staff was moving out. I suggested the hospital move to a new location and sell their old facility to the county. The county did acquire the facilities and the Methodists went out to Eagle Rock and built a hospital. It serves that area today.

I met with the ministers who were on the board of the Hollywood Presbyterian Hospital--the old Hollywood Presbyterian. It used to be the primary hospital of Hollywood. It served all th movie stars. Then the hospital service area began to change its demographic characteristics as the blacks came in from one side and the Jewish population from the other. As the population changed the doctors were moving out to the Valley with their patient population. The old hospital was somewhat going down the drain. I suggested at that time--they were talking about spending millions of dollars on the old plant--it was a waste of time, they ought to go out to the Valley and establish a new unit while they gradually phased out the old one. That disturbed the old ministers very much. I think I was an outcast for a while as far as they were concerned. They started to spend money on the old hospital and then donors began to raise questions. Then, all of a sudden, they did go out in the Valley and establish what is now the Van Nuys Presbyterian Hospital, a very successful facility. They gradually phased out of the old hospital and the nature of the service of the Hollywood Presbyterian changed. So, I was able to live through and see the physical

realities of some of my recommendations. Anybody probably could have guessed right because everything was favorable with the population growth, and so forth, but it was planning.

The projects mentioned were undertaken when I was with Jim Hamilton, before I went to the university. I continued doing some of this kind of work at the university. I did a survey for the Marin Hospital District, for the Contra Costa Hospital District, a district up in San Andreas, the Redwood district, and the Peninsula Hospital District. I did surveys, projected the needs. I was accused of being very carried away with my planning, that I was proposing a plan, a long-range plan, for building facilities which was way beyond their capacity. We had problems initially with the federal government in terms of granting money, but proposals were approved for funding as proposed. I conducted the surveys and recommended the programs. I am happy to report that every one of those facilities within ten years realized the capacity I projected for them. Marin County, the Peninsula, Redwood City, all of them have grown and prospered and developed. Again I point out the fact that everything was favorable because I was familiar with the land use and zoning plans. I knew the population growth and the industrial growth in the area. I knew also the immigration of physicians in the areas. Everything supported my estimates of needs.

At least it began to appear that my taking the step to get into planning was paying off in personal fulfillment. I began to see the dreams of planning become a reality.

Concurrently with these events, the University of California, because of urgent needs in the state and the need for health manpower of all kinds, had plans and visions of building a new medical center in San Francisco (replacing

an old one) and of starting a whole new medical school and center in Los Angeles. In the fall of 1947, Mr. James H. Corley, vice president of business affairs of the university approached me with Jim Hamilton's urging and asked me if I might be interested in working on the planning. I was just about 29 years of age. They were saying they wanted me to take on the job because they had to get started immediately on building the new medical center in San Francisco.

At that time the total state capital assets in the San Francisco medical center facilites were $2-1/2 million because the old hospital was donated to the state and the old medical school building built back in 1800s was worth about $200,000 or $300,000. The state had also invested about $500,000 in an outpatient building. But they wanted a tremendously expanded new modern medical center with education, research, special institutes, expanded nursing, pharmacy, and a dentistry school. They wanted to do the same thing in Los Angeles. So, again, I guess with th ignorance and courage of youth, I took the assignment.

I'll never forget vice president Corley calling a meeting of the deans and everybody else. He called it "get off the dime session." He said, "This man backed by the president and myself is going to serve as my designated representative for planning and developing these medical centers. You are all going to cooperate, and I want something done. You have been sitting for months. We got money from the legislature and nothing has happened."

So that started my career at the university. My first position was appointment to the university in the position of Director of Hospitals and Infirmaries. Dr. Ned Rogers, then the dean of the School of Public Health, was developing a program for graduate education in medical care, and also got

interested because of the Prall report on a graduate program in hospital administration. He came and talked with me about it. This was one thing that had been a concern of mine when I went to California and saw the administration in hospitals out there. Other than a few key oldtime leaders--old Ben Black over at the Alameda County institution, who was later succeeded by Otis White Cotton, George Wood at the Peralta Hospital in Oakland, Al Maffly at Herrick Memorial in Berkeley, Ritz Heerman who was the powerhouse in southern California with the Lutheran Hospital Society and later president of the American Hospital Association, a few others--there were few you would call leaders. Some of the hospitals even had nursing service administrators as administrators, some of them had retired clergy and business men. Administration of hospitals with the exception of the preceding and a few others in the large voluntary hospitals in the major metro areas was of questionable ability.

With developing the new hospitals I got concerned about recruitment of trained administrative people. In a sense there had to be a recruitment mechanism. I began to work with Jim Hamilton to bring residents out from his graduate program. I got them placed in key hospitals so later they became candidates for administrative positions. I actually was involved in recruiting the executives for about fifteen of the major, new district hospitals, because of my interest in the problem.

There was not a course in hospital administration west of the Mississippi, so with Dean Rogers' support I figured we could make a contribution toward improving the management of California hospitals by starting a course out there. So, again optimistically and without knowing what I was getting into, I started a graduate program in hospital administration.

WEEKS

Berkeley or Los Angeles?

STULL:

Berkeley. Berkeley was the first school in California. It was a graduate program in the School of Public Health. The reason we put it in the School of Public Health was not only because of Ned's interest but also because schools of business were all undergoing changes after the war. They were mainly technical schools; really not administrative schools. That change was occurring. We had freedom of curriculum in the School of Public Health we didn't have elsewhere. The dean was willing to go along so we could balance the curriculum between public health and management in that setting.

We set up the program there and established it as a one year graduate and a one year residency program. Also I introduced an interesting concept which was later phased out. We started what we called a "preadministration program" in the School of Public Health where we got bright young students at the end of their second year (undergraduate) interested in the hospital administration field, guided their curriculum to give them management in the last two years in the school then sent them out for a year of internship in a hospital. After that we brought them back for graduate level study. That concept probably went back to my preceptor experience at Duke. I knew that understanding the operating environment was important if we were going to do graduate level instruction. We would mix our crew up with say half of them who had experience--some military people, some others who had experience and wanted to come back for graduate training--and half from the young fellows who had preadministration with a planned management skills curriculum and a year's internship. The young ones were sharper than some of the ones who had had

experience working in the field. Those young interns would meet with the residents of other graduate level schools and match right up with them because they had had both combinations. After their internship the preadministration students would come back for a year of graduate. So that introduction to the field was two years of preadministration in undergraduate school, one year of internship, a year of graduate work, and a year of residency. They had a five year controlled program.

The results of that program can be seen in fellows like Sam Tibbits, who was in my first class, Tommy Tonkin who runs the Monterey Peninsula Hospital and a host of other who later became the leaders in the California field. Most of the graduates we turned out started in California and expanded and went on up to Oregon and Washington, and throughout the West. Later when I was moved up to vice president of the university I had to give up my directorship to Keith Taylor assisted by Ruth (Taylor) Stimson. They carried it on and did a good job with the program. So, I started it out and got it going over the period of my career with the university. That's where I got into education.

Even though my title was Director of Hospitals and Infirmaries (Student Health Hospital and Clinics on other campuses at Los Angeles, Davis, Santa Barbara and Riverside) in the university, I had the responsibility, and I had a staff, to run the hospital and clinic at the San Francisco Medical Center. Then I got relieved of most of that and concentrated on planning because then they started the Los Angeles Medical Center. I had to pick up with the dean that was appointed down there, Dr. Stafford Warren. He was from the Manhattan Project, a biophysicist-radiologist, a very dynamic and able individual. We started on the planning of the UCLA Medical Center.

So, concurrently we had in process two major medical centers: San Francisco came into being in 1952, and Los Angeles later came on track in 1955 or 1956. So in that period of time we put into being two totally new medical centers. In addition the replacement and expansion at the San Francisco Medical Center which included two hospitals, outpatient clinics and schools of medicine, dentistry, pharmacy, and nursing, we started a new nursing school, a medical school, and a new teaching hospital and outpatient clinics in Los Angeles, and the beginnings of another school of public health. Subsequently, during my tenure at the university I did the feasibility study for a second dental school to be, and which was, located in the Los Angeles Medical Center of UCLA.

I worked with the State Department of Mental Hygiene, and, with some legislative maneuvering--some of the politics I can't reveal--with others at the medical center we maneuvered to take over the operation of the old State Department of Mental Hygiene's Langley Porter Institute and incorporate it as a unit of the San Francisco Medical Center. It was an early approach to acute inpatient and ambulatory psychiatric care integrated with the other clinical teaching and research programs at the Center.

Following the success of the San Francisco model we embarked upon a venture to establish a similar hospital and clinic at Los Angeles. I went through three directors in mental hygiene to finally get the control and operation of it away from the Department of Mental Hygiene so it would be built and operated as part of the UCLA Medical Center. We finally succeeded and got it located on the university campus down there as a part of the medical center which had now developed a brain institute and other specialized research efforts.

This sums up my career in the university as director of hospitals. Everyone at the medical center knew I was involved in recommending to the president and the board of regents of the university matters relating to capital outlay, budgets, academic appointments and everything else so I guess they figured they ought to make it legitimate. So, the president recommended to the regents and I was named Vice President of Medical and Health Services of the University of California (statewide). I was the first nonmaster's degree, let alone no Ph.D. degree person ever appointed to such a position. To cut the story short, I was the first layman to head up seven professional schools and two major medical centers.

There were a lot of side issues I worked on with others of the chief administration officers of the units of the medical center and general campus in Los Angeles related to acquiring a large segment of land (the old C and H tract), which is now worth millions of dollars, from the VA for a very small outlay by the university. We planned this for a development of other affiliated or community-owned hospitals, teaching and research centers to support the UCLA Medical Center and to expand its programs of teaching, research, and service at the same time San Francisco expanded their facilities.

We worked to get money from the federal government for a Cancer Research Center, and a Cardiovascular Research Institute. Concurrently at UCLA a Brain Research Institute, and Eye Institute, a special children's wing, and a Primate Center were initiated with the financial assistance from private donors as well as the government.

Up to the time I left in 1960 we had developed the two major medical centers and seven professional schools, all going and successful. I might say that when I left there wasn't a teaching hospital not operating in the black.

I remember an interesting problem during my tenure as Director of Hospitals. It occurred at the time when Ford Foundation gave a large amount of money (several millions) to AHA to pass through to nonprofit hospitals. They declared that a university owned and operated hospital--in the case of the University of California--was a state institution not eligible for those funds. (This was before we built the new San Francisco teaching hospital.) So I explored the state constitution regarding the authority of the regents and about the situation at the university. The university under Article 9 of the constitution is an independent organization, an autonomous group. Therefore, since the existent university owned and operated teaching hospital was a hospital donated by the community which the university took over and operated as a community service, I developed, with assistance from university legal counsel, a case to prove that it was a not-for-profit institution. We showed that the state's only role was a third party payer for care for indigent patients who needed to be treated there as part of the educational process. The state in no way ran the hospital. It was not a state subdivision. We got the Ford grant. I went with legal counsel and we got the Ford money.

That developed a philosophy for me. I looked on the state as a payer for services that are not paid for by the medically indigent involved in the teaching process. In effect, state funds were a payment in support of clinical experience required in medical and dental education.

I had reached the point where the medical centers were developed and were successful in operation and on their way for a brighter and expanded future. The year before I left the university I was called on by the president of the university and representatives of San Diego County to look at the San Diego

situation of the new county hospital under construction and its potential as a part of a third medical school. So, I did a study on the feasibility of a medical school and center at San Diego. While doing the study I found that the county had built a big, new hospital and outpatient clinics to serve the growing needs of medically indigent patients, who were the county's responsibility. It was quite an undertaking and they didn't have adequate medical staff and they were experiencing difficulty in getting doctors from the area to join. Also, because of an improving economy there was the question of using the hospital's capacity. I figured, if we could set up a basic health sciences program at the university's new graduate school being activated as an extension of the Scripps Institute of Oceanography, which the university had taken over, and get the county to agree to lease us the new hospital and clinics and perhaps ultimately to deed over adjacent land to the university, we would have the clinical and basic sciences teaching environment for a third medical school, with a few minor changes funded by the university. The plan was developed, proposed, and adopted by the university and by the San Diego supervisors. The university took over the operation of the county hospital and we started a new medical school. It was under way when I left. I can't skip over this experience without recognizing and lauding the outstanding leadership, vision, and hard work of Dr. William Staedel, who during the time was medical director of San Diego County.

At the time I did the San Diego study there were rumblings in Sacramento about the need of another medical school in northern California. This was when the Feds were pouring a lot of money into medical school expansion and saying that if we turned out more doctors we would solve our problem. That, as we all came to recognize was a false economic decision. The San Diego

project report suggested a plan whereby the university's Davis campus, which was growing into a full-blown university, could start out first as a two-year medical school and feed their graduates into the San Francisco and UCLA medical centers for the third and fourth years.

Also I suggested as part of a longer range plan for Davis that the university ultimately might take over the Sacramento County Hospital as being the way to make the third and fourth years of medical education possible when timing was appropriate. Ultimately, some years after I left, they did.

My wife says I suffer from chronic irritation of job complacency. At about that time I took a look at myself. I was 41. I was vice president of the university. I had been appointed professor. By the way, I went through all the academic reviews and had to submit all my papers.

The report the dean made supporting my professional appointment was an interesting one; maybe you would like to read it. About research and creativity, he said, "Here is a man who is not like a professor who writes something on his thesis and won't live long enough to see if his ideas reach fruition. Here is a man who was creative in developing his hospital plan and facilities for this state. They are now physical realities. He has lived through to see his ideas come into being."

I had to submit all my many special studies and surveys and other required documentation. I went through the academic process and was offered the professorship at the university by President Clark Kerr. This was a full professorship without a master's degree.

As I said before, about this time I was doing some thinking about my job. Here I had been made a full professor, and I was a vice president. I was

responsible for one of the largest, if not the largest, university-operated hospitals and health sciences educational systems in the country.

Oh, in addition to planning and developing medical centers I was saddled with another responsibility because the University of California had the biggest program responsibility for the Atomic Energy Commission of anybody. It all started out with Ernest O. Lawrence, head of the radiation lab in Berkeley, who developed the cyclotron. From then on it exploded into responsibility for one of the largest cyclotrons on the Berkeley campus hills, the AEC's New Mexico and Livermore, CA centers and the consequent splintering off of the wide use of radioactive isotopes in the university's by graduate student and research labs and in the medical center clinical services. A serious problem developed in radiation safety. A separate division was created and named the University Statewide Division of Radiation Safety.

A physician who was director of student health on the Berkeley campus, a person I admired and respected as a physician and friend, was named head of the division, which ran all the radiation safety programs for the whole university in terms of the Livermore project, the Berkeley project, and all the other university campuses including the medical centers. The division was to focus on monitoring and assuring environmental safety for all activities involved in the use or development of radioactive materials. The president then assigned me the overall administrative responsibility for the division operations.

Additionally, and earlier as director of hospitals, I was handed the responsibility for student health services on all university campuses (at the time I left).

We had a student health hospital on the Berkeley campus which was like a community general hospital, 300 beds with local doctors, 800 outpatients. The Berkeley campus was, in effect, a city of 30,000 individuals.

At the Los Angeles campus we had outpatient student health services with some overnight dispensary type care and a tie-in with the medical center for specialty services and hospitalization. The medical center took care of the students instead of having a separate hospital because the medical center was right on campus.

At Riverside they were developing a new campus. They had a problem of growing, commuting student population. I said we could solve it in a different way. We set up a limited outpatient clinic and worked with Blue Cross/Blue Shield to provide local physician and hospital coverage for the students. The university paid the premiums and the plan would take care of the students' needs, off or on campus, as required.

At Davis we established a small dispensary into outpatient and limited overnight care. This was supplemented by an arrangement for more acute care with the Woodland Clinic and Hospital located some ten miles away.

So we developed all the student health services for all the campuses according to local conditions with adaptations to particular settings and for accommodating the rapid increase in enrollment that was occurring. In brief, it was accomplished by different patterns so it would work as needed. All of it was under the direction of my office at the university.

Another part of my university experience was in long-range planning. Concurrently with the planning of the medical center I got involved with the University Campus and Development Committee. You have to realize that when I went there we had the UCLA, San Francisco, and Berkeley campuses. We had an

agricultural field station at Riverside, an established agricultural school at Davis including a new school of veterinary medicine and the beginning of a liberal arts college. When I left, there were eleven campuses, all with undergraduate and graduate programs to varying extents. There were three medical centers (or two and a third in process). Also there was a tremendous growth in engineering and all the other scientific fields, which was where the emphasis was after Sputnik and on through the 1950s and 1960s.

Each year the university had to set up a campus development building program for all of the campuses. An overall university program with priorities for developing new campuses, perpetuation and expansion of existing campuses including new schools and multiple research endeavors, had to be prepared for the state legislature to get funding. The program had to be detailed in estimated funding requirements, in terms of original schematic drawings, and estimates of planning for next year and of building construction and of equipment--to phase it all in one overall funding request to the state. You had a big pot of money that had to be prioritized for all the campuses in order to keep a balance in education and be responsive to changing needs and demands for emphasis placed on the university. They suggested, since I had experience in planning the medical centers, I get tied into this activity.

As you see from my biographical resume', I was a technical consultant and also served for several years on the university-wide Buildings and Campus Development Committee which was responsible for preparing the program for the development of all the university's campuses and recommending policy, program, and funding matters in one overall state-wide program for approval by the president, board of regents, and the state legislature.

Each campus initially developed its own building program. This was submitted to the central planning group. We looked at it and set up priorities for all aspects of each campus' development, progress, and growth as related to data compiled on needs and facilities requirements. We coordinated all the information and prepared the university's total program and presented that to the legislature. This important committee became a major area of responsibility. I served the longest term on it, in various capacities--technical consultant, chairman, member.

I'll never forget the day when I had responsibility for the presentation to the legislature of the largest capital requests budget ever made by the university. I think it was 225 or 250 million dollars.

The first presentation was to the university board of regents. Fortunately, I had a very able and smart staff of people, the university's statewide Division of Architecture and Engineering who had already instituted the early use of computers in developing our space use, requirements, and allocation programs. We had a very sophisticated system for doing this, setting priorities for needs, dollars, feasibility for accomplishment schedules.

I appeared before the regents whose members at that time represented a group of political and financial power, probably unequalled in any other corporation in California. I presented a $220 million building program with charts and slides, and a one, two, three oral report, in about fifteen or twenty minutes.

Then I said, "Now, would you like to discuss it?"

They said, "We move approval. Go on."

Right after that I brought in the landscape architect for the Santa

Barbara campus development program. He was proposing palm trees to add to the decor and create a harmonius environment for the campus in keeping with the traditional Spanish cultural aspects of the local setting. The regents got into a serious argument whether he should plant a "one man" or a "two man" palm tree, which means simply size: one man could carry and plant, or two men could carry and plant. They spent an hour discussing it. Finally they made him go back and do his drawings over.

I got a $220 million building program approved in fifteen minutes by precise presentation, saying this is what it is. They were scared to death about getting legislative approval, but we went to the legislature and got it. It is an interesting story of the human reactions of high level policy groups comprised of experts in their own fields.

In the meantime, the course in hospital administration went on. It continued to develop, improve, and to turn out more students under Keith Taylor.

WEEKS:

Things were developing in your career that made you think of making a change, is that not so?

STULL:

Well, at this point in my career there were some changes in the university. The chancellors were getting upset, fearing an enchroachment on their authorities, particularly in regard to the medical centers. The proposal was to change the role and functions of the office of Vice President of Medical and Health Sciences, making it more in the nature of coordination and planning with less administrative authority. The university had to have a vice president during the building and development stages. Somebody had to be

the s.o.b. to get the job done, and that was me for that period of time. There was an interesting comment after my later experience in serving three terms on the Board of Visitors of the Duke University Medical Center.

Members of the Duke board asked a professor from the University of Colorado who had been a professor at the University of California while I was vice president there, "Was Stull as mean as they all report he was?"

He said, "He was mean, but he was fair. We never had it so good."

In any event, my position was undergoing change and modification. There was a new chancellor with local campus administrative and academic responsibility and the university was moving in the direction of putting more of the authority back on campus which I agree was appropriate at this stage of overall university development.

I told myself I had to consider what I was going to do. I was 41. I didn't know what I wanted to do. I said I was going to resign and take my chances. I could have gone on there. I could have retired at 55 from the university. I didn't want to do that, and I had built enough medical centers. I was tired of them.

Booz, Allen & Hamilton came to me and said they wanted to set up a division in health sciences consulting. That would be a good interim, it would give me more exposure and broader experience.

I could stay at the university. I could get tenure. Things were running smoothly. I had been to the legislature: I used to represent in all health legislation in Sacramento, and in Washington. I served on a lot of state committees, but I decided I wanted to look at something else.

So I went to Booz, Allen for a year. As soon as my alma mater found out they latched on to me; Duke University wanted a master plan for a medical

center. Immediately after getting a contract from Booz, Allen I went down to Duke and did a long-range master plan. It was a functional program and plan for the Duke Medical Center, which I did and presented in 1961. Today they are building that center. They will tell you that 80% of what I suggested in 1961 is being built according to the plan. Thank God they had it because it was a good argument with the HSA to prove they had a twenty year plan. It solved their problems in dealing with the HSA because it was a published plan presented to the university, and one which was approved for future implementation. I'll get on to that in terms of how I worked with the university in getting them to go out and borrow money, which was contrary to their beliefs.

Anyway, I went to Booz, Allen, did the Duke study, and then I did a study for a hospital in Delaware. This was the beginnings of the Delaware Medical Center. I did a study for one hospital and suggested that one of these days they had better get together a medical center for Delaware. This was the long-range suggestion. Also I did a management study of a children's hospital in the East Bay and considered its future and tying it in with teaching. However, the main one that year was with the Duke Medical Center.

Well, that convinced me. I went home one night after planning the Duke Medical Center, getting it finished, and accepted. I said to my wife, "That's over. I am convinced that I don't want to stay in consulting."

She said, "Why?"

I said, "When I finished that medical center plan and gave it to the faculty and the president of the university and they bought it, I wanted to go back, plan it, build it, finance it, and see it through. I am too much wanting to build and operate rather than to go out and consult and recommend

then let somebody else meddle with it. You don't have any satisfaction." I said, "I don't want to do that."

So, I didn't know what to do. I could have stayed on, making money. I brought in a chunk of money that first year. I brought in a lot of money for the company. They said they didn't want me to leave.

All along over the years I have done much reading and studying to develop my knowledge of financial management. I have had to because I have been dealing with millions of dollars. At the University of California I had a budget of about $80 million in 1961 for the medical centers. The university medical centers' operating budget was for 6,000 people on the payroll, and in those days it was unheard of--$80 million.

So, I had the experience with the consulting firm, I had done a lot of studying but I figured that I wanted to know about management skills applied in industry. I wanted to know whether they were the same in the health field as in other fields, or what was the difference. I wanted to learn the difference one to the other. I had a friend, John Willman, who had just been taken away from American Hospital Supply to head up the development of a Health Sciences Division for the Brunswick Corporation. They were having trouble with their bowling business so they were diversifying. To get new profit centers they bought the Mercury Outboard Motor Company and they entered the health business by buying up the Aloe Medical Corporation, mainly a marketing and distributing organization for medical and hospital supplies and equipment. The long-range plan was to convert this into a vertically integrated manufacturing and distribution corporation--potentially a more profitable structure.

John asked me if I would be interested in coming with Brunswick. I said, "Well, John, I haven't had any business experience in industry, but, if you say so, I'll take a flyer at it."

I went there. It developed from a small corporation of about $30 million to over $100 million at the time I left there at the end of four years. The concept of the vertically integrated manufacturing capacity--following the route of the American Hospital Supply in acquiring capacity for manufacturing lines of its own and developing family brands and things of that nature--was the plan developed and realized for the Health Sciences Division of Brunswick. The profit was in controlling the product from the raw material through manufacturing to distribution to customer--big profits. The division made a lot of profit for Brunswick at a time when it most needed.

I did find out one thing. I don't care what field you are managing, if you function at the executive level, the basic skills, tools, and techniques of management that you use are the same. It is the characteristics of the operating environment in which you apply those skills that causes you to employ different alternatives or options in the approach employed in application. Also the degree of external social responsibility--either profit orientation for producing dividends for stockholders or for public service--changes the nature of the business and its relationship to the consumers of its products.

As an illustration, the president of the health sciences division of Brunswick and I were talking one day about some of the problems occurring on the University of California Berkeley campus during the troubled 1960s. This was when Berkeley was going through some real crises and some of my friends would be writing and griping to me about some of the problems and issues.

He said, "I would straighten that out."

I said, "No, you wouldn't. You would be a candidate for the booby hatch the second day, or you would quit. You couldn't apply your style of mnanagement the same way in that environment."

He would have because he couldn't fire fifteen regional managers Monday if they didn't go with his product line. At Berkeley you were dealing with fifteen tenured professors or fifteen chiefs of clinical departments in medical school. That was a different ball game. If you had a strike, you couldn't shift support operations from Los Angeles to Reno, NV and from Seattle to San Francisco and then sit down for thirty days and argue with labor like we could in industry. You don't have those options.

So, what I am saying is the options, the alternative characteristics, and the environment are different. But the basic analytical skills and approach to analytical thinking and applying the skills--even though they are becoming more sophisticated, they still only enhance decision making--are the same, as far as I am concerned. You apply them differently according to the differing environments in which you are managing, and according to the social purposes of those institutions. I learned a lot in industry about the distribution of services, and the consolidating and sharing of services. All along I have proposed this in certain health systems plans I have spoken about over the years.

It goes back even earlier to a conversation that Jim Hamilton and I had in Los Angeles in 1947. He said to me and he said it in a public speech, "One of these days hospitals in the United States will be operated in chains, in multiple interinstitutional relationships to solve their problems, and be more effective in the provision of health services."

I remembered that and early in my career at the university when we initiated some university-wide shared support serrvices and later in industry I began to see the implications of having multiple distribution centers, manufacturing integrated with distribution operations--operations research tied in with the whole thing. My whole concept of planning and of the development of corporate approaches to the delivery of health services was strengthened. I think it had caused me to be a good advocate of that in the field today.

In any event, I went with Brunswick after I finished the plan at Duke. I stayed with them until several changes were initiated at the corporate and divisional level. In general, ground rules changed on profit bonus payments and stock options. Corporate and divisional administrative authority and responsibility relationships--with some top level changes in Brunswick--began to move in directions considerably different from earlier understandings and upset the whole apple cart as far as I was concerned.

I said to myself, "I am never home. I have twenty distribution centers over the United States, and am frequently negotiating for products manufactured in Germany, Sweden, and Japan. I never see my wife. It's a different rat race. I have no feeling of personal fulfillment. I get satisfaction if I can feel a sense of public responsibility or service. I think I have been motivated by that in the past. I am management motivated but my goals are more oriented toward service of public benefit. That's the way I look at it."

I have never been adverse to profit. I have never run an organization that hasn't been financially sound. When I came to the College (ACHA), they were $103,000 in debt. They had nothing. Now they have over $4 million in

assets and over $3 million invested, earning money. That's the way I left it for them in 1979.

I was satisfied that the rewards were not there (in the commercial, industrial setting), with the tremendous trauma, and all the upheavals, and the possible buyouts, and everything else. I said, "To hell with this I want to go back...I don't know what I want to do. I had been in the largest university..."

There is an interesting story about universities and about Ray Brown. I was the first lay vice president of a university in that capacity and at that level before Ray Brown became vice president of the University of Chicago. When Ray was being offered the position at Chicago, he invited me to lunch. He wanted to discuss the position with me.

I said, "Ray, it's a compliment to you. I am sure you can do it, but I'll tell you one thing: You are an operator and you will find out in that position you will be a lover and a coordinator. You will last so long as you make a contribution. You will make a contribution but I predict you will leave after no more than five years." And I said, "I have been through it and that was one of the things I was soul searching about. You move up there, you get into that position, you are not really in control over your operation."

He took the job but later on he left the vice president's job and went back into the academic world. I am familiar with that situation.

In any event, when I left Brunswick I didn't know what I wanted to do. I had been head of the biggest system of hospitals--in the sense of the university's hospitals. We had shared services, central architectural planning, central financial planning and computer and data processing

centers. So, I was early indoctrinated in the system approach, the corporate approach, to hospital operations. So, I didn't know what to do.

Boone Powell was the first to contact me about the ACHA position. I talked with Ray Brown and told him I was thinking about getting out of Brunswick. I didn't know what to do. I left it at that. The next thing I knew he had gotten ahold of Boone Powell and Ron Yaw and said, "Hey, you might be able to get Stull. He's in limbo, he can stay at Brunswick but I think he wants to get back into the health field."

I didn't know where I would go back into the health field. I was probably--as they would say today--overqualified for many of the jobs in hospitals. To have run a hospital would have bored me to death. There wasn't any counterpart to the University of California, and I saw enough of what was happening to teaching hospitals in the United States. I didn't want any part of them because you are not the operator there either. So I didn't know what to do.

Boone Powell and Zack Thomas and Ron Yaw approached me (about the job of running ACHA). I said I would think it over. Then Boone had me fly down and I met with him. He gave me a report of a recent study that an independent consultant had done on the College and some financial information. The latter was totally misleading.

"Boone," I said, "I'll take it for three years, maybe to get you going until I find out what I want to do. I have always been interested in developing this profession and enhancing and building management in this field. That may be a way I can make some kind of contribution."

It was an adjustment in income but I could live on what I was going to get. I had some income. I figured it would be worth the venture and give me

a chance to look around. Maybe some things would develop. I looked the job over and met with the selection committee to discuss details and to achieve understanding on the position. We agreed on the several points and the committee appointed me as the executive vice president of the College.

This was like everything else I had been in. It was the lowest possible level...it had kind of degenerated. It was kind of where it was not a real professional society. It was kind of a social society, an identity society. No meaningful educational program. Certification regulations and examination procedures were in the beginnings of some meaningful changes but neither was fully developed. A lot of things were needed to develop a truly professional society.

As I told you before, I found, only after getting on the job and really digging into the finances, that the first year I had to add the salaries for myself and a secretary to a budget already $103,000 in debt. You couldn't tell it from the books. The way I found out was when I came in in July I got saddled with full responsibility for the development of agenda and program for the annual meeting because Dean Conley was off to Hawaii with a group of affiliates for a seminar. Nothing was ready in the way of reports to the Council of Regents for their action. So I developed committee reports and recommendations and got a whole bunch of packets for the regents so they would be informed and we could conduct a worthwhile meeting.

The annual meeting was in San Francisco and much was accomplished as a point of departure for future and needed action.

After that annual meeting I got a call from the Harris Bank. The man said, "Mr. Stull, I haven't met you. My name is so and so, I am vice president of the Harris Bank. Isn't it about time for you to borrow money?"

I said, "What do you mean?"

He said, "Every year about this time the College comes to me. They have to borrow about $40 to $45 thousand, which they borrow against the next year's dues to meet their obligations for the year. Not only that, but each year you are getting deeper into debt."

I wanted to prepare a budget and I had figured on a certain amount of income. Here I found the College had already committed a large share (the debt) of potential income and I didn't have the amount available I had anticipated. It was a miserable financial mess. I had to sit down with the kindly and loyal bookkeeper and see where the accounts were six months or older so we sould begin satisfying creditors who were beating on our door.

Again I had a project that started with a need for rebuilding and major development over a period of years. The emphasis over the years has been to develop a new professional society in selected major areas. First of all, there was a tremendous need in the field for continuing education of quality. I think that most people will say that the offerings we provide today are quality for the field.

To begin a worthwhile educational program I went to Andy Pattullo of the W.K. Kellogg Foundation. He said, "I could help you out in terms of developing education programs which may help you in some of your other goals."

So I get a grant in excess of $200,000 from the Kellogg Foundation which started us on our educational program. We moved into a program of seminars. They were sophisticated and advanced seminars responsive to what we could identify as needs of the affiliates under the conditions prevailing in the field of operations. The programs grew to the point that these offerings with the Annual Congress (also changed and expanded) served over 6,000 affiliates

of the College and represented a million dollars a year business, which was self-supporting. The move into quality continuing education was consistent with the goals of a professional society and served to enhance the image of the College, as well as to provide worthwhile benefits for the members.

Another area of emphasis was to upgrade and make more meaningful the oral and written examination procedures. The written examination had to be totally redone and the old oral procedure needed radical changes. Earlier Dean Conley had secured a grant from Eli Lilly Co. to start on the development of an oral interview manual and examination procedure. The project had come to a standstill because of running out of funds. So I went back to Eli Lilly and got more money and renewed the project effort. The results were a programmed manual of instructions for the interviewer and a base of questions with a rating system to be employed in the oral exam. The scoring was to be done by an outside, independent agency. The oral examination procedure was approved and initiated along with a revision of the written examination. We were on the way with meaningful examination procedures which were fair and equitable.

Now the exam is under annual review and periodic updating to be relevant and current in the field. These changes in the College certification procedures did much for making membership and advancement in the College a desired good and a hallmark of professionalism.

When I came to the College they required only an undergraduate degree or its equivalent. With the outputs of the graduate programs and the increasing status of the position of administrator that requirement was for the birds. Therefore, emphasis was focused on upgrading educational requirements for membership, a good consistent with the mission of a professional society.

We had to move gradually, first to a minimum of an undegraduate, then on to the master's degree in hospital administration or an appropriate undergraduate degree or another master's degree, with at least three years experience. That was a sensible move because we ran into some problems with the master's because of specialization of management in the field today. If they all had to have a master's in health administration, we really wouldn't be getting some of the people we wanted and needed in the organization. We need MBAs from business, finance, industrial relations, and so forth. The whole field has changed in the direction of specialized management. Subsequently the College made other changes in regulations to keep pace with current realities and yet maintain high levels of educational requirements.

Also, there was the problem that if you are going to be a professional society, you ought to be concerned with others who participate in health deliberations and decisions and have impact on the field. So we changed regulations to accommodate potential members in related fields, and still maintain the same basic educational and advancement requirements. That brought us some people because Ross Porter, formerly of Duke University, had gone up to HEW and was responsible for recruiting some staff for HEW and its division concerned with hospitals. There were some young guys who wouldn't go into government service because they couldn't get into the College. We figured, hell, they get into positions which relate to and impact on the health field specifically, so we tied into the related fields.

We began to generate other potentials for membership. You had planners, academics, and all kinds of people coming into the field in varying health institutions or noninstitutional positions. These were accommodated by regulation changes and interpretations, again maintaining basic educational

and admission and advancement requirements. The largest number in the membership are still in hospitals or in the emerging multiple hospital system structures. All you have to do is examine the College's sophisticated, computerized data profile of the membership to see the distribution.

In the early years of my tenure we concentrated on the meaning of membership and the certification process, and on education. Then we began, as we could, to take on other kinds of special projects, studies, and publications via special task forces.

The area of political representation was then considered the jurisdiction of AHA. They were geared up for that. They were accepted as the representative in Washington and related their work with the efforts of the state associations. The national and the state associations had to get together on the matter of representation. There were enough problems without interjecting another entity like the College. However, as a professional society we got a lot of heat from our members about what the AHA and the state associations were or were not doing on political representation.

I could only say, "Well, you pay your dues to them, you object to them."

If there was something particularly in legislation which reflected upon administration practice, then we would let our voice be heard to and hopefully through AHA. An exception was the nursing home licensure situation and its potential for including hospital administrators. I was called to testify before the Congressional committees. I believe I helped to convince the committees that the College had a far better accreditation program which had the built-in factor of mobility and continued updating. Kennedy at that time was pressing for licensure of hospital administrators. I believe we staved it off by proving to the committee we had a better examination and testing

procedure than could be developed at the state level and which could be uniformly applied around the United States. Also, it didn't pose any mobility problem of being licensed in different states. Minnesota has state licensure for hospital administrators. All Minnesota could say they accomplished was the fact that licensure probably kept out the undesirables, but nothing much to prove that licensure improved practice.

Then the College began to get involved in broadening the horizons of thinking of our membership internationally and to generate closer relationships and understanding with our counterparts in other lands. I started developing and conducting international seminars on health services systems in other countries. We have held them in Canada, England, Australia, Japan, Sweden, and Belgium (including the nine countries of the European Economic Community). The last one, just this past year, was in Vienna. The seminars England, Australia, and Sweden resulted in publications distributed to all the membership and others.

As mentioned earlier we implemented a series of task forces or special study groups to examine, report, and recommend on topics, issues, or problems of concern to the membership and to cause involvement of more of the membership in the affairs of the College. I must credit Chairman Everett Johnson for sparking the movement at the start of his term in office and it carried on for a number of years. More members did get involved and several good reports on timely and important topics and issues were published and distributed to the members. Examples were: "An Examination of Shared Services," "Principles of Appointment and Tenure of Executive Officers," "Task Force on the Report of the Commission on Education for Health Administration," and others.

Another of my responsibilities was initiating, funding, and developing what has been referred to as ACHA's "Administrative Profile," a computerized universe of data on the College's membership, broken down to each individual membership. The profile had complete data on all ACHA affiliates which is cross-referenced with AHA tapes containing the institutional data. The profile of each affiliate, for example, will report data from the day of the individual's graduation from a master's program (including undergraduate major) on through continuing education experience--the same with career-long position mobility. The individual's personal data matchup with institutional information provides a broad focus on the background, training, and career performance of the majority of hospital administrators in this country and a large number of those involved in a variety of health services administration activities and included as ACHA members. The use of the computerized information system has been phased into the activities of all the divisions of the College. It now plays a key role in the College's ability to not only conduct its affairs more effectively but to extend its services of benefit to the membership and the field--the new Self-Assessment Program is an example. As of this recording, moves are underway to complete an inhouse minicomputer system responsive to the changing activities and programs of the College. The objective was fulfilled. The data profile system was developed, funded, and activated. It now serves to enhance the efficiency and effectiveness of the College's many programs and activities.

Another area of concern early in my years with College related to the involvement of the younger affiliates, or at least opportunities for them to share and exchange ideas on what was or should be happening in the field or in the ACHA. A group of young administrators submitted a proposal to me for the

development of some form of a forum for them. With some further development of their proposal, I met with Dr. Glen Claybaugh of Mead, Johnson & Co. and suggested a grant to help the College embark on a Young Administrators' Forum Program. The company responded favorably and the Young Administrators' Forum Program was on the way. The forums have been conducted in connection with the Congress and at various regional meetings. A spinoff of the YAFs was the encouragement of young administrator groups around the country. A few had been in existence and with assistance to these others developed--about sixty or seventy of them--in different organizational forms and under different names but with exchanges of educational endeavors of their own. All afforded opportunity of peer exchange.

In sort of a closing presentation of my efforts with the College, it is obvious that all of the reported growth and development in membership, programs and activities could not have been accomplished without a sound financial basis. Initially it was necessary to eliminate the 1965 deficit and begin to develop self-supporting activities, to undertake the enrichment of programs by seeking outside grants and gifts, and, finally, earn money from any College funds that were available. This involved long-range financial planning and sound money management.

During the thirteen years, I was involved in raising approximately $2.5 million from outside funding sources. The largest single grant was a personal gift of $1 million contributed to the College by a long-time benefactor of the College and a personal friend of mine for over twenty-five years--one I admire and respect as one of the great innovators and leaders in the field--Foster D. McGaw, Founder and Chairman Emeritus of the Board of the American Hospital Supply Corporation.

With the assistance of the grants and gifts, and with sound financial management we achieved the goal of fiscal solvency with the status of having over $4 million in assets, with over $3.6 million invested and earning money for support of ACHA's endeavors.

In sum, the College had progressed to the status of an accepted and respected professional society. To me the pace of accomplishment had been slow, but the exigencies of the times required an approach in program development in the areas appropriate for the College--where it would perform well within the limits of available resources.

In my opinion, there was much undone, and there remains some significant and interesting challenges ahead for the ACHA to remain as a viable force of benefit to the affiliates and public we serve. But at this stage we had built an excellent foundation for even greater accomplishments in the future. However, this would take time--perhaps more than I could give.

Things came to a point when I had my triple bypass in 1974, followed by a thoractomy two years later, and coming back to work in six weeks. I was getting tired. I didn't feel productive, and lacked energy to produce. I felt I had taken the College to a point where the next steps were giant steps to be taken over a period of about ten years, and I wasn't going to be here for that.

So, I went to the board and said, "I think it is time to do something. If something happens to me tomorrow, you are in a bad spot. There isn't the leadership strength required among the staff, we don't have a big headquarters organization. You had better start looking."

They appointed a selection committee, embarked on a recruitment venture and selected Stu Wesbury as my replacement. The terms for my relationships

were to help during the transition to Stu's takeover, and thereafter for the next two years lend assistance as requested by Stu, the new president. If he needed anything, fine. If he didn't, I was free to do things on my own.

All that we have discussed up to now highlights activities and organizational relationships I have been involved in for almost forty years. I have been characterized as being pretty gutsy, confident, and cocky about taking on things that needed to be built up, developed, and put into being as expanded and more effective enterprises.

So, most of my efforts have been in taking things which were down or just beginning, building them up, projecting them into long-range development, both in education and management.

I have been through changes in graduate education, and arguments about it. I have great concern about the numbers of graduate programs that are not of quality. I was called back by the Vice President of Medical Affairs at Duke to head up a group to look at their program last year with Russ Nelson and a few others. I chaired that group, we took the graduate program apart. It was academically inferior, and needed to be changed. If you get too many of these inferior programs they are going to tar the field with the brush and you are not going to get the quality you want. I have been concerned about the changes that are required. I have been concerned that as you develop, and particularly as you develop the multi-institution concept, or as the hospitals become bigger and take on more activities, you need a specialization of management which is not possible in a general curriculum. You have to take talented people like a corporation and bring them in and develop them in a work setting. I have been all through that from the earliest days of the preceptor type program to the old ex-hospital administrator as teacher, then

the program tied in with the school of business like Hamilton's program, and then my own program at Berkeley, as well as some of the other earlier ones. I watched them develop with a new concentration on research methodology, quantifying skills, medical economics. All of these are relevant to what's going on today, and fine as long as you don't forget management. Somehow you have to manage to be successful.

In between those times, as you can see from my chronology, I have been on assignments in other countries. I went to Indonesia with the dean of the medical school on the request of Eisenhower and Nixon, because that was a touchy area following World War II. They needed some changes in medical education, and medical manpower. I can tell you some exciting stories about what not to do and what the Americans were doing wrong in those countries and why ours were successful versus some others. I went over there and we developed a program where we took the professors from here over there, instead of the Indonesians coming back here and getting spoiled into staying here; we taught them over there, applied to their situation. There were interesting problems of approaching the dean and me for how to prepare baby food for their infants. After we mulled it over, we made a very hard decision. If we brought in all that powdered baby food for them, which we probably could have gotten support for, and they had survived those early days, then they would have to have rice to eat. Then you have to raise enough rice or they would starve to death.

We found that soy beans grew like dandelions over there in Indonesia. We called in our agricultural boys about developing the soy beans and our agricultural engineering boys for developing the technology to raise their own crop over there and to follow through on the gradual transition.

I ran into problems with Mr. Nixon about getting some of their people in Indonesia over here to the States for training. There was tremendous difficulty getting that through. I said to our government, "That's fine (to block the training), but the Chinese and the Russians are taking 2,500 of the top young people out of this country each year. They are taking them out of this country and are giving them an education in engineering and other things in Peking or in Moscow." This goes back to the early 1950s.

Our government said that the students couldn't get back in their own country after the training.

I said, "Don't tell me that. I know they are falsifying passports in Bali and Sumatra. Don't tell me the some of the chief of the village, the chief politician's son, is not going to get back into the country."

Well, if you'll follow the history of the gradual change from Sukarno...I spent time in his summer home. He was a very aggressive engineer who was doing something for them but he got trapped because he didn't trust the Americans. He leaned over to the Russians and the Chinese, and they took him for a ride. But as these young people came back (from training) they got in key positions. It used to be the Dutch who were behind it. The young people came back and replaced the Dutch in key positions and moved Sukarno into Communism, and they took over.

Alternately, by our process of bringing them over and extending an education in engineering--other universities got involved--ended in a student's revolt in their country and the fall of Sukarno. We could have avoided a lot of trouble if we had been wise enough, but our people in Washington said, "We don't want to get caught up in this."

I almost got run out of Washington, but I said, "You must understand that this is happening. If you don't work it out so we can get this program going, we are in trouble."

I could see it, I learned a lot about it. I had to deal with five different ministers over there: housing, finance, education, transportation, and what was the other one? I had to work with them to get all our facilities and to get the program developed. I went over and worked to build an educational system there.

I went back in 1960 and saw the result: the first graduation under the curriculum our dean had worked on, and for which I had helped recruit faculty from the United States. I had worked out all the housing and all the financial arrangements and everything else over there with the Minister of Finance. So, I went back in 1960 to see the graduates of the first class.

In 1952 I was called down to Australia. The university let me go down there to do a management study on a 3,000 bed hospital. They had the old hospital schools of medicine; the university was just starting the basic science program. The hospital schools were the old chiefs, you know. Private practice was pretty much outmoded after World War II. Australia knew it. So, I did a study which caused the first relations with the University of Sidney tying into the Royal Prince Albert Hospital for the clinical years, into basic sciences, getting joint appointments to start that precedent. Then there was a study on how five other hospitals could be tied in. I remember the headlines--the word "slate" means something to them, meaning you are really damned--"American experts slate Australian hospitals." The headlines were bigger than the headlines about the national rugby championship games. I did

the study for that program over there and developed some long-time relationships.

Then I went over to the American University in Beirut and worked with a doctor who used to be the assistant dean of medicine in Los Angeles. He was over there. I stopped in and helped him out in some of the long-range developments. I found out that the American University in Beirut was not fulfilling the purposes of the original Rockefeller Foundation support, that 85% of the graduates were coming out and practicing in the United States because the medical center could only accommodate a few and that medical center is very sophisticated. So the students would come over to the States, serve their resident intern, marry into the Lebanese colony, and stay here. Really you had another medical college for the United States. You weren't really doing what you should for the students over there because outside the walls there you had to teach midwifery, public health, environmental health, nutrition, and so forth, which were the problems of those people. The fact is under the Marshall plan we built a big hospital down in Sidon which never opened because we couldn't get the people to staff it, it wasn't even used.

Also I went down to Mexico City and helped with master planning and then also set the groundwork for starting a graduate program in health administration. This just petered out because of politics, but it did get started down there.

So, I have been on assignments like that. They have helped broaden my understanding of things. These jobs were worked in between my regular jobs.

There were all kinds of other things. I have been with AHA in terms of committees. I remember one committee I served on, there were three other members on it. Crosby appointed us to look into the Hospital Research &

Educational Trust-AHA organizational relationship. We spent a day on this and called Crosby down and said, "Here is our report. You have got to change this. You have got to get the hell off the board. You have got to get this straightened out, and get it independently structured."

He said, "The committee is dismissed." Then he implemented the program.

So, I have been in on things like that. It seems like I get tied into things where something has to happen, somebody has to be involved...

WEEKS:

I wonder if you would care to speak of the situation of the three organizations: AHA, ACHA, and AUPHA. In early history when Dr. Robert Bishop was president of the College there was a move to merge ACHA with AHA, but that was avoided finally.

STULL:

Yes, I think even Jim Hamilton--I don't remember when Jim was president of AHA--was making overtures that way also.

WEEKS:

This was about the same time, I think.

STULL:

That's right. I think Bishop was over here. Jim was president of AHA in 1942, wasn't he?

WEEKS:

Something like that. I think Jim was president the year before George Bugbee came to the AHA. George, I think, came in 1943. I have been wondering how was the situation resolved? How was the merger avoided? Again, speaking of interorganizational pressures, you have a very strong executive in AUPHA.

STULL:

Those situations have worked out over a period of time.

WEEKS:

You have the ACHA which has devoted most of its efforts, as I understand it, to raising the stature of the ...

STULL:

Professional practice...

WEEKS:

They had educational...

STULL:

With a real interest in being concerned about the education, yes.

WEEKS:

Then you also have AHA, which is, as I understand it, interested in political representation, in education particularly at the department level, and possibly some research through HRET.

STULL:

Which is where they should be.

WEEKS:

Now we are getting to the point where we are having accrediting bodies and...

STULL:

Which we are participating in. By the way, George Bugbee and I worked together in drafting the bylaws and articles of incorporation for the accrediting commission. (Also refining the bylaws of AUPHA.) I am one of the original signers, with Crosby and the ex-dean of the school at Michigan, of the incorporation of the accrediting commission. Yes, I got involved in that. We worked on the articles of incorporation, and setting up the

structure and everything else in the accrediting commission. The College is a representative member. It is a paying member for a seat on representation.

WEEKS:

How did you manage to build the College? How many members do you have now, nine or ten thousand?

STULL:

Oh, I would say of dues paying, about ten thousand, but if you include the student associates, up around fourteen thousand. When I came there were about five thousand.

WEEKS:

You have built this organization in spite of, for the want of a better term, the competition of AHA and competition of AUPHA.

STULL:

Yeah, on the basis of a professional society, of giving eminence, visability, and making the members, or hoping to make them, strive for professionalism in their practice.

We have had problems of groups in the membership of AHA getting mad with AHA and political representation. They have gone through some throes of changing and taking a much more positive, aggressive stance in the field, or trying to pressure the College in them. Let's be practical. That takes a lot of money. Membership dues aren't going to pay for that kind of thing. Big chunks of $18,000 institutional dues and other special assessments can help that type of thing. If we got into that, we would be so inundated that we would be diluting our efforts. Let's do what we can within the limits of our resources and do it best so that nobody else wants to do what we can do best. So, it was agreed on and accepted that AHA is political. We had a task force

that made a statement on our position: that we should be supportive of AHA, questioning of AHA when they do certain things we think are in the disinterest of the profession, but support their endeavors in Voluntary Effort, support them in legislation. You see, our members wear two hats. When they appear to testify, they are a College affiliate, but they are also testifying for AHA. So we do have an input. Then you have got the strengthening of state political action, which presents some competition with the AHA that has to be reconciled and carefully controlled. Then there are some splinter groups like John Horty's Council of Community Hospitals, I think it is. We felt that if you start fractionating the political effort you get into conflicts and competition and you don't have a united front. You had better work toward getting that. If you look at every one of the committees and trustees and officers of the AHA, they are all members of our organization. They are really representing the profession, sitting over there. So there is no sense of our getting into political activity.

Alex McMahon and others at AHA soon realized that they couldn't do the real job in education in that money had to go to higher priorities such as for research, to support their position in the field, to stimulate new approaches to the delivery of health services and new approaches to financing. There was a tremendous need for that. So those things were higher priority because the state and regional associations have developed educational programs. There is an educational consortium now that is financed by Kellogg grants. So there are all those in the field, and the College is in the area of top management. We can't do it all and we hope that others who are qualified will get in, but we try to do what we can. So, AHA is not arguing with us at that level

because they can't compete that way; they can't mount that type of educational program. So that carves out a pretty good niche for the College.

In terms of testing, examination, and certification we are now doing a study on self-assessment which ultimately will lead to demands for educational performance and guidelines for continuing education. That project is now under way so that we at the College are becoming experts in that area. The testing, examination, certification--the qualifications of people in the field--that's an area that takes some sophistication, even more so now than before. AHA would have to spend a lot of money and a lot of time to get into that work. This is a case of where each organization should apply its resources to make the best contribution and at the same time maintain the liaison which is important.

We do have a liaison committee between the College, and the officers of the College, and the AHA. If issues come up, or problems come up where AHA is seeking support from us in areas like Voluntary Effort, they make a presentation to our board. They have an observer at our board meeting; we have an observer at their board meeting. (I used to sit on them and read all the materials, so I would know what was going on and be informed.) So, there is this exchange between ACHA and AHA. At the departmental level this is less likely because they have to go through channels, through their superiors. However, the issues are resolved.

WEEKS:

How about AUPHA?

STULL:

That is going through some changes; it should go through some changes. As they grew and got a strong director...He is trying to develop a place in the

sun for their organization. In the beginning, to get it off the ground, even though the College had limited money they agreed to give $5,000 a year to the AUPHA. Then we got Blue Cross and AHA to give them some money to start. We continue to do that.

You have to understand the change taking place in the nature of education: the new faces in education; the young Ph.D.s; and the nonpractitioners. There have been some gaps between the practice world and the academic world. They are going off to build a place in the sun in the academic environment. At times you forget what your end product is really concerned with. Likewise the field out there says, "Under the old residency we..." (The residency programs are gradually being phased out except for a few schools. You still have some responsibility for practicums.) The CEO looks at the graduate program and says, "I want a finished product."

He expects something he is not going to get. Some guys will say, "I won't hire a HA graduate." He says, "I'll go out and hire somebody else."

Of course, he may get into a specialty problem. He wants an expert in financial management, for example. He can't get one unless the kid in the graduate program has a special emphasis in that. Usually the CEO hires an MBA or somebody else. So there are some schisms developing. That was part of the reason for a grant that I got through Kellogg about three years ago for educational development. I brought in two HA course directors to work with our director of education. The two directors did a separate study and reported. Then we reported to the board. The program was then turned over to Stu for a seminar to discuss ways and means for better interrelationships between academia and practice environement. Stu Wesbury was interested in graduate education, his interest much more recent or current than mine--mine

accused of being of the old school. They are starting to make some progress in that area.

I think this field itself has some reservations about the numbers of programs, the quality of the programs. I think there are ten or eleven director positions available. You take a young Ph.D. and put him in there and he gets into the political arena of academics. He is at a loss and usually ends up getting behind in course selections and other things. Some of the programs are built on soft money. They are not solid. Some of them are in environments that are not in disciplinary relationships. There are some variations, and, of course, there are some good ones too. I think, though, with the cutting off of federal funds there will be some purging of the trees, and they will get some of the better faculties concentrated in centers. Of course, some of the programs have moved into areas of planning, long-term care, health policy, and all kinds of things which are areas of the field other than practice. We still need a nucleus of good people who are management oriented. Some of the programs are turning out graduates of that kind.

Some might have accused me of dragging my heels on relationships with AUPHA, but I had enough to do to get our College going. We couldn't go in and subsidize and finance their organization. If I introduced my ideas, I would be interfering. So, we went on and gave what support we could. We stated the very strong positions of some of our people in which they were very antagonistic about what the graduate programs were doing. I had to do some reconciling before there were some positive things said in the field. I would say that the two positions are coming closer together, but the graduate programs are diverting into the specialty areas. They are not developing

management specialities, they are devloping people in specialized environments of health care, which is the difference I am talking about.

WEEKS:

Before we were talking about people getting education for middle management. Are we going to get the right kind of candidates? Are they going to be satisfied to run a hospital laundry all their lives? That is an exaggeration, but are they going to be satisfied with middle management? Aren't they going to want to run hospitals?

STULL:

Yeah. I would say that anyone that has any motivation or any aspiration for career ascent and success is going to have a goal which is: I want to be one of the top dogs in the management of this institution. For that job a special education is necessary unless it is functionally oriented like the laundry management, materials management, and so forth where you go into that work setting and perform and are satisfied to perform. If that person has any strive and go, he is going to want to go back to school, or try to get promoted into something else. I believe this can be a feeder for people to get into the work environment and then go on to graduate school. This could be a darn good thing.

I believe, if you are going to train people, really train them, to go into operational jobs with an undergraduate degree, then they ought to get into the functional areas of materials management, financial management at a certain level, systems management, data systems management--this type of thing. That says to me: Why do we need special health programs? My philosophy is that the skills, techniques, and tools in management are the same in any business. The variation occurs in the characteristics, the operating environments, the

alternatives for applying those skills, and the ultimate purpose of the organization.

WEEKS:

In other words, if you are properly trained in management, you can walk into a department and soon learn how to manage it? What do you think about the weekend programs they have?

STULL:

I am not familiar...

WEEKS:

We have one at Michigan where the student comes to campus on Friday and he spends Saturday and Sunday in classes. In fact, he is kept working intensively all that time.

STULL:

Is he a working student?

WEEKS:

He has a regular job during the week, but comes to the campus each weekend for intensive study then goes back to his job as usual on Monday morning.

STULL:

I think that is another way to develop people. If, for instance, we have a purchasing agent, but specifically purchasing, and we need to develop a materials manager, a person who knows and understands the logistics of supply, and distribution, and inventory management, which is critical in the organization, then the fellow in the work setting would be a candidate for more training. That person would understand some of the workings and machinations in the focal points of influence on purchasing. He would be able to upgrade his skills in management. Then he would be able to go back and

apply what he learned. I think that is a good procedure, if he is getting clinical experience, so to speak, in the work setting as a day to day operation.

Now, if I am that person, and I have a big budget, I ought to understand something about program budgeting, I ought to understand something about manpower resources, I ought to understand something about the economics of our operation, of the impacts on the institution. I ought to understand about interpersonal relationships because I am dealing with all these other people, they are dependent on me, and I can structure their services. So interpersonal relationships are important in the conduct of the affairs of that organization. I ought to know something about the organizational functioning such as how my unit functions in relation to the total organization. Those things will enhance the potential for growing on the job. If you have a proven operator out there, unless he is very limited intellectually, this gives him a chance to make his job bigger, his contribution bigger. It enhances his position in the organization. I think he will have to strive to get it that way.

WEEKS:

Do you want to say something about the multi-institutional hospital system? I gather from what you said here this morning that it is the wave of the future, more or less.

STULL:

Well, I have my supports and concerns. If you read my article in the special issue of Hospitals a year ago, I think I expressed my feelings very much when I said the great focus is from the management perspective rather than the delivery system perspective. Most of these multi-institutions have

occurred through pressures for use of capital resources, manpower resources, all kinds of things in management purpose. They assume in some areas there will be cost benefits, economies of scale, and so forth. Because of these pressures some big conglomerates have been built. The average hospital today out in the suburban area or rural area of 150 or 160 beds can't economically or otherwise acquire the management resources it needs to specialize, to respond to everything it has to respond to: labor negotiations, government compliance systems, information systems, and so forth. So that kind of hospital is going to have to rely on somebody else for that kind of service. That's good, we have probably done quite well in some of those management relationships. My concern is that those management expectations might not necessarily be consistent with public and government expectations for expansion and improvement in delivery of health care services. In other words, in any successful delivery system there has to be a good management system, but a good management system doesn't necessarily mean you have done a damn thing about improving the delivery system.

There has to be some fresh looks at that in the terms of the future. I have seen this happen where you created superstructures of management in a situation and haven't really done much about the better use of resources in certain of these areas. You have created the managerial skills to make them do a better job in what they are doing, but you really haven't questioned: Should this hospital be in this business to the extent that it is in the clinical practice of medicine? Should this hospital be in other areas of service such as ambulatory care?

There is the situation in the country today where the not-for-profits as they call them--I know those guys competing with the proprietaries who take

over and manage hospitals.. The not-for-profits don't do it for charity. I mean it's different. There are no dividends for stockholders, but there is money coming into the corporation. They are running for profit. They are competing for the same hospital but nobody asks the questions specifically: Are you perpetuating a situation which maybe should be let die? Are you putting a blood transfusion into a terminal patient, in terms of health services in that area? Are you making an economic situation survive when it's a real question whether its function plays a real role in the health services in that community?

WEEKS:

You mentioned making the decision as to whether something you do with this hospital is in the public interest. Who makes that decision?

STULL:

Usually under contract management it's a board or a group who has said this is what it is and now we want somebody to help us perpetuate this. It is a copout of the board to get somebody else to pick up their headaches and try to run the hospital without questioning whether this is what it should really be doing.

Somebody says to me in a session, "What is going to happen to all the 100 bed hospitals? Are they all going out of business, or become a part of a big corporation?"

I said, "That all depends upon whether you remain a hospital or whether you change the concept of your corporation for a new business and you become a health services distribution corporation." I said, "In your community with the 100 or 150 bed hospital there may be six nursing homes of 10, 15, 20 or 30 beds. There probably is a need for some short-term psychiatric care. There

are other activities such as those related to the provision of health services by the public health department. There are other things you could do: say you have got a 100 beds and you bring in 50 beds for long-term care, custodial care, long-term care for extended types of things. You also bring in some short-term facilities for psychiatric care; you start picking up some ambulatory, primary care activities in the community for a lot of the population under Medicaid. They can't always get into a doctor's office. Medicare patients are finding this out too, the difficulty of access to medical care. If you extend your hospital to that type of services, you might have a corporation which has the base for survival, that is, and independent organization. But you must change your business."

The problem is that some of the smaller hospitals are taking these activities on without realizing that they are changing the nature of the business. They just keep splitting it up, and it dilutes the primary effort, and makes the medical staff mad because you take on a primary care center. You have got the chiropodists coming in, and you have got the psychologists, and all of this. This is kind of strange.

What you must do in this situation is convince the medical staff and the board that you are going to have the main focus on quality clinical care for institutionalized hospital patients that support their practice. That is the purpose, but you want them to know that you have extended the corporation to get into other businesses in the health field. Those other activities will be separately budgeted and funded and staffed so they won't conflict.

The nature of your business is changed; you organize to accommodate those changes. No corporation goes into a business without looking at the market and saying: What are the resources, financing, manpower, and so forth in

organizational development necessary to accommodate that business? When you muddle in some areas, that's where you get into trouble.

I am realistic in saying that you should try to promote your new activities if you are going to run primary care centers and so forth. There is another thing you run into--getting back to the medical staff. If you are going to run a primary health center, you are not going to drag those physicians kicking and screaming into those centers because they have an office practice which keeps them busy, which is economically viable. They have plenty of business and they aren't about to be dragged out there.

So, you have to say that we are in this health care center business and we are going to have rules and regulations for practice but don't you interfere with us contracting physicians or groups of physicians to run this because it is another segment of our business. If you don't make that clear, then you are in trouble. Take the HMO approach--some guy gets upset because you are trying to deal with an HMO. The medical staff says this makes inroads in our business. This causes a problem. We don't like it, somebody has to go. So, these things have to be worked out and understood.

I am realistic enough to know that improvements in the delivery of health services are totally dependent on your ability to get medicine's acceptance for alternatives and arrangements for the practice of medical care either by themselves or through others. So, the next major moves in that area are going to have to come with medicine's cooperation in accepting certain alternatives. To do some of the things I have been talking about, there ought to be some planning in that direction. I hope there is more planning in vertical integration, but then you are coming back to the economic factor. They are proposing that the hospitals get into public health education and

well care programs--all this kind of thing. At the same time the Feds are putting control on capital and control on reimbursement for the primary purpose of their business. The economic pinch comes in and there is no financing for these other things. Now there is no way they dare extend themselves into that or otherwise they defeat their main purpose.

So, you say to yourself: My hospital is going to concentrate on being a high quality, concentrated, acute care center, and, as that, we will play a role in the whole community, but we will let the others provide the other resources.

You have three options: one, to expand your organization; two, to become a part of a multi-institutional chain, but then you are just another kind of customer service distribution doing the same thing you were doing before; or three, to concentrate on building up an acute general hospital, and, with the help of others, take on the things that are needed in the community. As a community plan is developed, we'll support those activities. But we can't play a role in contributing to it if there aren't the resources to do it.

WEEKS:

That third option, would that include some consultants or shared services?

STULL:

There are all kinds of advisory management. You can go down the list and name all kinds. The old partnership in health law says people are to have the rights to access to health care.

So, it is a national policy to have access to health care. I can show you a paper I wrote on that. It says that people have a right to access to care. Now, what we used to do was plan our hospitals to respond to the professional capacity of our medical staff. This is one of the areas of the old

Hill-Burton bed allocation. It's based on the experience of your medical staff. As you add specialities, you add beds to accommodate to that. It's a clinical orientation to planning. That is saying then in terms of population you are servicing the need of the community. When they say a person has right to access that says our focus must be on the potential consumers of our product, our market is the 210 million individuals in the United States. In that population are people with health problems. Those problems can be environmental, physical, or mental in nature. Those problems are just big categories.

Out of one big category take one individual health problem. I'll show you everything that is the product of that one health problem. Take a welfare mother with toxemia of pregnancy. She is depressed. She has got two kids that are suffering from malnutrition or lead poisoning from the environment she is living in. She becomes an emergency. So she is a health problem. You have got multiple problems like this, and genetic problems, and accident problems...I am just using this as an illustration. Service required for a health problem can fall into different categories: diagnostic, therapeutic, preventive, and so on. Take the case of the welfare mother. She can enter in many places. These are service environments. They are like business customer service distribution centers. A doctor's office is one, an outpatient department is one, a hospital is one--they are different environments of customer service. She can come in as a social service reference, or as an emergency to the hospital, or as a member of a group prectice plan or some other plan. In this case she comes in as an emergency case. She is put in the general hospital to get her toxemia straightened out. She's got some mental problems too. I don't know whether she will go into a mental facility;

she may go into a psychiatric outpatient mental program. At the same time somebody has got to be concerned that she has some problems back home which are environmental, public health in nature, about those kids and the environment in which they are living. Problems about income, the cultural consequences of poverty. So in the therapy or treating of her illness she goes to a general hospital, or maybe to a specialized hospital. Maybe she is acute. She may have to go for thirty days in the acute psychiatric unit. Maybe after that she has to go as an outpatient. If she can't be taken as an outpatient, maybe you have got to use supplemental services of visiting nurses, home care and so on to look after her problem. When they get into the home they find the environmental problems, and they have to work on these problems. All of these resources may be employed in some way in the different environments of care.

Look at the physician, where everything starts for the patient's improvement. That is with the medical prescriptive management of the physician. He initiates and he brokers all the resources to solve the patient's problem. Therefore, how these resources are used depends on how the medical management program manages her through those resources, using supplemental services, and so forth. In reality today the patients go in and get one phase of treatment then they are sent home. The patient goes back to her environment, in the case of the welfare mother. There isn't a followup. The patient is treated for the immediate consequence, dumped out and sent back home. We must be concerned with the way they use their treatment resources. The patient care has to be managed. So everything starts with the prescriptive management of the physician. This gets into the cost factor. The physician is the prescriptive manager for all the activities in the

hospital. He uses the biomedical research facilities, the immunologists...the physician is a broker.

My internist is my broker. I went to him. He said, "You have a heart problem so I am going to choose a heart surgeon for you. I am going to choose an environment for you."

He is my broker. Then he picked me up again. I had a kidney operation. He helped me decide on the specialist to do the kidney. He was a broker. He was a manager and a broker of my personal health in that instance.

There are various kinds of medical service programs that are provided: diagnostic, therapeutic, rehabilitative, preventive, consultative. In some instances the physicians are direct and personal--they manage your problem. In a lot of instances the physician depends on other resources to manage your problem. So other technical and professional services and assistance can be utilized, particularly in the hospital. Sometimes there is a broker for each institutional and professional service. Or there is another way, the HMO concept of doing this type of thing. So you see there is a marketing arm for the use of the resources. The use of the resources depends on the decisions they make for the management of the patient. The physician has other services available such as research, quality control, education, and so forth, but those are all parts of the medical management--what I call medical program management of physician services.

There are management product lines. These are the customer service distributions: facilitative, supportive customer service distributions. Also services to anyone for outpatient care, for a mental hospital, for doctors' offices, general hospital--all these things are required today, and they are becoming very sophisticated. Back of this: financial planning, over-all

planning, operational planning, planning control, financial management, audit negotiations for reimbursement, information systems, development and application of data systems, clinical planning--skills being developed in all these areas. Other activities that are necessary to the program: logistics and supply and distribution; manpower acquisition; training development; labor relations; employees' benefit programs; very sophisticated management. All these things are required to support any one of these environments in some sense.

You can look at the primary health corporation as multiple customer services distribution centers. You can see how you can pick off combinations of these to create multi-institutions, multihospitals, or multivertically integrated hospital systems, and so forth, because they all have a common denominator. The key thing is how you get the distribution of the clinical products, and the management of these resources. Until medicine makes some changes or is willing to adapt to changes, or to using different approaches, all the idealism about running primary care centers in all the general hospitals is not going to work unless the hospital says to the staff, "We have accepted this as another assignment. We are going to contract with other physicians or an HMO to do this type of thing because we want to be a pivotal point for much of the social medicine in this area. We have changed the corporation but we are not going to upset your applecart in this general hospital."

The new hospital corporations must be constantly determining the market need for their services and assessing their available or acquirable capacity for producing the products. Your social agencies, your unions, industry have become representatives of the public for negotiating and representing these

people in health care. The social agencies negotiate to get the best package for their constituency. The corporation is subject to the controlling effect of taxes or profits, so they have a responsibility when there are impacts on the corporation which could stymy innovation, which could stop creativity, and which could make it impossible to do necessary things. For example, everybody is talking about career ascension in the hospital. I said, "That's great, but if I move up that person in the laboratory and find I am going to lose my licensure..."

I'll give you an illustration of some of the problems of what you are expected to do, but by regulations you can't do. You talk about career ladder development: moving a gal from housekeeping into the laboratory. All of a sudden you run into laboratory accreditation. Or, you promote somebody somewhere else in the hospital or you take on new activities in the corporation and run into the restrictions of the HSA, or financing agencies, or facts of reimbursement, and accrediting agencies. Professional societies, the Joint Commission, and others can set things in there which at times impair any chances for doing things which are creative from the standpoint of management doing new and innovative things. Federal regulations are the same thing: building in rigidity, centralizing the decisions out of the institution, eroding the decision-making authority of that institution. So it's responding to regulatory controls. Under these circumstances, all of these regulatory agencies impact on how hospitals and other health service centers can respond. So, my point is that you have got to get the agencies (regulatory, social, public) to accept some social responsibility for their roles and impacts on this market. From this conversation of the past few

minutes, you can see all kinds of possibilities for multihospital relationships.

Now about technology. The technology that is already available is very sophisticated. Once new technology is announced, everybody expects it. New technology opens up new horizons of opportunity, everybody expects to have it. The technology that's in the making offers some very interesting breakthroughs. They will be much more sophisticated, probably in the long run better for health and maybe less costly but will be costly to implement.

The expenditures for health in this country are not going to go down. You build in inflation with what's promised, and more people are using what's promised, and, with the further application of what's available and what will be available in the scientific field, expenditure for health is going up.

What can you expect? The best thing you can expect, unless you make drastic cutbacks in what you are offering, is to maximize the use of your resources of manpower, money, and facilities for the best return on the use of those resources.

It has been shown with outpatient care. They thought outpatient care would lower the cost of hospital care. With the increased use of outpatient care the patient who is hospitalized is sicker and needs higher intensity of care. The dividends are accessibility of good care for more people, not dividends of dollars like in a corporation. The dividends for your investment of taxes, dues, premiums, and so forth are a concentration on the effective use of resources. The maximum purpose is to contribute the most to the benefit of the people. That is going to get us into some real human value judgments about new technology and who gets treatment, and so forth. I won't debate that.

WEEKS:

The kidney machine?

STULL:

Yes. I spent years on the Advisory Committee of the Kidney Foundation. I know something about the potentials of those and all this nice talk about how it saves the disruption of the household and all that kind of stuff. I have seen some horrible cases in that situation. That is beside the point. If you want to make an issue of that, think of the millions that are being spent in this country with perpetuating the nonproductive, vegetating, terminating people--millions of dollars of cost. Think of the productivity of that converted to better health care management, preventive health, and other implementations in the United States. We have a problem which we can discuss later...we are out of focus in the fact that we are spending more of our dollars to respond to high technology in medicine for a smaller segment of the population. That is the consequence of the National Institutes of Health directions in medical education, all of which they are now trying to scramble out of by creating a move back to the primary physician. Let me tell you, we are going to continue to have specialism and more specialism. You will start to do a better job of balancing your health care, but you are going to generate new needs. It is not going to solve the problem.

WEEKS:

What about technology as a new toy? I can remember years ago what I call the Dr. Ware Syndrome. Many years ago a doctor I knew bought an infrared lamp when they were very new. Everybody who went to his office got a treatment. If you multiply that by many, many times and look at CAT scanners, for instance, are we overusing our sophisticated technology?

STULL:

Probably there is a tendency. If you recall the introduction of penicillin, they started giving penicillin for every sore toe, almost. This is typical. However, with CAT scanners, look at recent publications, look at some of the research findings which show that actually the CAT scanners, with their capabilities are reducing costs in some cases and are doing a much better job of early diagnosis, early treatment and getting the patient out of the hospital. This is gadgetry in our field that is interesting. In the early 1950s after the atomic bomb and the conversion to biophysics, and biomedicine, there was the use of cobalt, the installation of cobalt bombs in hospitals. Everyone wanted to have a cobalt bomb. No, no, no, that's too expensive. That went through a whole series. Now radiation therapy is part of every program. The CAT scanner type of thing should be replacing a lot of the radiology. It will not substitute for some of the radiology, but it could for certain procedures. There could be a cost benefit. It could be better for the patient.

I read the other day about a new instrumentation that is going to be tested at Mayo's that does 70,000 different examinations that replace the CAT scan. They are so fine that you can actually plot the contractions and flow of blood through blood vessels. You couldn't use it for every patient. Here again it comes back to judicious judgment, back to medical programming. You have got to be aware of when to use this, where there are cost benefit returns, where it is in the best interest of the patient. You are always going to have that. As I said, you had the cobalt bombs. You had the first introduction of photographic radiology. All kinds of things like that have come into the field. They have been applied, but you have to have some kind

of judgment on when to use them. If you have general radiology and a CAT scanner and only one of these new pieces (they are trying out at Mayo's)--they probably will be in centers where you can refer patients because it will obsolete doing some kinds of angiograms and other kinds of things if it works out the way they say it will. Now, that comes to the question of making the wise decision not just to put everybody through the CAT scanner but to use some good clinical judgment of "Give them a chest x-ray." Or "Give them a GI, you can tell whether there is an ulcer from that. There is no need to go through the whole CAT scan line." So, it's judgment of the use of resources.

WEEKS:

Is there any way we can build up that judgment about the use of resources? Is there any way we can do as you suggested, develop centers for high technology treatments?

STULL:

I think some of this will come about. I would say that one of these days more hospitals will be forced to give in to having clinical review committees for technology and its general use in the institution. I think this is going to have to come. The feds have a couple of divisions looking into technology and its applications. One is in HEW, one somewhere else. They said they were not going to use their action as a judgment, but as a pressure to control the use of technology.

Maybe you have read that other paper of mine about the 1960s and the administrators' response to the sophisticated practice of medicine and the aggrandizement of the institution which were ahead of the effective use of the institution's resources. This was a trend. But, unless you get the people who apply this technology into the decision-making judgment, management might

be challenged, and should be challenged, and you are going to have to respond. If it is the economic survival of your institution to have this technology, as someone said, "Nobody got fired for spending dollars for this thing."

WEEKS:

I'll ask a question for which I think I know the answer. When you were talking about building all these centers and bringing doctors into them, really reorganizing the medical staff in a sense, during your early days in California, when did you bring the doctor into the planning?

STULL:

Into planning? Very early. Very early.

WEEKS:

Hasn't it been your experience that there have been places where doctors have not been told what was being planned?

STULL:

Oh, yes! There is a deficiency in some areas, I think, of administrators responding to a group of high admitters' or high users' desire for technology in the institution. There is the lack of administration taking an overall look at it from the medical practice and clinical management of their institution.

I'll give you an illustration of how you bring the doctors in, but you have to have your facts. When we turned over to the surgical departments of the medical school the task of coming up with a functional program for the surgical suites for the new teaching hospital in San Francisco, they came out with a program for twenty-five operating rooms for a 500-bed hospital. About five of these operating rooms were equipped with very special x-rays, and

three or four for one specific specialization. I took a look at that and said, "We just can't afford that in space or equipment."

We went back and analyzed all the surgical admissions, what number of those surgical admissions actually were operated on (even though they were admitted some never went to surgery), and what the surgical procedures were. We went back and analyzed the average hours per procedures. When the facts were in they showed that those twenty-five surgeries would be used about four hours a day for the convenience of the physician who wanted to see private practice, or had educational responsibilities, or house staff duties. This was an impossible situation because you had overlapping staffing.

We sat down and proved that starting the schedule at 7 a.m. we could work straight through. We could keep our crews going, and keep them turned over. With twelve to fourteen operating rooms with two specials--we could do the same volume as with their plan of twenty-five operating rooms. They couldn't generate any more volume under their plan other than about four or five hours a day. Their answer was that they had to be in a clinic or they had to do this or that. So, the problem got back to scheduling clinics, residents, and so forth.

I said, "If you want your plan with the twenty-five operating rooms, then you have got to give up some of your beds, or you have got to give up some other things."

Then they began to talk about it. You have got to go at them with the facts. That is what you have got to do in some of these other situations. You know, some new technology gets popular, then your medical staff sees the new instruments at another hospital and says that if your hospital doesn't put in the new equipment they are not going to bring patients to your hospital.

WEEKS:

It's the old status sort of thing.

STULL:

Yes. That was the 1960s. Then there was a lot of money and everything going, but now that can't be. We are going to have to face up. No longer can we expect...someone has said that we have just about reached the limit of what they can keep pouring into the system. So, you have to make some judgments. This is easy to say, but someone will say, "It's O.K." I say it's a way of life you are going to have to deal with. You are going to have to do more for less. That means you have got to use all your resources.

WEEKS:

And better management.

STULL:

Better management. That includes involvement of the medical group in deliberations and decisions and in what I call the integrated clinical and administrative decision-making process. I don't say decision making as a final stage because that final decision may have to be made by a board. But I do say that the doctors should be involved in an integrated clinical and administrative process to arrive at a recommendation for somebody else to make the decision, if that be the case. There is going to have to be more of that involvement.

This is where the information system comes in. Unfortunately we fractionate it. We have a clinical information system, a financial information system, an inventory information system, when this should be developed into a basic system in a more useful form so the varied groups could make intelligent decisions. To me the name of the game is going to be

management with a higher degree of sophistication than ever before in the past. Ever before.

As far as I am concerned, you can go just so far by focusing on management, because in these multihospital systems they haven't touched on the use of medical practice or interfered with clinical medical practice in those areas. The focus has been on the use of assets, physical money, people, and so forth. What has really been done in terms of medical capabilities in those institutions? Maybe in some institutions you upgrade it because you are able to do it better. The multiple systems don't have the medical staffs integrated under uniform regulations, you know. You don't have that. You can make headway in terms of cost containment and economies of scale in this area. But the next step is: How can you improve deliveries, the quality of medical care, the availability of medical care, the accessibility of medical care? Maybe we will never reach our goals in medical care, but we can do a lot better job than we are doing.

WEEKS:

Do you want to say something about the mental health program?

STULL:

That mental health thing in California was fascinating. I had a very interesting assignment at the university with the state mental health group. As I said in the beginning, we had this Langley Porter Institute, which was the first short-term neuropsychiatric institute in California, at the medical center in San Francisco, where psychiatry and medicine were brought together. There was short-term treatment even to the extent of lobotomies. Otherwise, there was a tremendous problem with treating mental illness. California had the old custodial mental hospitals, great, big, 3,000 bed monstrosities.

Something had to be done about them, so we started a program. I was on tha advisory committee. There were five deans of medical schools, myself, the director of mental health, and others advising the Governor directly. We gradually brought residency training into those environments, introduced drug therapy, and so forth, until we got rid of all those patients and went to community mental health types of things in the general hospital. California came out very much ahead of the others in developing this type of treatment eliminating the big, old institutions, the horrible snakepits. I have seen them. So the state was gradually getting rid of them except for a few which house the morons, the ones that have to have custodial care, that aren't psychiatric. I watched the psychiatric center developing at UCLA, and the training of residents and psychiatrists. I saw the start of the first community general hospital unit at Herrick Memorial Hospital in Berkeley, and watched the whole change occur over the years I was there. It was a fascinating assignment.

Then, fron that experience, I got tied in with the mental hospital group in terms of advising them about the reorganization of mental health care. I got the first administrative people introduced. I couldn't get the psychiatrists out of administration at that time but I sent in the first residents in mental health administration to get into the field from my graduate program. So, the whole change in clinical management was getting from the big institutions back to the community level of treatment. I went through that whole cycle while I sat for two terms on Earl Warren's advisory committee. It was a fascinating experience.

Another one I worked on was committee on nursing, where we moved into a two-year nursing program, a two-year degree program. This was one of the

first ones approved in the United States, the one at Huntington Memorial Hospital. Then there was the education for licensed vocational nurses. Also I was on the National Committee of Nursing. I was interested quite a bit in that because I had two schools of nursing. So you can see I got involved in nursing.

WEEKS:

Weren't you in some way doing some work about atomic energy?

STULL:

That was perhaps the most fascinating experience I ever had. The early 1950s was when atomic energy was getting very popular, you know, the bomb, the peacetime uses. All the scientists said we were going to light the world with it, we were going to heat the homes, we were going to run submarines (which we did), we were going to do all sorts of things with it. It had great potential as far as salt conversion which to California meant tremendous things. So the California legislature gave $500,000 to the university. The university didn't ask for it.

The legislature said, "Here. We are going to give it to you, Mr. President of the University, and we want you to appoint a committee to come up with recommendations for some peacetime uses of nuclear energy."

This is a fascinating story in people and individuals and relationships.

Well, the president of the university appointed the committee. On that committee were six ultimate Nobel Prize winners; three of them were already with Nobel Prizes: Ernest Lawrence, Melvin Calvin--Luis Alvarez got his later--and I forget the other ones who received them later. There was also Dean Warren, Dean of the School of Medicine of UCLA. He was the Chief Medical Officer for the Manhattan Project so he was a very sophisticated man. Bob

Stone, the radiologist, was the Chief Biomedical Officer for the Manhattan Project.

Here I am sitting with six Nobel Prize people and these other guys when the president, Robert Sproul, says, "Stull, you are chairman of the committee."

I said, "What the hell, Bob..."

Bob Sproul was the greatest man I ever knew for administration. I learned more from that man in maneuvering and handling people than you could shake a stick at. I thought: what am I doing--the brains of the country--Lawrence invented the cyclotron...Calvin, photosynthesis...Alvarez with the bubble chamber...and Seaborg, Glenn Seaborg, later chairman, he and I are quite friends (he was on the Pacific Coast Athletic Conference)--the identifier of certain elements, you know--tops, world's tops.

I am to be chairman of that committee! I said, "Come on...!"

He said, "Yep."

I said, "I don't even know what they are talking about. I don't know anything about it. I would have to get out a legislative report."

So, he appointed me, and when he told the old boys he had appointed them, they had to come. So, I went to the first goddamned committee meeting. Now you have to understand these guys. First of all, they had different interests, so in some areas they couldn't even communicate with each other. Secondly, with the exception of Warren and Stone and Seaborg, who were practical people, the others were the kinds of scientists who were totally out of touch with the world. I can tell you honestly that I had to appoint some business managers to help manage the affairs of two of those Nobel Prize winners so they wouldn't go to jail for not paying their debts or not keeping their property up or for neglecting their family. First of all, their

thinking is not concerned with the application of science to the benefit of society. Alvarez developed the bubble chamber for certain purposes, so, now he wants to go to something else; Seaborg finds an element, then he wants to find another; Calvin finds things in the radioactive carbon photosynthesis project. That's his field. Now, he realizes the tremendous potential for agriculture, because, you know, you can take a field crop and by proper treatment double the output, by understanding photosynthesis. Nicholson, I forget what his interests were. They are interested in finding out one thing, then they have need for something else, some new idea.

They started talking and exchanging ideas of what they were doing, in this committee meeting, and I am sitting there as chairman.

I said, "Gentlemen, I appreciate, and I am flattered, being chairman of this committee. Probably you wonder what the hell I am doing here. I can see that we are not going to get anywhere in terms of productivity of this committee, because I know you like to talk to each other about the things you are working on, but that is not our assignment." I said, "We are supposed to give the legislature a report on peacetime uses of nuclear energy such as salt water conversion--a practical application, a test plant, etc--, atomic power plants, agricultural benefits, and so forth, so the legislature will know what to do about spending money for these things in the future."

They could have cared less. Why should they be doing that?

I said, "I find myself in the position of being the one who has to represent your separate interests and funding before the state legislature. I have to sign the atomic energy contract for $50 million a year for the Berkeley Hill project and the one at Alamogordo. I have to negotiate with the feds on those contracts. After all, that is our source of funds. Now, they

are asking us to do some work and I can't very well fulfill my responsibilities if you don't cooperate with me."

You know, that got them going. It suddenly dawned on them, "My lovely laboratory--my support for the laboratory--I want the legislature to give me..."

It suddenly dawned on me out of the clear blue sky that I was sitting there with a big stick. They worked and came with a salt water conversion program over in Richmond Flats, which absolutely works except the cost of water for irrigation would be so high. In Israel and some other places that are dry the cost doesn't make any difference. One of these days when water is scarce...Then there are other points such as sewage filtration, reclaiming sewer water in Los Angeles, which would make millions of dollars in savings. There is a realistic possibility that when costs come down, a lot of things that came out of that study will be useful. We could have been there a year doing nothing but we did write a good report because we got them working together. Most of those men are strictly the scientists and are totally oblivious of what is going on in the world around them, or how we are living today, or how we should be living, whether your kids are eating, whether your wife is happy, it doesn't make any damn difference.

WEEKS:

They are just interested in pure science.

STULL:

Pure science. The ones who apply the findings of the pure scientists are the C graduates who are entrepreneurs, or who get out in the field and see a buck in it and then apply it--take some of those ideas and apply them. They take the risk in management and get capital and apply the ideas.

I just use this anecdote as an illustration of the interesting assignments that you get which teach you a lot about dealing with people, and what things work, where power can come from, and how you can use power even though you are not a bigwig. I am not about to be a Nobel Prize winner with the kudos they have, but I had a job to get done and it got done. There is the question of strategy and how to influence others to respond to get something done. I learned a lesson from it, and I thank old Bob Sproul for putting me in that spot because I learned a real lesson in how to deal with deans and scientists. I was better able to understand. I really had no confrontations...I had some confrontations but no problems. Never were any problems. I think you learn by exposure. You can't teach that type of thing in the classroom.

WEEKS:

You had some other interesting experiences on other projects didn't you?

STULL:

One was that Kellogg Foundation project on graduate study in nursing education.

The Western Interstate Commission for Higher Education was an interesting one. On a committee for them we had six medical school deans, one of them was Ward Darley, who also was head of the Association of American Medical Colleges for one year, and four university presidents appointed because of the tremendous problems in medical manpower needs in the growing West. Again, I got stuck in being chairman of a committee.

We did a study of the West medical manpower needs which was published. I think if you checked with Harold Anderson who was president of Ohio State, and who was president of WICHE in the beginning stages, he would tell you that was

the beginning of the medical school that developed in Utah, the expansion in Colorado, the one in Arizona, and where we plotted a gradual schedule of two year programs to ultimately go into four year schools such as we had in California. We published a report and most of the recommendations of the report were adopted.

That was another interesting exercise relating to university presidents, and deans of medical schools in terms of manpower planning for medical education. I have been stuck with more assignments like that where I was totally ill-equipped or unprepared, so to speak, as compared with some of the others sitting around, to do that assignment. Somehow or other I had to serve as a catalyst and get things done. Those were learning experiences.

With Booz, Allen, & Hamilton, as I said, my main project was at Duke Medical Center. Then I said I didn't like consulting and wanted to get out.

The Health Industries Association appointment was another interesting experience. I went on as a director, later as president elect and then president. Bob Cunningham will tell you I chaired the committee which developed the long-range plan for the industries which resulted in a new approach to the regional exhibits. The year I was appointed to the College I had to excuse myself from a regents' meeting and go down to another meeting and present the long-range plan to the industry, which they bought. Today they have a health industry association office in Washington--it's an outgrowth of those early days.

On that Health Industries Association committee I sat with a guy from American Hospital Supply, Wendell Crane, with the president of C. R. Bard, and with the chief executive officer of Johnson & Johnson. Bob Cunnignham was also on the committee. Out of that committee came the original plan for this

long-range development of the association. That was another thing I got into that was interesting.

As I said, I think I have done about twenty long-range plans in physical development for hospitals in hospital districts in California. I filled that in between teaching. The university felt that I was better informed and could teach better if I could get my hands in things. Then I got tied up with the legislature, national and state.

As to the AHA, my exposure was on committees, but in terms of leadership I just knew the guys by attending sessions. My whole efforts had to be devoted to the developments of the university which was a big enough job alone to build those medical centers and to plan them and to run them and to get the HA program started and to do all those other things and represent the university before the legislature. But I did get tied in with some of those AHA guys. I got to know many of them around the country.

I can remember one day in 1947 when we were doing the metropolitan Los Angeles survey. We were sitting in Jim Hamilton's room. He said to me, "You know, some day you are going to be in a very key position in this field. You are going to be involved in teaching and education in this field."

I said, "Come on, Hamilton, stop handing me your usual malarky."

By God, it came true. I started the graduate program in hospital administration, I got in the university, became a vice president, and finally a full professor, and then got out.

What was the next step? I was hurting for money because the universities don't pay much, you know. The kids were in school and college. So I looked around and latched on to consulting with Booz, Allen. I could have made a lot of money. That first year I was there I brought in thousands of dollars in

business. The Duke Medical Center was an $85,000 job right off; in those days that was a big job. When I finished the Medical Center consultation, I knew I didn't want to stay in consulting, because I had to get into building and managing things. Consulting doesn't give that regard, plus you are gone all the time, and you don't stay to get the rewards of seeing something come into being.

The next decision was to go into industry after leaving the university and consulting to broaden my experience. I always loved the health field and I was making money in industry but then they began to fudge on things. Then you find yourself working your can off to support some guys who are not carrying their own load. That got to be a little bit distasteful. I must say this, to be very honest about it, it's awfully hard, once you have been No. 1 in an organization, to go in as No. 2 or No. 3. You don't have the same control over implementing your own decisions. Sometimes somebody is second-guessing you, and it's hard. I would rather make my own desicions and stand by them and see if they fall or take. I would rather do that than do a lot of work for somebody, get it all done, think this is the way it's going, then have him say, "That's fine," have you bring the managers in for you to say "This is ...", and then about five o'clock that afternoon, change his mind and say, "I think we will be a little more conservative, we won't do this." Then the plan is held off two or three years, then it comes into being, but it is two years too late to do as much as you should have done. If it had been me I would have said let's go in the very beginning. But somebody else makes the decision. It is awfully difficult for somebody who has been in the key position.

WEEKS:

With your makeup. Some people could do it...

STULL:

I couldn't. I could not do that. That doesn't mean that I am smarter than the other guy, but I like to just take it on myself and get held accountable for my bottom line performance. That's the way I feel.

Now what other...

WEEKS:

Is there anything you want to say about the awards I have listed on that sheet you have?

STULL:

No, but I am highly complimented by the College Silver Medal. That was a compliment because it was by my peers. There is nothing so important to a professional as being respected by those whose judgment he respects, his peers. There is nothing so satisfying to a professional as the accolades of his fellow men for a job well done. That ACHA Silver Medal was one of the highlights.

Earlier the American Hospital Association gave me an Honorary Membership. Then in 1978 I got the Distinguished Service Award from AHA, the top honor of theirs, so they said.

Then, this year I got the Distinguished Alumni Award from Duke University, the first one given for the graduate HA program.

I have got to get a room to put all these things.

Interview in Chicago

April 9, 1980

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