

KENNETH WILLIAMSON

In First Person: An Oral History

Lewis E. Weeks

Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

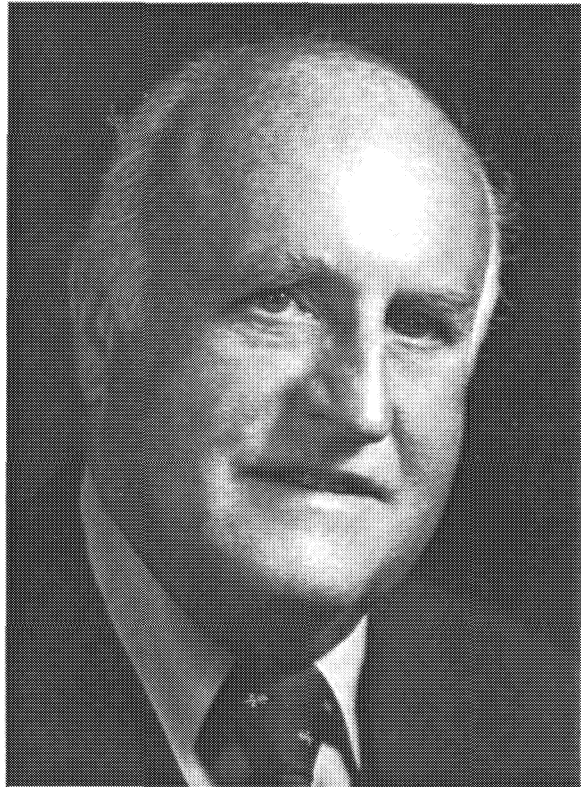
Produced in cooperation with

Library of the American Hospital Association
Asa S. Bacon Memorial

Sponsored by
American Hospital Association
and
Hospital Research and Educational Trust
Chicago, Illinois

Copyright (c) 1983 by Lewis E. Weeks. All rights reserved.
Manufactured in the United States of America

Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298



Kenneth Williamson

CHRONOLOGY

1912 born March 31 in Hull, England

1930-1937 Methodist Hospital of Southern California (Los Angeles)
 Assistant Director

1937-1939 Hospital of the Good Samaritan (Los Angeles)
 Business Associate

1939-1941 Hospital Service of Southern California (Blue Cross)
 Assistant Director

1941-1943 California Hospital Association
 Executive Director

1941-1943 Association of Western Hospitals
 Executive Director

1943-1950 American Hospital Association
 Assistant Director
 Secretary of the Council on Administrative Practice

1950-1954 Health Information Foundation
 Executive Vice President

1954-1972 American Hospital Association
 Director of the Washington Service Bureau

1972-1980 Consultant

AFFILIATIONS & MEMBERSHIPS

American College of Hospital Administrators

Honorary Fellow

American Hospital Association

Life Member

American Public Health Association

Fellow

WEEKS:

Would you like to begin the interview by talking about your first job in the hospital or health field?

WILLIAMSON:

When I was about 17 I worked Saturdays and after school in the pharmacy of a hospital, the Methodist Hospital of Southern California in Los Angeles. I got really interested in hospitals. I began to think about it as a career at a time when it was not visualized as a career to manage a hospital. People, through a series of circumstances, fell into it. Physicians became administrators, ministers became attached to hospitals and become administrators. Hospitals turned to somebody they thought had a social conscience, you know. Many, many nurses moved from supervisor to superintendent of nursing then into hospital administration. The field was made up of such people, not with many of them having intended a career in the field.

I thought it would be a smart thing to write to leaders in the field whose names I had read in the journals at the time. I wrote, as I remember, to five of them: Dr. Benjamin Black, in Alameda County, California who probably was

considered the leader in the United States in hospital administration at the time; Harvey Agnew in Canada, a physician; Malcolm MacEachern; and a couple of others I can't remember right now. The letters I got back from each of them indicated they couldn't suggest a formal approach for becoming an administrator. They didn't think there was such a thing was the tenor of their letters. As a matter of fact, they made it pretty clear that the only way to become an administrator was to know what you know as a physician and then have skills of administration--then you became an administrator. That would be their pattern.

The only one I got an answer from with any vision of the future at all was Malcolm MacEachern. He said there weren't any formal courses yet. He said, "I suggest you take these topics in school." He laid out a course: some hygiene, some physics, some economics, administration, some of the health sciences, and so on. So I set out to try to get a handle on some of these subjects.

Then it seemed obvious, if I could talk the hospital into allowing me to move around in various capacities, various jobs in the hospital, I might learn something. So I did. I went from pharmacy into working in the operating room for a period, then working as an assistant to the purchasing agent, working in medical records for a while, and then into administration. I started into school and I worked nights. I was in charge of admitting. Going to school in the daytime and working at night, I became the night admitting officer, and handled accounts receivable. From this experience I learned a lot about hospitals not from the textbook but from a very practical standpoint. I think anyone would be fortunate to have that opportunity today.

I also learned a lot about hospital people. I learned a lot about the

philosophy of the hospitals. I learned to have an appreciation for the importance of all the people working in the hospital. That terrible term, the so-called "lower echelons," stands for people who are very important to the comfort of the patients. There is a great discomfort in having no clean linen--that linen often taken as a matter of course. I had a great appreciation for the people who produce that service and all the other things that have to function. Everyone of them is important. Of course, I had a great admiration for nurses and nursing. There are two things that are necessary to make up a hospital: a good physician and a good nurse. At that time really all there was to medical care was what a physician had in his head and what he could put in his little black bag. That, accompanied by the skills of nursing, was all there was.

The hospitals were full of pneumonias, particularly in aged people. Their only hope there was being nursed through it. There were no antibiotics. It was hard work for the nurses, bathing them, doing all sorts of things for them, trying to keep them comfortable. Sometimes nursing pulled them through.

The hospital was full of children as well as adults. Children with mastoiditis--nothing seemed to really control the pain. You could hear them all night long.

Any infection, the slightest infection, you know, especially if it were a blood stream infection, became a great source of concern to physicians because of the limitation of what they could do about it. It was very different from today's atmosphere. I think there was a relationship between physicians and nurses then in a patient care sense that doesn't exist today. The physician knew his limitations then. He realized the skills of nurses from which he

would get the benefit. So, there was a different sort of appreciation. Of course, they were quite content, in my words, to abuse nurses economically, that was all right, but they had an appreciation of them.

WEEKS:

After a while you left Methodist Hospital. . .

WILLIAMSON:

I went from Methodist Hospital to Good Samaritan, which was a big hospital. It was the elite hospital in southern California, the Episcopal church hospital. It had a fine medical staff. It was a pretty haughty sort of place, really. I convinced them that they had no appreciation of credits and collections or of a systematized way of requiring people to pay when they were admitted and to collect when they were discharged and after. I sold them on giving me the opportunity to set up a program. Of course, this would increase my own experience and also give me a chance to earn more money. It was very interesting.

I had an experience there that got me some notoriety. There was a bandit in the city who was robbing hospitals right and left. He was getting quite a lot of money because hospitals had a lot of cash around them. He came to Good Samaritan one night when I was in the cashier's cage. He appeared at the window and stuck his gun out at me. He had a note which said to give him all the money. Underneath in the cashier's cage was a bar that you could raise with your foot. It was on direct connection with the police department. Being a young fellow, you know, I thought there was no hazard in it, so I kept putting my foot under it and leaning back as I pulled the money drawer out.

He got angry and said, "Hurry up!"

I was taking out money one hand at a time from the drawer, hoping the

thing would ring. Eventually I got as far as my foot would lift it, and it rang. The bandit got in a panic and I dropped behind the counter. People saw him, then the police came and caught him. That was an important event because I got a reward from that sufficient to enable me to buy an engagement ring. So it was not only notorious, but it also was a happy event, as it turned out. Of course, I was a damned fool because I could have been shot, you know.

I was at Good Samaritan for a while when Methodist Hospital wanted me to go back there as sort of an assistant business manager and assistant to the superintendent. So I went back there for a time. That period was important in my career as it turned out. I saw that changes were taking place in the patterns of patient care, and that the costs were going up. As the people would come into the admitting office, I would hear their stories. The cost of care was creeping up beyond the ability of most people, a great majority of the people, to pay.

I got an idea with another young guy that was active in the hospital at the time that we would go to some of the big companies around Los Angeles and sell them on paying us to administer their health programs. Many of the companies out there like Firestone Tire had a health plan for their employees, so did the May Company of the department store chain. We would administer their plan for them and use volume purchasing to get contracts with hospitals and physicians to take care of their employees. It sounded just dandy and the companies were interested, so we wrote the plan up and submitted it to the state authority. They sent it on to the insurance commission. We wanted to get a license. They said it was insurance and we had to put up \$100,000 to get insured. We had no such money, and it wasn't forthcoming, so we gave up that idea.

Another thing that was important at that time, as I think about it now, was that hospitals in that area had to operate from the money they received from patients. There literally was no other source of funds. If there was no money to pay, the county hospital system was where you shipped those patients. Hospitals had to be administered very thoughtfully because they had no funds other than those collected from patients. No endowments, no help. It was a high risk business.

I hear now about the funk that administrators are in today because the money they get today is insufficient. However, in many ways they don't begin to have the concerns the administrators had back then. As a matter of fact, today they have a constant flow of money, and it is assured to them in a way that never existed in the past. Then they had to worry about every buck. Now they don't, really. I think they have gotten spoiled and careless and extravagant in many, many ways.

Another thing in the past, in contrast to today, was, I remember, physicians would come in and talk to me about a patient they had that they wanted to get into the hospital. They would say this is what's wrong, and they were going to be in the hospital so long for surgery or whatever. The physician would ask what it would cost for the hospital. We would try to figure that out and tell the physician the estimated cost. The physician would say there is only a certain amount of money, would tell where the patient was employed and so on. Physicians had to know about their patients, their economic backgrounds. Then the physician would say that he would tell the patient to pay the hospital bill first and then he would work out with the patient how to pay him. That was a common pattern.

Physicians had a part in administration thereby. They had a part in the

economics of the hospital. They had to know what we were doing. Of course, physicians also had some well-to-do patients and the rest, as they do today.

I have said I think there was a difference between hospital administration then and now, and I think there is a great difference in physicians then and now. Physicians have gotten greedy. They are not content with having a very legitimate and reasonable flow of money from insurance payments, from Blue Shield, the government and whatever. They want money. They now have come to a frightful habit of just accepting that insurance money as though it were sort of a down payment. Not only that, many of them want to sock you for all they can get out of you. I think they are greedy and spoiled. In my mind they are going to have their comeuppance one of these days. Very unfortunately too, for the public in many ways.

WEEKS:

You were early in the Blue Cross movement in California, weren't you?

WILLIAMSON:

About the time my friend and I were trying to set up our plan to manage health plans for big California employers, Blue Cross became known and they talked about setting up a Blue Cross plan in California. I was interested in health affairs in the city at this time. I represented hospitals on the health committee of the Junior Chamber of Commerce. There were a couple of young docs and a couple of young, aspiring administrative fellows in the group. We had a lot of fun and did some things too. We stirred up things to beat the band, you know, so out of it I became interested in government, both state and local government. Through this I got to know the governmental process. So I got kind of recognized for knowing something in this area. When the hospitals decided to set up a Blue Cross plan, they looked around for

a fellow to run it. They got a physician who used to run a hospital in Los Angeles. He had some administrative experience; they thought he would be dandy. His idea was that if he signed up 40,000 people that would be neat. (I think they got the water and power company in Los Angeles through some circumstance.) He thought if he could run that tidy little group it would pay him a semiretirement income and would be dandy. He had no vision, he had no sense of what was happening to patients and their inability. They needed help. So they got rid of him and went from the frying pan into the fire.

They went to a fellow whose name was well-known. He was the fellow who brought the Olympic Games to the United States, to California, to Los Angeles. He sold the community on building the Los Angeles Coliseum to house that affair. He was known as Randolph Hearst's hatchetman. He knew everything and everybody and he knew lots of very important people, but he was no administrator and that became clear. He was a most likeable man.

I was appointed as his deputy. I met a lot of important people through him because he knew them well. At that early stage he even had a chance to bring Blue Cross and Blue Shield together into one organization, but he muffed it. He could have done it because of his prestige.

The experience was important to me because I went to every hospital in southern California and met with their boards to sell them on the idea of joining Blue Cross. It was a great experience and it was a great test of whether I could put across ideas. These boards had to be willing to put up \$8.00 a bed into a kitty and sign a contract, furthermore, that would make them responsible for guaranteeing the services. Blue Cross was nothing but an idea with some hope and a lot of risk for hospitals.

Thus I was involved in the development and organization of one of the

first Blue Cross Plans. I spent a few years there. Then the state hospital association was in difficulty; the guy who was running it left. This was the time Earl Warren was about to be governor of California. He committed himself to organized labor to produce a state-wide compulsory health plan. This is the Republican presidential candidate Earl Warren I am talking about. I went to the state hospital association to be executive director of it. By then I had a good bit of political experience with some good contacts. We joined in a force--medicine, dentistry, hospitals--to defeat Earl Warren's plan. So I left Blue Cross and went to the state hospital association where I stayed for period of a few years. At the same time I was director of the Association of Western Hospitals which was an organization representing all the hospitals in eleven states and the Hawaiian Islands. I spent a lot of time in Sacramento in politics.

At about that time Jim Hamilton was active in AHA. He succeeded in upsetting the applecart there. He got the credit and all the blame. AHA was kind of a dead organization. Jim turned it upside down. He got rid of the fine, old physician that had a very comfortable job doing nothing, had no vision about the future.

WEEKS:

Dr. Bert Caldwell?

WILLIAMSON:

Yes. Jim got rid of him and got George Bugbee to leave City Hospital in Cleveland and take over AHA. George wanted someone who knew the hospital field to be his right hand. I went to Chicago to interview for the job; it sounded interesting. I liked him and he liked me, so I joined AHA.

WEEKS:

Would this be a good place to describe what you found at AHA? I have a feeling that the younger people of the day think AHA at that time was a big, strong organization.

WILLIAMSON:

When I went to Chicago to join the AHA, the office was on Division Street, in a building that had been the Boys' Latin School. The showplace of the building was the Bacon Library. It was in the former gymnasium. Half way up the wall was the track that the kids from the Latin School used to run around. Incidentally Asa Bacon was one of the leaders in the field, who had been administrator of Presbyterian Hospital in Chicago. He also was treasurer of AHA for many years. In honor of him they called it the Asa Bacon Library. Then they cut that track out to make one high-ceilinged lovely room. At that time we used to say they cut the fat out of the Bacon when they took the track out.

There was a staff of thirteen people. The thirteen people turned out to be a lucky number, I think. When George Bugbee came into AHA, there was nothing there, really. There was no organized hospital field. There were a few spots of organization. Generally, it was unorganized and disconnected. The association had no platform, they had no program, they didn't know where they were going, they didn't know what to do when they got there. There was nothing. A group of people with lots of good will was all it amounted to. So it was an experience with a whole of a lot of work but tremendous pleasure also.

With George we used to go and sit together, about three or four of us, and think and talk. There were very limited funds and the task was to spend them to accomplish the most good. What do we do to increase those funds so we can

do better? We developed a set of guiding principles for AHA. I think today they need a set of guiding principles for the new era that, to me, they obviously don't have.

One thing came out of that talk and thought and experience with the field. We organized the field. That meant developing state hospital associations all over the U.S. That was one of my first jobs. I think there were thirty-six or thirty-eight state hospital associations I had a hand in organizing. I met with their committees, wrote their bylaws with them, met with the hospital leaders, sold them on doing this and that, and so on. It was a lot of fun but I was away traveling much of the time. Then from that came the hospital councils. Some of them we had a hand in also.

The strongest state association was probably in Ohio. In Cleveland the hospital council was the best known. It was best known because of the guy that ran it, a fellow by the name of Clark. He was a very unusual man and very tough to get along with. If he liked you, things were great. If he didn't, you were in trouble. He was a great contributor to the field. I think he set out some important precepts which the hospital field would have been well advised to follow. For example, with the enlightened viewpoint he got the trustees of hospitals which formed the board of his corporation to set up a trust fund for all the depreciation monies paid to hospitals as part of their reimbursement. Money could not be spent from the trust fund for construction or renovation or remodeling except with the approval of the hospitals jointly. Just think where could we be today if that kind of viewpoint had been followed throughout the country!

We gradually got the hospital field in the country organized, and gradually began to add staff. At that time George said we had to have our

five foot shelf composed of textbooks, or, if you will, primers on how to operate every aspect of a hospital. (I suppose George was influenced by Dr. Eliot's Five Foot Shelf of all the great books one should read to be truly educated--the Harvard Classics. The idea was very popular then.) Because of George's idea I got involved in setting up educational seminars and in developing manuals. We got the best laundry people together, for example, to learn every phase of how you operate a laundry and they wrote a text on operating a hospital laundry. We also wrote a textbook, a manual, on hospital housekeeping. That housekeeping manual was interesting because we got a fellow from the Fleischman Yeast Company to come and talk to us about sterility in the areas where we needed it. He went around and looked in some operating rooms. He said that if the areas where they made yeast were as dirty as those operating rooms they would be in trouble. I also got the chief housekeeper of Marshall Field's to talk with us. If you ever want an experience go into Marshall Field's when they open in the morning. It is something to behold. The floors shine spotlessly. There is not a fingerprint on the glass cases. As I said, it is something to behold. I got this man to go into some hospitals. He said, "If Marshall Field's was that dirty, we wouldn't have any customers."

That gave us a basic line. We wrote those manuals and other people worked on manuals on nursing and other subjects. We gradually developed the five foot shelf. This was very important for they affected the economy of the hospital. For instance, the purchasing manual written by purchasing agents who really knew their business led to standardization of supplies for hospitals. One example was meeting with the Bureau of Standards and working out standards with manufacturers of hypodermic needles and syringes so that

the number of needles needed was a limited number of sizes, not 300 as before. We went about the standardization process with a set of objectives that weren't there before. Fortunately this standardization helped us keep up as medical care changed and evolved. Hospital operation changed, patient care changed, costs changed. I think it was very fortunate for the public that hospitals were somewhat ready for those changes.

About that time I think I was instrumental--at least I was given credit for it--in doing two things that were real significant for hospitals. For one, I felt we needed a voice for hospitals in public forums all the time. I don't mean big, organized forums, either, but little forums that go on all the time in behalf of women. Women's auxiliaries we thought might do that. George Bugbee agreed, so we tried that.

We knew of a few women's groups around the country, but there weren't many. Some of these groups, naturally because of the age in the hospital field, were up in New England. After I found a half a dozen ladies from women's guilds, I went up to New England and met with them in Boston. There were a couple of women from other places up there also. I spent the day with them; it was a great experience.

I began by saying, "Would each one of you say what you do in your guild, your women's group?"

Many of these women...their mother's had done it, their grandmothers had done it. Membership was sort of handed down in the family. So the ladies began, each telling her story. I was making notes to see if we could develop something out of this. Finally it became the turn of one dear old soul, from one of the great old hospitals there in Boston.

She said, "The ladies mentioned nearly everything we do except one thing.

We give very nice teas to outgoing administrators."

I used to tell administrators that story and say, "You should be comforted by that thought because at least you would go out on fine china."

After that meeting other women, including Dr. Morris Fishbein's wife, got involved. One was Viola Pinanski of Boston. She became nationally known because she was the first woman to ever nominate a President of the United States. She nominated Eisenhower, gave a nominating speech. She was very much interested in hospitals in Boston and then in the United States. She became a party of this group. She was a member of this committee along with Mrs. Fishbein and a woman from Chattanooga, Mrs. Garrison Elder, to bring in the South, and a woman from Canada. Out of this group came the nationwide women's auxiliary movement. Somebody said that what we need is a group of women big enough so that the Congress of the United States will hear them even if they are not listening. The movement has grown to two million women. It was thought they would become a loud, clear voice in behalf of hospitals. They never have, unfortunately, I guess for a number of reasons but they do a lot of work for hospitals and patients.

The other thing I did involved the trustees of hospitals. It became clear that hospitals needed an organized community force. The administrators couldn't do it, and still can't. We had to find good trustees and use them as missionaries to get influence. I drew up a prospectus for a journal, Trustee, which was supposed to be a voice through which trustees could communicate with one another. Also there were other parts of this trustee program. It was then that we learned how frightened administrators were of their trustees. We wanted to mail stuff to trustees, to chairmen of the boards. The first thing we wanted to do was to mail a letter, which I'll tell you about in a minute,

to the chairman of every hospital board in America to uplift them, if you will. The administrators set a pattern and said, "If you send anything to our board chairman, you send it to me and I'll send it to him." This was without saying, "If I like it, I'll send it to him."

As a matter of fact, the administrators insisted on the journal Trustee even being sent to the administrator's office and they would send them on. I imagine quite a few still do that. In a way, of course, it is understandable. The administrator didn't want the chairman of the board to get something he didn't know about. However, it's worse than that, it's more profound than that.

I was going to tell you more about the uplift letter. I went to Charles Kettering, Choo Choo Charlie, you know, of General Motors fame and the Kettering Institute and all. He was interested in health. He had invented quite a few things in the health field. I went to see him to see if he would write a letter, a personal letter, to the chairman of every hospital board in America. After lots of talk back and forth he said he would.

I said, "We want it on your stationery. We will buy or pay for the stationery and postage and everything."

He said, "You draft something and I'll see what I don't like about it."

So I drafted something and sent it to him. We concocted a letter, a personal letter, on his stationery, which he signed. We sent one to the chairman of every hospital board in America. The results were just unbelievable. Talk about an experience! Kettering got personal letters back from the head of practically every big business corporation in the country. A personal letter addressed, "Dear Charlie." Letters from writers saying they had no idea he was interested in hospitals, that they were on a hospital

board, that they liked this idea and so on.

The Kettering letter had said that we have got to get a vehicle to come together to do something about the hospital field to protect it, to see big, to give it its rightful place in American society.

Then, just at this time, he up and died.

The program, that part of it, fell apart. I think the hierarchy was kind of glad to see it fall apart. The Trustee journal was all right. After all, we had a staff...you could control what went into it. The journal had a trustee committee and did some things but it never came to what I thought its mission should be. The journal became largely a staff concocted thing. It was pretty darned good and came to be read by trustees all over the country. Not by just the chairman but by a lot of the other trustees. They began to quote it and talk about it, so it has had an important effect. Out of this trustee experience came a big question mark in my mind. This was whether hospitals could have a strong trustee program. They didn't want it, they were a little fearful of it. I am not saying there isn't some good reason for fear. We had plenty of examples of horror stories about trustees, big shots who had retired and had nothing to do. They would practically take over the hospital if you let them. To the administrators living with those guys, it was a horror story. There was a lot of that.

So this fear wasn't without reason, but I thought then, and I think now, that the only hope of the voluntary hospital field is a strong trustee community voice and nationwide power structure, if you will. Left to paid administrators the voluntary hospital will one day disappear from the scene. Today I think it's clearer than ever. I think today it is also clear that it never will come about.

During this stage when the hospital field was obviously developing, several things happened: the Hill-Burton program; the Blue Cross prepayment; and the administrators began to sense the importance of a hospital organization to their own stature. Those three things.

Take the last of those first. I think the stature of hospital administrators changed, hospitals changed. The hospital field changed and its organized state had much to do with changing administrators. I don't think there are many around now that know that or had any sense of the change at the time. Some may sense it now more than before it became a pattern. Leaders began to emerge and come up through the structure of AHA. They would work on committees, then they would elevate to councils, then they would come on the coordinating council which was a semiboard, then they would get on the board. We wrote this pattern all out. This was one of our precepts in the days when we were planning how to develop people in order to develop an organization. So people were developed, this brought new strengths--and it brought quite a few weaknesses too.

Weaknesses showed up. With quite a number of administrators we were developing it was indicated that they were in the hands, in the throes, of capricious boards and medical staffs. I could tick off the past presidents of AHA who suffered from their service in behalf of all hospitals. Some were double-crossed, I think, by their boards. At that time, the way the development process was structured an AHA president had to take off a lot of time from his hospital. Over a three year period they took a lot of time when they were president elect, when they were president, and when they were past president. It was a nutty thing to expect hospitals to put up with, really, but it was done. I can trace the names of those who lost their jobs

afterwards. I remember each time when the day came for being sworn in. They would come there that day and bring the chairman of their board, the chairman of their medical staff, and their families. It was a big thing in their lives. The hospital had great pride in them and was honored. They all talked about it, and their hospital became known nationwide through their administrator as AHA president.

But there were more things to follow. The pattern of things as I listened to these fellows talk about it, and you know them very well, was: As an official of AHA they would be away from the hospital. They would leave a guy in charge. Things would happen.

Someone would say, "Where is Bill?" (The administrator.)

The guy left in charge would say, "He is away."

Then they would talk with the chairman of the board or another board member.

The chairman or other board member would say, "Why is it that every time we want that guy, every time we have a problem, he is never ever here? What the hell are we paying him for."

So all the objectives and so on went aglimmer. Not unreasonably so, except the board should have been honest enough to have known that and should have said to him, "If it means you are going to take all that time off, no, don't take the office in AHA."

There were quite a few good people in the field that were candidates for president of AHA that didn't take it because they couldn't take it, unfortunately because they found out their board said, "Hell, no! If we are paying you all this money, you can't be away all the time. We can't justify this, either the board or the community. It is a waste of money."

WEEKS:

Someone has said that is the reason O.G. Pratt was never president of AHA.

WILLIAMSON:

That's right. I could name quite a number of very fine people who were lost as it turned out. Quite a number.

The people who entered the AHA process grew and developed and became big in the hospital field. Some of them move to bigger and better jobs as a consequence. Their lives were greatly changed by that period. They made speeches all the time, met with groups, went to Washington, everywhere, you know. So the hospital field became known and developed through these people. They made a big contribution; many of them made great sacrifices.

The Hill-Burton Act was a big thing. Hill-Burton is under the gun now, you know. Hospitals are criticizing it all over the place. I read a letter in the New York Times recently from a man who should have known better, but exhibited an enormous lack of information and knowledge of the past because he criticized the federal government for its participation. He mentioned Hill-Burton. He mentioned Medicare and Medicaid, and so on. Without those things there would be no hospital field today, it would be a government program--if you really knew what went on. Hill-Burton came at a time when we had just had World War II. There had not been a dollar invested in the hospital field for some years before the war, during the depression, and the war. It was a period of great neglect of the hospital plant of America and neglect of all the areas that had no hospitals.

Also, a new kind of physician came out of the war, very new. In fact, he came out discarding the little black bag. He was a guy who was used to having organized means at his disposal. He was trained differently, too. So, a new

kind of doc had come back and the American people were hearing about the great advances in "modern medicine." Yet in thousands, I mean thousands, of communities all over America there was absolutely no means for modern medical care. You can imagine the pressures that came out of that: There are things there that will benefit us but we can't have them. Really from George Bugbee's leadership the hospital field saw that and realized something had to be done about this or it was going to burst the bounds some day. For the physicians pouring out of the armed services there was "modern medicine" and no place to practice it. There had to be means by which the health needs of the American public would be met, and that meant more hospitals.

So the Hill-Burton program came about which was an enormous story in itself. It was named after Senator Hill of Alabama and Senator Burton of Ohio. Burton really had nothing to do with the bill. Burton had just been appointed to the U.S. Supreme Court and left for that position just at that time. Senator Robert Taft was the guy that really was much involved in many of the big, big, social decisions in Hill-Burton. Taft was the guy that thought them out and visualized them. He was asked at one point why it shouldn't be the Hill-Taft bill or the Taft-Hill bill. He laughed and said, "Oh, no. If it will serve its purpose I am content to have it as it is."

(As an aside: I think that Senator Taft was one of the greatest men ever in the U.S. Senate. He was one of the most misunderstood and maligned. As to being an extreme conservative and all the the rest, that's poppycock. He saw the need for Hill-Burton, and he saw the right road for government in a way people didn't. I don't mean it in a slavish sense like a lot of stuff that happened since. He saw it in education. I remember a speech he gave on the role of the federal government in the education of children in America that

most Republicans had no idea about. He was anything but that extreme conservative. You know he was so maligned about the Taft-Hartley Act. But it was known he could go into plants, big factories, and talk with working men. They would end up hurrahing him. You know, this kind of thing. It is funny how a man could be so misunderstood. He didn't have the right kind of press, I guess.)

Anyway, the Hill-Burton program was terribly, terribly important to the hospital field. There isn't anybody who can see twenty-five or thirty years ahead and be sure about how the words in there will be interpreted. There were words in there that said that the hospitals would have to give within their ability some free care. That was a very casual thing. It was to give a kind of assurance. Now we have the day when they are interpreting those words in a hard way in Congress. The hospitals are being pinned down with lots of problems; they are damning Hill-Burton, but, if they only knew it, Hill-Burton is one reason we still have voluntary hospitals.

Couple this with Blue Cross. I mentioned earlier Rufus Rorem came out of the Rosenwald Fund with his hunk of money to do something with it worthwhile in the health field. About as broad as that. He saw need for what was later Blue Cross. He had an economics background, as you know. He was smart as could be. He began work at AHA and said that we ought to develop this baby (prepayment). There was space for him in the AHA building on Division Street in Chicago. Hospitals began to see the prepayment plans supported by other hospitals. They became committed to them. I spoke earlier about my role in southern California. The hospitals signed contracts with Blue Cross saying we support them. They backed them financially, they backed them in every way as the chosen vehicle. Then, of course, Blue Cross began to take off.

It is interesting and it is important to realize that Blue Cross took off and became big not because of management but because of labor. If it hadn't been for organized labor, it wouldn't have come about. It took place, the first big input of Blue Cross, its big change was in Michigan when organized labor kind of forced it down the throats of management. So this whole voluntary prepayment effort that is supposed to be the savior against government, you know, came about in spite of management, in its origin. We shouldn't forget that about labor and there are other things that labor did over the years I'll mention in a while. I am not gungho about labor except it's wrong not to recognize their goodness. So management got enlightened and prepayment became a joint thing and all was well.

Blue Cross recognized the fact that I mentioned earlier: Medical care and hospital care had arrived at a point cost-wise where it was beyond the ability of practically anybody. In those days we knew two things. We knew that 10 out of 100 people would be hospitalized in any year and they would remain in the hospital 10 days on the average. That is all we really knew. Then you could couple this with the third thing: hospitalization cost this amount of dollars this week. Three things were the "knowns" that could guide this whole movement, the Blue Cross idea. It took a lot of guts and a lot of high risks, and vision and faith to bring it about.

Anyhow, the AHA leadership had the wisdom to recognize Hill-Burton and its needs. They recognized Blue Cross and its needs, the public's needs and the hospital's needs, too. The hospitals needed the flow of money. There was some self-interest, and there was a lot of public interest. The AHA put its heart and soul into the public and hospital needs as commitments. It led the field in its commitment to Hill-Burton, which was necessary. When you think

about those things today (Blue Cross and Hill-Burton), I believe I could document that without them we wouldn't be talking about national health insurance, we would have had it long ago.

The AHA recognized that the pressure for health care had to be met in those two ways. To the undying credit of the AHA and the hospital field, when they talk today about leadership in the field, I don't know a single, solitary thing that even approaches that kind of leadership and thought that went into the development of the AHA and Blue Cross and Hill-Burton. In fact, in my mind, that kind of leadership is missing today. There is a lack of that farsightedness. Hospitals are too protective and display self-interest in a lot of ways.

Harry Truman was President at that time. He thought that national health insurance would be a good thing. I think if Harry Truman had had television, we would have had national health insurance. If we hadn't had Hill-Burton and Blue Cross, with or without television, Harry Truman would have had national health insurance. And it wouldn't have been the kind they are talking about now, it would have been a controlled, government program, without any doubt, because that was as much as was known. So, Blue Cross, Hill-Burton, and national health insurance were all basic to the field.

George Bugbee had been looking around for new quarters for some time. AHA had outgrown its old place. They were renting additional space besides the Division Street building, getting space here and there. Then a good possibility came along. I was in charge of a seminar at the Choir College in Princeton. It was a beautiful campus, a lovely quadrangle. We had a group of about forty people there. The seminar was on public relations. It was interesting, it was one of the early seminars. There was something about it;

I don't know why but it was not forgotten, even twenty years later. I'd meet people later who would say, "Kenny, do you remember Princeton?" They were alumni of that seminar. It had a message or something that made it remembered. Several nuns attended who became leaders in the field. There were others who became leaders also.

We were enamored with Westminster Choir College. George Bugbee went and looked at it. Afterwards there were other meetings there. Then they had a chance to buy Choir College at a very good price and settle AHA there, moving out of Chicago to Princeton. They were working out relationships with Princeton University which would have been very interesting. Professor Harlow Childs was there. He was interested in government and in health and other things. The move didn't come about. They got frightened, I think. They wondered about leaving Chicago. Chicago was the headquarters for health things. The AMA was there. For some reason you had to be near the AMA, God knows why. Then there was the legitimate question of transportation. There was the ease about Chicago, it was the center of things, rail and air. Princeton was hard to get to, you know, you had to have three transfers and so on. Anyway, they abandoned the idea. That fell through about the time Ed Crosby came on the scene.

I might as well throw in an anecdote about Rufus Rorem from that period. I remember an experience he told me about one night. He was acting dean of the school of business administration at the University of Chicago. That bright young man, Robert Maynard Hutchins, was Chancellor. Rufus had been acting dean for a year or two and felt that they ought to appoint him dean. So he got an appointment with Hutchins and went in to see him.

He said to Hutchins, "I think, Mr. Hutchins, that if I am good enough to

run this school, I ought to be appointed dean. I think I should be appointed, or I am going to leave."

Hutchins said, "Well, Rufus, I am very, very sorry because I have somebody in mind, so I guess you will have to leave."

Rufus said that was one of the lessons of his life. He said, "Don't cut yourself off until you know where you stand, where you are going." So he was left high and dry.

WEEKS:

Someone has said that during the thirties and forties several persons were beginning to stand out as leaders in the field.

WILLIAMSON:

Leaders began to develop during this period which you know were important to the field as you look back. The field grew. It grew in money and influence and power and recognition and in many other ways. Of course, Blue Cross became a salesman for hospitals, almost a door-to-door salesman, mentioning hospitals all the time until Blue Cross and hospital care became imbedded in the public mind. This was important for the future because hospitals looked to Blue Cross for financial support. Now you hear Blue Cross and hospitals jointly talking about retrenching, like they are talking about reducing people's use of hospitals. After they spent twenty-five years educating them to use hospitals, now they want, all of a sudden, to define a set of reasons why they shouldn't use the hospital. It is a tough proposition, you know. I think a lot of new, modern, misguided notions connected with this thought may end up doing a lot of harm.

Anyway, it came to a point without doubt where there was a lot of talk about socialized medicine because Truman failed in his attempt for health

insurance.

About this time there was a group made up of the leaders of the drug and chemical industry. They had been backing an endeavor to fight socialized medicine. They had a guy in Chicago who was, I think, a German refugee Ph.D. He was wild-eyed about socialized medicine. He could talk about it like nobody else. The group put up some money and he began to embarrass the devil out of them by what he did. The climax was a letter he circulated to physicians in New York City addressed to "Dear Christian physician." Many of the physicians were Jewish. His actions were hurting the drug industry. They had a lot of money in the group and they wanted to do some good with it, something to their credit. They talked with C.J. Foley who was well known in the field and he referred them to me. They talked with me to see if I could give them some advice.

I met with them a couple of times and talked about the health field and the things they could do. I put it in these terms: "You really ought to get involved in the social and economic aspects of the health care."

They decided to set up a kitty and a board and an organization. They called it The Health Information Foundation. They asked me to come and be the executive vice president, really to run it, under a public figure. They wanted somebody whose name was known in business, in finance, in government--in the big circles. They got Admiral Blandy who had retired from the navy. He was well known. He was the guy who handled the atomic bomb tests when nobody knew anything about the atomic bomb really. Truman looked around, and sought the advice of all the armed services to find the smartest man in the armed services. Blandy was the one, which is no small stuff I might say. So the Foundation got Blandy as president. He was a very

interesting man and a wonderful fellow, but he had not had a nickel's worth of experience in civilian and voluntary life.

I remember, as an example, when we were in a meeting with a group of health leaders I had brought together. It seemed simple there was something they ought to do at the conclusion. I was talking, you know, but they would have to form an opinion and the willingness to follow through. They weren't getting to that point. Blandy was getting redder and red. Finally he got up and left.

He came back in a while. Later at lunch he said to me, "Kenny, God damn it, I couldn't stand it any longer. You know I was in a position in the navy where I had (I think he said) two hundred thousand or more men. When I said 'You jump,' you jump. You know, you made up your mind what to do, and you do it. I can't understand this thing here. It is so obvious what should be done."

So he had a difficult time. But he admitted it, which was good. He was learning by it but it took a lot of patience. If you see the process through a Blandy's eyes, you can see that the so-called free, democratic process is a bumbling affair. Hopefully, you have to believe in the outcome.

So he was president of the Foundation and through his energies we got an advisory committee headed by Herbert Hoover. Herbert Hoover, Lee Bubridge of California Tech., Donald Douglas of Douglas Aircraft, a class mate at the Naval Academy of Blandy's, Admiral Lewis Strauss, Eisenhower's Secretary of Commerce, and so on, I can't remember all of them. He kept that advisory committee setup and used them to promote the acceptance of the Foundation and what we trying to do. They committed their names to it.

Herbie (Herbert Hoover) was a very interesting guy. The entree his name

could give us, you know, was just fantastic. We heard the advisory committee and then decided where to move this thing. We set a pattern of what and how to do it. One of them was to subsidize research, investigations into the health field. We had a thesis that community health facilities are as good as the communities want them to be, by and large. If the communities want them to be better they will be better. If they don't want them to be better, if they don't care enough, they won't be very good.

We went to some universities (for research projects) where they had sociologists and anthropologists doing research. One of them was at a university in Alabama. A textbook came out on that project. It was interesting how you move in a typical, old Southern community to do things, working with the power structure of the community. We did a number of studies through a number of universities, but we needed somebody to head it up. We tried a couple of people that were fiascos. Then I heard about Odin Anderson, and learned about him. I got in touch with him on the phone and talked to him. Then we got him to come down to New York. I interviewed him, then had Admiral Blandy interview him. We liked him very much. He became our research director.

At the Foundation Odin had money to do research. He had the contacts and he became a big figure, as you know. I thought that was a great accomplishment to get Odin Anderson to join us. I have always thought getting away from the usual public health approaches, which Odin did, was very important.

We were able to get a number of research projects going which Odin watched. Then we said we have got to communicate the results of these studies to the public. We tried several published communications but we thought we

ought to get into television and radio. We went to the television people and to the public service people and the radio people and got them to agree that they would carry skits. We took situations involving the health field and got some very good writers to write skits about them. Then we got very well-known actors and actresses to act in them. The skits were good enough to look at, they weren't canned stuff. The skits got tremendous play. Either at the beginning or the end there would be a statement about the motives of the Health Information Foundation and the drug and chemical industry. The industry loved that. It associated the industry with good works. It was in contrast to their past experience, and was believable. It led to their being quite good and substantial in their contributions to the Foundation and to their interest in it.

So we had this fundamental research going on and we had the television and radio publicity. Then about this time we undertook with Clyde Hill at the University of Chicago National Opinion Research Center the first nationwide evaluation of health since the one of the cost of medical care done many years before by a committee or commission headed by Ray Lyman Wilbur of Stanford University. Out of that cost of medical care study came a recommendation for national health insurance.

Odin and I had a lot of involvement working with the Opinion Research Center on the nationwide evaluation of health. A lot of recognition came to the Foundation for that study.

As I say, there was a lot going on. Every project had to be submitted to an advisory committee of the Foundation, the skits, everything. They wanted to know. The committee was a fine group. The chairman of the board of Johnson & Johnson, the chairman of Eli Lilly, Jack Searle, chairman of G.D.

Searle & Co. and other big names in the chemical and drug industry were on that committee. They were a very interesting and fine group of men. They never interfered, they never tried to load things. They cleared projects which they hoped would be good for the image of the industry. That was a reasonable approach, but some of the facts from the studies were very, very tough. Everything we said couldn't be commendatory to the system. I used to say that there is no sense in spending your money if that's all you want to do. You'd be kidding yourself. You'd spend a fortune kidding yourself. There is no chance of correcting the field and filling in the gaps--getting credit for goodness--unless you are willing to know what the gaps are. They were willing to know and went along.

There were a lot of fine experiences working with Admiral Blandy and a lot of difficult, difficult times working with him because he didn't understand how we did things. One thing I remember. I told him one great impediment to progress was the animosity between Blue Cross and the commercial insurance companies. I said that we have got somehow to get things into a common pattern for the public so we all benefit. I got some of the leaders in both of those fields--I mean top, top leaders--committed to come together every month for a year or so. We footed the bills for their hotels, for their meals, and for their transportation. They came together religiously. I mean the top, top guys in those fields. They thought together, they argued together. Out of those meetings we developed this into a set of minutes, all the time hoping to bring them together. They didn't want to be brought together. They really never did.

That kind of thing was fun. Blandy enjoyed meeting those people, but it took him a long time to sense that you have to do this kind of thing. You

know, how you move people voluntarily to do things. He used to say, "This is a great experience," when he got so he could stomach it. I enjoyed that experience with him.

We met a lot of interesting people and had an entree to Washington. I had had an entree to Washington with AHA during the days when Hill-Burton was being passed. I came down here to Washington a lot at that time. Then I had an interest in the governmental process way back at the state and local level, you know. So I met a lot of key figures down here and set up some participation in hearings and various things which was great for me personally.

Then Blandy, very sadly, died. I think I could have become president of the Health Information Foundation at that time. They had seen this public figure image, they had seen the value of that. Then they had seen what I could bring to it, and did bring to it, I think, in terms of knowledge of the field. I think they would have appointed me president, but I wrote them a letter and said...

George Bugbee had been talking to me and wanted me to go down to Washington and head up the AHA office there. The Washington Service Bureau, it was called. There was a lot to be done. He said he wanted somebody there that he felt comfortable with. It was so important because he'd know what I was doing, and know I was doing it. There wouldn't be a lot of nutty stuff, you know. So, I'd pretty well agreed that I was going to leave the Foundation (before Blandy died). So I wrote them, the board, a letter and said that I wanted to leave. Giving away money and running the Foundation were not up to my interests and energies. The Washington scene I thought would be better. The board was greatly disappointed. The chairman of the subcommittee appointed to pick somebody for Blandy's job said, "Kenny, we sure hate to see

you go from the drug and chemical field."

I hadn't really thought about it before, but once you are in that field and accepted, you are really in something, you know. I think, without a doubt, I had a life future cemented. I don't know whether knowing that before would have affected my decision or not. Afterwards I thought about it, I must tell you. Anyway, I said I was going to leave them. They had a meeting and they were very upset and so on. They began to talk with me about a successor. I talked to them about George Bugbee and said...

WEEKS:

Oh, did you? George was rather embarrassed about the turn of events.

WILLIAMSON:

Yes, I went to the AHA Washington office and he came to the Health Information Foundation. He felt a little as though he had moved in. I had already made the decision to go to Washington (before Blandy died). I wouldn't blame George for the situation. As I say, I recommended George to the Foundation to succeed Blandy, and I had called him to tell him that. As a matter of fact they had thought of George in the beginning way before they originally hired me.

So I told the Foundation, "You might find George Bugbee interested if you went after him."

The pressures at AHA were not good for George, not for his makeup. Alfred Lunt, his brother-in-law, was in New York so New York appealed to George. Also to do something, to be well paid, and have a more relaxed life was kind of fun. So, George, sure enough, was interested and he accepted. So he went there and I came here.

There was an interim there before he came and I said I would continue to

see the HIF place run. I would go up there two days a week then I would go to Washington for the rest of the week. When I went to New York I wrote memos for the board and followed through on things, so the place didn't fall apart. They were appreciative of that.

George went to the Foundation in New York City. We had a lot of things going. I think they had an impact. Out of it I learned a lot. It certainly was developmental to me in terms of people and experience. I had a taste of the Foundation field. I didn't much like it. One thing we did was publish a new magazine of the research going on in the health field. I forget now even what it was called. Odin, of course, was a big thing in this. We circulated that magazine. It became clear that all this research was going on in the hospital and health field and nobody really knew if anything was coming from it all. In fact, it wasn't. Even today there is a whale of a lot of research going on that's a waste of money literally, in terms of the public getting any benefit from it at all. We found that out. I thought the next step should be to find out how the research is being used or to instigate its use. Not just do more research, you know. Another thing I learned about research people: They'll spend all the money you give them, and they don't believe in deadlines. There are arguments in their favor but there are a lot against them. They waste an enormous amount of time frittering away because they are being paid all the time, and so on.

The other thing I confirmed at that time in my mind, because of all the contacts in the field, was the hospital field had come to the point where if anybody stops to think they call it research. I thought back to a lot of things that I knew had come out of the hospital field, and they came out because an administrator or someone sat and thought and said, "Let's try

this," and did some things. This is where the hospital association had a big role because they would talk about it, they'd bring it to a committee meeting, to a council meeting, to the board of AHA. The AHA would say to the country, "Do likewise." But that was too small a way to do it. Today--if anyone stops long enough to have an idea they have got to call it research. NIH is rampant on this, financing this kind of monkeyshine. There was a research guy in AHA a short time. He left but he had a lot to do with NIH. He made a prophetic statement at a meeting once. That is, he categorized much of research financed by NIH and being done there as "a drunk clinging to a lamp post, not for light but for support."

So I left the Foundation and returned to AHA. Ed Crosby took over from George Bugbee at AHA. I had hoped at that time, and I had reason to think, that at last I would be appointed to the top job at AHA. I had been down in Washington a while, I knew the field, knew everybody, knew all its history and background pretty well, you know. I was widely accepted. So I thought they might pick me as the director to succeed George. The guy who was chairman of the committee and president of AHA was one of my oldest, lifelong friends from California. With that I thought I had a good chance. For some reason, they had made up their minds that what they needed was a doctor. I think that maybe George felt this way too. Well, I disagreed with that. Let's say, strongly. Anyway, for whatever reason, Crosby was appointed and I remained at the Washington Service Bureau. When I wasn't appointed director of AHA, I thought a lot about leaving. It was at this point when I thought about my foolishness in leaving the Foundation because there I had had stature. I thought, on behalf of my family, I had lost out. But I pretty soon discarded that thought. I mean I was as interested in doing something down here at the

Washington Bureau as I was when I had first made my decision to leave the Foundation for the Washington job. I made my decision, so there! I can count my blessings but financially and every other way I'd have been better off as director of AHA, you know. Anyway, I set upon a new career down here in the hospital field.

George had been looking at buildings for the AHA offices, as I mentioned earlier. Ed Crosby established a relationship with Northwestern University to give him land on a long-term lease and AHA built its first building, its first headquarters at the present location at 840 North Lake Shore Drive in Chicago. When they moved in it gave the whole hospital field a great sense of pride.

One thing I often think about now is the week the building was to be opened, to be commemorated. Dr. Parkinson, of Parkinson's law and all the rest, was in Chicago at a meeting. They got him to come to the dedication to say a few words. He said a lot of words, but there is only one thing I remember. He looked around. He was on the first floor. At the end is a very lovely room. He said, "What's beyond there?"

They said, "Just some garden over a garage."

He said, "The first thing you should do is break a hole in that wall and put a tent out there because you never will get the kind of thinking and vision you need in this building. You'll get it in that tent out there. In here you will get fat and contented."

There is some truth in that, not altogether, but a lot of truth in that. It was two years later I learned that when Salk, the Salk vaccine guy, went to La Jolla and got set up there in that Taj Mahal, that palace for himself--the guy who went and did a study of this told me himself, did an analysis of his

operation, said it was a most elegant, dreamy sort of outlook.

The man who did the analysis said in his report to Dr. Salk, "One thing you have got to do, Dr. Salk, is get the hell out of this room. If you don't you will never have another worthwhile thought."

It's true. You know the guy's never really had another thought that amounted to much.

Anyway, the new AHA building opened for the hospital field. They had an enormous financial problem because the bids came in \$5 million more than the estimates. A lot of the blame was on the architect. Anyway, we had to go back and rally the hospital field. Everybody was asked to kick in some dough. Things began to develop there in Chicago and I developed a lot down here in Washington.

WEEKS:

Will you tell me a little bit about the structure of AHA?

WILLIAMSON:

I think it is worthwhile to talk about the AHA as it developed at that stage and about how it is now. This is just a personal thought. The AHA structure was committees, coordinating council, and board, and a lot of special committees, and the House of Delegates, an open forum for debate and discussion of issues. The Board's recommendations had to be debated there. They were smarter than the AMA in that the AHA bylaws provided that the House of Delegates could argue about it all and then turn it back, but it had to come back to the Board. They couldn't originate a different action with their quick thought. This has been one of the problems of AMA. They think on the floor, you know, and take actions that refute thoughtful recommendations of committees and all that. Anyway the AHA structure was as I said. The

membership had a voice, a strong voice, and at every meeting you had to think of who the people were in the field who might raise questions and argue. You had to be ready for it, which was good and healthy. It strengthened the Association.

One of those who questioned was Guy Clark from Cleveland. I mentioned him before. If it was anything he knew about, you could bet Guy Clark would get on the floor and force the Board, and George, and the rest of us to come out and justify openly, in front of God and everybody, everything we were going to do. The members thought things got too big for that, and they were a little leery of that, besides the process was time consuming. So they appointed a committee that came up with a regional setup. They established regional boards. There are seven of them as I remember. We talked about nine, but I think there are seven. They accomplished a lot. The idea was that the Board recommendations on the major controversies in front of the field would go to those nine regions. The chairman of the regional board was a member of the AHA board automatically. The regional group would discuss the issues and argue about them and then their recommendations would come to the AHA Board. That brought a lot of input and had many values. It had values for the people in the field, but it also lost a lot. It developed what I think are basic, basic weaknesses because there used to be in the field--and there are today--obvious, enormous values to dissent. I just happen to believe in individuality, which is often associated with dissent. You can organize to the point where you ruin dissent and you ruin individuality. I think that's what happened in the hospital hierarchy in AHA. It's so neat, so slick, so organized today. Things are talked out, so by the time they come to the Delegates meeting, you know, there is very little interest in the matter. At

meetings over the past few years I have talked about it with administrators who are part of the hierarchy. They say, "Yeah, it is really kind of pointless going to meetings because we are not going to do anything. It has all been done. There is really nothing to do but just let it out."

I think there is less interest. There is less controversy. I think as a result they have developed teams of trained seals. They don't need that. They need strong, strong advocacy, and strong, strong dissent and questioning. They need a democratic process to the hilt, and they haven't got it. They set about making sure that when they come to the House of Delegates meetings that they don't have any dissent. It's all slicked over.

As this thing was developing for several years I recommended that AHA have a national meeting in Washington to foster the political side of things, to get people in contact with their politicians, to talk to them about issues, to bring from every state a group of people, particularly trustees--not all staff people from the state associations. The people who were active in hospitals, bring them together in Washington. Have a meeting then turn them loose on their congressman. I had this idea about the Washington meeting and kept after it and kept after it. I remember a board meeting we had in Houston, Texas, the last time they went down there, the only time we went to Houston to the Astrodome, or whatever it's called, for the convention. We had the board meeting at that time and we had a chance to bring the idea up. The board finally voted for it. They said that they were going to split the meeting. They were going to have a convention with hoopla and all the exhibits and all. Then they were going to have a Washington meeting which would be the business meeting, the gut meeting. So that came about, which pleased me.

A great deal has come from that idea, a very great deal. A lot of things

happened. The hospital people know the legislators in a way they never did. It's stimulated a lot of contact, not just here in Washington but there has been followup. It goes on all the time. I think a lot of definite good comes from it. The hospital field, without a doubt, is a lot better known.

Along with the development of the regionalization idea in AHA was this growing prominence of the Washington office. There was a lot of pressure for AHA to "do more." Crosby talked to me about how we were going to do more. I talked with my staff and came up with the idea of having a regional representative in Washington for each district. We took the HEW districts as a pattern. We would have an individual who would work in Washington and would be the liaison between the hospitals in that district and its members of Congress and vice versa. The members of Congress would meet with the AHA representatives and learn their problems and service them in Washington, and so on. That plan of having regional representatives in the Washington office was adopted and we set about finding the staff. The people I wanted were not really hospital-oriented. I wanted Washington people who knew all about how you worked in Washington, who could tell them out there, could guide them, could help them with their problems. I thought that was the best way. We got six experienced Washington people and one hospital-experienced person. The last person was the least effective. Anyway those things have gone on and have been used to a fair extent.

WEEKS:

I don't think many people realize what the Washington office really does, and how it operates.

WILLIAMSON:

No, they don't. Anyway, there were reasons for the change. Out of all

this experience with AHA in those past years and down here I got to know a lot of fine people and a lot of, I think, kind of exceptional people, and some ordinary people. Some of the very ordinary people became presidents of AHA. I thought of it afterwards in terms of government, you know, the president and the whole government. If you take an organization the size of AHA which is a big example but miniscule in comparison (to the federal government), there are people who become president whose idea is to leave it alone, make sure it runs comfortably. They become known for no waves and no changes and nothing getting done. That has happened. Then there were those who wanted to change things. From this I learned a lesson that has been important down here. That is that you can't change a big, ongoing organization without total disruption. You agree on things last year say, and you get them in motion. You hire people and you spend money and you do all the work for the thing. You get involvement. Then you get a president this year. He looks things over and he says, "That is less important than this, and I want to do this."

You can't move that way. You become totally disorganized. First thing, you can't hire people. They look back and say, "What's my tenure in this place, for God's sake?" They are too unsure. You have to make guarantees.

So when people talk about the government stopping directions, it practically can't do it. With government you can do it more easily than you can with voluntary associations. It's going to be more heartless. In government you can just cut off the money, close your eyes, you know. You are too far removed. In the AHA you are not too far removed. So, this meant there were different kinds of presidents.

A number of people, since I have retired, have said to me, "You ought to write a book, Kenny."

I said, "I am. I am going to write a book called 'Presidents I Have Known.' But I won't. I think I have accepted as fact that everybody is as good as they are, so that's all there is to it.

The AHA began to change. They took on the corporate form of organization with the hired president running the show. They elected a person from the field to be chairman of the board, sitting on top. In many ways that was needed, because, as I told you earlier those elected guys had three years of total involvement. There were less and less men to do that. It was too much to expect of them. So, they changed this and reorganized it. I think there were some considerable improvements, but I think some things have been lost. I think that the paid executive officer, the president, became the sole voice of the hospital field of America, literally. I think that is a great mistake. I think that they lost an awful lot not hearing from active administrators working in the field.

I have really had a lot of experience down here in Washington. I have always felt, and I think it is more true now, that with Congress and committees and the administration the AHA needs to have people speaking for them who are on the firing line running the places, at least together with the paid president. They need individuals who can talk of those problems in terms of "my desk," and "my running it." I am not just talking about McMahon, it wouldn't matter who was in the job as president of AHA. To have that person presume that he can put over the kind of feeling and response that the guy on the firing line gives is wrong.

I had had a pattern and Crosby was always very supportive of it. Usually I or one of my top staff, depending on the function, but often myself, would accompany, before a congressional hearing or a top meeting, a member from the

field who was known to be outstanding for his ability in that particular area--most knowledgeable working with it. I went with him for continuity. I knew what had been said in the past, what we were saying now, and the interpretation of it. The interpretation is often essential. I think there are enormous values to having that person from the field. The situation is somewhat akin to the AMA appearing here and having a layman talk about some part of medical care. That is extreme but it's akin to it. He can't do it; they won't get the feeling.

There are often opportunities where a guy could say, "Well, what about in your hospital?" That has a lot more meaning than talking about the country as a whole. They sense this on the Hill, the Capitol. You can get lot in masses of figures.

Anyway, I think that was one change that was a great mistake, and they are paying for it. I think the paid staff meets the continuity but I think it has a role (acting with the people from the field). I think also in public forums people operating in the field are missing. I think having one paid voice (the president of AHA) is a mistake. It's too ego-building. It's not good for the field. There are a lot of bright people in the field. There always were and still are really bright people. They can tell you first-hand, not second-hand, I guess is what I am trying to say. You have got to have first-hand knowledge, not second-hand knowledge somebody told you or that you read in a book. After all, I have been a paid executive nearly all my life. I think I know the strengths of a paid executive, and I think I know the weaknesses. What I am saying is that there are great weaknesses and shortcomings, I believe.

There is another aspect. The hospital field, but the AHA in particular,

is in a great, great quandary today. It was always difficult but it is worse today because they expect to represent everyone. They represent the church hospitals, Catholic, Protestant, different Protestant denominations. They all have special, and in some areas, quite different, points of view. The Catholic Hospital Association and Catholic hospitals are totally against abortion. The Protestant hospital associations are quite for it under certain rules and circumstances. There are the nonprofit hospitals, community hospitals. Then there are the nonchurch community hospitals. There are proprietary hospitals and government hospitals. It has been a very tenuous situation, how to represent all those points of view and come out with a consolidated opinion or option of what to do. I think it has got to a point where it is much worse. I think the AHA, and the state associations to a great extent, has been forced into a position where they give inordinate emphasis to proprietary, for-profit hospitals and the government hospitals because they have large special problems. As a matter of fact, the proprietary hospital association is known in Washington as having the most effective voice in hospital affairs in America. This to me is sad. I am not depreciating the guy who represents them, I am depreciating the fact that the other side isn't that good. Mike Bromberg is their voice here. He has all that Hill background. He is very astute and sharp; he has effectiveness at hearings and at meetings. I must say it hurts me because I think it hurts the other part of the field, the not-for-profit side.

I wrote an article about this. It was published in Catholic Hospital Association journal. They asked me to write something for them, and I wrote the special identity of the nonprofit community hospital is being lost. The proprietary hospitals are involved in the American Hospital Association in

every way now. They submerged the other part of the field so they appear all the same. And a hospital is a hospital, an egg is an egg. See, that is what they have accomplished. I think, long-range, it is extremely hurtful.

Now government hospitals have enormous problems, every one of them. They have always been the dumping grounds of the field, you know, and they are just about that good or that bad, most of them. They are in trouble financially, in trouble in every way. So they have been using the AHA, and that's good too. Whether AHA can continue to be all things to all people is very questionable today because, I think, that they are sacrificing the big dues payers and their claim to fame, the private nonprofit community hospitals.

I think there is a great difference between the church nonprofit hospitals and proprietary hospitals. I have said to those groups (the church nonprofit hospitals) for five years now in meetings with them, "You ought to get busy. If I had one mission for you I would get busy--with the best brains you have got--and put down how you differ, what your claim to fame is, what the differences are, and the enormous strengths you have. Unless you have done so, when we get to national health insurance, you will be submerged. One hospital will be as good as the other and any reason to pay you more than the other provider hospital will be out the window. So, for your self-protection and for the public, you ought to be doing this."

Well, they have never done it. Nobody has given any leadership to it. As a matter of fact, I think they have gone down hill. Part of the proprietary hospital problem is the physician because by and large proprietary hospitals represent physicians. They are their corporate entities, you know, to a large extent. Some of them, of course, have public money in them, you know, through stock and all the rest, but it's the physicians that are running them. I

guess partly because of this pressure the AHA formed an alliance in a lot of ways with the American Medical Association, which I think is bad, bad, bad. I think it can be done only at enormous cost to hospitals in general. Right off you can say, "That's kind of a dumb thing to say. After all, what's a hospital without a physician?"

Well, nothing. I'm the first one to speak about the value of physicians, but physicians are entirely different animals than a nonprofit community hospital. A practicing physician is a small business man. He is a proprietor, an entrepreneur. If he has got half a brain, his interest is in making money. He does good works, when he does it, he has never hidden his light under it. He isn't nonprofit, he's profit. That's good within reason. To think that a nonprofit community hospital with its role can be the same as that, to me, is nuts. You can set up rules and regulations to enable that guy, that physician, to use his place in the public interest, but only in the public interest. There's an enormous difference. So, I say that an alliance with the AMA is just no good. It's hurting hospitals, and I'll tell you a couple of ways. Mainly that the physician has become known nationwide and recognized, in this city more importantly, as a "big money guy" making all kinds of dough. Now they facetiously say, it isn't Cadillacs you see in the parking lot, it is Mercedes Benz convertibles which cost twenty some thousand dollars.

How does a nonprofit community hospital argue its case before people who look at this as an alliance? You are no different than he is. What is all this stuff about nonprofit and your hardship and your community role, and so on? It's questioned by them--the honesty of all that, but it's worse than that, it's the disbelief. I think part of the problem with the public at

large and with government is a growing disbelief as to whether the nonprofit hospitals are as hard up as they say. In fact, aren't they just a cushy deal with the docs, haven't they got all the dough they need? I think that is factual. I am not just looking under the bed, or dreaming up some problems.

I would like to tell you about an example an administrator gave me the other day of what I have just been talking about, the AHA. The administrator said, "Do you realize, Kenny, there isn't a single, solitary physician on the staff of the American Hospital Association any longer? They get their medical advice from the AMA." This is too bad.

This has come about for a lot of reasons. It isn't any one person, it's the movement of the field that I think has not been guided in another way. I think it's important to say that proprietary hospitals can only flourish as long as there is a flourishing nonprofit hospital system. If there isn't a private nonprofit hospital system, the proprietary hospital will be down the drain because they will all become government. I think there are a lot of reasons for that. There isn't time to go into it but, I think, it's a hard tough fact. Therefore, to be putting as many eggs as they seemingly are into the basket, into protecting proprietary hospitals, making their image the image for all is wrong and hurtful.

The AHA is doing something else. The hospital field is into it hook, line, and sinker. That is they are establishing political action committees. That is the thing of the time. They are growing and growing. That was a thing of the times in the past. I think without any if and but, they are throwing the baby out with the bathwater. I think they are throwing their image away, cheapening it beyond belief. I know there are a lot of people who don't agree with me on this but, if I have any sense at all of this place down

here, and the hospital field, I think that is true. The physicians have been doing this through their political action committees and lots of money. Members of Congress assume, they know, physicians make a lot of dough, so they know there can be a lot of money in political action committees. They can expect a lot in political support. For the hospital to move this way with political action committees is, I think, harmful to their image. Hospitals are nonprofit, they can't put money in. They have got to get it from someplace. I don't know of any desirable force involved in the hospital field that will continually put up money, that their self-interest is sufficient for them year after year to put up real dough. That's in contrast to the physician. He has sufficient self-interest in his future to do that. That is quite all right. He knows his future is down here in Washington. The hospital's future is down here but I think they not only will not enhance it, but they will ruin it, by thinking they can buy political support. Once they have gone that way there is no way to counteract it. They can't all of a sudden say, "We haven't got any money this year." The belief is there. I think the future of a nonprofit community hospital is very dim indeed. At present it's up to the administrator. It's being left to him. I don't think it can be carried through the administrator, and again, I am not depreciating the administrators. I have enormous admiration for them, but I think I have a sense of what they are and what they are not. By and large, with very few exceptions, they aren't really community leaders.

The whole entity of the hospital is tied to its board. Hospital board members, trustees, are the only hope, supported by the administrator. The administrator is the organized support. He should use the trustees the way they need to be used. There isn't any question about the influence of the

boards of trustees nationwide. You can look into practically any community in America and find the power structure there. I learned eons ago that there may be too many trustees that are of no value on boards, too few that are good, but there are a lot of good ones. They ought to organize to get rid of the bums, and organize in such a way that they commit themselves to saving the community hospital. This is so important to this country socially. I think this can't be done any longer through the AHA.

The administrators by circumstances, and otherwise, have been a party to removing the trustees' responsibilities over the years. Gradually the responsibilities have been drained out. Administrators in their organized vehicles make more and more of the decisions that affect hospitals. Trustees don't. The economy of the hospital used to be the big thing for its board. Now they have some concerns but by and large the decisions are made downtown in the offices of Blue Cross, or at the state capital, or in Washington. Do the trustees have a role in that? By and large, they do not. The administrators do. You go to the AHA meetings or the state meetings--the AHA meeting is the big one--you go there and they will be talking about policy. In their regional meetings they talk about policies affecting all the hospitals in America and that guy's hospital. They decide it. The administrators decide it. There is no trustee input or participation that amounts to a hoot in all that. In many ways the administrator has been forced into this position because the trustees won't take the time and don't have the interest. But in various ways the administrator has been siphoning off the trustees' responsibilities.

I think that if there is to be any hope for the voluntary system they have got to find a way to get the trustee back into it. There ought to be some way

to organize trustees to come and talk to the Secretary of HEW about problems. The secretary can't pound on them the way he can on the administrator. The secretary doesn't dare because a trustee may be the head of a company that underwrites the president's election. You have to find the right trustees, they won't all do it. We have had a lot of examples of failures with them, but there are a lot of them who will work out. There are a lot of women. The hospital field is overly reluctant to use women. There may be reasons for that, but a lot of the reasons are not good enough any more. There are many examples where the organized voices of women auxiliaries before legislatures have carried the day. As I say, I think the role of trustees is being weakened. It is partly their fault and partly because the policy things have gotten bad. I think they ought to be reversed. I think administrators have got to set about reversing the trends. There are several organizations of trustees being established around the country now, and they may serve this need in part. They need to think about some problems outside their administrator's thought. What is the reason for that? Trustees didn't seem to sense what was happening. I don't know where this is all going to come out. I have made some attempts to do something with trustees but have not seen any success. Well, so much for what I think is the global picture of hospitals and AHA.

WEEKS:

Would this be a good time to say something about the individuals you worked with in AHA?

WILLIAMSON:

I can kind of end this part by saying there have been three chief executive officers of AHA in my time and I spent a great hunk of my life with

two of them, George Bugbee and Ed Crosby. They operated differently one from the other but both were very effective in their own ways and in their different times. I was part of most of the history of the Association. George was great to work with and we became good friends. Ed Crosby was good to work with. He gave me a full rein in Washington. He didn't interfere except on points where he needed to. I think he always felt me to be totally responsible and not harebrained. I knew he held me responsible. I think it enabled us to get a lot of things done down here. We didn't have to check every thing. If I had a question coming up or if I could foresee something and there wasn't time to go through the full procedure, I'd talk with Ed Crosby. He would say to either call this or that guy, the president or other officers, or he would do it and let me know--or we would get on a call together. Otherwise it went through the hierarchy. He was very good. That is the way we operated. I felt it was my job to make recommendations as strongly as possible, to argue with my last breath as to why I thought a thing should be done this way. When they decided, if they decided differently, so be it. I think I was fully loyal in carrying out the final decision whatever it was.

So I talk about my role in Washington at the Washington Service Bureau of the AHA, as it was called. It was involved in everything that had to do with Washington, the Washington scene as it was growing. It had to do with the hospital field in Washington and Washington in the hospital field. The Bureau kind of grew up as Washington's role grew up. You can plot three or four distinct phases of hospital relationship with government. The first was a time of total voluntary involvement. The federal government really had very little to do with hospitals. During the second World War they had

relationship through the Emergency Maternal and Infant Care (EMIC) program. That was a program to take care of wives and children of men overseas. The government assured them of care so the men wouldn't worry about their families. Incidentally, the basis of reimbursement of the EMIC program did more to foster uniform accounting in hospitals than anything else that ever happened. It came about--which is an important thing--because it indicated a role of government, its total force and pressure to require something. It's not altogether bad for the field, it can be very good.

Then Hill-Burton came along. That was voluntary. You didn't have to ask for money if you didn't want to, but you might be run out of business (for the lack of money to expand) if you didn't. There were other things that the hospital could choose to do or not to do.

Then we began to get exemptions for hospitals from unemployment compensation, minimum wage law, and National Labor Relations Board, the Taft-Hartley Act. We worked to get exemptions of hospitals from the effects of participating under those laws. So there was no federal compulsion under them. Later hospitals began to lose their exemptions under those laws and the government began to be a party to the operations of hospitals in a big way. Hospitals came under rules and regulations that commercial businesses were used to. So the ability of hospitals to decide whether or not to be related to government went out the window. They had to be related to government. This had-to-be-related side grew and the programs of government money grew. There were forces behind them and compulsions to really participate. This growth of government influence can be platted year by year.

At the Washington Bureau we got involved with killing off a lot of bills and propositions that came up for organizing the hospital field. Sometimes we

were the sole voice, sometimes we were a party with others. Part of our work was in helping organize the hospital field for action. This was done through the state executives. Some of them did it pretty well, some of them very poorly. Many of the states are well organized with effective state executives but from what I understand, some of them are mediocre, and a few not very good.

An annual effort for us was to get funds for getting Hill-Burton passed. Every year we had to get funds appropriated. The program is no good without money, you know. That took a lot of work and a lot of support. Incidentally, it was interesting how, by and large, the support came from hospitals who hoped to get money under Hill-Burton. Some support from those, and less support from those who had no interest in it. It was quite a problem. It wasn't too easy to get.

I think up until a few years ago Hill-Burton had put a billion and a half dollars into the hospital and health field, which brought twice as much as that, you see, because of the matching side. It was the nucleus. So, I give the federal government great credit, and I think the hospital field ought to, in spite of the problems they seem to face today.

Anyway, we were busy with Hill-Burton and with federal housing. We got the right of hospitals to participate in federal housing. We got that into the law. We talked with Albert Rains of Alabama, who was chairman of the House committee, about some interesting and unusual ways hospitals could build what amounted to housing facilities, apartment houses for aged people near hospitals. They could relate care to the old people there instead of bringing them in the hospitals. Some of that has taken place but the hospital field has not clicked with them very well.

We worked on the medical education financing bill and succeeded in getting

in the program hospitals that weren't owned and operated by universities. If they are recognized medical teaching facilities not owned and operated by medical schools, they could get that dough, and they got a lot of it. Interestingly, the fellow that was the key in getting us that was John Dingell of Michigan. Dingell is the son of the Dingell of the Wagner-Murray-Dingell bill for national health insurance. Dingell, the son, was very helpful in a lot of ways.

Nursing education. The AHA really instituted the federal government's role in nursing education, that of participating in the cost of that education. This was helpful to the hospitals because they needed nurses and many nursing students didn't have money to pay for education. So it was self-interest and public interest at the same time. Organized nursing had less of a role in that than the AHA did. They supported it, but we instigated the legislation and followed it through with their help.

WEEKS:

Did labor have any influence in the health field at this time?

WILLIAMSON:

During this period in Washington I began to know organized labor. Nelson Cruikshank was the major contact. Through him I came to a lot of other people. Nelson was known as the social conscience of the AFL-CIO. I would say this: organized labor is having an enormously beneficial impact on the health care field of America. They helped make Hill-Burton. There was one group we could turn to for money for Hill-Burton. They worked with us in this effort to get the bill passed. As I said earlier on, they were without doubt a primary, responsible party for Blue Cross succeeding, and therefore, for voluntary health insurance succeeding. There has been no stronger supporter

of high standards. They supported the Joint Commission on Accreditation. They supported voluntary efforts to do better things. They did all these things which is kind of fantastic when you think that the hospitals were dead set against the organizing efforts of organized labor. You know, that was quite a lot to take, wasn't it? For the unions to stomach. So, I give them great credit for good works and for being supportive of good works.

I represented the hospital field re Medicare. Many of the things we got in there, good things, came about because organized labor supported us having them in there, like the strong role of the Joint Commission on Accreditation. It could have gone to government accreditation, you know. I'll talk about that in a minute. Now I want to take time to say that labor is terribly important for the future and was terribly important in the past. They often did things with a bigger heart than a lot of the health field might have given them credit for. I recall talking to Nelson about the hospital field. The hospital field was fighting to maintain exemptions for hospitals, and he said, "Kenny, the time will come when you people will regret this. I really think if you people were farsighted you would get the field to understand that their workers have the same rights to protection as other workers have in America. The union is the vehicle. If we went to George Meany, he would guide us to a union that would be the right kind, that would be the kind of union you want." I often think about that. It was prophetic, believe me. Nelson Cruikshank was a very big guy. I am very fond of him, he has contributed an awful lot.

We established in those times the basic tax exemption for hospitals that has grown and has been built upon. We spent a lot of time trying to get the exemption changed because it isn't what it ought to be, it never has been. We

went through hearings and all the rest. We worked to keep hospitals free of unemployment compensation, the minimum wage, and social security. We kept hospitals free of social security until the field changed its mind and sought their inclusion.

George Bugbee reminded me recently how strongly I was opposed to AHA being against hospitals being involved in Taft-Hartley. I personally was against the exemption. I thought they should be in it. Later when it got to be that they were going to be under Taft-Hartley, I changed my mind. I learned more by then. George said, "I remember when you thought the dumbest thing I was doing was to seek this exemption. So we kept them all out, minimum wage, and so on. Later they lost those exemptions and we guided the impact of those laws, got special provisions for hospitals only.

Wilbur Mills, chairman of the Ways and Means Committee and a very good friend, called me in one day and said, "Kenny, you can see what is happening in unemployment compensation. It is going to move and we have got to pass it. You had better figure out how you want hospitals covered, because I am afraid they are going to be covered. We can't argue the exemption any longer."

That is an example of what you build up down here. Mills did clue us in and helped us. AHA finally had to give on the exemptions and we guided hospitals. That took a lot of work and time.

Then we had all the legislation during Lyndon Johnson's period. That was Mental Health Care, Care for the Handicapped, and the Regional Health Program, which was one of the greatest ideas that came down the pike but was a total flop. The AMA saw to it that it was a total flop. Lyndon Johnson thought that there was all this research money being poured into NIH, and the public was getting little benefit. So Johnson wanted to set up a system to organize

regional boards, kept up by federal support, to organize the means of getting the best and newest in medical care to the people. That is a short synopsis, but the AMA didn't want that because they thought it would interfere with medical care. That reminds me that when the Hill-Burton came along there was a provision in there that talked about the small hospital being related to the bigger hospital in the community, and then to the teaching hospital and a flow of patients up and down. Regionalization--that's what they are talking about today. The AMA kicked that Hill-Burton provision in the head for some good, some bad reasons. The physician down below would lose his patient, they thought. Truthfully, the output of the medical school is a kind of physician who doesn't want to sit down there at the lowest level where he is just a referral point.

The other thing about regionalization that would have been important was the community health center. If there was anything the AMA fought it was that. They thought the centers would be the means for the Public Health Service to start providing medical care to the people. It is too bad it didn't come about because I think it could have developed into a vehicle which the country badly needs today. Anyway, we were involved in all of those things and a lot of other things.

I personally had some fun during that time that I'll never forget. I had been involved with Hill-Burton and knew that the dollars were being given away in grants, big hunks, and that the needs of the field were such that the big need was modernization and renovation, not new construction. I got the idea that we could take those dollars and put them into loans where the government would pay for the interest on the money hospitals borrowed. The government could with the same dollars renovate the whole hospital field by paying for

the cost of the money needed.

Well, Wilbur Cohen, Secretary of HEW was much enamored with this. He set up an appointment with President Lyndon Johnson. Crosby and I went and had luncheon with Lyndon Johnson. He called in Mr. McNamara, then the famed head of the Department of Defense, formerly of Ford Motor. We ate lunch and President Johnson says, "Well, Wilbur what's this idea you are so hot about?"

Wilbur sat a minute and then he said, "It is the American Hospital Association's idea. They can tell it to you better than I can. I think it is worthwhile your listening, Mr. President."

So he turned to Dr. Crosby. Crosby said, "Kenny you know more about this."

So I gave them the book and the verse about what the needs of the hospital field were then and how the federal government could use its dollars to do a lot more good. McNamara was much taken with this. Johnson said, "What do you think, Mac?"

McNamara said, "I think it's a damned good idea."

The President told Wilbur to set in motion writing a bill. This was on a Wednesday, as I remember it. On Thursday I talked with Wilbur. He said, "In view of the budget they are going to charge 2% for the money. They will subsidize everything but 2%."

I said, "That's great!" Money was then seven or eight percent. But over the weekend it got to the Bureau of the Budget and they kicked it in the head. They convinced the President that any construction en masse in the hospital field was highly inflationary at the time, and so on. So he cut it off. Anyway it was the kind of experience I'll never forget. I have some pictures of myself and Lyndon Johnson shaking hands, and some with various other presidents. That was special fun.

WEEKS:

In the Hill-Burton days did Jack Haldeman administer it?

WILLIAMSON:

Nationwide. From Washington. The first administrator was Dr. Vane Hoge in Public Health. Vane, when he retired, came with me at AHA. We were together in Washington. He was my chief associate. Dr. Hoge was followed by Dr. John Cronin from Public Health as Hill-Burton administrator. He up and died one afternoon. He had just had his annual physical. They declared him healthy and he died on his way home. Dr. Cronin, incidentally, was the only person who could really explain the formulae for distributing the money, Senator Hill thought. Haldeman, I think, was third in line. Jack Haldeman ran it in Washington. He was the major focus, had a big staff and a big program. After Haldeman left the next administrator was Dr. Harald Graning who retired just recently.

During that time I also got involved in Latin America. AHA had an international program which worked with the State Department. Through their interest and help we got some money and a contract for a three year period, which was renewed time and time again. Jose Gonzales, a Mexican physician on the staff, came and joined us. He set up a program to help Latin American countries and he was quite successful. We had seminars down there. You mentioned Bob Buerki. Buerki, Hamilton, and Ray Brown, and all that kind of great lights, would go down. We would take five or six of them and we would have five day seminars. We would move from country to country. I went down there with Jose several times. We did a lot of missionary work. It was interesting because we would meet with the tops of all their governments, the top people and talk to them about voluntarism in health affairs. We would try

to inculcate an understanding in them. Many of their physicians had been to various medical schools in the U.S. We tried to get them to understand those places. They really had no idea how medical schools and medical centers functioned. They did not seem to comprehend people of their own free will wanting to do better. They only understood cost.

I used to talk to them about the limits of compulsion in government. We got a few things started. We got some hospital associations started in Venezuela, Colombia, Brazil and Mexico. They began to do some things, but they never really amounted to anything because the source of their funds was government, and they really never understood. There were really fine people down there, but they worked against enormous obstacles.

One thing I did learn of everlasting importance to me and that is that government is absolutely essential to the voluntary free enterprise system. The voluntary free enterprise system does not exist in a single place where you don't have government that believes it's worthwhile and makes it possible. That is little realized, I am afraid. I listen to people damning the government, from the business community or the Chamber of Commerce typically, as they are too inclined to do. When they are in trouble, of course, they immediately come to government. There is nothing in the Constitution or the Bill of Rights that talks about the free enterprise competitive system. It's business, but it's business aided and abetted by government in every way.

If you want to see the contrast, go to Latin America. I could see it. There never was the kind of government necessary to make a free enterprise system possible. It was worthwhile for me to go there just to see that one thing.

Things changed as hospitals lost their exemptions. President Kennedy started a lot of things. In terms of Washington he was kind of a flop as a president; he couldn't get anything through Congress. Lyndon Johnson picked up many of Kennedy's ideas and passed them.

WEEKS:

You were involved in the passage of Medicare, weren't you?

WILLIAMSON:

Medicare was the last really big thing I became involved with while I was at AHA, I guess. Medicare, I had a lot to do with. I think there were twenty-six provisions benefiting hospitals that we got in the bill. It was because I worked closely with and was trusted by the people who drafted the bill. They bought the ideas being outlined because they seemed reasonable. The word "reasonable" is of much consequence now but it also was terribly important then. At the time we wanted the words in the law to say that hospitals would be reimbursed their "full costs." Congress wouldn't go for that at all.

We had lots of discussions with them (the framers of the bill) individually, and we argued.

They would say, "If you don't want reasonable, then what you want is unreasonable costs, Kenny. If we stick to reasonable, they must be reasonable. We mean that. Not unreasonable."

We realized when we got the words that it would mean that forever, that there would be dickering and confrontation, and all the rest of it, as to what those words mean. It all sounds so simple now but it was a terribly difficult time and a whole new relationship between the health field and our government. I am proud hospitals differed from the AMA and tried honestly to

serve the public's best interest.

Someone asked me recently what I thought were some of the contributions I had made to the hospital field in my lifetime. I said that I thought: the trustee program, at least at the start; the women's auxiliary; some pieces of legislation; and Medicare, without doubt; and, lastly, Medicaid. Now that I am at an age I can use it, I can see the benefits of Medicare even more clearly.

One afternoon Congressman Wilbur Mills called me and told me about Medicaid. They had had the Kerr-Mills bill which had preceded Medicaid. Mills and Senator Kerr drafted it and it flopped. The states didn't support it. I was serving then as kind of a consultant to Mills. He would call me and I would go over and talk to him about why the thing was a failure.

Anyway, he called me this one afternoon and said he would like to see me. I went up there. He had John Martin, his staff director with him. Mills said, "We are drafting this program, Medicaid, for the poor. It will be a whole new thing." He sketched it out, and he said, "John will tell you the details. You can't talk about this, it is confidential at this stage. But," he said, "you have talked to me about hospitals and the way they should be handled, reimbursement and all." Then he said, "If you could put one thing in this bill in behalf of the hospitals, what would it be?"

I said, "That would be very simple. It would be to say that the states can't pay hospitals any less for care than they pay for Medicare. In other words, they must pay the reasonable costs."

Mr. Mills accepted the idea and put it in the bill.

That has meant billions, not millions, billions of dollars to hospitals. They have to fight for it now, they have had to go to court to justify it, but

that wording raised the level of payment to hospitals enormously. Before Medicaid the common pattern was to pay hospitals thirty cents on the dollar, or as little as possible. They thought the hospital could be forced into the position of being an agent to collect from the public. Charity. Enforced charity.

Anyway, Mills bought the idea and I worked with John Martin, his general counsel, who is a very fine man. I often think that in terms of money, there probably isn't anything I ever did that earned my pay more than that one day's work.

WEEKS:

May I interject a question here about Medicare? I have often wondered how the fiscal intermediaryship came about to handle Medicare claims.

WILLIAMSON:

I am going to talk about it right now. The payments under Medicare became an enormous thing. Of enormous consequence. We know it would require continued negotiations, as I have said. We couldn't get better than reasonable costs. We couldn't get full costs. After the first year's experience there was some thought it might have been possible for the hospitals to withdraw en masse. This would have had to be done very cautiously because of antitrust implications, but the AHA could have instigated withdrawal on the facts, and could have said to the government, "We are going to stop this program right now unless you begin to pay us on a better basis."

Of course this experience demonstrated how very little hospitals knew about their costs. We had endless discussions with the HEW people about "reasonable cost." Then we had the final go around in the office of the

secretary of HEW which I'll never forget. Dr. Phil Bonnet was president of AHA at the time. Dr. Phil Bonnet, Dr. Crosby, and myself and, I think, Clarence Wonnacott. Anyway, we were there with the Secretary and with Cohen and with Bob Ball, the Social Security Commissioner. They said, "There are these imponderables. You can't specify the costs attached to these items, so we will attach a 2% overriding factor for the unknowns that we can see are legitimate."

In other words a nonprofit hospital can't really isolate every cost so it's got to have a plus factor. So they went out of the room, the Secretary saying, "We are going to meet and talk about it, and you can talk about it." We hashed it over, the four of us, as I remember. They came back and said, "All right, we'll add 2% on the top of reasonable cost in recognition of these factors, which we can see are costs but which we cannot and you cannot attach a specific figure to."

After the first year's experience some states began to grumble. Michigan was one state where the state association acted to withdraw their hospitals and get out of it. They sensed that if they didn't do it they would be in the soup. Others wanted to do it, but they found that after the first year it was impossible for them to withdraw. The hospitals had the posture to withdraw vis-a-vis the public. I think they might have ended up with Congress taking them over by a quick action. In other words, they were in it too far. The Congress was in it and the federal government was committed to the public; the hospitals couldn't get out of it. This was tough but it was clear that hospitals now had an entirely different relationship with the federal government.

Then we got Nixon and his politics and his budget and his administration

which chose to ignore totally the good faith which the government had given us. It's in writing and everything, good faith. The good faith on the part of the hospital field had been carried out, but the Nixon administration broke faith with the hospitals and withdrew the 2% payment factor. Nixon's Secretary of HEW at the time was a real weak sister, a most ineffective man from California, named Finch. (He was a bird all right.)

Incidentally, I spent half my time during those first two years of Medicare travelling around the country, talking at meetings of hospital people about Medicare. I was often with Bob Ball, the Social Security Commissioner, or Art Hess, his deputy. So Nixon chose to ignore the government's commitment and he eliminated the 2% factor--real dirty pool. We put on a major drive to do something about that. That is where I learned something more about hospital trustees. I went to a big meeting in Philadelphia which was then kind of the seat of Republicanism at that time. They got together a luncheon with a big group of hospital trustees, key people, Republicans, and so on. The conclusion was as a spokesman said to me, "We think President Nixon and our support of him is more important than the hospitals and this 2%."

They wouldn't do anything. It got down to tough bargaining. I think the relationships then began to depreciate between government and the field. I continued to make harsh speeches and statements about Nixon and his administration and a lot of the things they were doing. I had very jaundiced views and I often expressed them about Nixon and his administration. I gave him full blame. Without doubt, it proved to be very harmful to me within the AHA hierarchy, my continued pounding away and raising questions about Nixon and his abuse of the hospital field. No doubt it harmed me. I expect later events revealed a basis for my criticism and I think away beyond the minor

assaults I made on Nixon. At the time the AHA leadership had several Nixon believers, advocates. They found me to be quite unpalatable. It's funny because I had been a strong advocate of Nixon and thought he really would be one of our greatest presidents, but sadly he was a crook at heart, a bad apple. I came to think so by his acts, some time before his public downfall.

During this period I had a philosophy that I used to talk about all over the field, and occasionally with the board. When we got a new Council on Government Relations I would have kind of an orientation. I would talk to them about the philosophy we followed to see if they wanted to change it. What is the philosophy? The philosophy is that the job of hospitals, the hospital field, is to meet the public need and that in major areas where you find you cannot meet the public need, where it is beyond your ability, then you work with the government so together you meet the need. That's very simple. That is the philosophy. That philosophy is in contrast to that of the AMA where they preached that working with the government is like a camel: It will get its nose in the tent and pretty soon the whole animal will be in and take the whole tent over. A total mistrust, you know. Worst of all, it runs the risk of failing the people's needs.

I think that now the AHA has joined that philosophy. They have abandoned the philosophy and approaches we followed. In fact, I think many people in the field would now tell you that "old" philosophy is naive. But I believe they are wrong.

They (the AHA) resort increasingly to the courts. In a lot of major ways I think the only benefits coming from the courts are for the lawyers. I think that going to the courts is often a sign of failure. You have failed to do in the line of action politically what you needed to do.

Year before last I went up to New Jersey and I heard one of the most important and one of the best speeches I have heard in the hospital field in eons. It was given at their association's annual meeting by a man who was the operating head of the Bell Telephone System in New Jersey. He's had all kinds of jobs and he is being groomed to head up Bell Telephone. A very impressive person. He talked about how they developed their rapport with government--with the government having a lifelock on them, on their economy. He told how they did this. I think he knows a lot about hospitals because he is a neighbor of Jack Owen who runs that association. So, he tried to relate his talk to hospitals. He kept saying, "with my limited knowledge." It wasn't limited, he was right to the point. He talked about how you can't win with a continued posture of confrontation. He spelled it out. You have got to find a way to live with the federal government. They are here. They are a fact of life. They aren't going to disappear. You have got to work with those people, those human beings, and find a way, and so on. It was a very profound speech. I wish the whole hospital field could have heard it.

Now the hospital field's role is one of confrontation in many, too many, respects and I believe it is a losing game.

The hospital organizations have meant a great deal to the public and to the hospital field. The AHA has a record of some enormous accomplishments. They had very real leadership over the years in many ways. I don't know of any recent actions of greater value or that took more vision and required more fortitude or cohesion on the part of the hospital field than it took in those past years. I see no similar type of approach now at all either in leadership or feeling or whatever it is. Hospitals sound like they are driven more by self-interest than public interest which I think is very, very sad.

I think it has been obvious that there is a change in philosophy and attitude at AHA. It represents to a certain extent changes in hospital attitude, in their membership attitude, and the fears they have and all the rest of it. It also follows the kind of thinking represented by the leadership they have had over the past few years. (Some of those "leaders" I know. It follows the thinking exhibited in the past.) Times were such that they (these leaders) came to the fore. And I don't think you can blame the "times" for the situation it is in altogether, not by a darn sight. I think there are a lot of other reasons. Anyway, who knows?

The situation is not good today. I am sure there are many people in the field, and there are many people in government, who would give their shirt if they could see some way to right things so that they could look at a common purpose and have some trust, some mutual trust. I am just one who thinks something can be done about it.

WEEKS:

Would you care to discuss the American College of Hospital Administrators?

WILLIAMSON:

Yes, I might say a word about the College. I am very pleased and have always been honored to be an honorary fellow of the College. I prize that. I have known about the College and have followed its development very closely for many years. I have watched its development as hospital administration developed. They were sort of one and one, you know. As hospitals developed, the field developed, administrators developed, and hospital organization developed. Very often over the years the people who were "it," the big wheels of the College were not the big wheels in AHA. Very often over the years it seemed obvious that people who, for a variety of reasons, didn't make it in

AHA, made it in the College. I have always felt there was personality involved here. That was shown in relationships over the past years between AHA and the College, which were never close. Neither one of them totally trusted the other. They always wondered what the other was up to.

Some of this was the people involved. You can go back over the years and find some of the people didn't succeed in AHA. I don't know why. There was the reverse in that, too. Some of the people didn't succeed in the College and then moved to become big in the AHA. Some succeeded in both. I can think of some names in that area. These administrators, and some leaders in the overall field, who didn't make it in one place chose another avenue for their ego. Generally, the people who are big in the hospital field have big egos. That is all right, too. Like big people do anyway. They seemed to fumble for a role, for a place in the sun. The College leaders and administrative were often irked with the AHA. That didn't make for the best or the most fruitful relationships. I've heard that has improved, I don't really know. I don't know internally in AHA whether it has improved a nickel's worth. On the surface it looks better. Looking back I believe the executive staff of both organizations could have done a lot they didn't do to make life easier, but there were strong feelings.

Some things have straightened out like the College was about to enter into the issue of national health insurance. I think, maybe, writing legislation, introducing it, a full role. What the process was that brought that about, I don't know, but I think it is fortunate they didn't. Each side of the field goes its way. It goes its way kind of foolishly. How can the AHA with its responsibilities and its role in behalf of hospitals be separate from the education of the people that make up the field? Some people would say that

means the College should be a council within the AHA. I don't mean that but there ought to be some tie, some strong tie, between the two so administrators don't think of the better things in life--of education and their own improvement--in terms of the College and not the AHA.

WEEKS:

Hasn't AUPHA often caused...

WILLIAMSON:

Yes, it has caused another confrontation. I think in parts it's personalities. The guy that runs that thing. I am sure he is part of it. Any commonality of the field is missing in some of their actions.

WEEKS:

Were you with the AHA when Jim Hamilton, I think it was, wanted to absorb the College?

WILLIAMSON:

Yes. I came to AHA when he was very active. I can't recall that it was Jim, but there were those who supported such thinking.

WEEKS:

I think it was while he was president of AHA.

WILLIAMSON:

It may have been at that time. It wasn't just Jim at other times. People would say, "How can the AHA do its job and have the College fiddling around here outside the program of the AHA?"

The AHA had a big institute program which I helped develop. We had that program tied in with universities, in joint sponsorship. We did it all over the country. The College worried about that. There was a lot of worry back and forth. The field has developed. I think the education of administrators

is in enough trouble by itself. I hear more and more very thoughtful, influential people saying that administrators are technicians, that they are not big enough. In other words, they think that people who go to MIT, for example, are better able to cope than the hospital administrator graduate coming out of the usual courses. They think the HA graduate should be relegated to the second level. A thinker is needed at the top. They have lots of problems in hospital administration, I am sure.

I have many friends in the College. As I say, I was very much honored when they made me an honorary fellow.

WEEKS:

Did you have anything to do with the Perloff Committee?

WILLIAMSON:

The last major effort I was associated with at the American Hospital Association was the Perloff Committee. That committee developed what became known as the AmeriPlan. That came about following discussion by the Council on Government Relations, which I staffed, and their recommendation to the Board of Trustees. From the pressure down here, I knew things were moving towards a renewed interest in national health insurance. We saw this happen when Medicare came about. We saw it and traced things that should be done. When Medicare came about, AHA couldn't come out too strongly for it because of AHA's relationship to AMA which was fighting Medicare. AHA came out half way. The board took action giving me authority and making me responsible down here in Washington to watch and follow any program, that looked like it was going to pass, that involved hospitals in a national health program. "Do all you can," is what they said to me, to make any legislation as beneficial as possible for hospitals.

As a part of that I got involved in two committees established within AHA, two separate committees, different groups of people, to study the issue. The first committee came out saying the only way to do it was through Social Security. The board and hierarchy didn't want that so they shoved it aside. So, they formed a new committee filled with people that they felt were strongly the other way. That committee after nearly a year of looking at the facts and talking with various well-informed people came to the same conclusion. They said the only way to do it was via Social Security. Thus two very different groups of people looking honestly and thoughtfully at the facts came to the same conclusion. The board thought there was no hope that way so they set up with Blue Cross another kind of approach, a kind of half-baked approach. They wouldn't take a firm stand on the Social Security approach except as a last resort, or as they said, a way out.

During those years I had kind of a bad time because the AMA was on me all the time. I would go out through the country and speak; they would have somebody there listening who would report back to the AMA. Then the AMA would go to Crosby and say, "You know that Ken Williamson has been out there talking about this program and its problems?"

Because of the years of relationship with Nelson Cruikshank, Alanson Willcox, Wilbur Cohen, Lane Kirkland, and other such people, I was in that group and was able to give the hospital field a strong representation. A very strong voice, really in the development of Medicare. One of the saddest things that ever occurred in this country was the posture that the American Medical Association got into on Medicare. A total confrontation, a total fight so that their best advice was never listened to. Medicare could have been a much better program if physicians, I mean real leading, physicians, had

had a voice. Well, we had a voice. I think the hospital field can take a lot of credit for the fact that Medicare is as good as it is. I think the public ought to be damned thankful too. The AHA had a big role in it.

Then came the time when things were stirring for national health insurance. Medicare wasn't sufficient. I was talking and listening to people--we all were. So I said the AHA has had these positions in the past. I sat down with the staff and looked at all the positions and postures that AHA had taken over the years. They weren't good enough. They didn't add up to anything. What we needed was a total look-see of the field, an evaluation of our posture and where we needed to go. That proposal went to the Council on Government Relations--I staffed that--and they agreed.

The Perloff Committee was set up out of that. It was a most, most interesting experience. Here was a very varied group; some business men, some hospital people, some physicians. Very conservative people. It was a cross section you might say. A lot of different kinds of opinions. I think it was eighteen months that we went through this. Gradually as they looked at everything, they came to a common view, all these disparate people. They came to a common view that there must be a major reorganization of the health field. How do we bring this about? The committee developed what it called the AmeriPlan. It was to be the vehicle for bringing about the reorganization. The guts of the Ameriplan is to get the health field turned to organizations with power and influence within communities coordinated at state levels, and so on with the federal government role carefully controlled. An approach was outlined.

I was given the responsibility of taking that idea to Wilbur Mills, chairman of Ways and Means, to see if he would introduce a bill. Wilbur Mills

went over it some and had his staff look at it. He talked with me at length. He told me he didn't want to introduce it. It wouldn't be well to. The primary reason was that as chairman of the committee, when they are going to consider an issue, it's bad if he has already staked himself out. He is freer to negotiate if he doesn't introduce a bill himself. That is sensible strategy. He departed from it sometimes, I might say.

He said, "You ought to see somebody else."

He wanted me to go to a Congressman I knew well, but he was not the kind of person this bill would appeal to at all. I had in mind a guy who was the number two man on the committee. I had had contacts with him, and I was very much smitten with him, Al Ullman. Mills agreed with me finally. It wasn't his first choice but he agreed.

So I went and had a meeting, unforgettable, with Mr. Al Ullman. Mills said--excuse me, I jumped a step--Mills said, "If you can take these great ideas of AmeriPlan you told me about and put them in the form of a bill, then come back." I believe he questioned whether it was possible to draft legislation to carry out AmeriPlan.

So I was responsible for bringing together a staff and a couple of bill writers who knew all the ropes in legislation in Washington. Alanson Willcox had been our attorney and was general counsel at HEW and together with Ted Ellenbogen who had drafted legislation for Congress over many years. We put that thesis, AmeriPlan, into a bill. Really it was an exceptional piece of work, because there was a lot of stuff in there that was very airy-fairy. How do you accomplish "good" in legislative language? I think all and all we did pretty well. Had a few stumbling blocks as we went along that had to be ironed out. Some changes had to be made because we couldn't accomplish just

what AmeriPlan said, but all changes were discussed with Dr. Crosby and the board of AHA, and approved.

The work on the bill was sent to the AHA board as we went along, and to Ed Crosby. They approved it. They approved the final draft of the bill and told me to take it to Mills, which I did. Mills, after he had said put it in bill form, turned it down. The board agreed I go to Al Ullman, they sanctioned that, to see if he would introduce it. I went over to see Ullman. He wanted to know what the major objectives were, what the major problems were. I told him very honestly the financing was cumbersome. He said he would introduce it. He thought things were hot then, he would introduce the bill.

I called Crosby and told him Ullman would introduce the bill. This time we parted company. They pulled the rug out from under me. Here I had a most influential congressman, who later became chairman of the Ways and Means Committee, agreeing to put our bill in just as is and they say, "No." To me it was kind of unthinkable. It didn't do me any good. I was very, very hurt. AHA went to various people, and got them to comment on the bill. On the basis of those comments AHA felt there were some things wrong with the bill so it shouldn't be introduced. Ullman was upset by that. I was more than ever upset.

Unfortunately, at that point, or shortly after, Crosby died. Right afterwards I retired. A number of circumstances made it propitious for me to get the hell out. I just want to say here that I had a lot of years working with Ed Crosby, and I mean working with him. They were great. I don't think I ever knowingly let him down. But with the AmeriPlan, he got worried about it and I think that is where his "doctor" came to the fore. Once a physician always a physician. I think he got terribly worried about the AMA because we

were now past talk. It was going to be confrontation, you know. I saw some of the written views from the people Crosby took the bill to. I thought they were very halfcocked and indicated there had been no real discussion. For whatever reasons, the officers decided to call it off, Ed and the officers. The worst thing about it was that Crosby and the officers sort of acted behind my back and didn't come clean with me. I had put an enormous amount of thought and effort in trying to move AmeriPlan into an effective piece of legislation.

I had a lot of conversation with Al Ullman afterwards about the bill and about the changes the AHA then wanted. He said that was the time to make changes. Some should have been made. He did make them. The AHA went back to him after I left and got him to introduce a bill with quite a few changes put in. Some weren't too good, some were all right. The bill still contained what I thought were major weaknesses. Anyway, it was a very unsatisfactory, and sad end to my AHA career.

I thoroughly enjoyed those years of activities and continued to feel the American Hospital Association was a truly great organization. Over the years I did an enormous amount of travel for them. I got to know thousands of people in the field. All kinds of them. Many of them, department heads I had met, would come up to me years later and say, "I met you..." and so and so. It was great. I loved it, knowing these people. The field's a great field. I had many, many good friends. I think I couldn't have enjoyed life more satisfactorily if I had plotted it out. I realize too there was a lot of sacrifice on the part of my family because I was away so much of the time. So, as I say I retired from the AHA after twenty-five years and started on another career.

WEEKS:

You were going to say something more about Medicare and the fiscal intermediaryship.

WILLIAMSON:

I might add two or three things on Medicare. It was a great experience when Medicare was passed and became law. All in all it was a good piece of legislation. The hospitals have been served much better by it than they think. The public has been very, very well served. I think Congress did some unfortunate things. I think, an enormous disservice to the aged people was this separation of physicians and hospitals in Medicare Parts A and B. The two sections, in essence, posed the problem for the old person of having to be able to buy physician service before they had entitlement to hospital service. It was real dirty pool. That came about for an interesting reason. It came about because Mills, the chairman of the committee, was a great friend of medicine. He had a close family physician friend that I knew well who encouraged him to hold fast against putting physician services in Social Security program.

Lyndon Johnson sensed where Wilbur Mills was, so Lyndon Johnson increased the size of the committee. He increased the Ways and Means from 18 to 25. Then he said to Mills, "We are going to out vote you and get the bill out of committee. Now, you can look like a fool as a chairman with no leadership, Wilbur, or you can be a party to this." He faced him with the hard facts.

Wilbur recognized this--a smart politician. He sought for some way to fulfill his commitment to physicians and that was, "I will see to it that you are not put under Social Security." So, he wrote Part B which is, as I say, a bad deal for the aged. It never should have been in there.

I guess to me came recognition of the long role I had in Medicare when I got a call one day that Lyndon Johnson was going down to Missouri to Truman's home and sign the bill. They asked me to go down there in the White House plane and be with them when the bill was signed. It really was something, you know. So I went to the signing. Lyndon Johnson wrote his signature with several pens and gave us each one of the pens. I have it at home, a prized thing. I have a framed copy of the bill and the pen that President Johnson gave me. It means a lot more than other bills I have pens for, because of the input I had. That was a great occasion. There were Lady Bird and Lyndon. He showed great deference to Harry and Mrs. Truman. There they were and Nelson Cruikshank and others that I had been involved with. They were all there besides a lot of other people who had come for the ceremony.

There was an amusing thing. I didn't know just what would come of this. I was going to the signing but I thought I would be way back in the woods. Instead of that, I was right there in front. My wife was watching television that afternoon. All of a sudden the picture came on and there I was on television shaking Lyndon's hand and he was giving me the pen. She said, "Kenny, straighten your tie, Kenny." Anyway, that was one of life's very pleasant experiences.

In the writing of Medicare there has been a lot of discussion, some of which is amusing to me, about the Blue Cross role. I can tell you one thing flatly, no if or and, the role Blue Cross had in Medicare I negotiated. The intermediary was my idea. If Ed Crosby were alive, I am sure he would say this. I talked with him about it at the time we got to drafting stages, that the hospitals needed a protection, they needed somebody they trusted between themselves and the government. The committee was discussing how to administer

Medicare as they drafted this bill. The first thought was to go to the states, naturally. Most of the states had had no experience, no ability to organize a health program or to administer one within the state. Private insurance? No. There was nothing in the government field with sufficient ability. The biggest supporting argument I had is that with Blue Cross you have the one entity organized in the field at the state level and coordinated nationally with the support of the people you must have, the hospitals. A voluntary approach with all the strengths of that, and the goodwill that would come from it. Intermediary...as a matter of fact, they were our words, maybe my words. We heard during that period, that McNerney was around talking against us. He was very fearful of an intermediary role. This was because, I guess, he and others at Blue Cross were fearful that this might be the end of Blue Cross. In other words they would just become a government entity and as they grew people would be less concerned with them. It would ruin their voluntary, independent look, you know.

The intermediary role had the strengths I have mentioned. Ed Crosby agreed with me. We needed to do something, there was no time to stop and talk and ask Blue Cross if they wanted it. As a matter of fact, I said that it was for their best interest if we decide this and just put it in. We decided and we put it in and they suffered the benefit. Interestingly enough, over the years I have heard all sorts of talk about how Blue Cross worked in developing this role. Hell's bells, it had nothing to do with it!

As a matter of fact, I think the intermediary role contributed enormously to Blue Cross and gave them the experience necessary to know how to administer mass programs, which is what they are doing now. They learned it with this government program. Also it's an enormous feeder to the financial support of

Blue Cross. I read that book Odin Anderson wrote about two years ago about Blue Cross.* I was more than amused by Odin's discussion of the Blue Cross role. Well, Blue Cross picked it up and did a great job, but during those times (of planning Medicare) I never remember Blue Cross being considered, or talked to, or having anything to do with the intermediary role in advance. It came about because the government at a point in these discussions said, "How are we going to administer Medicare?"

The arguments favored Blue Cross, fit the times, and I was able to sell it. Nelson Cruikshank and Wilbur Cohen and others bought it. Blue Cross didn't come to them with the idea at all. When it was an accomplished fact, Blue Cross had to go and sell their field on what to do about it.

There are a lot of things in Medicare that at the time were the best vision anybody had. Some of them are proved right and some of them are proved wrong. The "reasonable cost" is in ill repute now. The hospital fields admits in the stuff I read from the field that it is uncontrollable, it can be abused, and is abused. So, that has to go, no if or and. They are looking for other systems, other ways to handle the financing.

WEEKS:

You retired, or at least left AHA shortly after the Medicare bill was passed didn't you?

WILLIAMSON:

No, it was quite a long time later when I retired in 1972. I heard from some people who wanted me to do some things at home. So I set up an office in the lower level of my house. The Protestant Hospital Association asked me if

*Odin W. Anderson. Blue Cross Since 1929. Cambridge: Ballinger, 1975.

I would do some things for them, represent them in Washington, be a listening post, a voice, and so on. That caused some pangs in the AHA. Their officers, one in particular, saw all sorts of evil in that, which was real paranoia on their part. All of a sudden, under my aegis, the Protestant Hospital Association would become a dragon to slay them, you know. Nonsense. Anyway, I did some things for them and was their Washington voice. I developed a newsletter for them and followed out things, and gave them more of an entity, which they felt they wanted. All the members belonged to AHA, but they wanted some separateness and some identity. They wanted an identity but were not willing to do the things that would have been necessary.

Then they kept thinking they wanted some full-time voice in Washington. I told them, whether it was me or anybody else they had do it, they didn't have enough to do to make it worthwhile to have a good, really topnotch person here in Washington. I helped them find a young guy to run it who has since left. Anyway, they gave me that plaque up there for all my good works, they said. We did quite a few things for them. There were a lot of good people in that group I liked.

I also was a consultant to the Catholic Hospital Association for a while. I had lots of good friends, close friends in the Catholic field, that I did things for.

Let me go back a minute. I worked for the Protestant Association, then the Seventh Day Adventists had a problem and they came to me. The problem was the Taft-Hartley Act as amended--it was going to be amended to include hospitals (which had been exempt previously)--the National Labor Relations Act--it was a foregone conclusion. The AHA, to their everlasting discredit conducted a pitiful performance. They couldn't seem to make up their mind

whether they were for or against the amendment. They didn't understand what leadership was all about on an issue.

Anyway, back to the Seventh Day Adventists. They have a strong principle in their church about separation of church and state. With them it was an abiding thing, and they have opposed labor at various times on this issue. They wanted to see if I could work with them to get an amendment to the amendment that was coming that would exempt their hospitals. The exemption couldn't apply to church hospitals generally. I knew a lot about the situation. The language could be tailored so only two groups would benefit potentially. The Seventh Day Adventists and the Mennonites met the criteria. Very tough criteria. We developed the language with what the amendment would be. Mr. Erlenborn who comes from the Seventh Day Adventist district in Illinois was going to carry it in the House. Then I went to Senator...the chairman of the Watergate committee...

WEEKS:

You mean Sam Ervin from North Carolina?

WILLIAMSON:

Sam Ervin, yes. I went to Sam Ervin who is a great constitutional lawyer, you know. States' rights. So one day I went to talk with him about the states' rights on this issue and freedom of religion--he's big on that you know. So he picked up the cudgels in the Senate and carried the ball there. It was Erlenborn primarily over in the House, plus a lot of other people we worked on. Anyway, I worked with the Seventh Day Adventists to get that amendment through. It does give them special dispensation under the rule so their employees can't be forced to become a member of a union.

I had two or three other people who wanted things done, so I thought: I am

spending all my time home arranging to get letters typed, doing my own filing, and sending out bills, and answering the phone. I thought I had better set up an office. Then I decided I needed an assistant, some young fellow who knew enough and would do leg work for me, and be with me as an associate. So Joseph Rees came with me. He had had a lot of congressional experience; with Senator Birch Bayh for four or five years; a couple of years with a congressman, as his administrative top guy; so he knows how Congress works. In fact, as a young guy he was one of the pages up on the Capitol Hill. Joe came with me five years ago or more and we have been together ever since. It has been fun, interesting.

All our clients are health clients, but they are not all in the hospital field. We have four or five big medical centers that have problems all the time with government or they have questions or things that need to be straightened out. We have them on annual retainers. We have groups of hospitals like the New Jersey Hospital Association and the United Hospital Fund which serves about fifty some big hospitals in New York City. Then we have some other associations that are national and involved in the health field. We have had them in the fields of nurse anesthetists, dentistry, optical laboratories, and so on. As I said, all our clients are in the health field. We serve them on an annual retainer because it is the only way you can work. You can't be working for them and see something that needs to be done and then stop and let them decide if they want to have you do it, spend some money on it. So, the annual retainer works very well. It works out well for them and is fair enough for us, too. They can call us at any time and ask us to find out something or will we tell them what they need to do with this problem, or will we set up a meeting with somebody if they come down here to

Washington, and so on. This kind of thing we do all the time. Fortunately when I retired I had quite a few friends in the field, a lot of good friends in the field, and many good friends in Washington. I had close contact with those who have been helpful. I think it has given me a chance to use my experience developed broadly over a lifetime. I know how a lot of things have come to be. This I see as a great advantage. I have had the chance to develop some new ideas, which is fun. It's been enjoyable and it's kept me busy and interested.

I am surprised that there haven't been a lot more hospitals come to us, or come to somebody, than have, because at the AHA we never could find a way to serve the individual hospital with individual problems. Rarely, because you can't represent the field, you can't wear the hat of the whole hospital field and then go to a federal official and all of a sudden taken that hat off and put on the hat of this individual hospital. It never worked out. We used to see if we couldn't develop a Washington consulting business but one harms the other. You can't be all things to all people, so we gave up on that. So I thought that, as the field is more deeply involved with government all the time...there would be many more hospitals with individual problems.

One interesting development brought the Catholic and the Protestant organizations together. Their membership, their key people, were getting very, very concerned at the time when cost containment was in vogue, or in law, during the Nixon era. They felt AHA was not representing the private nonprofit community hospitals well at all. They decided that something had to be done to have a stronger, more positive voice for their views. Some Protestants got together with a group from the Catholic Association and they formed a joint alliance on that issue. Since I represented the Catholics

somewhat and the Protestants a lot, I was involved in it.

They needed somebody to guide them, legally and all. I helped to sic them on to John Harty, who is well known as a lawyer in the field, as you know. John got together with some people and they developed a very positive program. They developed an alternative because it looked like, if the government threw out cost containment, it wouldn't throw it out altogether. Maybe it would keep it in effect for hospitals only. So John and his group developed an alternative and some political support at the moment it was needed to throw it in. The AHA had no alternative. They were very lucky on the issue but not prepared.

Through the joint Catholic-Protestant group they did some good and important things, that joint effort did. Afterwards when the law was amended and the exemptions were thrown out, they said there were still things they needed to be together on. So Harty then organized an association--the Protestant Hospital Association had nothing to do with it, nor did the Catholic Hospital Association but members of both groups did. They set up the National Council of Community Hospitals. They have 150 to 200 hospitals around the country that belong to it. They are doing all kinds of things in Washington. They think they are doing the things the AHA can't do or aren't doing enough about. They believe they are representing the private not-for-profit hospital more effectively than the AHA in some ways. I have nothing to do with the organization now. I am not a member of it and I have nothing to do with the Protestant Association either.

WEEKS:

Do you think this trend toward multihospital systems is going to have a good or bad effect?

WILLIAMSON:

The multihospital private not-for-profit system has to be, is coming to be, and it's one way they can compete with the proprietary. When hospitals get down here before Congressional committees, they (the committee members) are inclined to think the proprietaries can show great economy of operation. That is only true incidentally. As a matter of fact, I know that Kaiser hospitals don't operate less expensively at all per day than do the community hospitals in the area. There's a supposition that there is something magical about multihospitals systems. Hospitals really don't have to get together that way if they would just work together, but they won't work together really. There are too many jealousies in the medical staffs, in administration, and in the board of trustees and on and on. So it takes an entity that they will give into. It's coming about, and, from what I see, some of them are very good and very effective. I think people talk about the evils, the bad part of the federal government that comes from its bigness. The same evils can happen in voluntarism, in my mind. There isn't any special brand of person in voluntarism and there is not some kind of rotter that goes into government. That's a bunch of nonsense you know. It's the forces and the facts and the people involved.

Administrators come down to Washington with a couple of people and stay three days. It costs them the fare back and forth, quite a lot of money usually. They come down here, put up at a hotel, have three days of living, \$100 apiece each day, maybe. They don't know who to see or how to talk about their problem. Often it is an utter waste of time.

I used to cogitate about the hordes of people who descend on Washington every day by train and plane. They all come in and they all want something.

I used to wonder when I would see them on the planes at night and I would hear them talking, about what they got for their day. Most of them didn't get anything. Sometimes they did, but it takes a lot more knowhow than most of them have.

That's the thing about these big hospitals we represent. If they don't come down here and wander around fruitlessly...if they want to come down here and wander around, we will tell them who to wander with and where. We'll set up appointments or we will do the work for them and let them know what the facts are. Sometimes it takes a meeting and they have to be there. Then we set the meeting up and they come and attend it. At least their time is spent more fruitfully.

There is another part to that which I recognize too. There is a kind of excitement about coming to Washington. With a good many of these hospital people it isn't the best way to do it, and they don't need to come down here, but they come because of the excitement.

WEEKS:

It makes a nice impression on the people back home.

WILLIAMSON:

Oh, yeah. "I went to Washington. I saw so-and-so, I didn't see so-and-so." And all the rest of it.

WEEKS:

To be effective in Washington you have to know your way about, don't you?

WILLIAMSON:

Like everywhere, but particularly here, there are ways to do things and there are ways not to do things. You have to know them. You don't just know it. You have got to do it. You have to experience doing it wrong a certain

number of times too.

I'll never forget an experience I had once which was of great value. Senator Lister Hill was very close to the hospital field, very close to AHA. I was very close to him. I saw him all the time. There was a bill which came up at the time Lister Hill was running for re-election. The bill came up. I knew it was again all the things he believed in. I heard that Lister Hill was favorable to some amendment in that bill that was just bad.

I said, "I don't believe it."

Jim Forrestal, who was AMA's top lobbyist and a very fine person, told me, "You are wrong. He is."

So I said, "I am going up and see him."

I went up to see him. He wasn't in his office. They told me he was over on the floor. I went over there to the Senate floor and sent a message in. He said that he would come out in a minute.

He came out. He was always very gracious, a real Southerner. "Ken, what is it?"

I told him what the problem was. I said, "I appreciate your coming out, Senator. It's crucial because I have to tell our people what the situation is and decide if we are really going to oppose this or are we going to sit and watch it. I can't believe, Senator, that you are for it."

"Ken, now son," he said, "you know I am here for six years at a time. Five of those years I am trying my best to be a statesman. The sixth year, Ken, I have to be a politician, because, unless I am re-elected I am no good those other five."

That's the truth, the real truth.

WEEKS:

Have you seen him since he retired from the Senate?

WILLIAMSON:

I haven't seen him for three years but I hear from him and I hear from his lawyer down here who handles all his legal affairs, and a close friend.

During these past few years I think I have been doing some good things, some worthwhile things. I think I have and I believe our clients think so. I am going to retire and end my working life completely.

WEEKS:

What are you going to do? Go fishing?

WILLIAMSON:

No, I am going to move away. We are building a house and are going to move away from Washington.

My associate, Joseph M. Rees, is going to continue the business. He is going in with a couple of bright young men who have quite a reputation in Washington. They will be helpful to one another. I think our clients are going to remain with him.

This has been a great city. Now I think about stopping things, clearing out my desk, and files, everything, throwing away a whole lifetime of memos. I want to get rid of those. So I think about Washington. It's been a great place. You hear that there is a lot of skullduggery going on here, but there is also some greatness going on here. I have always been impressed with the visitors. Their garb is disgraceful, you know, the way they dress when they go around here. They go around the city, and if you are near them, you'll see them reading things. They look at the monuments and the buildings. They can see words and inscriptions. They see the words "Trust" and "God" and

"Integrity" and all. They read these things often aloud. You hear so many bad things about politicians but I think you have got to remember all those great words and thoughts were written by politicians, sometime. So it's been a great place. Fun to live in. Very exciting.

Our children grew up here most of their lives and had enormous opportunity. They had access to all kinds of things. I'll never forget when my daughter was graduating from high school here. They appointed a committee to select the speaker. They could have gotten Hubert Humphrey, one of his kids was in the class. They could have got a Supreme Court justice. They could have gotten nearly anybody they wanted. The committee chose a youngish fellow who was a vice president of RKO. A couple of them had heard him speak. I had never heard of him. The committee went to talk to him. He knew how to talk to young people and they were impressed. So he was the commencement speaker. To them all the big names didn't amount to a hoot.

The libraries that they had access to were like none others. So it was a fine place to grow up and to live in. The city has changed in lots of ways; it isn't as nice as it used to be, but it's still attractive.

Shall we stop here?

Interview in Washington, D.C.

April 18, 1980

INDEX

Administrators 1-2

AFL-CIO 53

Agnew, Harvey 2

Alabama 20,28,52

Alameda County, CA 1

American College of Hospital Administrators 67-69,70

American Hospital Association 9,10-26,31,34,35,36,37,38,40,41,42,43,44,45,46,
48,49,50,53,55,57,58,60,63,65,67,69,70,71,75,76,80,81,83,84,85,87

Asa Bacon Library 10

Board of Trustees 36,37,70-71

Council of Government Relations 65,70,72

House of Delegates 37

Presidents 17-19

Textbooks and manuals 12-13

Washington Service Bureau 31,34,35,39,50,51,52,70

American Medical Association 24,36,42,45,46,56,60,65,71-72,75,87

AmeriPlan 70,73-76

Anderson, Odin 28-29,33,79fn

Association of University Programs in Health Administration 69

Association of Western Hospitals 9

Astrodome 38

Atomic bomb test 26

Ball, Robert 63,64

Bayhr, Senator Birch 82

Bill of Rights 60

Black, Benjamin 1

Blandy, W.H.P. 26-27,28,30,31

Blue Cross 17,21,22,23,25,30,48,54,71,78,79

 California 7-8,9

Blue Cross Since 1929 79 fn

Blue Cross/Blue Shield 8

Blue Shield 7

Bonnet, Philip D. 63

Boston 14

Boys' Latin School 10

Brazil 59

Bromberg, Mike 43-44

Brown, Ray 58

Bubridge, Lee 27

Buerki, Robin 58

Bugbee, George 9,10-11,20,23,24,31,32-33,34,35,50,55

Bureau of the Budget 57

Burton, Senator Harold 20
Cadillac automobile 45
Caldwell, Bert 9
California 6,8,34,64
 County hospital system 6
California Institute of Technology 27
California Insurance Commission 5
California State Hospital Association 9
Canada 2,14
Care for Handicapped 56
Catholic Hospital Association 43,44,81,83
Chamber of Commerce 59
Chattanooga 14
Chicago 9,21,24,26,35,36
Chicago University of 24
 National Opinion Research Center 29
Choir College see Westminister Choir College
Clark, Guy 11,37
Cleveland 37
Cleveland City Hospital 9
Cleveland Hospital Council 11
Cohen, Wilbur 57,63,71,79
Colombia 59
Commercial insurance companies 30
Community health center 56
Congress 21,39,47,60,63,82,85

Consulting 80-85

Cronin, John 58

Crosby, Edwin 24,34,35,39,41,42,50,57,63,72,77,
Death 75

Cruikshank, Nelson 53,54,72,77,79

Dentistry 83

Dingell, Congressman John 53

Douglas, Donald 27

Douglas Aircraft Co. 27

Eisenhower, Dwight D. 14,27

Elder, Mrs. Garrison 14

Eliot's Five Foot Shelf 12

Ellenbogen, Ted 74

Emergency Maternal & Infant Care (EMIC) 51

Erlenborn, Congressman John N. 81,82

Ervin, Senator 81-82

Finch, Robert 64

Firestone Tire Co. 5

Fiscal intermediary 62-63,76,78-79

Fishbein, Mrs. Morris 14

Fleischman Yeast Co. 12

Foley, C.J. 26

Ford Motor Company 57

Forrestal, James 87

General Motors Corp. 15

Gonzales, Jose 58-59

Good Samaritan Hospital, Los Angeles 4-5

Graning, Harald 58

Haldeman, Jack 58

Hamilton, James A. 9,58,69,70

Harvard Classics 12

Hawaiian Islands 9

Health Information Foundation 26-34,35

Hearst, Randolph 8

Hess, Arthur 64

Hill, Clyde 29

Hill, Senator Lister 20,58,87-88

Hill-Burton 17,20,22-23,31,51,52,53,54,56,57,58

Hill-Taft 20

Hoge, Vane 58

Hoover, Herbert C. 27,28

Horty, John 84,85

Houston, TX 38

Humphrey, Hubert H. 89

Hutchins, Robert Maynard 24-25

Illinois 81

Irwin, Senator Sam 81-82

Johnson, Lyndon B. 55,56,57,58,60,76-77

Johnson, Mrs. L.B. 77

Johnson & Johnson 29

Joint Commission on Accreditation of Hospitals 54

Junior Chamber of Commerce 7

Kennedy, John F. 60
Kerr, Senator Robert 61
Kerr-Mills 61-62
Kettering, Charles 15-16
Kirkland, Lane 71
La Jolla, CA 36
Latin America 59
Lilly, Eli, Co. 29
Loans 57
Los Angeles 1,5,8
Los Angeles Coliseum 8
Lunt, Alfred 32
MacEachern, Malcolm 2
McMahon, John Alexander 41
McNamara, Robert S. 57
Marshall, Field Co. 12
Martin, John 61,62
Massachusetts Institute of Technology 70
May Co. 5
Meany, George 54
Medicaid 19,61
Medical education 53
Medicare 19,54,60,62,64,71,72,76-77,78,79,80
Mennonites 81
Mental Health Care 56
Mercedes Benz automobile 45

Methodist Hospital of Southern California 1-4,5
Mexico 59
Michigan 22,53,63
Michigan State Hospital Association 63
Mills, Congressman Wilbur D. 55,61,72-73,76-77
Missouri 77
Multihospital systems 84-85,86
National Council of Community Hospitals 85
National health insurance 23,29,44,53
National Labor Relations Board 51,80
National Institutes of Health 55
New England 13
New Jersey 66
New Jersey Bell Telephone Co. 66
New Jersey Hospital Association 83
New York City 26,28,32,33,83
New York Times 19
Nixon, Richard M. 63-65,83
North Carolina 82
Northwestern University 35
Nurse anesthetist 83
Ohio 20
Ohio Hospital Association 11
Olympic Games 8
Optical laboratories 83
Owen, Jack 66

Parkinson, James 35
Perloff Committee 70,72-75
Philadelphia 64
Pinanski, Viola 14
Plus factor 63
Pratt, O.G. 19
Prepayment 17,21,22
Presbyterian Hospital, Chicago 10
Princeton, NJ 24
Princeton University 24
Protestant Hospital Association 43,79-80,81,84
Rains, Albert 52
Rees, Joseph 82,89
Regionalization 39,56
RKO Corporation 89
Rorem, C. Rufus 21,24-25
Rosenwald Fund 21
Sacramento 9
Salk, Jonas 36
Searle, G.D., Co. 30
Searle, Jack 29
Seventh Day Adventists 80-82
Social Security 63,64,71,76
Socialized medicine 26
South 14
Standardization 13

Stanford University 29

State hospital associations 11

Strauss, Lewis 27

Taft, Senator Robert 20

Taft-Hartley Act 2,51,55,80

Taft-Hill 20

Taj Mahal 36

Tax exemption for hospitals 55

Truman, Harry S. 23,25,26,77

Truman, Mrs. Bess 77

Trustees of hospitals 14-17,48-49

Trustee journal 14-15,16

Ullman, Congressman Al 73-75

United Hospital Fund 83

U.S. Department of Commerce 27

U.S. Department of Defense 57

U.S. House of Representatives 81

 Ways and Means Committee 55,72,77

U.S. Department of Health, Education and Welfare 39,49,57,62,64

U.S. Naval Academy 27

U.S. Public Health Service 56,58

U.S. Senate 20,88

U.S. State Department 58

U.S. Supreme Court 20

Venezuela 59

Voluntarism 86

Voluntary free enterprise 60
Voluntary health insurance 54
Wagner-Murray-Dingell bill 53
Warren, Earl 9
Washington, DC 19,31,32,34,35,36,38,39,40,41,50,51,53,58,60,71,80,83,84,86,
89,90
Watergate 81
Westminster Choir College 23-24
Wilbur, Ray Lyman 29
Willcox, Alanson 71
Williamson, Mrs. Kenneth 77-78
Women's auxiliaries 13-14,61
Wonnacott, Clarence 63
World War II 19