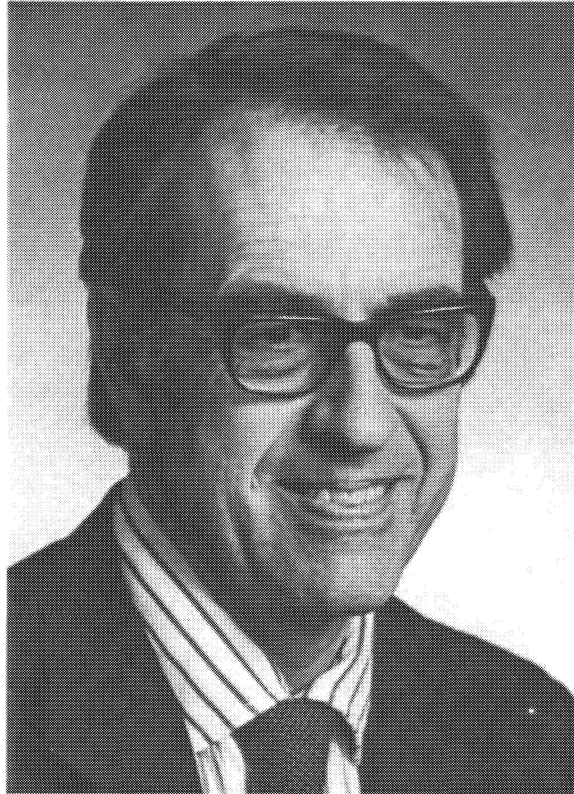


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Vergil N. Slee, M.D.

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CHRONOLOGY

CHRONOLOGY

- 1917 Eaton Rapids, MI, born September 24
- 1937 Albion College, B.A.
- 1941 Washington University School of Medicine, M.D.
- 1941-1942 Barnes Hospital, St. Louis, MO., internship
- 1942-1946 Flight Surgeon, USAAF
- 1946 W.K. Kellogg Foundation, Fellow Public Health Administration, Van Buren County, Michigan
- 1947 University of Michigan, M.P.H.
- 1947 University of Michigan, Nonresident lecturer School of Public Health
- 1947-1948 Barry County Health Department, Hastings, Michigan, Director
- 1949-1954 Barry County Health Department combined with Pennock Hospital, Hastings, Michigan, Director
- 1952-1955 Governor's Study Commission on Migratory Labor in the State of Michigan, Member
- 1953-1954 Southwestern Michigan Hospital Council, Professional Activities Study, Director (voluntary)
- 1954-1956 Southwestern Michigan Hospital Council, Professional Activities Study, Director, full-time
- 1956-1971 Commission on Professional and Hospital Activities, Ann Arbor, Director
- 1958-1970 Ann Arbor Board of Health, Member
- 1959 World Health Organization, Expert Advisory Panel on Health Statistics, Member

CHRONOLOGY (continued)

- 1959 Joint Committee on Coordination of Hospitals and Health Departments of APHA and AHA, Member representing APHA
- 1961- Medizinische Dokumentation (Germany), Editor
- 1961-1968 U.S.P.H.S., Division of Hospitals and Medical Facilities, Bureau of Hospital Services, Consultant
- 1964 Michigan State Medical Society, Committee on Maternal and Perinatal Health, Member
- 1964-1965 American Association of Medical Records Librarians, Nonmenclature Project, Appointee of the American College of Physicians
- 1965-1966 Michigan Hospital Association, Committee on Accounting and Statistics, Member
- 1965-1968 National Center for Health Statistics, U.S. National Committee on Vital and Health Statistics, Subcommittee on epidemiologic Uses of Hospital Data, Member
- 1966 American College of Physician's Committee to Review AMA's Current Medical Terminology, Member
- 1966 Health Planning Council of Michigan, Research Committee, Member
- 1966 Joint Commission on Accreditation of Hospitals, Project Advisory Committee for Research Program, Member
- 1967 Ann Arbor Chamber of Commerce, Community Research Committee, Member
- 1967-1968 AMA Committee on Medical Facilities, Consultant
- 1967-1968 Washington University Advisory Panel for a "Study Relating Air Pollution at Community Levels and Health Effects." Member
- 1967-1969 American College of Physicians Ad Hoc Committee on Biomedical Engineering, Member

CHRONOLOGY (continued)

- 1967-1969 Michigan Association for Regional Medical Programs,
Task Force on Methods and Evaluation, Member
(Chairman 1967-1968)
- 1967-1970 APHA, Statistics Section, Member
- 1967-1969 Michigan Association for Regional Medical Programs,
Task Force on Incidence and Prevalence, Member
- 1967-1970 Michigan Health Facilities Data Clearinghouse,
Chairman
- 1968 Ann Arbor Chamber of Commerce, Director
- 1968 JCAH, Internal Medicine Advisory Committee, Member
- 1968 JCAH, Medical Records Advisory Committee, Member
- 1968 DHEW, FDA, Bureau of Medicine, Consultant
- 1968-1969 DHEW, FDA, Drug Experience Advisory Committee,
Member
- 1968-1970 AMA, Committee on Community Health Care, Consultant
- 1968-1970 Michigan State Board of Education, Citizens' Committee
on Education for Health Care, General Advisory
Committee, Member
- 1968- AMA, Council on Medical Education, Survey Team, Member
- 1969 Association of American Medical Colleges, Council of
Teaching Hospitals, Advisory Committee to COTHMED
Project, Member
- 1969 Michigan Blue Cross Committee on Hospital
Effectiveness, Member
- 1969 University of California, Allied Health Professions
Research and Instruction Projects, National
Technical Advisory Committee, Member
- 1969-1970 Washtenaw County Council on Alcoholism, Advisory
Committee, Member
- 1969-1971 Michigan State Medical Society, Committee on Group
Travel Plans, Member

CHRONOLOGY (continued)

- 1969-1971 Michigan State Medical Society, Committee on Medical Socio-Economics, Member
- 1969- DHEW, National Center for Health Statistics, Panel of Advisers, Member
- 1970-1971 National Research Council, Division of Medical Science, Ad Hoc Working Group, Member
- 1970- DHEW, National Committee on Vital and Health Statistics, International Classification of Diseases Subcommittee, Member
- 1970 Federal Interagency, Working Party on Health Facility Statistics, Member
- 1971 National Academy of Science, National Research Council, Division of Medical Sciences, Ad Hoc Planning Group for Study of Institutional Difference in Postoperative Mortality, Member
- 1971 Washtenaw County Council on Alcoholism, President of Board of Directors
- 1971-1972 AHA, Advisory Panel on Peer Review, Member
- 1971- CPHA, President
- 1971- AHA, Classification of Surgical Operations for ICD, Working Party, Member
- 1971- Public Health Alumni Society, U. Michigan, Board of Governors, Member
- 1971 Washtenaw County Board of Health, Member
- 1972 Michigan State Medical Society, Committee on Maternal and Perinatal Health, Subcommittee on Perinatal Morbidity and Mortality, Member
- 1972- Michigan State Medical Society, Committee on Computers, Consultant
- 1972- American Academy of Pediatrics, Joint Committee on Assessment of Quality of Inpatient Hospital Care for Children, Member

CHRONOLOGY (continued)

- 1972- National Academy of Science, National Research Council, Division of Medical Science, Committee of Principal Investigators for Institutional Differences Study, Member
- 1973-1976 AMA Consulting Task Force on Guidelines of Care, Advisory Committee on PSRO, Member

This is Vergil Slee. Perhaps it might be well to start with a brief biography. I was born in Michigan in 1917. My father was a Methodist minister. I was born after my father and mother had been married seventeen years. I was an only child. I graduated from high school in Coldwater, Michigan, when I was 15 and then I went to Albion college. I graduated from Albion in 1937 with a bachelor of arts with credentials for teaching in a secondary school and also with premedical requirements completed.

I didn't have enough money to go to medical school or I would probably have taken only a three-year premedical program and then gone directly into medical school, but I stayed in college to get a teacher's certificate. Meanwhile, in that fourth year in college, Washington University in St. Louis, Missouri announced the first offering of something called "Jackson Johnson Scholarships in Medicine." These were brought to my attention and I applied and was one of four students granted a scholarship for four years in medical school. It may be of some interest to know the size of that scholarship. I got \$400 a year which took care of all my tuition and fees, and then I had

\$300 in cash to live on during the medical school years. It only took about \$300 more beyond that to meet my requirements in medical school in the late thirties.

I graduated from medical school in 1941 as something like fourth in my class. I took an internship in internal medicine in Barnes Hospital, which is the major teaching hospital affiliated with Washington University. So I stayed right on in St. Louis for the fifth year. My graduation date was the 10th of June and on that date I not only got an M.D. degree but I got married, and I got a commission in the United States Army as a first lieutenant in the medical corps.

In the winter of 1941, of course, a war started. I had my appointment as a first lieutenant in the Army medical corps. I was permitted to finish that year of internship, but during the winter the U.S. Air Force came along and was recruiting physicians. I looked at the amenities and I felt that it might be nicer living in an air force environment. I also observed that if one is in the air force he might become a flight surgeon and the flight surgeons got flight pay which was about \$100 a month at that time over and above salary, so I accepted the offer of the air force to go to work for it.

I received the call to active duty and reported to Selma, Alabama, July 1 of 1942. After I'd been on duty there in the air force for a few weeks I was called to active duty by the army, but I threw that one away and I never heard anymore of it. I spent four years in the air force, became a flight surgeon. I got out on 1946--March or April. By that time I had two children and I had a problem of what to do and how to earn a living.

Let me double back and put in a couple more factors. I had been planning

to be surgeon. I'm told that my general personality is much more that of a surgeon than that of an internist. I took the year in medicine at Barnes simply as a stepping stone to surgery. As a matter of fact, I had been doing some work with a neurosurgeon at Barnes Hospital in preparing to analyze a series of brain tumors. That's relevant to my career because we decided that to analyze these 350 to 400 tumors we would have to find a way to handle the data about them. So the first thing we did was to develop a protocol for recording dozens, in fact hundreds, of bits of information, and symptoms, and findings about the particular type of brain tumor patient. As I recall, that may have been enough to require about 25 to 30 punch cards per case. That was my introduction to the fact that there were such things as tabulating machines and punch cards, and that they had 80 columns and 12 holes in a column, and so on.

In fact I had an appointment as n assistant resident in neurosurgery coming up at Albany, New York when I was called to active duty during the war. My colleague in St. Louis was called back to Albany and then, interestingly enough, was called to active duty as a private first class although he was one of less than 100 neurosurgeons in the United States. He eventually got appointed to the medical corps and it was in Time magazine about his taking neurosurgery to the front lines in the Korean War. I think he was absent without leave when he did it. He proved a point that if you put good care up at the from line you saved a great many lives. Of course, that was sort of a transient phase, because by the time of the Viet Nam war you simply picked patients up in helicopters and brought them back and you could achieve the same thing.

Well, back in getting out of the air force in 1946. I was a little slow in getting out because of the way the points necessary for discharge were compiled. So when I got out in '46 my residency in Albany had vanished. I still was interested in pursuing surgery but there was a glut of applicants for surgical residencies and internships. We kept saying that by that time there would be eight people between me and the operating table, say, and that wasn't a good prospect. Nor was there any money coming in from internships in those days.

So, I came to my parent's home for a visit. They lived in Michigan at that time. My father had retired, and he was living in Coldwater. Somehow I went to the local health officer there because somebody said that he had been a surgeon and became a health officer--that happened to be Albert Heustis who later, for a number of years, was health commissioner of the state of Michigan. He told me that he had been a surgeon. As I recall it he had tuberculosis and had to spend a number of months in the hospital here at the University of Michigan. Then he was advised to live a less strenuous life and found public health administration very satisfying. Al suggested that I go over to Battle Creek and talk to the people at the W.K. Kellogg Foundation, which I did, and got acquainted with Dr. Matthew Kinde. It turned out that I was then able to test my interest in public health because the Kellogg Foundation gave me a fellowship for that summer in a local health department, specifically the Van Buren County Health Department. I lived at South Haven, Michigan and the County Health Department was housed there and in the county seat at Paw Paw.

Well, I found that kind of fun. The work was consistent with my nature

which has to do with things that carry over long periods of time to get results. Translate that into my surgical interest I suppose I would have been an orthopedist or plastic surgeon and maybe neurosurgery wouldn't have been my bent because this long-range interest is important. Well, during the summer there in South Haven, where, incidentally, my wife and I had two children lived in tents because the housing was so tight--literally. We were given permission to pitch a tent in the backyard of the office manager whose parents ran a fruit farm. So we lived "under canvas" that summer.

I sought and obtained a scholarship that fall to go through the public health school here at Michigan from the Commonwealth Fund, as I recall. I'll have to check that. I also was able to obtain GI educational funds, so, starting in the fall of '46 and graduating in '47 with a master of public health, I got the money from the two sources--the fellowship and the GI money.

When I was in Van Buren County Dr. Merle French, was the health officer. I was a member of the original group in the seven Kellogg Foundation counties. When the Kellogg Foundation was formed it got interested in public health. It formed a cluster of counties in southwestern Michigan which were its experimental counties. That was kind of an interesting thing. The health officers were all hand-selected for their specialities as well as for being general public health officers. One health officer, George Stucky, in Eaton County, was a tuberculosis specialist. Merle French, that I worked with, was an epidemiologist--an A-1 epidemiologist. Fellow over in Hillsdale, I think it was, was a health educator in interest. So, amongst the seven health officers there were these seven strong points as well as health administration.

These health officers in those days were going through the last year or so

of the original relationship with the Kellogg Foundation. The health officers convened religiously every month in Battle Creek. They kept minutes of their meetings, of their plans for the programs in various counties: they would agree to try something in one county with school health; another county with something else; and compare notes. They also kept minutes. These minutes were carefully put together, but they had to be reviewed by the executive of the Kellogg Foundation. At that time it was Dr. Emory Morris. He either approved or disapproved of their decision. As I recall it, if he approved he had a stamp which was a star and he would stamp a star opposite that item in the minutes. This was a "green light" to go ahead. Now the reason he could do this was because up until this time virtually all of the financing in those counties had been Kellogg money.

I got there just at the transition when Kellogg money was being phased out. The formulas had been developed to let the county or state or somebody take over the financing and Kellogg would withdraw their money, say 20% a year for five years, or whatever it was. I'm not clear about what the formula was, but it was an interesting thing to be there in those days. It was quite clear, of course, that if the activities in those counties were to be transferable or translatable they couldn't all be subsidized by Kellogg money because nobody would believe them. In fact nobody did believe, really, that you could do anywhere else what we did in those counties. The other people would say, "Well, you're unique, you've got all that Kellogg money behind you." So, it was important to pull out from that.

I was inside this early group, just on the fringe of it. In the course of that contact with the Kellogg Foundation, I, of course, learned a lot of

things. Graham Davis was still with the Kellogg Foundation as the head of the hospital division, Andrew Pattullo was his understudy. Graham had conceived an idea. It was that the way to solve the problem of getting the qualified medical administrator in a small county was to combine the administrative function at the hospital and the administrative function in the health department and give it to one physician/administrator. He had that idea back in the late '40s and he went around these seven counties and tried to peddle it, and he peddled it to Barry County. Barry County is a county of about 25 or 30,000 people midway between Grand Rapids and Battle Creek on one axis and Kalamazoo and Lansing on the other, if you want to put it on the map, a very rural county. The county seat had about 6,500 people--it was Hastings, Michigan. The hospital was about 35 beds. Well, Graham persuaded that county to try this. I suppose he was primarily able to do this because of the health officer who was there, a fellow named Ken Altland who later went on to the Michigan Department of Health. I was in the Van Buren County experience when Ken was just phasing out of Barry County and going to the State of Michigan. So, the Kellogg Foundation gave Barry County \$60,000 to experiment with this health officer/hospital administrator concept. Before they could do anything World War II came along. Well, now after World War II I'm in the group and looking for work. This strikes me as an interesting opportunity--it's not just a traditional health department. It's got other factors. So, in 1947 then, as I was getting ready to graduate from the University of Michigan, I applied over at Barry County for this job. I was given the job and I went to work about the first of June 1947. I don't think I came back here for graduation.

As I recall it, my starting salary was \$6,500. My first job actually was

only to run the health department, but there was the understanding that this merger would take place. The next eighteen months, that is from mid-1947 to the end of 1948, I spend being a health officer, yes, but also preparing for the joining together of the health department and the hospital. I was working out the details which really ended up as a gentlemen's agreement that I would devote roughly half time to each duty-administering the hospital and running the health department. I would get half my salary paid from the hospital into the county, then out to me, or something like that.

Another feature of that situation which was of interest and importance was that Barry County was a field training center for the University of Michigan School of Public Health. Dr. Henry Vaughan was the first dean of the public health school. He conceived a plan that the students would be farmed out from the public health school into various county health department for field training for a week. Prior to that the county health officer and maybe supervising nurse, or sanitarian would come in and meet with the students there at the university. So, I ran a field training center out there for the University of Michigan School of Public Health and that made me a non-resident lecturer here. I still have maintained that status up to the present time. That gave me a contact with the faculty and an inside arrangement with the university, which was easy to maintain since I had the month before been a student and I was familiar with the faculty and continued out there.

On January 1 of 1949 this "merger" took place and it was called the Barry County Health Center. We had a letterhead that said it was coordinating that Barry County Health Department and the hospital. I was the executive. Then we developed plans to build onto the hospital, to get up from 35 to 70 beds,

as I recall it, and as a part of that construction we put the health department offices inside the hospital.

It might be interesting to comment just a little bit about the relationship between a hospital and health department under this kind of a management. It could be good or bad. When, as the hospital administrator, I was able to deliver for the local doctors the things they wanted, my public health program thrived because they could take it out on me by failing to cooperate with my public health programs, which was pretty apparent, at least to me. For an example, an easy illustration is if I got them a backup laboratory service in the hospital, which I did part of the time, I could have anything I wanted in public health. But when we lost a good person in the hospital lab and I couldn't find anybody to take his place--I remember we hired some fellow who was kind of shaky and scared the patients when he tried to draw blood--they could get back at me. But generally speaking it was very good.

As I observed the scene, the biggest problem a health officer has in working with a group of clinicians is that they forgot that he came from the same place they did. If he wants to be successful he has to find ways to bridge back to clinical medicine. They won't build the bridge the other way. You can remind them periodically that it all came about when there were epidemics. The doctors said they were very tired and they wished they could get some rest at night.

Some doctor said, "Well, let me see if I can stop the epidemic and we can all get some rest."

They loved him at that time. He then got the epidemic stopped and stayed

on in public health. Pretty soon they forgot why they could sleep at night. The health officer became some sort of an orphan or outcast. You see that played over and over again. So a successful health officer, in my opinion, has to try to build these bridges back. For example, I was kind of unknown to them--to the clinicians. The first or second day that I ran that hospital they brought somebody in as an emergency who had, I think, a dislocated shoulder. I happened to be walking around and was in the emergency room. At that time I still knew how to relocate a dislocated shoulder, which I did. That bridge lasted for several months, as far as my prestige went with the clinicians. But when something like that would wear off, I'd have to figure out some way to generate prestige.

As a public health officer I continued in public health affairs throughout Michigan, and a little bit nationally. I became president of the Michigan Health Officers Association before I got through. On the hospital side, I participated primarily in the Southwestern Michigan Hospital Council, which was about 30 hospitals. I didn't get very prominent in hospital affairs. I think I represented that council to the Blue Cross board for Michigan for some years, but mostly I was local.

Well, maybe around 1949 or '50 Graham Davis, the Kellogg Foundation hospital man, told this Southwestern Michigan Hospital Council, as I recall it, that in Rochester, New York a fellow named Paul Lembcke, was doing some interesting things in a program which he called the "Medical Evaluation" program or project. I remember the first two words specifically, Medical Evaluation. As was quite common in those days the Kellogg Foundation made suggestions to this southwestern Michigan hospital group as to things it might

like to do, and, if it would like to do these things, the Kellogg Foundation might like to supply the money for them to happen. The hospitals were pretty receptive. They usually wanted to do what the Kellogg Foundation wanted to help them do.

So the Hospital Council said, "Well, that sounds very interesting. Whatever Dr. Lembcke is doing in Rochester we might like to try here."

So, they sort of bought a pig-in-a-poke. It turned out that Lembcke had a program going in Rochester in which the hospitals each filled out a medical statistical report and sent it to him at the hospital council office. He drew these statistics together and then fed back to each hospital comparisons of what they were doing. For instance, what percentage in each hospital were surgical patients, the average length of stay, and so on.

We said, "That's great, we'll be glad to copy that."

We sent someone to Rochester, we brought the binders back and the blank forms, and so on. At that point it seemed to make some sense to have some kind of committee. Again, a very logical move because it was getting into medical territory and I was the only physician amongst the group of hospital administrators. All the other administrators were either professionals administrators, or nurse administrators, or whatever. I said, okay. I'd be chairman of such a committee. Then the question was: Who was to be on the committee? We actually appointed a committee of four people. Besides myself, there was Matthew Kinde, from the Kellogg Foundation, a physician, who was willing to serve. (I think this was quite unusual in those days for the Foundation people themselves to serve on a governing body, so to speak, of a

project they funded.) We also appointed Arthur Humphreys, who is a pathologist in Battle Creek--still in practice--and Doris Duxberry, who was a statistician with the Michigan Department of Health. Here I was able to draw on my contact within public health to get a statistician. Humphreys was interesting in that, as I understand it, he in fact was brought into Battle Creek in the first place by the Kellogg Foundation who saw a need for pathologist there for the usual reasons. In those days I suppose one would simplify it and say a pathologist in their point of view was somebody who kept surgeons honest, or tried to. So, Art was one of the members. Doris Duxberry was very useful. She broadened some of our contacts as, for example, to Paul Densen, the statistician who is now in Boston, a very distinguished statistician.

This steering committee met and we worked with about perhaps 30 hospitals in southwestern Michigan which were willing to fill out these forms. We got the forms together. The differences amongst hospitals were very interesting, but very frustrating, because we could not go behind these differences. If the hospital in Coldwater, for example, as I recall it, gave a lot of blood transfusions, as compared with Hillside--I may be wrong about details, but this is the idea--the people would simply say, "Well, I guess it's because Coldwater is at the intersection of US 27 and US 12 and has a lot of auto accidents." We had no way to find out if that was the reason or not. So, we had all this conjecture and speculation.

We kept collecting these statistical reports that came into Hastings where we, by then, had placed the Southwestern Michigan Hospital Council office. We had a part-time record librarian who was the record librarian at the Allegan

Health Center. Her name was Maribell Rosser. She went out to the hospitals and helped people fill out these forms a little bit. The forms came in and then we had a problem of what to do with them.

One of the aspects of having this hospital and health department together was the I had a public health engineer working for the health department, a fellow names Vinson Oviatt. Vince was my public health engineer. He was, therefore, perfectly comfortable within a hospital. It was the only place in the state of Michigan that a public health engineer could get inside a hospital apparently. The hospitals were a little resistant and the engineers didn't feel comfortable going inside, but here he worked for me and that made it all very simple. Later the state of Michigan took him to be their man for hospital sanitary engineering. He went on from there and he is now the chief person in the United States Public Health in hospital sanitation. In fact, he has an international reputation in this field and is now on loan to WHO.

Well, Vince's wife, Carla, had been a math major in college. She was starting to raise a family. She was the only person around that we saw we could hire to fiddle with those numbers that were coming in from the hospitals on this medical evaluation project.

Incidentally, in Michigan we never called it the Medical Evaluation Project like they did in Rochester. We immediately said we didn't know if one could evaluate medicine this way, but, even if he could, it would make no sense to tell the hospitals, and particularly the medical staff, that this project was to evaluate them. If we wanted to go at all, we had to call it something far less pointed. We said that all this is doing is looking at the

professional activities in the hospitals, so we called it Professional Activity Study (PAS).

Well, Carla used to take this set of reports and build big charts on her kitchen table. Then we would have something to send back to the hospitals and we would say, "Here's the range of proportions of patients in surgery and how many deliveries you have in each hospital," and so on.

I will never forget being told that I should report to the hospital council. So, Carla made some big pieces of paper with lots of squares on them and compared the hospitals. In those days, incidentally, we labeled every hospital by name at the request of the hospital administrators. They said there's nothing secret here, just put it down so the community knows where it is, where Coldwater, Borgess and Bronson are, and so on. If my memory serves me correctly, at this meeting of the hospital council, we had a big poster-like thing up front with all these numbers on and there were asterisks on over two-thirds of the numbers. And the asterisks were footnoted stating "this information is unreliable." That was a great lesson. I remember a very prominent hospital administrator coming to the front and speaking in support of the whole project to the effect: "Now we're getting somewhere." The lesson for me was that you had to have this visible material even though the footnote said you couldn't believe it.

I said, "Yes, that's true."

I smiled inwardly, and we got the support from the hospitals to continue. Well, it was true that these data were unreliable and certainly were unsatisfying for the reason I stated, that you couldn't get behind them.

Now, I go back to my medical school senior year and internship experience

of trying to develop a method of handling the data we were going to get by analyzing brain tumors. It seemed that it would make sense to find a way to reduce the information that we were really working with, which was something out of medical records, to a summary of each record and do it in such a fashion that we could put that summary in a punch card. If we had the information on each patient in the punch card, then it would be a simple matter to find the patients that got blood transfusions or that were in accidents or whatever. So, about the middle of 1952, late in the summer, our advisory committee got this idea together. We thought it would be possible. We met with the hospital council executive committee and we said we were thoroughly fed up with where we were. The only way we thought it made any sense to continue PAS at all was to take this project and see if we couldn't get information on the individual patients. The hospital council was very compliant and agreeable and said, "Fine."

They said, "Where would you go to get machines or machine services?"

We said we thought there were three possible places to go. We knew that Blue Cross had machines. We knew that Michigan State University did and that University of Michigan did. I was asked which one I would go to.

I said, "Well, the only place I really have an in is the University of Michigan where I do run a field training center still, where I do have some kind of a faculty appointment."

They said, "Go ahead."

So I came down to the University of Michigan. Now, that was a little complicated too, because the University of Michigan was the home of Nathan Sinai and Nathan Sinai was sort of the prime enemy of the clinician, or at

least doctors in practice thought Nate Sinai was just about as bad as you could get. He was perceived to be Mr. Socialized Medicine, and here was the University of Michigan with Nate Sinai prominent in it. So, I went, not to his part of the university, the public health school. I went to the statistics department where I was in good shape with friends. The chairman of the department then was Clarence Velz. He saw quite quickly that this idea made some sense, but he couldn't believe that hospitals would release these data.

I said, "I don't think that's any problem. If you're willing to let us use your machines, I don't think the hospitals will give it a second thought."

There's another learning experience there: that is, it's a lot in your attitude, you can pull off almost anything if you think you can. I had no problem; I never did have any problem getting this information out of hospitals.

Clarence said, "Go ahead."

I said, "Who do I talk with?"

He called down the hall to a fellow named Fay Hemphill. Fay Hemphill was in the process, I guess, maybe at that time--or maybe he had just gotten his Ph.D. He was not a young fellow. He had been in statistical work and in the public health service. He came to Michigan and got his Ph.D.

Clarence said, more or less, to Fay, "If you've got time to help these people, it's fine with me."

Fay said he guessed he did.

Then they said, "We've got a young fellow working on his Ph.D. that might be interested in this. Happens to be a fellow who's interested in quality

control techniques in clinical laboratories, fellow named Robert Gilbert Hoffman."

That was about October of '52. Andy Pattullo was at the board meetings and listened in on this conversation. The next thing we did was to work with a couple of hospitals, probably Community in Battle Creek and Allegan where this record librarian was that was with the project. We developed a sheet that was set up so that each line was one patient and the columns were headed, patient # and diagnosis code, and age and sex and so on. The latter part of that year--maybe in October and November--these two records people went through medical records and proved to themselves that they could fill out such a paper extracting or abstracting key information. After having gotten that through our heads we then thought it would make sense to not have separate lines but have separate pieces of paper for each patient. So we sketched out what the content of that paper would be.

There was a fellow down the block from me that I used to go fishing with. We helped each other on various projects. He was an engineer who worked with one of the local factories, mechanical engineer. That meant he had a drafting skill and a drawing board and a T square, and pencils; Jack Foster was his name. He came over and helped. Then we recruited another key person who was our lab man at Pennock Hospital, Elmer Sanborn by name. Sandy was a cut above the lab person you would expect to find in Hastings, Michigan. He since has become a key person at the Upjohn Company. There were five of us, as I recall: Sandy and I, and Jack Foster, and the young lady who was resident in pathology with Humphreys, and then this young statistician, Bob Hoffman. The lady resident, Margaret Waid, came up from Battle Creek to Hastings. The five of us sat around on the floor of the Slee living room on a weekend and

designed the first case abstract. Jack Foster was responsible for turning it into a piece of paper that was neat so that people could fill it out. Subsequently, Margaret Waid and Bob Hoffman were married--that is just sort of a by-product in this enterprise.

This was in late '52. So, the council board met again and Andy Pattullo was there. We said, "What we propose is to either give Kellogg the money back that is left as we think the other method is useless, or try this new idea." We learned then that foundations don't want money back; it's embarrassing, as I see it. If they got money back, it must mean that they selected poorly in the first place, either the person or the project to which they gave the money. We didn't want to embarrass Andrew.

We said, "We have two or three thousand dollars out of the original grant, which had been about \$5,500."

Somebody said, "How long would that run you with this new idea of getting each patient on a piece of paper and turning it into punch card, sorting it or whatever?"

We figured quickly and said "That will run about three months."

The Kellogg people then said, "That doesn't make much sense, there really isn't enough time. What would it cost you to go for a year?"

So, we did a little quick arithmetic on the back of an envelop and we gave a figure of something like \$15,000.

They said, "Okay, here's the money."

It turned out later in the year that we were \$800 short, and they made up the \$800. So the first year's budget of what we might call the modern PAS, in 1953 was \$15,800.

We started then in January of 1953. As I recall it there were about

thirteen hospitals out of the original thirty who were willing to take up the new method. Their record librarians were convened at the Battle Creek Sanitarium between the holidays. We went through this new form and what it was all about and said, "Let's go." In January and February they sent the "Case Summary Code Sheets" in and we learned quite a lot. We used the Standard Nomenclature Of Disease and Operations of the AMA for coding diagnosis and procedures. That gave us some problems. The codes were very long; it took about fifteen digits for one code if all components were filled in, and there was quite a chance for ambiguity. Miscoding was fairly easy. We got these case summary code sheets, we called them, together and Bob Hoffman sat in the basement of the public health school and did his own key punching and sorted things out. He made little reports, which he printed with a hectograph. The hospitals got kind of excited about the project. They felt this was very interesting information when it could be as refined as it was. We realized that hospitals compiled the statistics that they had earlier sent to us from the very same information.

So we said, "Why don't we compile the statistics for each hospital in return for its giving us information on each patient?"

That determined in part what we put on the form. We also had to have diagnosis to make any sense out of this. We knew that hospitals indexed their medical records by diagnosis and by operation and by physician in order to be accredited. The Joint Commission was just being born at that time and it carried on what the Hospital Standardization Program required, which was indexing. There were hospitals that were nervous. They've always been nervous about whether they pass the accreditation examination or not. They had always showed the surveyor a Kardex. You'd find a card that said

"diabetes" and you'd flip it up, and on that card would be a list of all the patients with diabetes plus their chart numbers and their ages and sex or something like that. Well, we said it would be a very simple matter to have this IBM machine just print out a list of all the patients with diabetes.

The hospital said, "That doesn't look the same and maybe the surveyor won't accept it."

So, we said, "It is just the same, but we'll go ahead and get you a ruling on it."

We wrote the Joint Commission. It was then run by a fellow named Ed Crosby, who was the first executive, as I recall it, of the Joint Commission on Accreditation of Hospitals. Something slipped in that communication because a letter somehow came back to the effect that Pennock Hospital in Hastings, Michigan was too small to have an IBM machine, which wasn't the question that had been asked at all. We were very puzzled by that. At the Tri-State Hospital Assembly that May, Crosby was on the program and I went up to him. We later convened in Pattullo's room or my room at the hotel and talked about this. We ended up with the ruling from Ed Crosby that a machine-printed listing of cases by diagnosis or by procedure or by physician would be acceptable to the Joint Commission. That was an interesting bit of exchange to get that out of him. I've never quite understood what the problems were, because it seemed perfectly straightforward to me. As I said, we eventually we got this ruling.

I think the fourteenth hospital to join PAS probably was Mercy Hospital in Benton Harbor which had been earlier in the other program, but was just a little slow in getting started. If memory serves, it came in about May of

'53. Then along about that fall we realized that of all the hospitals we had, the largest was Community Hospital in Battle Creek which was then under 200 beds, if I'm not mistaken. We didn't have a single hospital with interns or residents. We thought that if we were to have any credibility, and to get experience, we'd better find something bigger. So I picked up the phone and called Blodgett Hospital in Grand Rapids. Ron Yaw was the administrator.

Ron was an old friend and it probably didn't take two minutes before Ron said, "Count me in."

So, Blodgett came in about December and that made the fifteenth hospital. They had interns, residents, and a good teaching program, and a cooperative management.

Late then in 1953, probably about midsummer into the fall, I started writing a report to the Kellogg Foundation about the project. As I recall, it was unique in that I called it a "problems" report. I still have a copy somewhere. They were not used to getting that kind of report. They'd get progress reports. All I did was spend fifteen or twenty pages listing out the obstacles where we were in trouble. One of the most critical problems was the fact that hospitals had gotten hooked on PAS. The ones that were participating had abandoned their old Kardexes and their old monthly statistics. They were sending information in to us on a case-by-case basis. There was always a lag, although hospitals, theoretically, could get information to you instantly or within a day or two. So, by the end of that year there was at least a ninety day backlog. The Kellogg money was running out December 31st. Yet the work to be performed for those hospitals clearly would extend until about April of 1954. So, the proposal to Kellogg was that

we had to know what to do next year. We laid it right on the line that if they couldn't make up their minds by say the first of November, we would fire everybody except enough to stay on to finish the work that we had obligated ourselves for to those hospitals. This was, again, kind of a cavalier approach to a granting agency but it worked. They thought it over and they came back with a proposal.

The proposal had two stipulations. It said, in essence, "We will entertain a request for two more years. This is showing promise. If you are going to go for two more years you're going to get the money, but you are going to have to do two things. You're going to have to set up a national advisory committee and you, Slee, are going to have to take over as executive full-time."

I agreed to both stipulations. As a matter of fact, early in the project, it might be 1953, it became apparent that the project had to have an executive. Decisions had to be made. You had to place orders for paper and you had to get people paid, and you had to commit money for travel even within a \$15,000 budget. So the hospital council had given me authority to act as the executive to the project. I made a budget. For years '54 and '55 the two-year budget was something like \$180,000. I said that I would not accept the executive job until a replacement was found for this Hastings/Barry County situation which was experimental. I didn't think that it was fair to the Barry County experimental project, namely, the joint administration of hospital and health department, and pull out of it without a replacement. That was okay. So it took two or three months and we found a Canadian by the name of Joseph Heaslip who took my job. That project kind of went down hill

and has since been abandoned. In retrospect, we should have probably hired somebody younger. Joe was approaching retirement and was primarily public health oriented. He maintained the public health department pretty well but the hospital relationship didn't thrive. I don't know how successful the whole idea is generally but that's what happened there.

So, in April of 1954, I became a full-time employee of the Southwestern Michigan Hospital Council. We appointed an advisory committee that had perhaps eight people on it. We had Crosby from AHA. We had General Paul Hawley, who was executive of the American College of Surgeons by then. He'd been General Eisenhower's chief medical officer in World War II, in the invasion. Then he'd been chief medical officer in the Veterans Administration. We had Norman Miller, the obstetrician here at the University of Michigan, professor of OB. Wesley Eisele was on it. They were both medical educators. We had a couple of statisticians. Fay Hemphill and Ozzie Sagen, Oswald Sagen, who was at that time a statistician for the state of Illinois. We had a couple of hospital people. Bill Erickson from Three Rivers, and Tiffany Loftus. That was about the composition of the advisory committee. The advisory committee proposed that, indeed, this program was worth pursuing, but it was not really an appropriate venture for a little hospital council to get into if the plan were going to go national, and it was interesting to these people from a national standpoint. The next step was that we decided that perhaps another corporation should be formed that would be roughly parallel to the Joint Commission on Accreditation to Hospitals in sponsorship. At that time the Joint Commission had five sponsors: the American Hospital Association, the American Medical Association, the American

College of Physicians, the American College of Surgeons, and the Canadian Medical Association. The Canadian hospital people were in the process of breaking off from AHA and setting up the Canadian Council on Hospital Administration. Since that was a foregone conclusion we never tried to put them on the sponsorship of CPHA (The Commission on Professional and Hospital Activities), as it was finally called. All I can really remember for the year of 1955 was an endless series of meetings and trips to develop some kind of a relationship between these organizations, and we achieved it.

Kellogg said, "If you can get that kind of sponsorship put together, we will entertain another application for three more years."

We got the sponsorship put together. Kellogg ended up giving us a grant of \$260,000 a year for the next three years: \$20,000 to equip initial offices, and \$80,000 a year as an operating subsidy. In connection with that \$80,000 they gave us a formula. The formula required that the hospitals that were participating all start paying for the service. They started paying 25¢ per discharge, which was enough to cover our costs of processing their information, if we could get the volume up to about a million discharges a year.

Another part of the formula from the Foundation was that after a certain amount of income, maybe \$75,000 a year, from participating hospitals, at say 25¢ a discharge, a part of the income would spare the grant. In effect, the amount spared would reside with the Kellogg Foundation until the end of the grant; at which time we would be able to apply for that money. Whether we got it or not was their decision. To leap ahead, the way we grew we did spare about \$50,000 of the \$240,000. In that three years we took about \$190,000 from the Foundation.

The first hospitals to join outside of Michigan were two in Syracuse, NY: Crouse-Irving and Syracuse Memorial. They came in about December of 1954 after their records librarian heard about PAS while they were attending a conference at the American Association of Medical Record Librarians' meeting in Detroit. Then other hospitals started to have some interest.

The year of 1955 then saw the arrangements worked out that these four organizations were sponsors.

Discussions led to naming the organization the Commission on Professional and Hospital Activities, which has never been a terribly good name. We never could figure out anything better and we had to get on with it.

We incorporated in Michigan as a nonprofit corporation in December of 1955. The incorporators, as I recall it, were: Kenneth Babcock, who was then the executive of the Joint Commission on Accreditation of Hospitals; Luther Carpenter Jr., a surgeon in Grand Rapids; and C. Tiffany Loftus who was administrator of the hospital at Benton Harbor, Michigan, Mercy Hospital. Kellogg then came along with the grant and we rented space in downtown Ann Arbor in the First National Building. We had already gone out on a limb and ordered IBM equipment so that when we did get out of the university we'd have something to work with. We really didn't have any authority to do that but we could always cancel our order. Furthermore, it put us in the queue to get equipment. So, we opened shop downtown in April of 1956. I was still living in Hastings where I had been throughout. At that point we made family arrangements to move down to Ann Arbor in June of '56.

Very few people know that the American Medical Association was ever a sponsor of CPHA. In January or February of '56 the person that they had named to represent them on our governing body, an anesthesiologist from Cleveland,

died. We went back to AMA for a replacement. The best recital we ever got on this was that there was sort of a curbstome consultation in AMA headquarters. AMA was under the gun for some kind of interlocking directorate problem and their legal counsel, I think it was Joe Stettler at that time, wondered why they wanted to ask for one more vulnerability, another interlocking directorate. So they just let us quietly go on without them and that left the three sponsors that we have persisted with: American Hospital Association, the American College of Physicians, and the American College of Surgeons. Each one of those got two members on the governing board finally, and the Southwestern Michigan Hospital Council, as point origin, got one.

When CPHA was formed Southwestern Michigan Hospital Council sold PAS and all of its assets and data to CPHA for a dollar, and that was it. We kept going here in Ann Arbor.

Prior to that time I had had two offices in Hastings: one for running the hospital and health department, and then, across the corridor, was an office for PAS. I had a secretary there and a clerk and finally we had about six people in Ann Arbor at the University of Michigan before CPHA was actually formed. We had the statistician and the keypunch operator and an operator of tabulating machines, and so on.

We opened downtown, and then we had the throes of getting the new corporation off the ground. There were a lot of interesting things. We were sort of an unknown quantity to our new board. Crosby was, I think, the first chairman of our board. One of the steps that was required of us was that every month we would do our bookkeeping and then we would package up all of our bills and checks and everything and send this box full of materials,

registered mail, to Chicago. John Sullivan or somebody at AHA would check us out and see if we were doing everything all right and then we would pay our bills. I don't think this lasted very long.

There was great nervousness about whether I could be trusted to speak without getting somebody into trouble, so my public utterances had to be screened. If I were going to write a speech it had to be written well in advance and passed in front of a censorial body. I can't recall ever being censored but this practice persisted. Even later, for probably ten years, there was a public utterances committee on the CPHA board. Of course, I did quite a little extemporaneous speaking along the line, as you might expect. This board was unsure of our competence, our ability to manage.

In the early days every applying hospital had to be approved. The first year, 1953, we had about 50,000 discharges per year from all the hospitals put together. By the time CPHA was formed we had maybe 75 or 80,000 per year. One of the significant decisions made in June 1956 at the first real meeting of the new board was to allow us to go to 200,000 discharges per year, at which time we were required to put a freeze on the whole thing until the board was satisfied that we could manage that. We also had some interesting experience. All reports that we were to publish had to be reviewed by the board. Mostly that means by Crosby at AHA. He soon realized that wasn't the way to say it "all reports" because every hospital was getting three or four different reports each month and that wasn't the kind of reports he meant. So, what that really meant was anything we wanted to publish: a little research paper, or whatever. That soon was given up also.

One of the first things we did after we were formed was to apply for federal income tax exemption. As a 501(c)(3) organization you can qualify under four possible headings: scientific, religious, educational, and charitable. We contended that we were everything amongst that listing except religious. We filed as soon as we could, which was at the end of one year of business as a new corporation. This meant we got papers out as early as possible in the year of '57. The papers went through the usual channels. They got lost between Detroit and Washington, and all had to be reconstructed. We got countless inquiries of this nature and that nature about the application. At one time, for example, they called for names and ages and dates of employment of everybody who ever worked for us and what each person did. We had enough records so we could do it, but it was a lot of work. We sent that in.

Then finally, they sent us a letter and said, "You are not qualified to be tax-exempt."

This must have been in 1958. This was rather crippling to us. Fortunately it came toward the end of the year, just as the Kellogg money was about finished. Once that ruling was in place, the Kellogg Foundation could not continue to grant money to us without jeopardizing its own tax-exemption. So immediately in late '58 we went to work on appealing. We spend a lot of time and a lot of energy. We got tremendous help from a tax man from Ernst & Ernst by the name of Melvin Levy, who was then in their Washington office. I spent weeks, day on end, in Washington working out the appeal, the brief, but the Kellogg money was shut off.

Another interesting thing was at that time we were in the process--I

primarily--joining with the Kellogg Foundation and others in sketching the Hospital Administrative Services program, HAS, which was germinating out in Nebraska, Colorado, and South Dakota. One can speculate that had we been qualified as a 501(c)(3), since we already had data processing capability, HAS might have ended up here. As it was, when it was ready to be born, we weren't available. So it went to AHA.

It took us about 11 or 12 months to get the ruling reversed. That year was pretty hard because we were very short on money. When we got the ruling reversed, we went back to Kellogg Foundation and asked them for the \$50,000 spared from the grant and they gave it to us without any strings attached just for further development. That was quite a relief, I tell you.

That was the last of any basic subsidy to CPHA. Ever since then CPHA has been self-supporting from revenues with one exception. (Of course, any grant is not exception if it's a grant for a project, because that would come for work to be done and studies to be performed and thus there would be an offset.) I'm talking about basic subsidy.

We were located in downtown Ann Arbor. We occupied space in the First National Building and we rented other space. Eventually we took over the entire old Montgomery Ward store. We used to say we specialized in ladies dress shops. We were in four or five locations within a single block in the main part of downtown Ann Arbor. To get between these, you would have to walk through an alley or down the street out in the snow. We eventually occupied maybe 45,000 square feet of space in downtown Ann Arbor, and we kept growing. It was terribly inefficient. For example, we had buildings with no elevators but with computer (in 1961) and punch card operations that used a lot of

paper. So we had people carrying boxes of paper up and down stairs.

We kept telling our troubles to the Kellogg Foundation and they kept saying, "You've got a thriving operation, Why don't you just borrow some money and go ahead and build?"

About 1965, or something like that, we got wind of a piece of property in northeast Ann Arbor, about 36 acres, which we brought. We had enough money by that time to buy this property. I think we paid something like \$11,000 an acre. Then we started figuring out how much it would cost to build and how many square feet we would need. We couldn't earn money fast enough to stay ahead of rising prices and get a down payment on the building.

Finally, one day, probably in 1966, I got a phone call from the Kellogg Foundation, from Pattullo. He said something like this: "Whatever you're doing next Thursday, cancel it, because the boss wants you down here for lunch." This was in February or March. I drove down to Battle Creek and we went out and had lunch; Emory Morris was the boss. He, Pattullo, Kinde, Herb Hasson, who was Kinde's assistant, and I.

At the lunch, Emory Morris said, "How much money do you need to get your building started?"

Well, I gave him some figures and he took a pencil out and worked on the tablecloth. It turned out that if we had \$500,000 with the equity we had in the land and all, we would have about 30% of what we would need ultimately. That was enough to get a mortgage out of a lending agency.

He turned to Pattullo, and said, "Do you have enough to write this up?"

Andy said, "Yes." So we went back to the foundation. Dr. Morris took farewell and went back to his office, and we went to Pattullo's office.

Kinde said, "You're going to get your money."

I said, "How can you be so sure?"

He said, "I've been through this many times, and I have never seen the boss write on the tablecloth but what he gave the money."

Within three weeks we had a check for \$500,000. I swear I do not think we ever placed a written application at the Foundation for the money to get this building started. Bricks and mortar were out of thier scope of interest at the time, and still are. They typically don't build buildings. It's a rare day when they build a building but they gave us that front end money and we went ahead and got the mortgage money from Mutual of New York and that was it.

When we started PAS in 1953 we realized we had to code diagnoses and operations and at that time all of us had been required in our training to code to the Standard Nomenclature of Diseases and Operations which was published by the American Medical Association. It was a code that was very orderly: it had six digits for topography and six digits for etiology, for diagnoses, and three digits of supplementary codes which were "Manifestation" codes. That meant that we put on our case abstract room for twelve digits or fifteen, whatever it was. We tried that and by the end of the first year we were pretty frustrated because there was so much miscoding, so much ambiguity. So, as I recall it, Bob Hoffman, who was our statistician, and Bill Kincaid who had come on as our first punchcard machines operator--he was a graduate student at the university--thought that perhaps we could go to the International Classification of Diseases. I didn't know anything about these things at that time except that it was the book that doctors used for coding death certificates. In exploring it we found that the United States Public

Health Service Hospital in Baltimore with a record librarian by the name of Loyola Voelker, and the Columbia Presbyterian Hospital in New York whose record librarian was Dorothy Kurtz, had both been on that same track. They had taken International as it came from the World Health Organization and they had deleted the rules that pertained to cause of death. They had added certain details to make the codes more specific and they were using it successfully. So, we took their experience. We bought the books from WHO and inserted these refinements. In July of 1954 all the hospitals in PAS, twenty or so, switched over to the International Classification of Diseases as subdivided and modified for hospitals use by us. I think that was the first time in any group of hospitals, that International was used for indexing and statistical purpose.

Shortly thereafter, the federal government set up a research program that was operated jointly by the Association of Medical Records Librarians, which is now the American Medical Record Association, and the American Hospital Association, to compare the Standard Nomenclature (AMA) with the ICD - that's the International Classification of Diseases. The upshot of that study was that the International did a better job of retrieval; and that it was easier to code from; and it was more likely to get the doctors the cases they needed for review purposes and for clinical research. The general idea is that if you want to study gallbladder disease, say, you want to be sure you have all the cases of gallbladder disease at the risk of having a few too many. The Standard Nomenclature was so detailed and intricate that you might only get half the cases you needed. At one time, as I recall it, we found five or six different ways in Standard Nomenclature one could legitimately code acute

myocardial infarction. One would be infarction of the muscle; one would be an occlusion of the blood vessel, and so on. Now, if you went to retrieve cases and you forgot to specify these alternative wordings, which also had their own unique code numbers, you couldn't get all the cases. So, there were great gaps in people's studies because the doctors went down to the record department and forgot to tell all the ways that something might have been coded. It's very important that you have only one way to code something so that cases all fall in the right pigeon hole.

So the federal government commissioned the construction of the International Classification of Diseases Adapted, ICDA, which was for hospital use. People from our staff worked on that as did the American Medical Records Association and others, and it was published in 1959. Two or three years later it was clear that we needed to get it indexed and to modify it. So CPHA got a contract which was in the neighborhood, I think, of \$17,000 to rework ICDA with the advisory committees. The result was Public Health Service Publication No. 719 revised, which came out in 1962, the one we did by commission. Meanwhile, the federal government was working with Geneva to come out with the 8th revision of the International Classification, which was due in 1965. It actually came out in about 1968. When the Geneva product came across the sea in draft form, the United States government people realized that it would not meet clinical or hospital needs so they gathered a working party and built a multi-purpose book for the United States, which became known as ICDA8. It was the International Classification of Diseases Adapted for use in the United States (for all purposes) as contrasted with ICDA which was just for hospitals. ICDA8, for both mortality purposes and hospital purposes, was a little confusing for both kinds of users. We had some members of our staff

who were on their advisory committee. We didn't get very good feedback from some of the people we happened to have appointed. William Kincaid, who was later our executive vice president, withdraw from that federal committee, because what he was saying they wouldn't listen to. So, we got a draft from Washington in 1967 or 1968 of how ICDA8 was going to look and we realized that we could not expect hospitals in PAS to use it without making modifications to meet the needs of the hospital and the hospital physician. A basic part of PAS is the ability to make comparisons across hospitals, in fact, that's where it started on day one. To do that, you have to be sure that the coding of diseases, operations and other things is uniformly done in each hospital. So we saw no choice in '67 but to go to work and produce a modification, an adaptation that we thought we knew from our experience would satisfy hospitals. We did, and we called it H-ICDA, Hospital Adaptation of ICDA. This we published in '68 just about the same time the federal government published ICDA8 and that started a whole series of confusions and complexities in the American hospital scene. Eventually, about half the hospital discharges were coded to the federal government book which was listed as official but really wasn't very official, except that the government printed it--I guess that makes anything official.

In the early '70s we realized a need for further modification and so we went to our clinical sponsors, the American College of Physicians, and the American College of Surgeons, and those two sponsors gave us advisory committees on classification. Then we went to the American Academy of Pediatrics, to the American College of Obstetricians & Gynecologists, to the Society of Teachers of Family Medicine, and to the American Osteopathic Association. All of these gave us advisory committees. By 1973 we published

the second edition of H-ICDA. We also made a bargain with these speciality groups that we would transmit their wishes on classification to the United States government as input for the 9th revision of the International Classification, which was due to come out in 1975.

The federal government in 1970 had appointed me to the subcommittee for the 9th revision. The subcommittee reported to the United States National Committee on Vital & Health Statistics, which in turn, transmitted to Geneva. Then they also appointed me as a member of the delegation to Geneva for the conference for ICD9; that was at the end of September 1975. I had had about two months to look at the draft material. I got over there and saw some real problems from the standpoint of what American hospitals need. I found that there was really no chance to make any changes. One of the most interesting episodes occurred with regard to maternity classification in which the upcoming ICD9 did not have codes to tell whether the mother delivered or not, to tell whether her complications occurred before, during or after delivery.

I protested at the WHO meeting that this was not the way that it would be accepted in the United States and the people from Geneva looked at me in great dismay.

They said, "We got our input for how to do this maternity chapter from FIGO, the Federation International of Gynecology & Obstetrics, and we understand that's a supernational association. Furthermore, the committee on classification of FIGO was chaired by an American obstetrician-gynecologist from Detroit, Paul Hodgkinson."

Incidentally, Paul Hodgkinson sat with the first advisory committee to CPHA back in the mid-50s, so I knew him. That left me surprised because I had been dealing in the mid-50s, so I knew him. That left me surprised because I had been dealing with the American College of Obstetricians & Gynecologists, and their committee had reviewed the Geneva draft and had empowered me to make these protests.

I said, "I don't know how it works but American College of Obstetricians & Gynecologists does not agree."

It turned out that nothing could be changed. When I came back to the United States, I re-examined ICD9, and finally one more time decided that if we adopted it exactly as it came from Geneva, hospitals would be forced to make their own modifications. If they did that independently, we'd lose all ability to compare within PAS. But bear in mind, the world has changed a good deal and PAS isn't the only place where one makes comparisons. The United States government today is collecting data, and has a uniform hospital discharge data set. It has PSROs and HSAs, all of which are assuming that they can get uniform data out of hospitals so that they will be talking about the same thing when they talk about one hospital or another. So, we felt there wasn't any way that we could work in the United States unless we again made a United States modification or adaptation. But we weren't sure that the federal government understood this, so we started talking with the American College of Surgeons and explained the problems.

The American College of Surgeons agreed with us on the problems: those from the obstetrical codes; the alternative coding propositions that would permit you to code a given case either as a manifestation or as a cause; some

of the psychiatric codes; and even some of the typography--all were against the adoption of the Geneva book as it stood. They said they would support us in protesting to the federal government. We went to the American College of Physicians and got the same support; and to the American College of Obstetricians and Gynecologists, the group that were the most affected, and American Academy of Pediatrics. They all agreed that a protest should be made. So, in January of 1976 I wrote to the Secretary of HEW and told him that we saw serious problems and we'd like to talk with him about an adaptation for the United States.

In looking the situation over we also decided, these five organizations, the fifth being CPHA, that it would be well if we banded together more formally. So, we formed the Council on Clinical Classifications. To avoid having to set up a secretariat, to avoid having to go through qualifying as a tax-exempt organization, and obtaining computer and other services, we decided that it could be done by rather an ingenious mechanism, operating it as what we now call an affiliated division of CPHA. The Council on Clinical Classifications has its own governing body. It has official recognition by its sponsors. I am its president by virtue of my office as president of CPHA. Its governing body has a chairman and vice chairman. This permits all these clinical organizations to speak with one voice. Subsequently, we added the American Psychiatric Association, so there are now six sponsors to the Council on Clinical Classifications. It's still in existence.

It was just last week we had our annual governing body meeting, discussed the future question of procedure of coding in the United States. The sponsors agreed that they would tell the government that their input on procedure

questions would be via CCC. So this gives great strength to the clinical voice. Well, CCC then, in the early 1976 was strong enough to persuade the National Center for Health Statistics that we really had to look at the question. By September of '76, the National Center was persuaded.

The National Center gets into this because that is the part of the United States Department of Health, Education & Welfare, the Public Health Service, which links to the World Health Organization on classification matters. Furthermore, in about 1976 WHO established a North American Center for Classification, and the National Center for Health Statistics agreed to take on that task, wearing another hat. So, there was agreement at that level in the United States that modification--they preferred that word to adaptation--was in fact justified. We agreed to do the work on it, with the Council of Clinical Classification as a part of CPHA for support purposes.

The primary contact person in the federal government is Robert Israel who's at the National Center for Health Statistics and runs this international North American Center. He appointed the steering committee with representation of all the organizations that legitimately had an interest in classification of diseases and procedures for statistical purposes. This group met periodically and gave general opinions as to the direction to go, but all of the technical work and all of the labor of modifying International was done here with our staff. Our staff would draft and ask for reactions to the draft from technical people who did coding, nosologists, people in the American Medical Records Association, other health data systems, and so on, and in the federal government. After their input was obtained we did another draft and sent it to our physician task forces from each of the CCC sponsors. We got

their input, redrafted again, and finally had a big consolidated meeting of all these different clinical specialists together--consolidated their information--and were able to go to press in the summer of '78 with The International Classification of Diseases, 9th Revision, Clinical Modification (ICD 9CM).

The product is completely collapsible back to ICD9, so that any data coded in the United States to ICD9CM, can be brought back into absolute conformity with the international code. The United States has a commitment to use ICD9 for diagnosis in all international exchange of data, as I understand it, and that permits this to be done without loss.

There were some interesting episodes along the way. For example, the first decision as to how to modify required we use unused fourth digits in the code, and that was reversed later on by the federal decision that wanted as little tampering with the first four digits as possible. So, our work had to be done over with the new modification put into the fifth digit. It's interesting that one of the changes between ICD9CM and ICD9 itself and previous versions is that the new one is five digit codes while the earlier were four digit codes. It's important that all five digit must be used or you lose significant information, so we're pretty distressed now to see people giving abbreviated code lists for insurance companies, say, that only use three digits. It's going to be an awful mess when people try to make sense out of codes in which two digits have been dropped off. Older codes were sort of hierarchical, in that if you took certain three digits say, you knew that you had all of the diseases, all kinds of pneumonia maybe, and the fourth digit only subdivided and the fifth might only further subdivide, but that's no longer true, so we're going to have some interesting problems within the

next few years. I have on my desk a pronouncement from one of the Medicare intermediaries telling all the providers that they only have to code the first three digits. I intend to take that to the attention of somebody in Washington. Not that it would make any difference.

So that is how it all began.

Interview in Ann Arbor

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