

ANDREW PATTULLO

In First Person: An Oral History

Lewis E. Weeks
Editor

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Andrew Pattullo

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CHRONOLOGY

- 1917 Born Omaha, Nebraska, February 12
- 1941 University of Nebraska, B.S., Business Administration
- 1943 University of Chicago, M.B.A., Hospital Administration
- 1943-1944 W.K. Kellogg Foundation, Fellow
- 1944-1951 W.K. Kellogg Foundation, Associate Director,
Division of Hospitals
- 1949-1955 Michigan Hospital Association, Board of Trustees,
Member (President 1954-1955)
- 1951-1967 W.K. Kellogg Foundation, Director, Division of
Hospitals
- 1951-1974 Michigan Hospital Council, Trustee (President 1967)
- 1954-1956 Gubernatorial Commission on Government Relations
(Michigan), Member
- 1957-1960 Boy Scouts of America, Nottawa Trails Council,
President
- 1959-1960 YMCA, Battle Creek, President
- 1959-1962 American Hospital Association, Council on Research
and Education, Member
- 1960 United Fund, Battle Creek Area, Chairman (President 1963)
- 1960-1967 Hospital Research & Educational Trust, AHA, Advisory
Council, Member

1960-1972 Michigan Advisory Hospital Council, Member

1962 Advisory Commission on Prepaid Hospital and
Medical Care, Member

1962-1963 Michigan Welfare League, Community Betterment Award
Committee, Member

1962-1964 United States Public Health Service, Consultant

1962-1965 American Red Cross, Calhoun County Chapter, Trustee

1963-1966 Governor's Action Committee on Health Care,
Michigan, Member

1964-1970 National Health Council's Committee on Health
Careers, Member

1965-1972 Michigan Mental Health Facilities Advisory Council,
Member

1965-1973 Federal Hospital Council, Member

1967-1971 W.K. Kellogg Foundation, Program Director

1968-1978 U.S. Department Health, Education and Welfare, Consultant

1968-1969 National Advisory Committee on Nursing Home
Administration, Member

1971-1975 W.K. Kellogg Foundation, Vice President-Programs

1972- W.K. Kellogg Foundation, Trustee

1973-1974 Great Lakes Health & Education Foundation, Board
of Directors, Member

1975-1978 W.K. Kellogg Foundation, Vice President

1976 Massachusetts Institute of Technology, Corporation
Visiting Committee for Sponsored Research, Member

1976-1978 American Cancer Society, Calhoun County Unit, Board of
Directors, Member

1977 University of Missouri-Columbia, National Advisory
Committee on Health Services Research Center, Member

1978 American Cancer Society, Foundation Division, Michigan
Division, Chairman

1978- W.K. Kellogg Foundation, Senior Vice President

Andrew Pattullo

MEMBERSHIPS AND AFFILIATIONS

Abstracts of Health Care Management Studies

Editorial Board, Member

American Hospital Association

Life Member

American Public Health Association

Fellow

Inquiry Editorial Board

Member

International Hospital Federation

Member

Michigan Hospital Association

Life Member

Michigan Public Health Association

Member

Andrew Pattullo

AWARDS

American Association of Hospital Planners

Award of Merit 1966

American College of Hospital Administrators

Honorary Fellow 1957

American Hospital Association

Trustee Award 1972

Association of University Programs of Hospital Administration

Award for Advancement of Education in Hospital

Administration 1968

Baylor University (Army) Hospital Administration Alumni

Association

Honorary Member

Boy Scouts of America

Silver Beaver

Canadian College of Health Services Executives

Honorary Membership 1976

University of Chicago Health Administration Alumni Association

Distinguished Service Award 1953

Hospital Management Systems Society of AHA

Distinguished Service Award 1974

Latin American Hospital Federation

Honorary Doctor of Science Degree, 1979

Michigan Health Council

Distinguished Service Award 1973

Michigan Health Hall of Fame, 1978

University of Michigan Hospital Administration Alumni
Association

Honorary Member

Michigan Hospital Association

Key Award for Meritorious Service 1970

University of Minnesota Hospital Administration Alumni
Association

Honorary Member

University of Nebraska Medical Center

Honorary Doctor of Science Degree, 1979

Tri-State Assembly Award 1963

PATTULLO:

My first exposure to the hospital field occurred when I was a student at the University of Nebraska back in the late 1930s and early 1940s. It was necessary that I work for my keep and for my education, which was not that uncommon in that particular era when we were coming out of the depression and before we went into World War II. My family was of rather modest circumstance; I lost my father when I was 5 years old, and my mother went to work. It's a story that has been repeated many times, but I did feel a college education to be important, which again I would guess was not uncommon at that time for people of that age and circumstances. In my senior year at the University of Nebraska, 1940-41, when I wasn't quite sure if I would be able to cut it or not financially, I had the good fortune to learn of an opening at the Lincoln General Hospital, at that time a municipal facility of perhaps 150 beds which in that era was a pretty good size, really.

I worked for my board and room, beginning as a night switchboard operator in the office and the reception area from, as I recall, 11:00 p.m. until 7:00 in the morning. After several months something else opened up in the business office and I moved into that, working late afternoons until 11:00 p.m., which had some modest effect on my social activities but was well worth it because

of my growing fascination with hospitals. The superintendent (as they were called in those days) was a nurse. Her name was G.G. Smits and she was very capable I think, reflectively, as an administrator who seemed to have a good rapport with her board and with the medical staff but still ran a pretty tight ship as they were wont to do. I used to discuss with GG, as we called her behind her back (Miss Smits formally), something of my growing affection and interest in hospitals and wanting to know more about how one became actually involved in administration. I don't recall the circumstances exactly but GG was cognizant of the only formal training program in health and hospital administration in existence anywhere in the world in 1940-41, the University of Chicago, and advised me as to that fact. She was also quite discouraging as to my getting in because a young man in somewhat similar circumstance had worked at that hospital and had applied the year before and did not gain admittance. I think the class limit was twelve, a figure which Chicago held onto fanatically for many years. I never knew what was so magic about it, but at any rate I got the information as to where I could write and so forth.

I really believe that a major circumstance of my being admitted was Dr. Art Bachmeyer (whom I will later discuss depending on your patience in part), the head of the program and who placed extreme importance upon having experience in the field -- actual working experience -- and his preference was to take people who had that and who usually had worked a few years, etc. Well, the circumstances of course were we were almost on the eve of World War II and I think that affected many people who might have applied normally (they were uncertain as to what was going to happen, etc.). You were committed to a two-year program and faced the possibility of being drafted (the draft came into being in the fall of 1940). Whatever the circumstance, I was accepted in

the fall of 1941.

On a personal note, my wife, Jean, who came from Colorado, was an X-ray technician at Lincoln General and our romance bloomed in the halls and corridors of the hospital; a very happy turn of events for me over many years. We were married the summer of 1941, shortly before we started out on that great adventure of going to Chicago from Lincoln, Nebraska. I had seldom been east of the Missouri River before that time (with the exception of western Iowa), and Jean, I believe, only once. We took that train into Chicago and got off at the old Englewood Station, which we thought to be only a fairly short distance from the campus, on a beautiful day in September, not knowing exactly what we were going to get into, and walked a considerable distance through the south side of Chicago to the campus, where we spent the coming year.

Jean went to work as an X-ray technician at Presbyterian Hospital in Chicago to support me. The superintendent was J. Dewey Lutes, a very prominent figure in the American College of Hospital Administrators (ACHA) and one of its founders. He functioned for a while as a part-time executive secretary of ACHA in an era before they obtained any full-time staff. I came to know Dewey somewhat. He was a very interesting chap and I enjoyed talking with him. Asa Bacon, another giant in the field, had only recently retired from the Presbyterian superintendency. Dewey Lutes succeeded Mr. Bacon, but Asa was still around Chicago and later on we engaged him as a consultant at the Foundation to help in the development of our rural hospital program in Michigan.

Speaking about ACHA, another link was Gerhard (Gerry) Hartman, who became a very prominent personage in the hospital field. He was the part-time

coordinator in the University of Chicago program when I arrived in the fall of 1941 and also part-time executive secretary of ACHA as a dual situation. Gerry left in early 1942 to go to his really first hospital superintendency at Newton Lower Falls, Massachusetts. From there he went, later in the 1940s, to the University of Iowa, succeeding Bob Neff, then superintendent of the University of Iowa Hospital, quite a prestigious position, especially in that era. Subsequently Hartman established a program in hospital administration, which included the first doctoral component in the field. In 1978, although these many years later, we still don't have that many doctoral programs in the country.

In 1951 I became the Director of the Foundation's Division of Hospitals and in that capacity was the Program Officer responsible for various support we provided for the development of the Iowa program. Of course I came to know Gerry very well, although I never recall his ever mentioning our earlier association as teacher-student at Chicago!

In this same "University of Chicago" connection, Dean Conley, for many years ACHA's chief executive and its first full-time staff member, succeeded Gerry at ACHA. As a student I had some contact with him, and later again came to know him well as the Foundation assisted various ACHA activities.

Very shortly after my arrival in Chicago, I felt incumbent to call upon the "patron saint" of the hospital field, Dr. Malcom MacEachern. Mac was a Canadian whom I came later to know quite well, and I think in very friendly terms. Mac was an amazing individual, a prodigious worker, somewhat forbidding in demeanor, and a visionary in many respects. He was the individual, as you know, who really put over the American College of Surgeons' pioneer hospital standardization program, the antecedent of the present Joint

Commission. Dr. Franklin Martin, who I never had the pleasure of meeting and whose autobiography, The Joy of Living, I think is one of the most interesting but least known treatises in the field, started the standardization program; Mac made it work and, again, was a very dynamic, forceful individual. His office was in an old East Erie Street mansion which housed ACS. I remember climbing up to about the third floor; we came in, Jean and I, unannounced and said we would like to see Dr. MacEachern and, God love him, he received us just that way and spent about a half hour or so visiting about what our aspirations were and why did I choose health administration and what was my motivation -- a very good question. Again I guess I sort of referred to my fascination for Lincoln General. I think I had a bent towards something which was "social" (forgive that somewhat hackneyed phrase) inasmuch as my undergraduate work had been in business administration. I took business administration, I think, on the basis that it could provide a livelihood in some way or another when I finished; and then the opportunity to combine the business background with a social type of mission such as I thought the hospital might represent seemed to be a very satisfying opportunity. Having said all this, I wonder how many other young hospital administration students over the years have substantially given the same explanation! Mac was most gracious and kind and this was the beginning of an acquaintance and eventually a friendship that lasted until his death.

One other comment concerning MacEachern. As previously mentioned, he was in many aspects the "patron saint" of the field. The religious sisters loved him; he had a real flair for the dramatic and unusual. But there was great substance as well. He was internationally known and made various such journeys to "spread the gospel" of hospital standardization, including at

least two to Australia.

At Chicago I don't think our class quite had the "magic quota" of twelve; I believe we had ten, and there was one dropout, coming from a variety of backgrounds and different age ranges. All of us had had some prior experience, most for several years. For instance, Dick Highsmith, who later became a very successful hospital administrator in California in the Bay area, was a pharmacist by background; Allan Barth, who was the first full-time director of the Michigan Hospital Association (I was somewhat involved in his coming to Michigan and to the Association) had worked for several years at the University of Iowa Hospitals and was one of the more senior classmates.

The year in Chicago on the campus was busy, interesting, and difficult for me. The work in the School of Business and the Graduate School was quite rigorous. Bachmeyer was an amazing teacher; he met with us very religiously in a weekly seminar where he endeavored to bring together in a very excellent manner the basic courses that we were taking in the School of Business and the field trips and other related experiences. Bachmeyer was Associate Dean of the Division of Biological Science, which meant that he also was the Dean of the Medical School and the Superintendent of the University of Chicago's Hospital and Clinics. Quite a triple threat!

Actually, the founder of the Chicago program was Dr. Michael Davis in 1934. Mike was Medical Director of the Julius Rosenwald Fund and in the late 1920s made a national study for the Rockefeller Foundation as to the need for training hospital executives. He persuaded Dr. Robert Maynard Hutchins, the University's President, who was very strongly biased against what he called any kind of "vocational education," that such a program was something that would be desirable for the country because of the fact there were no formal

ways of preparing hospital administrators. Parenthetically, in this capacity with the Julius Rosenwald Fund, Mike also provided the "seed money" for the program, which in fact was his "brain child." Bachmeyer arrived in 1935 and provided from that point the impetus and his genius in organization, teaching, etc. Subsequently, my association with Bachmeyer was continued because he was Director of the National Commission on Hospital Care, which the Foundation funded along with the Commonwealth Fund and the polio people (now the National Foundation), and even later the National Commission on Financing Hospital Care.

WEEKS:

Was this in the 1940s?

PATTULLO:

The Commission began in 1944 and its report provided most of the basic framework for the Hill-Burton Hospital Construction Act enacted, I believe, in 1947.

Well, getting back to Chicago, at that time the program consisted of one year on campus and one year out that we called an administrative residency, and I went to the Orange Memorial Hospital in Orange, New Jersey, under a chap named F. Stanley Howe. Dr. Bachmeyer tried to couple his students, I think, with people in the field with whom he felt they might have some affinity. I never was quite clear on that, but he went through sort of an interview process; however, I believe it was all pretty well preordained. I really do think, God rest Stanley's and Art's souls, it was not a very happy arrangement, at least from my standpoint. Stanley and I were not intellectually or personally very compatible, but I will not go into any differences. It was not an especially happy year for me although I'm sure I learned a fair amount and probably far more than I thought at the time.

When I was in Chicago for the academic portion, one of our field trips (in fact the only one that occurred outside of the great metropolis) was to Battle Creek, Michigan. The Kellogg Foundation and Graham Davis (the Foundation's hospital consultant) each year invited the Chicago students to visit (at Foundation expense which was quite a thing!) two or three days, examining and discussing the Foundation's program in rural health which was centered in seven counties in southwestern Michigan and obviously with a particular interest in the hospital side of it because that was quite a prominent feature of the total program.

Well, I was very interested in that visit and particularly Graham Davis, who was a most unusual person. Graham was a Tarheel from North Carolina and still had a distinctive accent from that region; he was a very earthy person and had a farm which he actually operated not far from Battle Creek. He had an interesting background, starting out in the philanthropic world with The Duke Endowment. The Duke Endowment was created in 1925, prior to the Kellogg Foundation, by Mr. James Buchanan Duke, the tobacco and utility magnate. Their activities were and are still centered in two states, the Carolinas, although they have always had two offices -- New York and Charlotte. Very early in The Endowment's beginnings, Graham started in the New York office without any background at all in the hospital field, and I have never known exactly why in terms of his background, which I believe was accounting. Later he was assigned to the Carolinas in their hospital section--he must have gone there in the 1930s--and then came to the Foundation in 1940 as our first hospital consultant. Prior to that time the Foundation sent people from Michigan to the Carolinas for on-the-job training in hospital administration. They would spend a number of months in the demonstration hospitals The Duke

Endowment was then assisting. That explains something about Graham and his background; he was very prominent, I might say, politically in the hospital field. He was the first nonhospital superintendent to be elected president of the American Hospital Association (AHA). This was quite an unusual happening and I don't think there has been another since; but I am not certain. Graham was President in 1947-48 and very active before that in their councils, etc. Graham left the Foundation in 1951 to become the first director of the Commission on Financing of Hospital Care which was under the aegis of the AHA's Hospital Research and Educational Trust.

In the short exposure provided by my student visit to Battle Creek I became interested in the work of the Foundation and was very impressed by Mr. Davis. I also had a conviction that the experience I was receiving at Orange Memorial Hospital in my residency was inadequate and that I really needed more "seasoning." I thought the Foundation might provide such an opportunity and I wrote to Mr. Davis inquiring as to the possibility of a fellowship appointment. At that point the Foundation had a very extensive program in the Michigan Community Health Project (MCHP) and involving various health professions. As it happened, Jim Dixon (who later became Commissioner of Health in Philadelphia and President of Antioch College and then subsequently headed up a Foundation-supported commission on health administration education) was a Foundation fellow at the County Health Department in Marshall, Michigan. The Foundation had two kinds of fellows, those who were inhouse (attached to the central office as we called Battle Creek) and those who were out in the counties and attached to the County Health Department. At any rate, there was an opening and I was accepted for a one-year central office fellowship; again I thought probably because of the shortage of people due to

the war. By that time I had been declared 4F because of a spinal arthritic condition, very troublesome to me in my earlier years, but I was probably a fairly prime commodity in some ways, because of my exemption from the war.

I arrived in Battle Creek in July of 1943, hardly with one penny to rub against another -- I remember that very well -- and Jean didn't join me until the following month when I received my stipend, which it was appropriately called, and which was I think \$150 a month. That first month I literally lived off peanut butter and crackers until I got that first check. Really it was quite an experience; that first check I guess I should have framed, but I couldn't afford to do it! My assignments for the Foundation were in regard to its broadly gauged health program, with particular attention to hospitals. The Foundation basically started, as you know, quite modestly as to its scope of operation and reflected Mr. Kellogg's own biases I think. When I came in 1943, the Foundation was 13 years old. As I think about it, we hit our 50th anniversary in 1980 so I will have been here obviously most of the life of the Foundation--a thought both satisfying and depressing!

Mr. Kellogg was still alive when I arrived and I had the pleasure of some acquaintance with him until his death in 1951 at the age of 91. Mr. Kellogg was somewhat of a foreboding character; he was not easily approachable and I understood from people who knew him very intimately that was pretty much his character here for as long as anybody had known him, rather an enigma because he was such a successful businessman in the sense of marketing and all of his innovations, flamboyant in some regards: one of the first if not the first, electric sign at Times Square depicting the Sweetheart of the Corn beauty contests, passing out to households free samples of corn flakes, and things like that. On the other hand, personally he was quite shy, an introvert and

difficult to know. I visited with him briefly occasionally, but by that time he had become blind, which obviously had an effect on his lifestyle. His custom was to spend summers in Battle Creek, usually arriving in May and departing in October. At that time in his life he had an apartment in Pasadena and a home in Palm Springs so in the winter he would divide his time between Pasadena, which was close to Pomona where he had his former home and Arabian horse ranch, etc., and Palm Springs. Mr. Kellogg's life has been well documented. He was an extremely complex person; incidentally, his early background was in hospital administration -- he was the business manager for the Battle Creek Sanitarium for some 25 years.

In terms of Foundation program development, we started very modestly in southwestern Michigan, although the hospital component thereof was quite prominent. Hospitals at that time in rural communities were somewhat controversial, and of course still are. The case for the need of a hospital in a rural community -- i.e., the larger rural communities such as, in Michigan, the Hillsdales, the Hastings, etc., which now approximate 140-150 beds -- has been pretty well made. However, in the era I am talking about, the early 1940s, most of the hospitals in the Hillsdales and the Coldwaters were usually in an old mansion adapted for hospital purposes or in an otherwise very inadequate facility. The Foundation's approach was to assist these communities in developing what was regarded at that time as model facilities, not only as to their physical plants but also in terms of their organization and operation.

My duties as a fellow really were in part to work with these rural hospitals; I would be assigned to a hospital for perhaps several weeks at a time working with the administrator, assisting in whatever manner possible.

Another very important assignment was in cooperation with the University of Michigan School of Public Health in Ann Arbor and Dr. Nathan Sinai, whom I regard as one of the great, great figures in public health and probably the founder of the field of health economics, particularly as related to schools of public health. This assignment was a study of the pattern of hospitalization of the people in two Michigan counties, Branch and Hillsdale. For residence we would use a zip code today, but in those days we used their township, incorporated village, or what have you. There was a very detailed questionnaire that had to be completed for each hospitalized individual, not only occurring in the two counties, but also attempting to trace the flow of Hillsdale and Branch residents for hospitalization purpose to surrounding larger cities such as Jackson, Battle Creek, and Ann Arbor to determine their diagnosis, length of stay, and many other details. Dr. Sinai was the study director, and I was assigned to work with him in the field. I had no input as to writing the report itself, which was published about 1945.

The report, of course, was Hospitalization of the People of Two Counties, which was a classic of its period. A young doctoral candidate at Michigan and a student of Dr. Sinai's, Odin Anderson, was also intimately involved in the study and ultimate report. Odin subsequently became internationally recognized as an outstanding researcher in the health field, and also became the Director of the University of Chicago's Center for Health Administration Studies and Director of the Health Administration Program.

Let me touch upon the whole question of a more national organization of hospital services, as well as regionalization; I think it is germane here. Graham Davis was convinced, and, mind you this was in the early 1940s, as to the validity of the regionalization concept. Let me give you one example:

diagnostic services. At that time a radiologist and a pathologist in a typical small hospital was unknown in this country. We promoted the idea of "circuit riders" in radiology and pathology who would serve multiple hospitals; the specialists being located in larger community hospitals. The pathologist would attend the monthly hospital staff meetings in an effort to introduce educational content. He supervised the laboratories; specimens as necessary were forwarded to his home-base regional hospital. The real deficiency was his inability to be on-site for "frozen specimen" analysis during major operations. On the other hand, we were also advancing the idea of staff qualifications for surgery, i.e., a referral of major surgery to regional hospitals. The radiologist's "beat" was much more of a chore. He had to be a circuit rider in a very real sense -- spending most of his time on the road.

That early project beginning then expanded over the state, and which was one of my major responsibilities in the later 1940s in covering Michigan. With that kind of initiative the Foundation's role was to help hospitals in recruiting specialists, the radiologist and the pathologist, and to provide necessary remodeling and equipment. I can remember clearly going into several rural hospitals where the only X-ray equipment would be a portable. I recall very vividly the situation in Alma, where the hospital at that time was located in an old mansion, and I asked the president of the board if I could see the X-ray facilities. So he opened up a closet and said, "Here you are." That was it. We also subsidized the cost of the X-ray and laboratory operations for a specified period of time.

This brings up a most interesting issue, and which perhaps may have been an idea of Mr. Kellogg's -- but of which I am not that certain. The premise really was very simple in concept -- the greater the volume, the lesser the

cost. So, the more X-rays, laboratory examinations, etc., the lesser the unit cost to the patient's benefit. But here we ran afoul of two very differing viewpoints -- those of the hospitals and the specialists -- both were looking for greater income. Our probably naive thought was that if the cost could be reduced, more necessary exams would be ordered. Of course, that was also a much different era -- one in which the patient paid a significant amount of his hospital bills.

In 1945, at the conclusion of the war, in all of Michigan's Upper Peninsula there was only one radiologist attached to a private clinic in Sault Ste. Marie, and no pathologist in the entire UP. We helped every UP hospital in some kind of modest capability in X-ray and laboratory. In the later 1940s and early 1950s we tried to take the same concept nationally and helped several states through state departments of health, which were the conduit. We also contributed to the whole movement of regionalization of hospital councils. Hospital councils extant in 1942-45 were in the major metropolitan areas of this country and extremely limited at that. We really created, under our direct aegis, the Southwestern Michigan Hospital Council. Now one can't probably say that it was, for all surety, the first in the United States, but it had to be among the very first. Our friends, in The Commonwealth Fund somewhat later on, post-World War II, picked up the thread and supported some demonstration hospital councils, the most notable being in Rochester, New York; but we started the Southwestern Michigan Hospital Council, firstly as a vehicle for getting hospitals together to talk about problems and opportunities for cooperation and then from that stem came a number of different programs, including one of the first centralized purchasing undertakings which began probably in 1946 or 1947. You know today this type of cooperative is

mundane in the field; back then it was a very unusual thing to do, to have that kind of multi-institutional agreement.

WEEKS:

Well, they had some rough sledding.

PATTULLO:

Today the program is known as the Hospital Purchasing Service of Michigan. I was delighted to attend its 25th anniversary celebration a few years ago. Indeed it has had some rough sledding; the program now has some relationship to the Michigan Hospital Association and is apparently going very well. Then from the Hospital Council later on stemmed the Professional Activities Study (PAS) which I will get into later; but I think the concept of regional coordination and sharing was pioneered in this area. A number of those thoughts and concepts later really came into play in recommendations of the Commission on Hospital Care.

The Foundation at that time was an "operating foundation," meaning you ran things more or less or had a major part in making things happen in terms of any given hospital, hospital council, health department, school district, etc. This was the somewhat planned approach on a broader scale in 1944 when my fellowship year ended, and I was asked if I would stay on for a while with the Foundation to help in the planning for the postwar era.

We were committed to going from an operating foundation as during pre-World War II and in a circumscribed area, to a national and, in fact, international kind of apparatus and which took us out of the operating and into the grants-making type of procedure and activities. In 1944 we also went into a divisional structure; I was named Associate Director of the Division of Hospitals and Graham Davis was Director.

We had counterpart Divisions of Medicine and Public Health, Nursing, Dentistry, and Education. Because of the war, we were operating with very few staff. Mr. Davis was older and therefore not involved with the war (he was in WWI), but many of our other people were in the armed forces and were not to come back until 1946. Helping determine strategies for what the Foundation might do in each of our program concerns post-WW II was a very challenging and enjoyable period of my professional development. I was somewhat assigned health administration by Mr. Davis, and I would guess you could say our romance with health administration education began about that time. Part of our strategy was to bring together advisory committees in each of the different disciplines. The first Hospital Advisory Committee was appointed in 1944 and included prominent people at that time in the hospital field such as Jim Hamilton, who was a past president of the American Hospital Association and had really turned that organization around (as I am sure Mr. Bugbee would have said): he brought on George Bugbee as AHA's Director and raised the dues substantially at the 1943 annual AHA convention in Buffalo (I was there -- consternation reigned but they got it through the House of Delegates). John Mannix, a pioneer in the prepayment movement, was another Committee member, as was Robin Buerki, a physician and very prominent hospital administrator/medical educator who had been a director of a national study in graduate medical education in the early 1940s and who ended his career at Henry Ford Hospital in Detroit. Dr. Harvey Agnew, who was regarded as the patron saint of hospitals in Canada, was another, as was Dr. Basil MacLean, another great hospital administration figure and personality in that era. Over the subsequent years our Hospital Advisory Committee changed in composition, but continued to contribute a great deal to our program concept and development in

the field. Such individuals as George Bugbee, Ed Crosby, Jim Dixon, Ray Brown, Art Bachmeyer, Walter McNeerney, Jack Haldeman, George Cartmill, and Matt McNulty were members. In the mid-1960s we dropped the standing committee format, going to "ad hoc" groups who focused on a single problem and which approach has also served us well. It is also important to note that similar advisory committees in the other areas of our program concerns have been equally effective over the years.

As to the original group, we brought them together and asked their advice about what the Foundation could do in terms of the hospital field specifically to improve services, quality, etc., and it was unanimously agreed that education for hospital administration was a vehicle that had tremendous promise and should be our highest priority.

So, we did two things, again somewhat as an operating foundation we decided to create a commission on education for hospital administration, but rather than being under our direct sponsorship, we went to the AHA and George Bugbee who was then on board and to the ACHA where Dean Conley had been the executive for three or four years. They became the co-sponsors for what was called a "joint commission" because of the two organizations, but Graham felt that our support should go through the AHA as grantee. I don't really recall the circumstances attendant to his so feeling, but that is the way it was. The AHA was not an eligible grantee so they created the Hospital Research and Educational Trust. (It was either that or the Commission on Hospital Care which was the first recipient. I would have to go back and check that, but HRET did come about because of our needing an appropriate mechanism to undertake the study.)

Thus, the commission was formed. Bob Bishop, a prominent Cleveland

physician-administrator, was chairman. It was politically very sound with good people on it. The study director was Charles E. Prall who had been the Dean of Education at Pittsburgh. They embarked on a two-year study to determine what a model curriculum might be like and then some strategies for developing specific programs. Charlie did a very neat thing, he decided to go out in the field and poll not only administrators themselves but trustees, department heads, physicians, and so forth, as to what they thought the responsibilities and the problems of a hospital, not the administrator, might be. They made that analysis and then from that tried to derive a curriculum that would presumably address those problems in terms of preparing administrators. There were, therefore, two sorts of publications that came out of this, one concerning the problems of hospital administration and the second a curriculum approach. By 1945, Northwestern had come into being; it was the second program to be viable -- Chicago started in 1934 and then Northwestern began in 1943. So in 1945 there were two programs, probably with a combined annual output of 25-30 graduates.

We then went to a number of universities that we thought might have an interest in starting a program if we provided initial support. The Advisory Committee had a great deal to do with the selection of those original universities. There was a very definite orientation towards schools of public health as a site, in good part because of Dr. Basil MacLean. Dr. MacLean, a past president of the AHA, was the director of Strong Memorial Hospital in Rochester for many years. Basil had a strong feeling about the need for administrators to have, in addition to management capabilities, an appreciation for community health concerns and which he felt could best be conveyed in schools of public health. So that was the bias, and we followed it. With

the exception of Washington University at St. Louis, every program that we helped to initiate at that time was located in a school of public health. There were six, one in Toronto and then, in this country, Yale, Columbia, Johns Hopkins, Minnesota, and Washington University at St. Louis (situated in the medical school). Of those initial programs all survived except Hopkins, where there was a hiatus for many years and then later a reincarnation. That impetus in the mid-1940s by the commission and our starting those first programs was also attracting the many people returning from World War II who had served in the Medical Administrative Corps (MAC) but had never had any other previous exposure to hospitals and who were presumed to be a potential pool.

George Bugbee was very interested in this latter circumstance some time ago. My recollection is that ACHA in cooperation with the Army's Surgeon General did develop a questionnaire which was distributed to MAC personnel, inquiring as to their interests upon discharge, etc., in a civilian hospital administration career. I am certain there was such a survey but its origin I'm not really clear about; I don't know if George ever ferreted it out or not. The response was very positive and consequently when the new programs came into place beginning in January 1946, (I think Columbia started at that time) with the war ending in August of 1945, there was a pool and a ready acceptance. Jim Dixon, for instance, was in that first class at Columbia. Well, following that (the development of a number of new programs) we have been involved, I guess one could say, with education for health administration ever since, supporting one dimension or one phase or another. AUPHA is just one example. I think their first meeting -- an informal grouping -- was in 1948, in Atlantic City during the AHA annual convention. We helped bring

together in the early 1950s AUPHA and some other interested parties for a conference in Battle Creek to attempt to identify some of the needs at that time in the field, which was very much in its infancy. In the early 1950s I expect there must have been only a dozen or so programs, and that conference resulted in a number of suggestions which we followed through on: the need for more research orientation in the field and for more faculty being very prominent. At any rate, we did provide support to a few universities in an effort to strengthen what might be described the field's "intellectual muscle" -- among them Minnesota, Chicago, Michigan, UC-Berkeley, and Iowa. And from these efforts came some future leaders in the field, e.g., Gary Filerman and Mickey Meilicke (Minnesota). I think that prompted us to help support some of the doctoral efforts beginning in Minnesota and which produced Gary Filerman.

Later on in the 1950s we funded a second study commission, headed by Jim Hamilton as chairman with Herluf Olsen as director. This commission's report came out in the mid 1950s. It was very divisive in the field and created quite a schism between programs in schools of public health and other settings. We tried to mend that rift by bringing them together through several conferences that were held -- at least one such was on Mackinac Island -- trying to concentrate on more positive aspects of the Olsen report; this succeeded, I think, to a reasonable extent. We were also supporting AUPHA in various ways and I think Mr. Bugbee referred to their moving to a full-time secretariat and how that came about. At that time AUPHA had part-time secretariats that were usually based at the University of Chicago program. Mr. Bugbee had only recently arrived at the University as Director of the Center of Health Administration Studies and became interested in AUPHA and its purposes and needs. One evening we did have dinner and a discussion about

AUPHA with Chuck Goulet (who was a AUPHA part-time secretary). I recollect a suggestion was made that the Foundation would not be adverse to considering support for a reasonable period of time for some kind of a full-time secretariat if there was an agenda toward some objectives. From that conversation they did make such a proposal and the first secretariat was hired in the person of Gary Filerman. I think this proved to be a sound investment on our part and a wise decision by AUPHA because it has become quite a viable organization and very influential in moving the field forward.

It is difficult to remove the Foundation in terms of developments concerning education in health administration because of such an extensive involvement including support of commissions which are, at best, gambles! Speaking from a broader perspective, we've assisted a great many commissions in different fields. It's interesting to sort of look back as to their impact and different ways of approaching their tasks, and they have varied. I think a model that, for whatever reason, has worked quite well in terms of its productivity and perhaps even eventual impact is one that Dr. John Millis has so aptly followed -- a format whereby the chairman is the director and the members constitute a "working group." Jack Millis has been the director of two such commissions which we have supported -- dietetics and pharmacy. We were the only supporter of the former; we were one of several donors to the second. The jury is still out on the impact of pharmacy; that study was only recently completed. Results of the dietetic commission, I think, were perhaps serendipitous but the major recommendation of that study was really to integrate the former fifth year internship with the undergraduate curriculum and it is now a collapsed program whereby the degree is obtained in four years. That move I believe is quite well accepted now; there has been a major

shift to the four-year format.

I have mixed emotions about commissions. Looking at the hospital field, the Commission on Hospital Care was a major payoff. I think it was quite influential in the shaping of the Hill-Burton legislation. Today, of course, the Hill-Burton program is not of that great a repute, but the philosophy and rationale for hospital planning was inherent in the legislation. I believe this fact has been overlooked by the present criticism of the program, principally directed to its contribution to over-bedding in the country and emphasis upon inpatient rather than ambulatory care. But it seems to be forgotten that the program did mandate state-wide planning and with a strong emphasis upon regionalization -- and this was in the mid-1940s. And in the 1950s under Hill-Burton the first community planning agencies were established as pilot demonstrations and which were certainly the antecedents of our present HSAs.

Back to Foundation supported commissions, the Commission on Financing of Hospital Care was originally headed by Graham Davis, who left the Foundation in 1951 to direct this study and then, because of problems midstream, resigned. He was replaced by Dr. Arthur Bachmeyer who had retired and had been head of the previous Commission on Hospital Care. Dr. Bachmeyer tried to bring the venture together; however, he died of a heart attack in Washington National Airport, and another director, John Hayes, came on board. By these events you would have to believe the Commission was ill starred. I have been somewhat critical, or I guess depreciating, of that report but I'm not so sure today; you know it was completed back in 1955. Ed Crosby believed it had some considerable influence on the development of Medicaid -- it was a forerunner then -- but I don't know if that's true: I really can't say.

As to the three commissions which we have supported concerning education for hospital/health administration, the Joint Commission in the 1940s and the Hamilton-Olsen in the 1950s were good investments. The first provided the impetus for the Foundation's initial support. As mentioned, the Hamilton-Olsen report was very controversial and created considerable bad feelings, but I think from that there were very positive results. The divisiveness as to the program's various settings, public health, business, medicine, etc., resulted in a recognition that regardless of site there was a commonality of purpose and each discipline had a contribution to the purpose. Today I believe this particular ghost has been well laid. It's still too early to determine the effects of the Dixon Commission, which was completed in 1975. However, I am ambivalent as to the overriding question of whether or not commissions are worthwhile or necessary or if they accomplish that much. A lot of money has been put into commissions by us and others. Have they really been that productive? I don't know -- obviously the results have been mixed and I have been too close to several to be that objective. You were inquiring about studies of one kind or another, and I was addressing more of a commission approach as against others.

We've supported a number of studies and in some instances I think they have been quite helpful in the field. Many of them, as you are well aware because you have had a role and a very important part in several, have been derived from projects in which we had an interest or concern. For example, the study that was done in the Traverse City area by Walter McNerney and Don Riedel concerning hospital regionalization -- Regionalization and Rural Health Care -- related to early Foundation support of such a project in northern Michigan. I've been somewhat surprised in latter years that it is described

as a classic in terms of regionalization and especially because of its candor in describing the program's failures. The particular effort was one which the Foundation, together with Joe Homminga and Jordan Popkin of our Hill-Burton program in Michigan, jointly sponsored. It was a demonstration of an arrangement involving two larger hospitals on regional basis with smaller satellite health centers. We sort of force-fed that, and the study was quite critical in that regard; suggesting there was too much from up above and not sufficient local commitment. I have no quarrel with that judgment. The Foundation supported the study as well as the publication. I believe it important to report the results of Foundation programs, the bad as well as the good. As a footnote to this, some 20 years after the initial project, one of the "satellite" units, Kalkaska, approached the regional hospital in Traverse City requesting a management arrangement that extended in scope considerably beyond that of the original compact. My judgment in retrospect is what we attempted to accomplish was too far advanced for the time, perhaps, regardless of its "being laid on" the communities involved. But I must say that I derived considerable satisfaction from the recent reapproachment!

The McNerney study, Hospital and Medical Economics, which again I believe is considered a classic of its kind, came about in somewhat of an unusual manner. As seems to be always the situation, Blue Cross of Michigan was under severe attack from various quarters and needed to come up with some improved basis upon which to make judgments or whatever in terms of their benefit structure, reimbursement, organization, etc. They turned to the University of Michigan Bureau of Hospital Administration as to the availability of people there, specifically Walter McNerney, and then concurrently to us to determine if we could provide the necessary support. We felt the problem was

sufficiently acute and in the public interest and so agreed. On that rather simplistic basis, the study group came into being and out of it came the two volume report on hospital and medical economics in Michigan which I gather is still regarded as a prototype work in the field. And it also deservedly vaulted McNerney into national prominence and his appointment as President of the Blue Cross Association shortly thereafter.

The studies seem to fall in different bases of value, origin, need, etc. We are not a research organization. However, sometimes in the process you should make some investments in the type of work that is represented by McNerney or the kind of evaluation such as the Traverse City project referred to earlier. Recently we have tried to put more emphasis on evaluation as an important part of our programming process in trying to be more effective. Much of our present activity is evaluating a particular project or program in which we have had involvement; and I guess a commission in part is another look at the same thing. I think another subject that ties into some extent with the whole matter of studies perhaps, is our engagement with quality health care, or today described as "quality assurance." We've had an extensive interest and relatively large investment in various approaches to quality determination for many, many years, and again dating back to MCHP in the early 1930s and 1940s. Also in that era we provided support to the American Public Health Association for development of an assessment instrument eventually used by all local public health departments in terms of criteria for program effectiveness, which I think was a very successful qualitative approach in the public health field.

In hospitals, our concern began with a feeling there was a need in the hospitals with whom we were primarily engaged back in the 1940s, i.e., in

smaller hospitals for improvement of what they were all about -- patient care and the need, among other things, for continuing education of their staffs, and very much so the physicians. In other words, we were considering what came to be known as the "medical audit" as a means of assessing quality of care and, very importantly, then developing continuing education as based on needs identified. It was that simple, but there was very little going on about that concept in the mid-1940s. Dr. Paul Lembcke, director of the regional hospital council in Rochester, New York, mentioned earlier, also had a great interest in this same subject and he began to develop some approaches in that council to the same question. However, we decided to try to enlist the interest of medical schools in this question and we went firstly to Ann Arbor -- I think Graham Davis handled that -- but it didn't fly; the University of Michigan did not have the interest in the medical school that we were looking for, I believe the School of Public Health likely would have had a great interest but we didn't think that setting was the appropriate vehicle for this particular purpose.

Because of my previous relationship with the University of Chicago and Dr. Arthur Bachmeyer, I approached them as to their interest in working with us and examining the quality of care in a selected number of rural Michigan hospitals. Bachmeyer was interested and identified a young faculty internist named Wes Eisele as a possible participant. I talked with Wes and he, too, expressed interest. Wes came out for a look-see and I took him around to Hillsdale and other community hospitals. We worked out an arrangement with Wes whereby he was a consultant to the hospitals; we provided the means and wherewithal, and he began to develop what we would now term a "medical audit."

Very shortly after Eisele began his activity with Michigan hospitals, the

American College of Surgeons (ACS) approached us for possible support of a proposed medical audit activity. However, at that time the term "medical audit" was verboten -- various euphemisms were employed because of the considerable sensitivity of the American medical community to this term. General Paul Hawley, who was Eisenhower's Chief of Medical Staff in the European Theatre in WWII, had only recently become ACS's head, coming from the VA where he was Medical Director. The general was a very interesting and dynamic person; I greatly enjoyed my subsequent relationship with him. Interestingly enough, I think there was a tie-in too with the then recent movement of the hospital standardization program from ACS's auspices to the Joint Commission on Accreditation. Hawley was convinced that there was a role for ACS to play in standards of care nationally, and he believed the medical audit offered such an opportunity. This concern happily coincided with the Foundation's own considerable interest as well.

Thus, we provided support to ACS for a program to develop a national approach to a medical audit process in hospitals. The sponsorship of a prestigious group such as ACS in a meaningful evaluation of hospital medical care was critical. The Joint Commission accreditation program did not get at it and would not until many years later. To head the program ACS engaged a very enthusiastic and energetic physician, "Spike" Meyers. Eventually ACS's effort came together with PAS and Vergil Slee's operation -- the genesis of what is the present MAP within the Commission on Professional and Hospital Activities was the original ACS program, in part at least. The other linkage was that going on in the Hillsdale, Albion, Michigan hospitals, etc., with Wes Eisele. On another front was the Southwestern Michigan Hospital Council and somewhat of a linkage with the people in Rochester and Paul Lembcke. What

later became the Commission on Professional and Hospital Activities started as a modest comparative assessment of medical practice among the Council hospitals. In the group of administrators at that time was a young physician, Vergil Slee, who was the joint health officer and hospital administrator in Barry County (Hastings, Michigan). Vergil was named chairman of the Council's committee concerned with the comparative analyses. The fact that he was a doc made it a very fortuitous appointment and Vergil became absolutely enamored with the project. It began as simply a summary of data from the participating hospitals that the medical record librarians would provide each month to Vergil. A part-time record librarian who was based in Allegan went around to help the hospitals compile these summaries. Vergil came up with the thought that the data wasn't worth that much and it would be a lot better if we could get it for each patient and with much more information than we were then getting in terms of the monthly summary for all patients. To do that he had to have, of course, the capability and access to processing equipment. He approached the University of Michigan School of Public Health in Ann Arbor, they were interested, and we made available a one-year grant (I think of \$12,000) to experiment with this approach. Vergil got 12 hospitals in the Hospital Council to agree for a year's time to send in data for each patient. It worked out very well, I think; in looking back over the years that project probably has been one of the Foundation's most spectacular in terms of where it started from and where it is today, albeit there are presently some problems.

I would also want to mention again Paul Lembcke and his parallel work with the Rochester hospital-group. In our early experimentation with comparative data, there was considerable interaction with Paul. However, he left

Rochester to go to UCLA where he continued his work and interest in the medical audit process. Unfortunately, he died at much too young an age, but he was a pioneer in the movement and contributed substantially to it.

Returning to the comparative data project in Michigan, it became fairly clear that its potential was much greater than use by a few hospitals in southwestern Michigan, and we then faced the decision as to how to phase it -- do you really go in a sense national in one leap? For better or worse, we decided to go under a national umbrella immediately. That involved some very delicate negotiations in a sense with the American Medical Association which never did come in, AHA, ACP, ACS, and also including the original sponsor, the Hospital Council. It was tough going; it took a number of sessions to get agreement and the real difficulty was with Ed Crosby. I've never known why, but he and Vergil from the time they met were like two cats; if you got them in the same room they could always get into something. AHA basically during Ed's lifetime never supported the Commission (CPHA); it was a tacit thing. They were a member of the sponsoring group but that was it; they appointed their duly designated representatives to the governing body but that was all. Now there were some good people who came from there and who were very helpful in PAS' growth, but as an organization -- helping promote it and so forth -- they didn't do anything. Well, in regard to quality assessment, PAS/MAP is only one aspect of Foundation support in this arena. We've carried it through the years-- the support we've given to the Joint Commission for several new ventures, e.g., their program of quality assessment, our involvement with a group of PSROs in a "private initiative," and currently we are supporting several projects concerning quality assessments. It's the name of the game, you know.

WEEKS:

Have you felt that the hospitals have put these data to good use?

PATTULLO:

That's a very good question. One of the points of contention that Vergil and I have had over the years, and there have been a few, is that I have always been unhappy with the use of the data by the field. It has nowhere begun to reach the potential that is there; in effective use I don't think it has ever been fully tapped. Obviously, there must be some exceptions in that. I'm not saying it hasn't been useful, but its potential has not been reached and I've felt in part this is because much of the information that comes in through PAS is of such a nature that it is almost unintelligible. There is so much and it serves usefully the purpose for such things as indexing, but it really does not help a medical staff or a board or an administration understand and be able to move in usage of the data; and you know Vergil was sitting right where you are about two weeks ago and has reached the same conclusion. They recently made some efforts by adding some field representatives. It may develop more of a linkage with the client but I'm not quite sure it's helping the client that much in terms of use of the information. I suppose that's one of the great overall problems in the field today. There is so much information that comes in, and how people use it. So quality, I think, is something we have made a contribution to in terms of medical care, broadly speaking, and hospitals very definitely.

I think a project we're involved with now, Private Initiative in Quality Assurance (PIQuA), and which is sort of a successor to Private Initiative in PSRO, is very promising. Its concept is to link the hospital, the data base there, and the resources of the medical record department with the physician's

private office practice. They're starting out on a pilot basis with selected hospitals in the California Bay Area with the hope, to the extent possible, in a few hospitals it can be validated and taken a step further -- then the plan is to go to a larger number of hospitals. It is a very interesting concept, and there is the potential of linking it to recertification by the professional societies that are involved. The American College of Physicians, the American Society of Internal Medicine, and the American Hospital Association are sponsors. I am very interested in this because of its qualitative implications.

I'm going to back up a minute to education for health administration and one other anecdote that possibly may have had some influence and in which I was involved. It is true I was very critical of AUPHA in its "club" days when it was principally a group of the program directors who got together periodically and socialized and talked a great deal and nothing ever very much, in my judgment, came from it, which was probably not fair in view of their limited resources. At least in terms of presenting some proposal to an organization like the Foundation, not that much ever seemed to eventuate from AUPHA and it would seem to have been fairly clear that we had a very well demonstrated interest in a number of AUPHA activities. Mention to you was made by Mr. Bugbee of a dinner group or conversation about the future of the organization and some comments I made from which at least in part came a proposal to us for support of a full secretariat. In addition to that, I was asked to meet with the group at its annual sessions and occasionally to make some remarks. The particular occasion which comes to mind was at the meeting in Dearborn, Michigan, and it may have been somewhat coincidental to the dinner conversation, I don't know, but in that presentation I did very

definitely point out what I thought were some needs in the field and which the programs should be addressing more fully. I outlined on sort of a five-tier basis what I believed to be the responsibilities of a program in health administration and I delineated them something like this -- the preparation of practitioners, the conduct of necessary research to advance the field, the preparation of scholars or forthcoming faculty, service to a community in a given area or region, and, lastly, providing continuing education programs to the people out in the field. At that point in time their major preoccupation, or most completely so, was the first function, that is, the preparation of practitioners, and very little really was being done on the other four. Those five elements were subsequently incorporated in the accreditation process, firstly under the direction of AUPHA when they were the operating vehicle and then more latterly under the Commission on Accreditation of Health Administration Programs. Parenthetically, I believe the accrediting body, to which incidentally we have provided support, has been a major factor in the field.

I'd like to comment about the Foundation's interest in progressive patient care, intensive and coronary care. You indicated that your memory was such that, at the time of our first becoming concerned about so-called progressive patient care, there wasn't that much going on in the country, and that's true. I cannot be at this time really explicit as to why and how initially this was brought to our attention, but we were convinced from what information was available that it seemed to make a lot of sense that hospitals could be organized around the needs of patients in terms of level of care. I looked into what hospitals were involved and what was written about it. At that time I think there were about two such hospitals in the country; I'm sure you are very well acquainted with them -- St. Johns in St. Paul and another in the

east, in Manchester, Connecticut. The administrator in Manchester was, I believe, Ed Thoms.

I did not visit the hospital in St. Paul but I did go to see Thoms in Manchester and spent a day with him. I felt they had something; it seemed to be such a rational approach and the kind of experiment in the field with which the Foundation should be involved. I want to emphasize that I think we really began on the premise that it was a complete package and the part that eventually, of course, became universal was the intensive care unit and its subsequent derivatives. Surely that was a critical aspect, but it was the whole concept that was important. Therefore, we provided rather substantial support, which you have well documented in part yourself,* to the movement and assisted in various dimensions. Of course, the McPherson Hospital in Howell, Michigan, represents the total implementation, but we did assist individual components, e.g., home care, etc., but always with the hope that it would evolve into a total program. Now, may I temper what I said: Hospital administrators are practical people and I think it was very difficult for Vernon Root at Community Hospital here in Battle Creek to convince himself, not to mention his board and his medical staff, that they should in one fell swoop put in the whole gamut of PPC. On the other hand, he could see a real logic and justification for intensive care; the need was much more identi-

*Lewis E. Weeks and John R. Griffith (eds.) Progressive Patient Care: An Anthology. Ann Arbor: University of Michigan, 1964; Lewis E. Weeks. The Complete Gamut of Progressive Patient Care in a Community Hospital. Battle Creek: W. K. Kellogg Foundation, 1967; John R. Griffith, Lewis E. Weeks, James H. Sullivan. The McPherson Experiment. Ann Arbor: University of Michigan, 1967; John R. Griffith, Lewis E. Weeks, Robert A. DeVries. A Reappraisal of the McPherson Experiment in Progressive Patient Care. Battle Creek: W. K. Kellogg Foundation, 1970.

fiable, explainable, etc. Some of our support thus was to discrete elements, e.g., the intensive care unit, and we did help with a number. Another aspect was home care -- the hospital reaching out into the community -- and we helped some other hospitals in that; and then again PPC, the total experiment. Now, coincidentally the Public Health Service had a concurrent interest in the concept. Jack Haldeman, who was the head of the Hill-Burton program, was somewhat of a partner with us. Jack did endeavor to promote it and then his successor Harald Graning subsequently did likewise. Today an assessment of PPC: I think it was a tremendous advancement in the field; I guess I would say I have been disappointed that the whole package never really "flew," you know, maybe the fact of the matter is it just isn't that viable. Now the self-care unit, the modern version it just isn't, but I am still disappointed because I did feel and still believe that it does have substantial benefits. One important deterrent of course to self-care in the hospital has been reimbursement policies and the belief that "self-care" patients shouldn't be hospitalized. But the idea basically of self-care was to provide a service much like that of a hotel, with such patients having the benefit of diagnostic services and various treatment modalities convenient to them.

Now this leads me to another dimension of PPC, the Coronary Care Unit, and this is one of my favorite anecdotes. CCU, as you know, is a derivative of intensive care, and a physician from Standish, Michigan, Dr. Malcolm Dolbee, got in touch with me and wanted an appointment. Standish is a small rural community, and the hospital at that time I think was maybe 35 or 40 beds. Perhaps in the scheme of things today it shouldn't be there, but at least at that time it was there (and I suppose it still is). Dolbee was convinced a coronary care unit was a good thing for his hospital and, when he began his

presentation, I really thought he was off his rocker. He tells the story that at the time he left our office he had a check in his pocket or something equally implausible; but he's right in a sense that from initial skepticism I became much less so. I did not immediately buy the whole thing, However, we (Matt Kinde, my colleague in the medical side of things at that time, and I) visited Malcolm and the hospital and then went to Ann Arbor and talked with Dr. Park Willis, who was a prominent University Hospital cardiologist, and his staff. He knew Dr. Dolbee, who had taken various refresher courses in Ann Arbor. I think Dr. Willis and associates were probably likewise somewhat skeptical. But we agreed on an experiment to help Malcolm Dolbee develop his CCU with a couple of conditions -- (1) that it had to be evaluated by the University and (2) that the nursing personnel had to take some training in Ann Arbor. Well, it really was a very successful undertaking; there was a recent subsequent follow-up study of the unit by the University, and the data still looks good, in fact, very good. Well, from that beginning stemmed a statewide program in Michigan and harking back to an earlier Foundation era very reminiscent of our diagnostic services program where we helped hospitals, smaller ones, develop their diagnostic capacities. Well, this was in coronary care, so for a period of a few years we helped a number of hospitals in the state, all small, again in relation to develop and train people and establish their units; and the University maintained a surveillance of their results and compiled them overall. The result of the total project was that there is a well-defined role, at least in terms of impact on mortality, in regard to a unit of that size. We never took that program nationally because the need for CCU in that size institution is now well established. But at the beginning, going back to Dr. Dolbee and Standish, it certainly wasn't.

WEEKS:

But you did support the architectural people?

PATTULLO:

Oh yes, that's another aspect and a very important one; I'm glad you brought it up. Now when Bob DeVries came on board our staff, he picked up the CCU program and had the responsibility for its further development, including the architectural aspects with Mr. Clipson and his colleagues of the School of Architecture in Ann Arbor. Out of it came a publication, as you're suggesting, of real merit in regard to its utility and its value in the planning and design of CCUs -- both to architects and engineers as well as physicians and administrators. So CCU is an interesting development. The regional burn care program that came along later was developed, from our standpoint, by Bob DeVries. It's been a very interesting program; we helped establish through the University of Michigan Burn Center, a regional demonstration in a number of hospitals in the Great Lakes area, ranging from Minnesota (Duluth) to Ontario. That project is winding down now; I believe it has been an interesting and valuable demonstration. This is one of the things, looking at Foundation programming, philosophically perhaps that is, an occasional orientation toward a given disease or medical area as against a broader generic approach. We've had some criticism or at least questions as to that, you know, but I'll defend what we've done -- I think in their nature we have made a contribution.* I recognize that it isn't our bag to do the whole spectrum of needs -- we can't, but those things we have done I think have been useful and contributory in their context and time.

*Colin W. Clipson and Joseph J. Wehrer, Planning for Cardiac Care. Ann Arbor: Health Administration Press, 1973.

I want to go back again to the quality aspect, another anecdote, back when we had roughly two or three years' experience with Wes Eisele and his involvement in the initial development of medical evaluation methodologies. I was asked to give a paper at an American Hospital Association meeting in St. Louis. I remember very well Charlie Letourneau was the program coordinator and the subject roughly concerned quality; I can't remember now the exact thrust of it but at least that was the general nature. Word of the work we were doing here in Michigan had gotten around in one way or another; we were not necessarily trying to keep it under wrap but it had not been publicized very much. So I delivered a modest paper on what the project was all about and its aspirations, etc. Well, it was a very sensitive subject back in that time (this was in the early 1950s), so much so that I did not feel it prudent to identify either Wes Eisele or the involved hospitals. I referred to Wes as Dr. X, not very original, and the community hospitals I gave fictitious names, though anybody could have found out. The wire services picked it up and dwelt upon it. I didn't think it was very lurid, but it was true there were some things that Wes had determined were not exactly high quality. So I got back home and found Dr. X had caused a little furor -- the Foundation in those days was very low profile to begin with and I must say that the description they used of the Foundation and Dr. X didn't meet with universal acclaim here at all. I think it was amusing as to how far the field has come today in matters of quality assurance!

WEEKS:

Probably if you had used the real names the press wouldn't have been anywhere near as interested.

PATTULLO:

Well, I wasn't that smart. I think you are absolutely right-- they wouldn't, but it was an episode I have thought about occasionally since, quite amusing really, and how times can change. One of the major interests the Foundation has carried across each of our principal fields of concern -- agriculture, education, and health -- has been, to use the new term, "lifelong learning." Regarding MCHP I referred to in our beginnings in seven counties in southwestern Michigan, a very principal emphasis in that early program was lifelong learning, or continuing education, looking at it from the standpoint of a health perspective and recognizing the need for hospital trustees, administrators, and medical staffs to become more proficient in what they were doing -- what they were all about. Now there were very few opportunities at that time to provide meaningful organized experience in continuing education in these areas of concern. In the medical field, for instance, we found it necessary to go to medical schools such as, oddly enough, the University of Buffalo and the University of Chicago, to organize special courses in subjects that were determined to be of interest and need for physicians in rural southwestern Michigan. These courses represented some of the earlier efforts in continuing education on the part of those universities' medical schools. As indicated, there were also programs for trustees as well as administrators; but I recall more clearly, for whatever reason, the courses organized for the physicians and how they represented some of the early beginnings by these medical schools in continuing education for doctors. This broad interest in lifelong learning has been carried on over all of these years to a point now where we have a senior program consultant, Dr. Cyril Houle from the University of Chicago, and one of the leading people in this field, who works with us in this area of programming. A program with which you have acquaintance is that

for trustees of hospitals and the assistance we have provided to associations, AHA, state hospital associations, both in this country and Canada. And our concern for improvement of citizen boards is much broader than the hospital; we are assisting efforts to relate to the boards of United Ways, Big Brothers, Big Sisters, YMCAs, and similar agencies.

I think that lifelong learning/continuing education is assuming somewhat of a different significance perhaps in terms of recertification. I think this ties in, for instance, with programs in health administration education; that's a very critical role for them, and a needed one in the future will be in continuing education and its relationship to competency certification. I think that the need will be there and I visualize this will be a very substantive part of what they're all about. With most programs in health administration education today it's not that much; however, I do believe it's going to be a significant aspect in the future. We have supported centers for continuing education in the general field of education, beginning at your alma mater, or Michigan State -- I guess that's yours, isn't it?

WEEKS:

Yes.

PATTULLO:

Duly blessed, beginning there, and then we supported a total of ten such centers across the country and made some definite contributions to the development of residential continuing education centers nationally. Today in our total programming we are trying to interrelate more effectively our capabilities in the general education side with those of the health professions in determining ways in which we can be continually supportive towards the advancement of lifelong learning. I cite that as another reason

that perhaps we haven't talked that much about the philosophy of Foundation programming, which is something we can do another time, but I think it is important that at least in some areas foundations stick with them long enough to make definite impact. Education in health administration and continuing education are two such examples, I believe.

WEEKS:

Could you be looking far enough ahead to say that you think there will be recertification of professionals and that this will be a preparatory step?

PATTULLO:

Exactly. I think that is a very important part of the whole picture. You know it's coming into being, looking at the administrative side of things, the federal government legislated the mandatory licensure of nursing home administrators several years ago. I was a member of the Nursing Home Administration Advisory Council that was first set up when Wilbur Cohen was HEW secretary and which gave advice in the implementation of the legislation. Although I don't think it was specific in the legislation, in the regs and the deliberations of the Council recertification was believed critical to the legislation's purpose. I'm not that close to it today to know how many states do have recertification of nursing home administrators. As to hospitals, my guess is that recertification is not going to come through a state process of licensure but rather through an appropriate professional society, which does not mean necessarily that ACHA would be the sole such body in the hospital field but undoubtedly the most dominant. I think that particular vehicle may well be more in terms of how government will approach it.

WEEKS:

Could this be sort of a left-handed thing, that it will be assumed that to

qualify for Medicare their administrator has to be such and such, that kind of thing?

PATTULLO:

No question about it; no doubt about it. In this same context, years ago when I used to make speeches much more than I do today to state hospital associations and the like, I emphasized the importance of understanding the emerging need for community health planning and that the handwriting was on the wall: the implications of Titles 18 and 19 and "conditions of participation" that simple phrase that had such portent for the future. Oh my, oh my, I stressed to the hospital association and similar groups that planning was here to stay! I was on the Federal Hospital Council for several years -- they snuck me under the tent before that as a consultant to the Council. I met with them regularly and I would occasionally even forget my status and vote! But I can well remember the Council's discussions on areawide planning; the first such funding came from Hill-Burton, and the resulting demonstrations under Jack Haldeman. Out of those simple beginnings, called "Areawide Planning Councils," came the present generation's HSAs. My message to the field then and now was that you have to get with the planning process. I didn't suggest then or now that you dominate the process but at least you have got to be a part of the process and, if you take the attitude that it is "just going away" and why bother, you're going to die in the sense of retaining some reasonable autonomy. Yes, today I think the recertification approach will be through the government saying a condition of participation for the hospital will be that the chief executive officer is accredited through a recognized professional organization and that such status be recertified periodically.

WEEKS:

Continuing education will be a part of the recertification.

PATTULLO:

Look how it's developed in the medical field. AMA and the state licensure, and the continuing education programs in medical schools, e.g., the Towsley Center in Ann Arbor. I would guess a major part of their activity now relates to programs that are given for so many CME credits. Now that's the "Mickey Mouse" approach to recertification in the professions, although to be sure a useful first step.

WEEKS:

The thing is to make it work, not only attend the meetings but have some way of absorbing it.

PATTULLO:

Yes, the real thing will come when recertification is based on actual performance by examination and that's going to come, I think. But continuing education for whatever profession will be a key factor. In that regard such programs I believe will be very closely linked to competency assessment procedures. The individual will then be able to specifically address his identified deficiencies through targeted continuing education. I might say I believe the Foundation has already made some promising program investments in this whole area and I expect will continue to do so for some time to come. It is a fascinating approach that cuts across many disciplines and professions and has great promise for the public's benefit.

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