HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

John Alexander McMahon

JOHN ALEXANDER MCMAHON

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPTIAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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John Alexander McMahon

CHRONOLOGY

1921	Monongahela, Pennsylvania, born July 31
1938	St. Petersburg (Florida) High School
1942	Duke University, A.B., magna cum laude
1942-1943	Harvard Business School
1942-1946	USAAF, Colonel Reserve (retired)
1948	Harvard Law School, J.D.
1948-1959	University of North Carolina, Professor of Public Law and Government; Institute of Government, Assistant Director
1950	North Carolina State Bar
1959-1965	North Carolina Association of County Commissioners, General Counsel, Secretary-Treasurer
1965-1967	Hospital Savings Association, Chapel Hill, Vice President for Special Development
1968-1972	North Carolina Blue Cross and Blue Shield, Chapel Hill, President
1972-1986	American Hospital Association, President
1986-	Duke University, Director Graduate Program in Health Administration

MEMBERSHIPS & AFFILIATIONS

American Hospital Association, Ad Hoc Committee to Study Ameriplan, Member 1970-1971

American Hospital Association, Council on Finance, Member, 1970-1972

American Hospital Association, House of Delegates, Member, 1971-1986

American Hospital Association -- Blue Cross Association Joint Committee, Member 1969

American Medical Association National Commission on the Cost of Medical Care, Member 1976-1977

Blue Cross Association, Board of Governors, Member 1969-1972

Blue Cross Association, Diversification Committee, 1968-1972

Blue Cross Association, Executive Committee, Member 1969-1972

Blue Cross Association, National Human Resources Advisory Group, Member 1969-1971

Blue Cross Association -- National Association of Blue Cross Plans, Liaison Committee, Member 1969-1971

Blue Cross Association -- National Association of Blue Shield Plans, Committee to Nominate Governor-at-Large District V-VI 1970, 1971, 1972, Member

Blue Cross Association -- National Association of Blue Shield Plans, UNIT Board Committee, Member 1969-1972

Duke Alumni Association, President, 1968-1970

Duke University Board of Trustees, Member 1970-1971, Chairman 1971-1983; Chairman Emeritus 1983-

Economic Stabilization Program, Committee on Health Services Industry, Member 1971-1974

Economic Stabilization Program, Industry Advisory Committee, Member 1971-1974

Greater Chapel Hill Fire Protection District Commission, Member 1956-1968

Health Planning Council of Central North Carolina, Chairman 1963-1969; Member 1969-1972

International Hospital Federation, Council of Management, Member 1975-1985; President, IHF, 1981-1983

Kate Bidding Reynolds Health Care Trust, Advisory Council, Member 1970-

J.L. Kellogg Graduate School of Management, Northwestern University, Member of Advisory Council, 1973-1986

Kings Mill Precinct, Orange County (NC) Democratic Party, Chairman 1964-1968

Life/Health Pavilion, Epcot Center, Walt Disney World, Advisor 1982-1984

National Academy of Science, Institute of Medicine, Member 1974-

National Center for Health Education, Board of Directors, Member 1975-1986
Vice Chairman 1981-1986

National Council on Patient Information, National Advisory Board, Member 1984-1986

National Health Council, BCA delegate 1970-1972

North Carolina State Bar, Member 1950-1972 (Inactive 1972-)

North Carolina Citizens Association, Director 1972

North Carolina Committee to Study the Financing of Industrial Facilities, Member 1961-1963

North Carolina Community College Advisory Council, Member 1963-1972

North Carolina Courts Commission, Member 1963-1966

North Carolina Governor's Council on Comprehensive Health Planning, Chairman 1968-1972

North Carolina Governor's Commission for Education Beyond High School, Member 1961-1963

North Carolina Hospital Association's Council on Hospital Planning, Chairman 1970-1972

North Carolina Joint Conference Committee on Medical Care, Member 1969-1972

North Carolina National Bank, Chapel Hill Board, Member 1967-1972

North Carolina Recreation Advisory Committee, Member 1959-1963

North Carolina Regional Medical Program/Comprehensive Health Planning Liaison Committee, Member 1970-1972

North Carolina Tax Study Commission, Member 1965-1966

Oil Industry Lifesaving (OIL), Flights Board, Member 1984

Orange County Democratic Executive Committee, Member 1964-1968

Orange County Welfare Board, Member 1956-1963

Piedmont Urban Policy Conference, Member 1969-1971

President's Commission on Health Education, Member 1971-1972

President's Committee on the Health Services Industry of the Cost of Living Council, Member 1971-1974

Public Agenda Fund (NY), Advisor 1982-

Research Triangle Foundation, Director 1970-1983

Robert Wood Johnson Foundation, Community Programs for Affordable Health Care, National Advisory Committee, Member 1982-

Social Security Administration Task Force on Hospital and Extended Care Services of the Health Insurance Benefits Advisory Committee, Consultant 1967-1969

3M Company, Board of Directors, Member 1982-

U.S. Chamber of Commerce, Committee of Nation's Health Care, Member 1977-1986

University of North Carolina (Chapel Hill) HMO Steering Committee, Member 1972

Veterans Administration Special Medical Advisory Group, Member 1973-

HONORS & AWARDS

American College of Hospital Administrators
Honorary Fellow 1974

American Hospital Association
Distinguished Service Award 1985

American Medical Association
Citation of a Layman for Distinguished Service 1978

Association of American Medical Colleges
Special Award 1985

Georgetown University
Honorary Doctor of Science 1985

Hospital Association of Pennsylvania
Distinguished Service Award 1983

Illinois Hospital Association
Special Award 1985

South Carolina Hospital Association
Distinguished Service Award 1978

Wake Forest University
Honorary Doctor of Law

BOOKS

The County Yearbook. (editor) 1959-1964. Chapel Hill: The North Carolina Association of County Commissioners

North Carolina County Government. Chapel Hill: The North Carolina Association of County Commissioners, 1960

North Carolina Local Government Commission. Chapel Hill: The North Carolina Association of County Commissioners, 1961

WEEKS:

I have you as being born in 1921, in Monongahela, Pennsylvania.

McMAHON:

That is correct.

WEEKS:

And I have you graduating from Duke in 1942, with a magna cum laude.

McMAHON:

Right.

WEEKS:

And then, somewhere, I think it was Jim Hague's article that he wrote about you when you first came here, he mentioned that you wanted to go to law school but, in 1942, we were in a war and you were afraid you couldn't complete a law course.

McMAHON:

Yes. The advice that I got from the people I talked to in the law school was, "Don't go to law school, you're not going to last a year." I was twenty when I graduated from college. I was to be twenty-one that summer, of course. But they said, "You're not going to last very long because there are no deferments in law school. The military doesn't need any lawyers, any more than they've got. Don't take a year because you'll forget it when you are going to be away from it for a number of years. So don't try. Either go into the military or take some other kind of graduate work." That's when I applied for and received a scholarship to the Harvard Business School. So I went up there for a year. It was very useful because it deepened my knowledge of finance and accounting, particularly.

WEEKS:

Then you did go into the Air Force?

McMAHON:

Yes. Well, I went into the Army, as it was then. I enlisted in the Army while I was in the business school. I applied for a commission in the Navy, but because of my eyes and the glasses I wore, the Navy wasn't interested. But the Army would take anybody. So I didn't have any problem enlisting.

WEEKS:

So that was the old Army Air Force.

McMAHON:

Yes, I went into the Army but one of my professors in the business school who taught statistics was involved in the statistical control activities of the Army Air Forces, so the long hand of the statistical branch of the Army Air Force reached into that induction center in Pennsylvania and hauled me out and sent me as an individual down to Orlando, Florida, into the statistical control unit down there. I had a marvelously interesting career as a result.

WEEKS:

You are now a Colonel, retired, right?

McMAHON:

Yes.

WEEKS:

Then you got into Harvard Law School.

McMAHON:

Yes. About 15 days after I left the South Pacific. I was stranded in Eniwetok, I think, for a period of time because I wasn't a priority, I was just going home. But by the time I got through and was processed out at Camp

Atterbury, Indiana, I had a couple of days with my father in Monongahela to buy some clothes before I went off to the law school.

WEEKS:

I think it was Hague who said that one of your original goals was to be a corporation lawyer.

McMAHON:

Yes. It was indeed.

WEEKS:

But you didn't end that way.

McMAHON:

No, that's right. I knew there was a substantial amount of money to be made in corporation law. But about half way or two-thirds of the way through law school, I decided I didn't want to spend my life worrying about other people's contracts and their torts and their divorces and so on. So I began to look around for other branches of the law that might be interesting. I discovered that there were a couple of places that had interesting programs. One I remember was the Bureau of Municipal Research at the University of New Hampshire. The other was the Institute of Government at Chapel Hill which involved a combination of teaching and writing and research. Particularly, the teaching of people that were doing work, city managers, county managers, finance officers, attorneys, who were actually doing day-to-day work in local government. I had gained an interest in local government and state government as a result of some of the courses I took. So that's what I decided to do. I would at least start out in that area.

Instead of teaching law; I had never cottoned much to the idea of teaching without practicing first. At any rate, at the Institute of

Government at Chapel Hill, I could do some of both because it was actually working with hands-on people. So the county commissioners and county attorneys and county managers and county accountants of North Carolina gave me a good solid education into local politics as I was trying to teach them some of the aspects of the law they were working with. I taught them accounting, too. I wrote a couple of guide books on how to account for the taxes and the expenditures and other revenues, both in counties and in small cities in North Carolina. I actually installed some accounting systems down there.

WEEKS:

It sounds like you had a good experience.

McMAHON:

Yes. It was a happy combination, both of the business school education and the law school.

WEEKS:

In the meantime, you were admitted to the North Carolina Bar.

McMAHON:

That's right.

WEEKS:

How did you happen to make the move over to the North Carolina Association of County Commissioners?

McMAHON:

The Institute of Government had a strong tradition of not getting involved in any kind of lobbying activity. It was strictly an educational program. I found that there was something a little sterile about that. There were some things that I thought needed to be done in county and municipal law. I couldn't do anything about them at the Institute, so when the North Carolina

Association of County Commissioners decided in 1958 that they wanted a full-time executive officer, combination of secretary/treasurer/general counsel and chief lobbyist, I decided I wanted to do it. So I moved over. I never regretted it because it was then in the day-to-day business of representing the hundred counties of North Carolina in the legislature, sometimes in the courts. I found it a very satisfactory and satisfying activity for seven years.

WEEKS:

That really paved the way for some of the work that you've done here.

McMAHON:

That's right, I learned the lobbying trade by doing it.

WEEKS:

You wrote some books while you were there too, didn't you?

McMAHON:

Yes, I did. One on the North Carolina local government commission, describing its activities. A county or a city in North Carolina could not issue bonds without the approval of the local government commission who wanted to be sure that the financial base was sound enough, that the purpose was appropriate. The local government commission was set up, I think, in 1935 -- somewhere in the mid-1930s -- as a result of some defaults of local government bonds in the Depression. North Carolina always had a habit of meeting crises in great style. Some of the things that were done in North Carolina to straighten out both the state and the county government were superb.

By the mid-1950s, twenty years had gone by and people said -- especially local government officials -- "Why this state interference in what we want to do?" So the attempt to describe the background and the procedures and the

safeguards that it had, not only for the local officials but for the taxpayers, was thoroughly appropriate.

I wrote some other things too about the structure of county government, a little booklet called North Carolina County Government, and did some other things at the same time. These were to describe the structure -- why we had county commissioners. It came from an Ohio general right after the Civil War. They had county commissioners in Ohio so when the occupying army rewrote the North Carolina constitution in 1868, they adopted the county form of government from Ohio using county commissioners instead of the Justice of the Peace system that we had had before and that I think Tennessee, for example, still has.

WEEKS:

That sound like wonderful experience. You did edit the Yearbook too, didn't you?

McMAHON:

I inherited the Yearbook. It had been used in part to support the County Commissioners' Association because it sold advertising. I wasn't all too enthusiastic about the advertising business, but it was a tradition that had started. It was a useful thing for county officials. It had a directory as part of it. Then what I did was to organize the annual convention in the summer around a particular theme that then could, with the text of the speeches including some of the question and answer stuff, actually become the text of the Yearbook that carried the advertising. We increased the dues substantially and the advertising wasn't all that important. But it was a useful thing to continue.

WEEKS:

How did you happen to move over to the Hospital Savings Association? That's Blue Cross isn't it?

McMAHON:

That is Blue Cross and Blue Shield. Some of the legislators that I had met in my lobbying activities for the county had asked me several times if I was interested in moving into the private sector. Blue Cross and Blue Shield, of course, has traditionally been not-for-profit but it's still in the private sector. I wasn't very much interested in insurance, health insurance, didn't know much about it. So I said I wasn't interested. Then after representing the counties, running the association for six years, I thought I'm not sure. I was then -- that was 1964, I made the change in 1965 -- I was 43. I didn't want to do what I had been doing for the rest of my life, though I found it interesting. Here was a chance to both do something interesting and substantially improve my income opportunity. So finally in early 1965, I began to meet with some of the officials of the Hospital Savings Association in Chapel Hill. I decided that summer that I would move over and try that side of the world for a while.

WEEKS:

Was the purpose of their hiring you to bring about a merger of the plans?

McMAHON:

No. It was precisely the opposite. I was given to understand that they had had some merger discussions with Hospital Care Association in Durham but decided that a merger was not in the interest of either of the two plans, their management, their employees, or their subscribers, and that that issue had been settled for all time. I didn't understand how unique it was at the

time. But I was given to understand there was a comparable organization in Durham and we would continue to compete with one another except for some cooperative activities. But it was very clearly the reverse.

The reason they were looking for somebody in those early years was the then president of Hospital Savings Association was approaching retirement. I think he was 68 at the time. What they wanted to do was to find a successor. They didn't see one inside because some of the senior people on the inside were approaching retirement age as well. So they were looking outside. And as they saw Blue Cross and Blue Shield moving more into the public arena -- Medicare was on the horizon, Medicaid, more activity on the part of the states -- they thought that somebody who knew state government particularly, and knew lobbying, would have some useful attributes.

So I joined Hospital Savings as Vice President for Special Development in October 1965. After we agreed on the change and the timing, Medicare and Medicaid were being considered in the Congress of the United States and were enacted that summer. So my first duties became the implementation of the Medicare program in North Carolina because the two plans, Hospital Savings and Hospital Care, were given the intermediary role jointly. I was acceptable to both of the plans as the one individual without prior scars, and we divided up the work on a fifty-fifty basis. They knew there was going to be more dealing with the government and for that reason decided that somebody that understood government and the way government works would be useful attributes. And it was understood that I was going to succeed Mr. E.B. Crawford, who was then the president, in a couple of years.

WEEKS:

That probably helped bring about the merger. How about the other

executive?

McMAHON:

Same age. They had both begun the two separate Blue Cross Plans, one in Chapel Hill and one in Durham. The one in Durham closely allied with Duke, though there were some other interests as well. But there was an interest on the part of the Duke Medical Center, then a fledgling medical school, in having a prepayment mechanism. Of course in Chapel Hill, the University of North Carolina's, then, two year medical school was interested in starting a plan. So they both started in 1932-33. Two of the, I think, original four Blue Cross Plans were those two Plans in North Carolina. So they had had a long history. And the two presidents of the two Plans in the mid-1960s were both about the same age because they had started them as young men in the early 1930s. They were both approaching retirement in the mid-1960s.

There wasn't anybody in Durham, who was heir apparent over there in the Hospital Care Association. What happened, Lew, is that I observed very early that these two separate Plans were unique in the country, they were competing head-to-head as both Blue Cross and Blue Shield Plans. There was a lot of wasted effort, a lot of duplication of management, of computer capability. As they were competing head-to-head, they were paying more attention to out-competing one another than they were taking on the commercial carriers. We had strong commercial carriers, Provident Life and Accident in Chattanooga had a great part of the textile business in North Carolina. Home Security Life was there in Durham. Jefferson Standard Life and Pilot Life Insurance Company in Greensboro were strong competitors. Here we were competing, these two Plans within the Blue Cross and Blue Shield family, competing one with another and not paying attention to those other large, really competitive carriers in

the environment.

Then when I took a look at the Medicare Program, Hospital Care was processing half of the claims in Part A. We lost Part B to Pilot Life Insurance Company because they didn't want another division. They were locked in for Part A because the hospitals all nominated the Blue Cross Association as the intermediary. Blue Cross gave it to the two Plans. Blue Cross wasn't interested at all, in those days, nor was Blue Shield, in bringing about Plan consolidation down there. There was a lot of belief in local autonomy.

So here we were. I could see the inefficiencies in what we were doing and that at some time the federal government was going to say, "We're not going to put up with this any more, we're going to look for one Plan to do it." I thought the best Plan to do it was a consolidated Blue Cross and Blue Shield Plan. So I explained that to the Hospital Savings board, and with some reluctance, they finally saw that it did make sense. It was not hard then to sell the idea of merger to Hospital Care. I think they had been more interested in merger in Durham than they had been in Chapel Hill in the early days. So at least I was on the right side to convince a group of people that consolidation was in the best interest of everybody, most of all the subscribers that we were in the business to serve.

WEEKS:

It was rather unusual, wasn't it, to have two Plans competing and they were only ten or eleven miles apart?

McMAHON:

That is right. The closest other competitive situation was on the West Coast, because most of the other Blue Cross Plans, where there were several in a state like Pennsylvania and Ohio, divided up the area and there was no

encroachment. On the West Coast, in California and perhaps in Washington, Blue Shield competed with Blue Cross. They had a Blue Shield Plan in San Francisco, two Blue Cross Plans, one in Oakland and one in Los Angeles. But the Blue Cross Plans sold an indemnity physician package and Blue Shield sold an indemnity hospital package. So they competed one with another. But in the rest of it Blue Cross and Blue Shield were cooperative and there was no other area competition like the North Carolina situation.

WEEKS:

Today you have to ask every day how many Plans there are because there are so many mergers going on.

McMAHON:

Absolutely.

WEEKS:

Ohio is one. They have had some mergers down there.

McMAHON:

Yes, indeed they have.

WEEKS:

This is sort of off the story, but did you build the new, beautiful building in Chapel Hill?

McMAHON:

Yes, I did. It was the first thing I did after the Plans were consolidated on January 1, 1968, because I knew that there would be problems if we tried to place the headquarters either in Chapel Hill or in Durham. The best answer, being ten miles apart, was to do something in the middle. I discovered, after some discreet inquiry, that there was an old farm -- old, because the buildings were old, and it was no longer a farm -- that was owned

by a retired member of the faculty of the medical school at Chapel Hill, Dr. Foy Roberson. When I discovered that farm was for sale, it was obvious that it was a big enough piece of land to take care of a building and expansion and parking and so on; and because it was between the two cities -- now things have grown up around it but they hadn't then -- there was plenty of room for future expansion.

So I bought the farm and then moved my office into the farmhouse. It was satisfactory. The way we consolidated the two Plans was to consolidate the two boards. Each board had twelve members and with the president a member of the board, twelve and twelve and one, twenty-five is the way we started out. There wasn't any difficulty in indicating that we would have had trouble expanding in downtown Durham, and trouble in downtown Chapel Hill as well, so we were going to have to do something. The best thing to do was to put a building right between the two cities. It was in Orange County, as Chapel Hill is, but one piece of the property went right up to the Durham County line so we ended up with a Chapel Hill address and a Durham telephone number which helped. The communities are fairly small cities, both of them. Chapel Hill, then, was about forty thousand and Durham about sixty or seventy. It meant that it was a convenient location for people to travel to.

We sold the Chapel Hill property to the University of North Carolina. We kept, for some of the activities because it made sense to do so, the Medicare processing in the Durham location. Because then, if the government, and that was always a possibility, took over Medicare, we could get shed of that property. So it made sense to keep the Medicare processing in Durham.

After we got the farm, as I say, I moved into the farmhouse with a couple of people. We took the living room and the dining room downstairs and opened

it up so there was a table for staff meetings and I had my office upstairs along with a secretary. But it established a principle that that's where we were going to be. Then with a couple of the board members we began the process of planning.

The architect first brought in plans that looked like a fortress, didn't tie in with anything and it wasn't an open kind of thing. Neither the committee nor I liked that. So we sent them back to the drawing board and then they came back with that three dimensional parallelogram, a rhomboid; it was ideal for that climate because the walls slanted away from the western sun and slanted away from the southern sun, open to the eastern sun and the northern sun. So it always got plenty of light and good air. Both the architect and we got some notice for this. I've kept up with the architect from time to time. We became good friends in the process, as I did with two sculptors in St. Louis who did some of the landscapipng and did some of the sculpture work, exterior sculpture work. So it was an exciting project. It was completed after I left Chapel Hill and Durham. In October of 1973, I went back to the dedication. Of course I pass by it from time to time. I'm very please that I had a small hand in that.

WEEKS:

I was in Chapel Hill in 1976, to talk with Jim Veney. I was succeeding him as editor of Inquiry. One of the sites that he took me to after dinner was to see the new building. That is really something to go out of your way to see.

You were very active in Blue Cross Association affairs during those years too, weren't you? I have you down as serving on the Board of Governors.

McMAHON:

Yes, I served on the Board of Governors of the Blue Cross Association. Even more importantly for what was to follow, Blue Cross nominated a couple of people to serve on some of the AHA Councils, particularly the Council on Finance. Within a few months of my arrival on the BCA scene, I was appointed to the Council on Finance of the AHA. Then I was nominated by Blue Cross to take one of the two seats -- or whatever it was, maybe only one -- in the House of Delegates of AHA. So from the Council on Finance and getting acquainted with officers and staff here at AHA, then I served on a couple of AHA committees at their appointment, particularly one that was involved in the final position on the Perloff plan. I think I also served on one that was dealing with how to make state rate regulation appropriate. But the result of that activity, more than the Board of Governors of BCA, was becoming acquainted with a lot of the officer leadership and the staff and some of the board members of the American Hospital Association.

WEEKS:

You also served on some BCA liaison committees with Blue Shield?

McMAHON:

Yes. There were some liaison committees with Blue Shield, though I was never on the Blue Shield board. But, of course, as a Plan president after 1968, I always attended the national Blue Shield meetings. I think there were also some committees. But the one I remember best in the overall liaison area was that I was on the Blue Cross side of the liaison committee with AHA that worked out a statement of Blue Cross relationships with hospitals. And it overlapped the time that I made the change. So I started out on one side, but at least I was consistent; I didn't have to change my mind or change my

position.

WEEKS:

What was the date of the separation of AHA and Blue Cross, back when they changed their symbol and all this sort of thing?

McMAHON:

It was earlier, before I came on board. Because when I became the CEO here at AHA, there were no longer Blue Cross members of the board of trustees of AHA and there were no longer AHA trustees on the Blue Cross board.

As part of the change, the CEO of AHA became the president of AHA, so I became the president of AHA. Ed Crosby had been the executive president before the change and up until the time he died.

WEEKS:

Oh, the title changed before you came in?

McMAHON:

It did, yes. Because I came as president. It seems to me that Ed never was the president, because the change occurred about the time he died. At any rate, it was all done by the time I came. AHA changed the name of the president, who had been the annually elected officer, from president to chairman. Steve Morris, Steve served in 1972, was both the last president and the first chairman of the board of AHA.

WEEKS:

I was thinking also that Madison Brown was called temporary president or something like that, wasn't he?

McMAHON:

Yes, he was. I have forgotten just what Madison's title was. That summer, when the selection process was under way, Steve was then the Chairman

of the Board, and because Ed had died in February, there was no president. But that was the position they were looking to fill. So it may have happened sometime at the annual meeting. I have forgotten that detail myself. I do remember Steve did take office as president and then became the chairman of the board when the title was changed.

WEEKS:

That selection of you was quite a process, wasn't it?

McMAHON:

I gather it was.

WEEKS:

Without your being privy to what was going on.

McMAHON:

I have no idea.

WEEKS:

I think you and Walter McNerney were the two candidates that were seriously considered.

McMAHON:

There were a number of candidates who were seriously considered, including some of the then officers, I gather. I really have never asked about it. I wasn't particularly interested in knowing. I thought maybe the less I knew, the better it was. But I do remember getting a call on a Friday night, just before I was going to come up to Chicago anyway, I think probably on Sunday, to the annual meeting I didn't even know that the board was in session until the telephone call, because I wasn't that familiar with the activities of the board and the house. I was coming up on Sunday as a member of the House of Delegates to the AHA annual meeting. I had a call on Friday

night, when I got home from the North Carolina Blue Cross and Blue Shield office. My wife said that Steve Morris had called and would call back at seven o'clock. I said, "That's interesting. I suspect he wants to tell me that they've decided on Walter, and will that mean any disruption in the Blue Cross Association."

When Steve did call and tell me what was up I said, "Wait a minute, why me? You've got a perfectly good Blue Cross type that I understand is being considered."

He said, "Well, he's not under consideration now. There is only one person under consideration and it's you. Will you come up and meet with the board tomorrow?"

I said, "I will come up and meet with the board tomorrow, but I have no idea whether I am interested or not. I am perfectly happy here, and I don't know that I would look forward to moving to Chicago. It's a great community, but I've got a fine job and I'm not sure; but I'll come and talk to you."

That was what I did. I came up to Chicago and talked. Then the board voted, I was told later, late Saturday afternoon to inpower the officers to meet with me that evening and talk about details and arrangements and so on. I had made no commitment. I said I would continue the discussion to see how things might go, but I wanted to think about it because I still didn't know whether I wanted to come to Chicago. So I met with the officers that night and they gave me until Monday morning. It was interesting, because there was a big Blue Cross Association cocktail party between the board meeting and my meeting with the officers and there was some discussion about the inevitability of Walter's selection and who was going to head Blue Cross and was I going to do that. Obviously that was premature because I had no idea

whether I'd be interested or not. You don't understand what it's like to be a North Carolinian and live in the Durham-Chapel Hill area and have your kids in a good environment like that.

So then I met with the officers, and we worked out some details, and as I said, they gave me until Monday morning to think about it. I sat up most of that night with a yellow pad writing pros and cons. I think the final thing that I thought about was the seven years I had at Blue Cross and Blue Shield, that I had thoroughly enjoyed it, but I had also enjoyed my days with the County Commissioners Association. I knew what it was like to run an association, though that was an association of Democrats and Republicans, instead of easterners and westerners. I'm not sure they are all that much different. But I knew what consensus-building was, and I knew what an association executive was expected to do and to be. And I liked, in addition, the decision that had been made by the American Hospital Association as a result of the work of what was called the Leadership Committee that John Stagl chaired, that the president of AHA should be the voice of hospitals to the outside world and the elected officers should be the voice of AHA to the membership. That meant that I didn't have the kinds of problems that I saw, even from afar, in the AMA where there was not that clear division. It meant, yes, I was the voice of AHA to the world, to the media, of course to the Congress, to the administration, to the executive branch of the government. So it was a good clean operation, very much of the kind I enjoyed with the North Carolina Association of County Commissioners. Although there I started out with a secretary and ended up with two people. There's a little difference to go from two to eight hundred. But I knew how to deal with eight hundred because that's about what we had at Blue Cross and Blue Shield.

WEEKS:

Is it true that you said that you would like to retain your place on the board of Duke University?

McMAHON:

Absolutely. That was one of the considerations. I had just become chairman of the board. I went on the board in 1970 and became chairman in 1971. Another interesting thing: I said, "I haven't even attended an executive committee meeting," when I was asked to be the chairman. But I knew the president and I knew the former chairman because the former chairman had been a longtime, part-time, state official whom I had lobbied together with because he was also an executive of the R.J. Reynolds Tobacco Company. He had been on the State Personnel Council and the Merit System Council. The Merit System Council was the one that dealt with the county welfare and county health departments. So I knew Charlie Wade (the former chairman) very well. He was going to have international responsibilities with R.J. Reynolds and knew that he could no longer serve. I had known Terry Sanford (the new President of Duke). Terry was on the staff of the Institute of Government just before I arrived. So I had known Terry in the political years, and I was very close in all his four years as governor. So they said, "We want you to do it."

I said, "All right, I'll be glad to do it."

I started as chairman in May of 1971. One of the things that came up in the AHA discussions was that I said I want to continue to serve as chairman. It was not a time consuming job. We had then only three board meetings a year, and we had about six executive committee meetings. They were always on Fridays and Saturdays.

If they had said, no, we don't want you to do that, I don't know what I would have done. It never became an issue because they said, "It's marvelous to have as the president of AHA someone that another distinguished institution thinks has leadership capabilities.

WEEKS:

It appealed to the academic world and gave you a certain reputation there.

Before we leave North Carolina, I have a few notes I made on positions that you held in North Carolina. I might name them and you can tell me whether they are important or not. The Comprehensive Health Council...

McMAHON:

The first one was called the Health Planning Council of Central North Carolina. It grew out of, really, a key individual in the Durham community who, in the early sixties, came to realize that Duke University, the University of North Carolina, what was then the Watts Hospital in Durham, the Lincoln Hospital in Durham, and Rex Hospital, St. Elizabeth's Hospital, and Wake Memorial Hospital -- all three in Raleigh -- were all making plans for expansion and renovation. The costs of the capital investment would be borne by all of the people in the communities through their health insurance. He was involved as the chairman of the board of the Central Carolina Bank, but also as the chairman of the board of Home Security Life Insurance Company. So he knew that these uncoordinated plans were going to come right back on the community and thought that something ought to be done.

Those were in the early days of health planning. The leadership came from Durham, Orange and Wake Counties. I served as a representative from Orange County, because I had been on the welfare board in Orange County and

had done some other political things. I was the precinct chairman of the Democratic Party in my precinct in Chapel Hill and thus on the executive committee of the Democratic Party in the county seat. Thus I had met some of the political figures both in Durham and in Wake, because we were all in the same congressional district. That meant that when we caucused at the Democratic state convention, I became acquainted with the Democratic Party leaders in the other two counties in the congressional district. It has since been changed, but that's the way it was then.

So I was asked to serve from Orange County, along with one or two other people. I think we started off with about a twelve man board. Maybe there were two or three from Orange County. At any rate, we began to see what we could do. There was a little Hill-Burton money available but it was before the Comprehensive Health Planning Act of 1964 or 1965.

We put together this Health Planning Council of Central North Carolina and I served as chairman. We began to review the plans and bring about some coordination. But it was important, Lew, because that was my first real introduction to the health care world, other than as a consumer of health care services. I had four children by that time. I hadn't had any personal experience with the overall system, but I had had personal experience with the health system. That's all I knew about it.

WEEKS:

Did the committee have any teeth? Were they able to approve or disapprove plans for expansion?

McMAHON:

Not in the beginning. In the beginning, it was by cajolery and getting people to talk with one another. Of course when the Comprehensive Health

Planning Act came along and "certificate of need" was injected into the environment, it then had teeth. But it didn't in the beginning. It didn't need it. North Carolinians get along with one another pretty well, and the clout of the business people themselves, both in Wake County where Raleigh is, and Durham County, and Orange County where Chapel Hill is --the clout of those business men was enough to talk to board members. So it worked out. I'm not sure that when the clout came that it made any great difference because they had begun some coordination.

WEEKS:

I'm interested because in Michigan we have a situation now about lithotripters.

McMAHON:

Yes. We've got the same situation in Durham, Chapel Hill, and across North Carolina.

WEEKS:

There were supposed to be three in Michigan so three hospitals ordered them before they had approval. Now the state has disapproved two of those who had spent probably $2 million each. The question in my mind is what is going to happen next?

McMAHON:

It wasn't so much then back in 1963 and 1964 -- oh, we talked about the burgeoning number of cobalt machines, that was the early thing twenty some years ago. It was more just construction activity and the increasing number of beds that were on the drawing boards. Before the technology. None of the discussions had to do with the cobalt machines and nuclear magnetic resonance. That all came later.

WEEKS:

It's a big question that has to be settled before we go much further I think.

McMAHON:

Absolutely.

WEEKS:

You also referred to the Research Triangle Foundation which I don't know much about. I used to have some contacts with them.

McMAHON:

The Research Triangle Foundation really was the holding company for the headquarters of the Research Triangle Institute and the headquarters of the whole Research Triangle development operation. I was on the Foundation as the chairman of the board at Duke. It wasn't a great big thing. The Research Triangle Institute was the active research organization. The Foundation, I think, generally approved the sale to certain research organization, Chemstrand and Monsanto, IBM — some of the early ones. But it was a pretty pro forma thing. The action was elsewhere.

WEEKS:

What kind of research do they do?

McMAHON:

All kinds, using the faculties of the three universities, Duke, University of North Carolina at Chapel Hill, and North Carolina State University at Raleigh. A lot of it is in the health area, a lot of it in population because there is a population center down there -- population trends. A lot of it using the big computer operation operated by the Triangle Universities Computer Center. So the research goes broadly across the board.

WEEKS:

Another thing I wanted to ask you about was the Kate Bidding Reynolds Health Care Trust. The reason I'm interested in that is a talk I had with Haynes Rice three or four years ago in which he was telling me about being at the Kate Bidding Reynolds Hospital.

McMAHON:

That's where I first met Haynes.

WEEKS:

It was quite a marvelous story when he told it about the one woman...

McMAHON:

Kate Bidding Reynolds?

WEEKS:

I mean the woman who ran the hospital, a black woman.

McMAHON:

Oh, yes.

WEEKS:

About how they did everything and finally they got the community interested. It was a very good story.

The health care trust, does this support hospitals?

McMAHON:

Yes. The Kate Bidding Reynolds Trust -- Mrs. Reynolds was the widow of Mr. Will Reynolds, one of the Reynolds of the R.J. Reynolds Tobacco Company. When she died, she left the bulk of her estate -- I don't think she and Will had any children -- so she left the bulk of her estate in trust, 75% of it for hospitals throughout North Carolina and 25% for social welfare projects in Forsyth County. The job of the advisory board -- the trustees were two of the

officers of the Wachovia Bank and Trust Company and the chief executive officer of the Trust -- the advisory board was to advise on the disposal of the 75% that went to hospitals and other health care activities throughout North Carolina.

I was invited to come on the advisory board, as the chief executive officer of Blue Cross and Blue Shield of North Carolina. I have served on it ever since. They want me to stay on now that I'm coming back. I have not been a regular attendant, unfortunately, in the years that I've been up here. But I attended all of the meetings last year. I will continue to have an interest.

Early -- because the Trust goes back a long way -- early, the Kate Bidding Reynolds Trust was set up so that that 75% in effect paid every hospital in the state seventy-five cents a day for every day of charity care. The Duke Endowment paid a hospital one dollar a day. I observed, because the proponents of the legislation were good friends, the modification of the trust law in North Carolina to say that if the purpose of a trust becomes unnecessary, or circumstances change so that the will of the grantor of the trust no longer makes sense, then on application of the court modifications can be made in the trust instrument. It was designed basically for the Kate Bidding Reynolds Trust but also for the Duke Endowment. And I was interested from the Duke Endowment side.

That law went through and then petitions were made so that that 75 cents a day and the dollar a day, which didn't make any sense when you got to $100 and $200 a day. When they were set up it amounted to a substantial portion of the cost of hospital care for indigent patients. The modification was to do other things that would be of direct assistance to hospitals. So it was then

that the advisory board was set up to advise on that 75% of the Trust instead of the automatic 75 cents a day. So the Kate Bidding Reynolds Trust has made grants to hospitals to provide full-time emergency room staffing, to provide health education services, in some cases to provide home health services. It has been an interesting and productive addition to the North Carolina health care environment.

WEEKS:

The Carolinas are fortunate in having this and the Duke Endowment also.

McMAHON:

Absolutely. And the Z. Smith Reynolds Foundation in Winston Salem, and the Mary Reynolds Babcock Foundation. The Kate Bidding Reynolds Trust with these other two grew out of the R.J. Reynolds Tobacco Company. There was more from the Reynolds side than from Liggett and Meyers or from Lorillard in Greensboro. Yes, North Carolina has been very fortunate.

WEEKS:

Are there any other activities that you were interested in?

McMAHON:

Yes, there were. And one had a bearing too. It goes back to planning. I guess I stumbled around a little while ago when the first Comprehensive Health Planning Act was enacted. There was a planning act that came fairly close on the heals of Medicare and Medicaid. Maybe it was 1965 or maybe 1966. In any event, when the certificate of need thing was created, every state was directed to set up a comprehensive health planning agency at the state level as well as regional organizations.

Governor Dan Moore in the mid-60s succeeded Terry Sanford -- I had been involved in that campaign on the other side, because the Sanford wing of the

party pretty much supported Richardson Pryor. We were kaw school contemporaries, he had served as a judge, and he later went to Congress. They supported Rich for governor, but Dan Moore won in the primary, one of the swings that regularly takes place in North Carolina. Dan Moore called me and asked me if I would serve as the first chairman of the advisory council to the office of health planning in North Carolina. So I left the Health Planning Council of Central North Carolina, which then went beyond the three counties into a larger region. It took in some of the surrounding counties. I was the first chairman of that advisory board and then we began to pass on the recommendations of the regional agencies for major health projects that were subject to the certificate of need.

We gave advice to the state agency that in effect granted the certificates of need and did some other things. It was also, that advisory board, formed for discussions of problems of a health related nature -- relations between doctors and hospitals. The medical society and the hospital association were involved. But because of that involvement, along with Blue Cross and Blue Shield, I was getting more heavily involved in some of the other kinds of things that were then to be very useful when I got here to AHA. Through Blue Cross as well as through the planning operation, I became acquainted with the hospitals of North Carolina and their problems, along with doctors and their problems, because one of the things as a Blue Shield president that I did was to attend the medical society meetings. So I broadened my acquaintance among the physicians in North Carolina. I still know most of the leaders of the North Carolina Medical Society. I guess one of the advantages of advancing age is your acquaintance broadens out rather remarkably.

I served on that state advisory board until I came up here.

WEEKS:

That brings us up to the death of Dr. Crosby in 1972.

I talked with Earl Perloff shortly before his death and he told me he was in England, he and his wife and the Crosbys were in England, after the Perloff Committee had finished their work. I think Russ Nelson happened to be in London at the same time, when Crosby became ill.

McMAHON:

Yes, I think he was.

WEEKS:

Of course they were close. I guess he served as physician until they could get Crosby back to this country. In fact, didn't Russ Nelson serve as chairman of the search committee?

McMAHON:

Yes. There were a series of committees but I think Russ was the chairman of the first committee that made the recommendation to the board about Walter McNerney.

WEEKS:

That was kind of a complicated structure. I think there was an advisory committee to the search committee.

McMAHON:

Horace Cardwell, I think, was the chairman of the advisory committee. It seems to me that in one of those things that you've done, one of the interviews that I've looked over in preparation for this, there was some comment about the fact that that advisory board only met once and got the very clear indication that the search committee didn't need any advice. Wasn't

that about the way it was?

WEEKS:

It turned out well anyway.

McMAHON:

I know it did for me. I have thoroughly enjoyed these fourteen years, and I trust it turned out well for the hospitals.

WEEKS:

I'm sure it did. In fact, I don't know if you ever heard -- maybe Walter told you, either he or Bob Sigmond told me -- Walter was so impressed with your work in Blue Cross, that if Walter ever left Blue Cross he was going to recommend you for his job.

McMAHON:

I had heard that he might do that.

WEEKS:

I think this was before AHA came up. He felt very good about working with you.

McMAHON:

And of course I felt good about working with him.

WEEKS:

Do you want to make any more comments about Ameriplan, about its possibilities, its reality and so forth?

McMAHON:

I think it was a rather remarkable piece of work. Obviously it was ahead of its time. I am sure the national health insurance debate would have gone on if the AHA had not taken a position, had not thought through on its own what kind of national scheme would be suited to the American environment. I

didn't know then, but I know now more clearly for the same reason that Ed Crosby went to England -- he and I both served on the Council of Management, the executive commmittee, and as president of the International Hospital Federation -- I know now that the English scheme wouldn't work here. We're not comfortable in this country with queues, waiting in line. We are not comfortable with government allocation of resources. If we want something, we want to buy it if we can.

So the English scheme wouldn't work. None of the schemes abroad would be readily transportable here. But the hospitals had to think their way through that and say what kind of national health insurance plan would work. So the fact is that we had thought our way through it, as the AMA was never able really to do -- they just didn't want to see things change. But AHA saw that some change was likely to come about, and we hospital folks ought to work our minds through what kind of proposition would be acceptable.

Ameriplan was developed. It was a farsighted scheme. It went through the House of Delegates unanimously, although the support wasn't all that great. I'm sure you know that there were some repercussion among the medical staffs of some of our hospitals against some of the hospital people that had had a hand in developing Ameriplan. There were some heads that rolled as a result, because the doctors weren't satisfied with the regulatory aspects of a health care corporation. But we did work our way through it. And it generated, as a result, a substantial amount of debate. Obviously some of the organizations that we're seeing today in the health care world look very much like health care corporations, though they are not franchised and thus not regulated to the same extent. But it was an important concept. It was coming along just as I came up here from North Carolina. I'm not sure whether Al

Ullman by late 1972 had introduced his first piece of legislation based on Ameriplan. I think he might have. But then he regularly introduced it in subsequent years.

I became aware very quickly that while we had a position we had better just leave it as such. If we started to push it vigorously I was going to have a lot of my members falling off the sled, because they did not like the regulatory aspects of it.

WEEKS:

This is something I have a note on. You have the problem of representing many, many diverse kinds of people, organizations and so forth. That's a very difficult thing.

McMAHON:

Absolutely, from large to small, from east to west, from regulated states to unregulated states. It is a disparate constituency.

WEEKS:

I think you mentioned the Council on Finance of the AHA. You sat on joint committees and you were a member of the House of Delegates before you came here. Were you on the AHA board?

McMAHON:

No. I might have in time under the earlier arrangements, but the interlock was abandoned in 1972.

WEEKS:

After this board exchange was abandoned, was there another medium of getting together?

McMAHON:

Yes. There was a joint liaison committee, seven on each side. I served

on it from the Blue Cross/Blue Shield side. That was before the merger with Blue Shield so I served on it from the Blue Cross side. Then, of course, once I got up here I changed sides of the table. The three elected officers, the chairman of the Council on Finance, the president and a couple of others, were the AHA members of the joint committee. So we continued the discussions.

WEEKS:

How about AMA? Did you have a joint committee arrangement with AMA?

McMAHON:

No. My predecessor, and Jim Sammon's predecessor and predecessors before that there were several in a period of time -- didn't get along very well together. They didn't see much reason to sit down with one another. I saw it vastly differently, because I knew that nobody called a shot in the hospital except the doctor, as far as admission and discharge and ordering procedures went. I remember some early airplane rides with Bert Howard, then the executive vice president when I came up here. Bert and I got along well. He had some encouragement to get along from the then chairman of the board of trustees of AMA, John Robert Kernodle of Burlington, North Carolina. John and I had been friends for a long period of time. As a matter of fact, when I got back to North Carolina after accepting the AHA position, the first phone call I had was from John Robert who said, "I want you to come over here and have dinner with me."

I said, "You name it."

He said, "Tomorrow night."

I said, "I'll be there."

So I went over to Burlington and John said, "I have never been satisfied with the relationships between AMA and AHA. I want you to know you get all of

the cooperation in the world from me, from the board, from the officers. All we need is your readiness to sit down and talk."

I said, "John Robert, I am here because I am ready."

He said, "We'll have no problems what-so-ever."

So I think within two months of the time I arrived at AHA, John Robert invited me to come to an AMA board meeting as an invited guest, to one of their retreat meetings down in Puerto Rico. Before very long John Robert had trouble. He was a bank director and had some difficulties growing out of that, far removed from the practice of medicine.

Then Jim Sammons replaced John Robert as the chairman of the board of AMA. The whole atmosphere was still "Welcome, glad to see you, here's another southern boy, we intend to get along."

We never formalized it into a committee thing. I visited regularly with Bert, and then with Jim Sammons who started as executive vice president in 1974. Jim and I of course came from the same part of the world, same collegiate background. Jim was at Washington and Lee after the war, and that's only a hundred miles from Durham. I had been up to Washington and Lee on the soccer team and the swimming team. So we just hit it off from the very beginning, as I did with all of them. So officers began to meet. That seemed to be a useful way to do it, but I suppose more than anything else it was the personal relationship between Jim Sammons and me that obviated much necessity for any formalilzed relationship, because we had the strongest informal relationship in the world. I have been to Jim's golf course for member-guest. He's been to mine in North Carolina. We have visited back and forth. Our wives know each other well. We've just had a close personal as well as a close associational relationship.

WEEKS:

I am going to talk with him in May. Is he resigning?

McMAHON:

Certainly not soon. He is somewhere maybe in the middle of a five year contract. Jim is five or six years younger than I, seven maybe. Not close to retirement yet.

WEEKS:

I haven't started to work on his background yet.

We were talking about the relations with AMA. Do you work together on the Joint Commission, JCAH?

McMAHON:

Absolutely. Because Jim gets instructions from his House of Delegates and I get instructions from mine, it's not always easy to work things out, but Jim and I, over and over again, have made the statement that it seemed that before our time the AMA and the AHA, even when they agreed, agreed disagreeably. Most of the time they happily disagreed. We said there will be times when we have to disagree but we will make that agreeable so that we live to cooperate on other issues. So we have had a very close relationship on the Joint Commission and have worked out some compromises, particularly with respect to the role of the governing board of the medical staff -- one of the sticky issues we have on a regular basis. But even when we have disagreed, when the AMA commissioners, for example, have had to follow an instruction from the House of Delegates, there have been times when they said, "We are following an instruction from the House of Delegates and we will vote 'No' and we don't care how the rest of you vote." It's an interesting way of waltzing around some things.

WEEKS:

You also come together at CPHA too, don't you?

McMAHON:

No.

WEEKS:

Aren't they on the board?

McMAHON:

No, they are not. They decided for some reason that they didn't want to be. So it has been the College of Surgeons.

WEEKS:

Then there is a little friction sometimes between the AMA and the College of Surgeons.

McMAHON:

Oh, yes.

WEEKS:

I gathered that.

Could we go back a minute to George Bugbee? George said that when he became executive secretary or executive director...

McMAHON:

Something like that. I know that Ed was executive director at the outset. George might have been executive secretary, before they changed it.

WEEKS:

He was new to association work. He was sort of a protege of Jim Hamilton. He had a retreat in which the members of his small staff went off somewhere to a hotel room and locked themselves in and tried to decide what their goals should be. He came up with three goals: representation,

education, and research. Could we look at those as to what you found when you came here? For one thing, according to Bugbee they were to represent all of state, local, regional, and national organizations at a political level. Of course George did his lobbying and representation in the Congress for Hill-Burton -- didn't like it. Then for a while the Washington office operated with Kenny Williamson having a pretty free hand.

McMAHON:

Absolutely. George didn't like it and Ed Crosby didn't like it, so you are exactly right. They hired Kenny and gave him pretty much a free hand and said, "You handle things in Washington, we don't want to have anything to do with it."

WEEKS:

Then Kenny got into trouble with his remarks about President Nixon. I think before you came the change had been made.

McMAHON:

Yes, it had been. Kenny had been retired or separated or whatever, and Kenny's deputy, Leo Gehrig, took over.

WEEKS:

Yes. And then he was later succeeded by Jack Owen?

McMAHON:

No. Al Manzano and then Jack Owen.

WEEKS:

That's right.

McMAHON:

Back to the question that you started with George Bugbee.

I didn't know that or at least I have no recollection of it. I didn't

think there was a set of purposes. I don't remember. But I knew that I needed to know what I was doing, and more importantly the Board of Trustees and indeed the House of Delegates and indeed the whole constituency needed to know what I was doing. That is to say, what the AHA was all about. It may have been that I discovered the Bugbee goals, because the parallel is remarkable.

I said there were six things. First, we put representation and advocacy, but representation and advocacy is a result of the development of certain policy positions. So the AHA is a convenor that enables the hospitals to decide where they wish to stand. I didn't think about the associations. I didn't think about them, because I knew that some of the state associations were weak, there was uneveness in the metropolitan associations, and there was a vast difference in the strength of the regional organizations -- the Association of Western Hospitals, the New England Hospital Assembly, the Middle Atlantic Hospital Association, the Southeastern Hospital Assembly, and so on.

I knew we got our money from the individual hospital, therefore we better have a mechanism to involve the individual hospital in the determination of policies. Then it became an executive function to represent and to advocate those policies. So representation and advocacy was first, and policy development a companion second.

Third, was education. But we were involved in more than education, so fourth was information. Some people take more kindly to information than they do to education. We've got a lot educational work, but Hospitals magazine is not an educational tool, it's an informational tool. And Hospital Week isn't educational, it's informational. So I broke education into education and

information.

Research, clearly, was fifth. That is the reason for the Hospital Research and Educational Trust. We needed to do research into what's going on or what the circumstances were. If you don't know where you are, you have a hard time figuring out where you need to go. In addition to that, there was the kind of things we are doing here in the library, particularly, Lew. You and I talked about that when we dedicated that area downstairs. There was the clearinghouse function, and that was the sixth function. The library was a place where we could gather materials of all kinds, a central locus.

So those things were the things that I sent out in less than a typewritten page, passed around and said this is what we're up to. If you think we ought to be up to something else, then let us know. When I, when the staff of AHA is measured, here's the things that we are doing that we say to you we are doing, so these are the things you measure. Don't tell us that we didn't do something else because we are not doing something else. These are the things we are doing.

So it is remarkable that George Bugbee came basically to the same conclusions that I did. But I don't remember pieces of paper that I could follow or that I amended. We just didn't have what I considered an adequate statement of mission of the American Hospital Association. So that was one of the first things that I developed.

WEEKS:

I've wondered what the effect is going to be on the hospital association with all of these new groups that are coming up. I can understand the church groups such as the Catholic Hospital Association and the Lutherans and Methodists and Presbyterians. I can understand that they have certain

interests peculiar to them. But I am interested in what's happening to the community hospital. Is it Horty that has the Council of Community Hospitals?

McMAHON:

Yes, it is.

WEEKS:

The Federation of American Health Care Systems, and the Voluntary Hospital Association, and these new multiple hospital groups, and I see a growth over in the College. They are developing an umbrella organization too. They are bringing in all kinds of people into the College to change their name.

McMAHON:

Yes.

WEEKS:

How is this going to affect the American Hospital Association? Can you still be representative?

McMAHON:

Lew, I don't know. I think it's one of the challenges that lies ahead, because clearly it is a markedly different world from what it was fourteen years ago. Let me illustrate. You mention a number of different groups. I tend to categorize them. We've got some national associations. There is the Catholic Health Association, the American Protestant Hospital Association, the National Council of Community Hospitals -- the Horty group, though I don't hear very much about that any more. It may be a star that rose and fell. There is the National Association of Public Hospitals that Larry Gage has. There's the Federation. Now there's the Consortium of Jewish Hospitals out in Oakbrook. There is the National Association of Childrens Hospitals and

Related Institutions, and there is the Association of American Medical Colleges and the Council of Teaching Hospitals within that structure.

So there are lots of different associations in the environment. Hospital people have always had a horrendous propensity for joining things. I don't know enough about the other worlds to know if it's typical. There is in the education world, of course, the Association of American Universities, the American Council on Education, the Association of Governing Boards of Colleges and Universities, the Association of Land Grant Colleges. So maybe there are other worlds like ours, but we certainly have got more than our share it seems to me.

The only thing we can do -- we can't keep anybody from joining any of these other associations -- what we try to do is just to make sure that we are coordinated. That each of them knows what we are up to and that we in turn know what they are up to.

So Jack Owen, for example, has developed a coordinating group. I used to do it in Washington, because there wasn't any great interest in anybody else in bringing about some coordination. I started some meetings in Washington on legislative activities with these various associations just so we weren't surprised, using the argument, "If we are going to go off in different directions, none of us is going to be effective, none of us. Because the the Congressmen or the Senators are going to say, 'These hospital people don't know what they are talking about. We hear different kinds of songs.'"

So I think we have kept the association world in relatively fair shape. John Horty was never very cooperative in that kind of thing. He always wanted to go off on his own, which didn't serve his constituents, but it served John.

I'm unkind; I don't particularly appreciate John Horty. I think the feeling is mutual.

As far as the others were concerned, it has worked fairly well. I don't know how long we are going to have all those various associations. Clearly cost containment, competition, means that hospital folk are beginning to look at dues in ways they never have before. The result of Humana's withdrawal from AHA is an example. But that's the association world.

Originally the development of multi-hospital organizations began in the investor-owned field, with Hospital Corporation of America and Hospital Affiliates International. They then merged. There is AMI and NME, Humana, Charter in Macon, Georgia and so on. As they began to develop, nobody was very much concerned, Lew, in the 1960s, about 750 investor-owned hospitals, mostly doctor-owned, mostly individual hospitals, locally owned. But as the not-for-profits began to see the development of these big chains, began to think how they were going to respond. The not-for-profits sensed the for-profits were very powerful. What happened was we changed from 750 investor-owned, mostly doctor-owned hospitals, to the same 750 in multi-organizations. The number hasn't grown in the acute care world. I am talking about the 6,000 acute care hospitals. It has been remarkably stable at 3,300 not-for-profit, 1,700 public. The publics, of course, are widely different. They go from Cook County to the Charlotte-Mecklenburg Hospital Authority that operates very much like a not-for-profit. There are big inner-city hospitals, and then there are the county hospitals that Hill-Burton triggered off. Seventeen hundred public. Seven hundred fifty investor-owned and about 350 federal government hospitals -- VA, military hospitals and originally the Public Health Service hospitals.

As the 750 began to move into the chain organizations, though that's an oversimplification because they didn't all move -- the chains bought some not-for-profits. The thing is it has been a remarkably stable 750. But it frightens some of my not-for-profit constituents. So some of them began to see the advantages -- it wasn't always the big chains, there were some small organizations of four or five investor-owned hospitals that were making a mark because they were consolidating their purchasing activities, they were sharing information, they were narrowing down some of the management and the board structure and so on.

What happened, more in response to the development of the investor-owned chains, not the not-for-profit chains like the Lutheran Hospital Society of Southern California, Intermountain, the Lutheran Hospital and Home Society of Fargo, North Dakota. The biggest not-for-profit reaction was the development of -- to keep this neat -- what we can call alliances. The Voluntary Hospitals of America, American Health Care Systems, Sun Health, Sun Alliance, the Yankee Alliance that's developing in New England. That's a different breed of cat. That's not an association. It is not a multi- in the ownership sense but they are certainly pulled together to operate in a competitive environment, as a competitor of the chains. They are doing things, looking at ways to use their strength for capital acquisitions, since they don't have access to the equity markets. They are looking for ways to consolidate their strength in the purchasing area, not only in the purchasing of supplies and equipment but the development of insurance captives, not only malpractice but for other coverage.

Well, these things cost money. The chains cost money in dues from the individual institution. So I don't know, Lew. I think we have come to the

end of the associational proliferation. I'm sure we have not come to the end of the alliance proliferation. VHA and AHS, Sun Health, are still growing. I suspect we haven't come to the end by any means of the development of smaller multis. I think the capital situation is likely to prevent the development of another Hospital Corporation of America. I don't know where they'd get the money to buy one another.

There are some problems there. Especially when you can do by contract, by joint venture, many of the same things that you can do by outright purchase.

But what all of this means with the not-for-profits and the alliances now being ready to compete with the for-profits and the investor-owned chains, I'm not sure. There are mutterings now, perhaps more than mutterings, that we are going to see CHAMPUS, the Civilian Hospital and Medical Program of the Uniform Services, going out to contract instead of the free choice program they've had. The investor-owned chains and the alliances are going to compete, I suspect, for that business.

So it's more the competition, the free-standing institution versus the alliance versus the investor-owned chain that I think is going to make the AHA's job of developing a consensus and then representing it increasingly difficult. I don't know exactly how we are going to deal with it.

One time I started to discuss the situation that I saw when I got here. We got dues from individual hospitals, therefore we'd better serve individual hospitals and not become an association of associations, state hospital associations and metro. We wanted to serve the individual hospital. I wasn't sure, as I said at one point, wasn't sure that the state hospital associations were serving all hospitals very well. Some of them tended to be dominated by

smaller groups of hospitals.

There are the separate interests of, for example, the large medical centers. They have less difficulty in adjusting to a decrease in occupancy. A small institution has a much greater problem adjusting to a 20% drop in occupancy than a big institution does, because the big one then can close some beds, a wing, a floor or what-have-you. A smaller institution has very great difficulty in downsizing because it needs a range of skilled staff to handle the first patient that walks in the door.

At the same time, a tertiary care institution doesn't have the same problems that a secondary care institution does. The latter is not burdened, for example, with a big teaching program, for both medical students and house staff. And the inner-city hospital has different kinds of problems, different costs, because of security costs, location, cost of land, from a suburban or a small city hospital even of big size. Like the hospitals in Rochester, Minnesota. So we've got a very differentiated constituency with different kinds of problems. When you add to that now the competitive environment, Lew, and the alliances competing with chains competing with other kinds of organizations for patients -- and that's what it's all about, what it's getting to be -- it becomes increasingly difficult. There is the money necessary to support all of these various organizatons.

One of the things that we will talking about at the board retreat next week in southern California is, "Am I seeing aborigines in the fuel supply?" as my mother used to say, when I see some people beginning to look at all of the dues they pay. Because there are not only the dues to all of those associations, there are the dues to the alliances, there is support to the headquarters of the multihospital owned organizations. There are the state

hospitals and the regional and the metros, like here in Chicago. In addition, there are all of those dues being paid on behalf of all of those people in the hospital that belong to the personal membership societies.

I think there may be some problems of keeping this organization together -- this organization that has for many years represented almost all of the hospitals in the country -- around 80% of all of the acute care hospitals and probably 90% of the beds and 90% of the money. I cannot tell you how long that is going to last with the proliferation of these competing organizations.

We are not alone, of course, with some of these problems. We invited the Executive Vice President of the American Bankers' Association to come to a meeting several years ago with the state hospital association execs to describe the problems of the ABA in dealing with very many of the same things that we deal with -- different kinds of states. Like Illinois, that used never to have any chain banking. Other states that did. Big banks and little banks. Chain banks and independent banks. Differences in regulatory climate and so on. Some of our folks thought we were inventing a brand new wheel in this competitive environment and my message was to show, no, this exists other places. But it's going to take some give and take and just as the ABA exec said, "There are some issues on which we walk away, because we cannot get a consensus." In that case the best thing to do is to leave it alone so we can keep the constituency together in areas where we will be united.

WEEKS:

Let me see if I can give you a picture I see and see if I'm right or wrong. Things have changed a great deal for a man in your job since George Bugbee. His representation was mostly for Hill-Burton and when that was passed, I think he was pretty well satisfied about it. He didn't spend any

more time in Washington than he had to but I understand you have spent probably more time than Crosby did or Bugbee did.

McMAHON:

Yes. Oh, very clearly. I probably spent more time in the first couple of years than either of them had in their careers. Because I understood that's what the constituency wanted. We had Medicare and Medicaid, we had comprehensive health planning, we had the regional medical programs, we had the continuation of Hill-Burton, though it was declining in strength, we had other kinds of federal encouragements. There was the development of the VA system, which is a competitor at least for employees to many of our hospitals. We've got CHAMPUS and we've got the national defense military system, we have a lot of activity. So they were looking very clearly. The message was clear as a bell; the constituency was looking for someone who was comfortable in Washington to speak in Washington on behalf of the hospitals, and that's what they thought they had not had adequately and wanted more. That is the reason why, in my original agreement, the officers said to me, "We don't care whether you live in Washington or Chicago. You decide where you want to live, because you are going to spend a lot of time in both places, and we will buy you an apartment in the other location."

And that's about the way it was for the first ten years, up until the last few years because of a couple of changes in Washington itself. I spent a third of my time here in Chicago, a third of my time in Washington, a third of my time on the road in regional meetings, state meetings, AMA meetings, and so on.

WEEKS:

It's been a busy life, hasn't it?

McMAHON:

Yes. It has indeed.

WEEKS:

How do you approach the representation problem now? For instance, let's distinguish, if you will, between a local or state problem and a national problem.

McMAHON:

Okay. On the local and state problems we don't do anything in a direct AHA sense. I know enough about state legislatures to know that no state legislator in North Carolina is going to pay any attention to somebody from Chicago. The same would be true in Bismarck, North Dakota and it would be true in Sacramento, California. What we do do is to help the state hospital association with any resources that we can muster, information from other states, discussions at meetings from time to time about ways to approach legislators -- although we don't do much of that. Most of the state associations have understood that their leader has got to be a good lobbyist as well. But AHA's job is to provide information and provide help from elsewhere to deal with the local problems. So the local problems we leave alone except for the assistance to our hospital associations and then to hospitals that are trying to deal with the local problem.

It's on the national issues where we focus our attention. Once we have a policy we do a couple of things. First, we make sure that the key congressmen, subcommittee chairmen and staff understand our position. Then we work on the membership of the committee, and occasionally the membership of the total body -- House or Senate. We use a network through the state hospital associations to get them to contact their own people, and we give

them arguments so they are convincing. Because, again, I don't vote for people except in Illinois. So they are interested in the information that the AHA staff can bring to it, but when it comes to making the decision as to how to vote, they are going to vote the way their constituencies tell them.

So we must get messages going in from people who vote for them. That's the network that we have put together over these fourteen years.

WEEKS:

Do you use the elected officers at all, of AHA?

McMAHON:

In Washington? No. Their role is to the membership. There is good reason for that. If we used the elected officers there would be, again like the AMA, a succession of individuals appearing before the committee but no continuity. It is much better if the CEO of the AHA and the head man in Washington make those appearances because then there is continuity. Members of Congress get to know the individual, they get to trust the individual, and credibility is a great dimension in the lobbying business.

WEEKS:

Now we come to education, or as you applied it, information. How are the seminars and meetings that you set up working out?

McMAHON:

They are growing all of the time. On the revenue side, we have passed ten million dollars a year in the amount of money that these educational programs and seminars bring in. We thought we were going to make more money in the teleconferencing business, through the use of satellites and receiver sites. That hasn't worked out quite the way we thought. But our whole educational business is now in excess of $10 million. On an $80 million

budget it's maybe 15% and it's growing. And it makes sense, because then you charge the people that are getting the value instead of using dues. It used to be when I first came that our dues were a little above 50% of total revenue covering total expenditures. Now it's a little under 50%. I expect it will continue in that direction.

WEEKS:

Your convention is still good?

McMAHON:

Yes. The convention is a big item in the revenue and expense budget. It doesn't make a very substantial contribution, net of expenses. Well it carries some of the staff. It doesn't make a big contribution to the bottom line though. It goes up and down depending on where the meeting is and the number of people who come.

WEEKS:

How about publications? Since about the time you came here, the publication field has changed a great deal. I'm thinking now of the book publishing field. When we started Health Administration Press at Michigan, there really wasn't much competition. A little from Aspen, but that was about all. Now, everybody is in the business.

McMAHON:

That is right.

WEEKS:

And the same thing is true with journals. Your Hospitals journal has a lot of competition now. I would think in looking at it that you may be losing some advertising. Everybody's conscious of every expense now.

McMAHON:

That is right. And we have lost a little advertising. Modern Health Care has always been the biggest advertising competitor that we had. And there was a period when it was a McGraw-Hill publication that it went down, and then Crain took it over. Before Crain picked it back up, we had maybe 70% of the total advertising pages. Now it's back closer to 50/50 and Modern Health Care has reestablished itself.

On the publications, because of the tax laws, we had to spin off Hospitals and Trustee. We sent the Hospital Medical Staff, the Volunteer Leader and Hospital Week along with them. We sent them over to the American Hospitals Publishing, Inc. It is a separate taxpaying, subsidiary corporation, because we were going to be taxed on the income anyway. It was better to put them in a separate corporation. It continues to make a modest contribution to AHA's bottom line. Then we moved the books over because we have always lost money on the books, and we could offset that loss against some of profits from the magazines. I have always taken the position, Lew, that we weren't in the magazine and publications business to finance the Association. They are our ambassadors to our members. They've got to be good, because we want good ambassadors going out to the membership so that membership is a value. They are paying for it in effect through the dues they pay, on the allocation of some of those dues to the publications. But that is one of the services they get. If they weren't getting that, they wouldn't be hearing from us. Therefore, the magazines and the books are a very important part of our relationships with our members.

WEEKS:

You probably know that right this month there probably will be

consumation of the sale of Health Administration Press to the American College. Along with the books there will be about four or five journals. I don't know how this is going to affect AHA's publication efforts. I have no idea how much the American College is going to stress this deal.

McMAHON:

I don't know either. Obviously we track what is going on in the publications world, both magazines and books, because we are looking for our niche and don't want to duplicate something; if we were duplicative, we would spend money to publish something that not enough people would buy. It's a changing world. I think it's a little harder to adjust to the educational world, because we've got lots of educational competition. Go back to the alliances for a minute; VHA, American Health Care Systems, and Sun Alliance are developing their own educational programs, because they've got the volume to do it. The same thing is true of the big investor-owned companies.

WEEKS:

HCA, I know, is caught up in that.

McMAHON:

Sure. So we have to keep a weather-eye on it. But that isn't as big a problem, to me, as the development of the policy consensus. There is always the risk that in the development of a given policy, we are going to aggravate a significant portion of the membership and that may give them the excuse to say, "We're not going to support that organization any more."

It is very important on the policy side that we keep that consensus together and it will become increasingly difficult as the competition between hospitals gets tougher.

WEEKS:

AMA has certainly fought that battle for a long time. The situation is different but they have tried to keep their membership percentage up and there's always somebody drifting away.

McMAHON:

That is right. Their penetration, of course, of the regular practicing physicians is much lower than ours of the hospitals.

WEEKS:

Could we talk about research? I was thinking in terms of what you do at HRET and what the Council on Research and Development does.

McMAHON:

We have organized the Hospital Reserach and Educational Trust as a 501(C)(3) tax-exempt organization, because then it is eligible to receive tax-exempt contributions from taxpayers. The contribution from AHA dues and income itself has increased because I have always had a strong belief in the fact that we need to do a substantial amount of research, though in some cases it may be massaging data rather than basic research or it may be more in the applied research area. But what are hospitals spending and what are they spending it for; where is their revenue coming from? The data base that we've had here has always been extremely important, important to the world to understand hospitals, important to us so that we know what is going on amongst our membership.

Then the use of that data for some research related activities has always been a high priority for me as it was with Ed and as it was with George. I think it's one of the contributions we make. We've got a stronger HRET board than we ever had before, exerting themselves and saying, "We want to know what

it is you are doing because we know that organizations can let research run away from them."

An example: We might be given a grant that would be tempting to take because it could cover some overhead, but it's not in something we ought to be doing. So the board, as we have moved through these last ten years, has taken an increasingly strong role in sitting with the staff and saying, "What are your priorities? Yes, those make sense," or "No, let's re-think some of them."

Obviously we have a substantial amount going on in the area of aging. One of the big problems that lies ahead is that more and more people are older and as they live longer there are a whole series of issues that spin off as a result. We've got substantial research effort in the question of biomedical ethics. There are going to be issues that come up about the quality of life versus the cost of maintaining somebody and so on, Lew.

We have set up another institute or center within the Trust devoted to looking at issues of quality of care, because we have always lacked that in the health care field. We don't know what our output is. Is it a well person? Hardly. We're not sure what wellness is. It certainly is not a discharged individual, because sometimes the discharge is because the patient died. So we need to devote time to what are the adequate measures of the quality of care.

And finally, we just set up a center on the legal side to use the Trust as a way to get money to do some research into some of the legal issues that face us.

So, as it was in George's day, but probably a little different thrust. What we were doing when I arrived here was mostly getting money from the

Kellogg Foundation to do a number of things, and we did the things that they were interested in doing. Now, I think, we have taken more control of our research agenda and saying, "What is it that we need to do?"

Some of the research went into, and continues into, the questions of uncompensated care; -- we use the phrase "uncompensated care" because it is not only poor people who don't pya their hospital bills. Much of uncompensated care comes from people who are employed but employed in low wage jobs or low income activities like farming or the one person grocery store, where the ability to pay for health insurance to finance needed health care is not there. So we have done some research there. I think we'll continue to do it. The agenda probably will change over time, but we now have an automatic built-in core support from AHA itself because research is important to the field in the service of our members. That, then, gives us the wherewithall to attract money from donors to do other kinds of research activities in the priority areas that we've identified for support on an ongoing basis.

WEEKS:

So you can channel the funds through HRET.

McMAHON:

Right.

WEEKS:

Let's go back to 1972 when you come to Chicago. I'm going to ask you about the way you organized your staff. Going back to George -- George had a great difficulty in delegating. He had to be in everything himself. He had that nervous type of energy. He admits it himself. He says it publicly, so I'm not disparaging him in any way. Dr. Crosby had a stranger way of delegating, I think from what I've heard. He was more impulsive rather than

in an organized way. I gather that after you came here the organization was set up a little differently and you delegated duties.

McMAHON:

Markedly differently, and with substantial delegation, at least from my perspective.

WEEKS:

And you spent more of your time in Washington as we spoke of before. Was Larry Hill your first operating officer?

McMAHON:

Yes.

WEEKS:

Followed by Gail Worden?

McMAHON:

Right.

WEEKS:

I have forgotten some of the others.

McMAHON:

Joe Curl.

WEEKS:

Did you develop the divisions of responsibility?

McMAHON:

Yes, and rearranged some.

When I got here, I've forgotten what the organizational chart was and my memory may play me false. There was Ed and there was Madison Brown and then all of the other key people -- and there must have been sixteen or eighteen -- that all reported to the two of them. Ed was here. He didn't travel a great

deal. That probably is not accurate, but he certainly didn't go to Washington very much. He did make regional meetings and other meetings. But he spent much more time in Chicago than I knew I was going to have to spend. I could not operate with trying to manage eighteen people and all of their activities. So it became a question of how to put them together and how to single out an individual then to be in charge.

I didn't think I was going to have enough time in Chicago to supervise as Ed had done. I needed somebody whose main work week was not going to be as much away from here as I was going to be away. Then I planned to give him a substantially free hand to decide what would go together and how to manage it.

So I began to look for someone with hospital experience, since I did not come out of the hospital field -- though I knew a good deal about hospitals in general because Duke had three hospitals during my tenure as chairman. But I didn't come out of hospital administration, and I knew that I needed somebody that did. There weren't many here on the staff at that time who did. So I began to look around for an executive vice president. I was satisfied with the way things were going in Washington so I didn't need to make any changes there. But I needed somebody to run this building and the people in it. Larry Hill was the first executive vice president.

He and I talked about how things might be put together and arranged, and how we would continue to keep the councils manned with staff and to keep the other activities -- the educational programs and the support structure -- going along. I think Larry had a great deal to do with the way the internal organization was organized. I have forgotten. I may have made some moves even before then to consolidate some things, both to bring in some new people and to reassign some people here. I would have to go back and take a look at

how some of those things developed. But I knew, because I wasn't going to spend as much time here, there was no way I could manage the organization the way that Ed did. I wasn't that kind of individual for one thing. I think you are right about Ed that a lot went on gut feeling and impulse. I think people are more comfortable if there is more stability.

WEEKS:

As we mentioned before, times were changing during this period too.

We talked about the Washington office. We were talking about the different kinds of organizations that you have to represent and among them were some of the smaller ones like the Protestant and Lutheran and so on. Williamson told me that after he opened up his consulting office, some of the smaller groups came to him because they felt that their problems were small and would be lost in the national picture. Of course he was probably competent to help them.

The Economic Stabilization Act was just getting started when you came here, wasn't it?

McMAHON:

It went into place, Lew, in August of 1971. So it was about a year old. I served on the first health services industry committee, or whatever it was called, as a Blue Cross representative. So I had seen the inside of the economic stabilization program from that vantage point. When I came here, I was asked to stay on the committee. It was useful, very clearly, to be involved and to advise on some of the directions they were taking.

I then ran into the interesting issue in 1974 of still serving on the health advisory group -- whatever it was called at that time -- but very intensively lobbying against the administration in the cost of living council

and President Nixon's desire to keep controls over both hospitals and doctors. But they understood. I think John Dunlop was one of the last directors of the Cost of Living Council, and he understood that I could both give advice and argue against the existence of the economic stabilization program itself.

WEEKS:

Did the voluntary effort come out of a response to the economic stabilization program?

McMAHON:

No. Not at all. The economic stabilization program ended on May 1, 1974. The voluntary effort grew out of the efforts of President Carter and Secretary Califano to put caps on hospital expenditures — the plan that they promulgated in 1977. In the fall of that year, we defeated the "Carter Caps" as we called them, and then created the Voluntary Effort and proceeded ahead.

Apropos of that, I remember one time, Lew, of looking back over some of my early speeches, talks, comments, writings and so on, and it is very clear that for twelve of the fourteen years that I have been here the biggest issue was cost containment. Now it's shifting. But even in 1972, I was convinced that we had real deep problems of containing costs and the problems were not of our making. The payment system — cost reimbursement — was expansionist in itself, deliberately so. In addition to that, of course, there was the increasing demand for health care services fueled by first dollar coverage in health insurance. So there were no limitations on individuals. We were paid on a cost reimbursement basis which was deliberately expansionist. We had systemic problems to deal with. The voluntary effort proved that. It was successful the first year and then began to deteriorate because the incentives weren't there. You didn't have any incentives on patients because health

insurance benefits weren't changing. We didn't have a payment system for hospitals that had any cost containment incentives in it at all.

WEEKS:

Do you think that the patients expect too much? For instance, we eat out several times a week, my wife and I. We find that there are a great number of so-called retired people eating out also. I'm a great listener to conversations. I'm surprised at how often health is the subject. It usually comes into the conversation somewhere. And how many times they've been to the doctor and how many pills they are taking and they only took two x-rays this last time and they should have taken four. Are we overusing our services do you think?

McMAHON:

Yes, I think so, for a number of reasons. You start off, I think, with the insulation of the individual from the economic consequences of demand, because of comprehensive health insurance. Health insurance, Lew, that is heavily weighted on the acute side. Insurance pays for acute hospital care, and it pays for doctors' services in acute illness or injury. It doesn't pay so much on the prevention side. So there is a motivation for the individual covered by Medicare or group health insurance to use this marvelous coverage that the employer or the friendly federal government has provided, -- in spite of cost-sharing and co-payments and deductibles.

Secondly, I think the malpractice crisis in part encourages the same thing. When anything goes wrong and patients don't like the outcome, they are ready to sue. So that says to me that there is a huge expectation in the system. I have been absolutely fascinated by some of Joe Califano's recent writings. Joe, of course, was involved with President Carter in attempts to

control us. Now he says that's not the way to do it. He says, "What we as a people ought to be doing, and now as a Chrysler board member, what we are doing at Chrysler is emphasizing the prevention side." We are doing that here -- I always believe in practicing what you preach. We now have weight-watchers clinics at AHA, anti-smoking clinics, and screening programs. I figured if I as an employer wanted to talk about good employer practices, I had better practice what I preach. So we have emphasized that, and we changed our health insurance coverage, adding alternative systems and cost sharing to our traditional coverage. As a result, we have markedly reduced the rate of increase in the cost of health insurance to AHA. We went from $100 on an average to $200 a family, I think, in four or five years -- say from 1977 to 1982. Now we've gone from $200 to only $215 per family in the last four years. So we have markedly reduced the rate of increase. Some of it results because we added co-payments. Some of it is attributable to the fact that we've offered our employees a number of HMO alternatives. But some of it, I am sure, goes to the fact that we talk about staying healthy, working healthy, healthy life style and making available information to our people.

I think there is an expectation that this great American health care system can cure anything or correct anything that grows out even of an individual's own carelessness or own fault. So, yes, we've got a great expectation and it's part of the reason for cost escalation. But I think it's also changing because of the changes in insurance coverage. I think it will change even more as we move to capitation because then there will be real incentive on the providers in a capitated scheme to keep their subscribers healthy.

WEEKS:

I'm sure you are right.

You were speaking of malpractice insurance premiums particularly, I am thinking about right now. Somewhere in the paper somebody came up with an odd statistic which you, with your interest in statistics would probably want to change some way. The paper said that malpractice premiums, on an average, was the equivalent of about 17.5% of the average doctor's total revenue, or gross revenue. No question that it's being passed on to the patient.

McMAHON:

Absolutely.

WEEKS:

I had a talk with Chaiker Abbis. You know him. He said that in Canada they have a quite different legal system.

McMAHON:

Absolutely.

WEEKS:

This contingency fee and so forth is not there.

McMAHON:

Their's is like the British system.

WEEKS:

And they have very little, very few, awards especially for pain and suffering and that kind of thing. There are many efforts under way right now to correct that. As an attorney, what would you say would be a fair way of doing it so that it's fair to both?

McMAHON:

Several things. Let me go back at one point to the statistic, the 17.5%

I suspect is right on average. But you know the old story about drowning in a lake whose average depth is six inches. The biggest problem is the variation. It's a heck of a lot more than 17.5% with some specialties in New York where the doctor's premium, if he is OB/GYN or neurosurgeon, is $80,000 or $100,000 a year. Well, he's not making $600,000, certainly on an average.

Interesting little sidelight. Jim Sammons' oldest boy left the Navy after he finished his tour and went to practice medicine in Baytown, Texas. His insurance premium was so high he couldn't make it. So he has gone back into the Army or the Air Force. An example of what's happening with malpractice insurance, just as an episode.

So we've got a real problem. What do we do? The Chicago Tribune this morning was defending pain and suffering, though it said we ought to get rid of punitive damages. The tort system is supposed to compensate the injured and punish the guilty. Punitive damages grew out of the latter side in addition to making the wrongdoer liable for any direct expenses that the injured party suffered. I think we need to get rid of, or at least cap, all of the non-economic damages. You see, if we say no more punitive damages, then we'll come back and see extraordinary awards for pain and suffering. I think that first, we've got to cap the non-economic damages. Yes, there ought to be responsibility for the direct economic suffering, though all other recoveries ought to be taken into consideration. That's the second thing. That's the collateral source rule. An individual ought not to be paid twice because we are trying to compensate for the injury, not to over-compensate. Because then what you do is encourage more suits. So we ought to do something about the collateral source rule.

I favor, myself, some limitation on contingency fees because I think that

tends to escalate the amount of money that is being asked for. Frankly, I'd prefer the Canadian or British system, as an attorney, where you don't have contingency fees. The losing party pays a reasonable amount for the cost of attorneys. I don't think we'll get to that. We Americans don't make drastic changes so we have to tinker a bit. I think some limitation on the contingency fees would be appropriate.

The other thing, Lew, is the joint and several liability thing. The Tribune, again, this morning was commenting on that. It doesn't like the limitation on joint and several liability. So you get a jury saying that so-and-so was 5% of the cause of the accident; for example, the city didn't cut down a tree that then tended to obscure a sign, particularly to the driver of a fast-driving automobile. But the real cause was the fast-driving automobile. The fast-driving automobile driver had no money. So you came back then to the city and say that the city is jointly and severally liable. It made a very minor contribution to the accident, but nobody else can pay. Therefore, the city has to pay. Result: the city's insurance goes up or the city can't get insurance. So it, then, is in a bad way. There are other services that that city provides that are then threatened.

What we are seeing, for example, is the elimination of some of the park and recreational activities because a city can't get insurance to cover them. I think that in spite of the fact that, yes, that might leave an injured person out of luck, but the injured person would have been out of luck if the only cause was the judgment-proof driver. So to say that 5% can become 100% if one of the other parties is judgment-proof doesn't make any sense to me. I think we ought to do something about that.

Those are the four that I'd start off with. On another issue, I've had a

change of heart. I used to think that we ought to go after the malpractice problem and stay away from other kinds of tort liability. I think now with the problems of local government, with the problems of product-liability, we may get some generic reform of the whole tort system. If we do, I would go at it with the same kind of changes I discussed before.

WEEKS:

This would affect the hospital then.

McMAHON:

Yes. And make the insurance market a little more stable. What the insurance market is afraid of now are these horrendous judgments -- $6 million dollars for a ninety-four year old person -- that just doesn't make any sense. Nobody is going to benefit from that but the heirs. That's not what the tort system was designed to do.

WEEKS:

I wonder how successful some of these small groups, such as Hospital Association of Pennsylvania, I think, has a subsidiary. Have they worked out?

McMAHON:

Pennsylvania Hospital Insurance Company. That has worked out quite well. There are some others, but some of these so-called captives are in deep financial difficulty. Bill Robinson was telling me just last night that there are a couple that are in real difficulty because they didn't set adequate premiums, they didn't do adequate underwriting; they didn't say to the hospital, "What do you have in place to identify problems and correct them before something happens? Or at least to deal with a problem quickly and responsively as soon as it does happen?" Some of them, in the days of high interest rates, got the premiums and counted on a long period before there

would be any claims and before any money had to be paid out -- and they anticipated that interest rates would take care of that. Well, now the interest rates are down, they are not getting large returns on invested premiums. The premiums were too low, and the underwriting was bad.

Some of them have worked out very well. The one in Pennsylvania, the one in Ohio. We are doing all right with our Health Providers Insurance Company. But some of them are in bad shape.

WEEKS:

I wonder if those insurance companies take on physicians or is it just the hospital that they cover?

McMAHON:

Most of the hospital captives, our so-called hospital formed insuring organizations, just do the hospital. There are physician captives from the medical societies that are taking on physicians.

WEEKS:

Some of the investor-owned are trying. HCA has their own.

McMAHON:

Yes.

WEEKS:

I don't know what Kaiser does, but they cover their physicians apparently.

McMAHON:

I don't know what Kaiser does on the insurance side.

Clearly, the malpractice issue, or tort reform broadly, is one of the major items on our agenda.

WEEKS:

One of the other things that you are probably worrying about is all of the effort to tax premiums of Blue Cross. I'm projecting that. If they do that to Blue Cross, what will they do to hospitals next?

McMAHON:

I have always found, Lew, "If so-and-so, what next," is a marvelous way to make an argument. I'm not sure it ever holds up logically. There are different reasons for going after Blue Cross than there are for going after hospitals, but obviously we have to watch that. We haven't done a great deal because we've got our own problems in federal tax reform legislation. The argument, of course, is that Blue Cross is no different from hospitals. The problem that Barney Tresnowski has is that in some states, the Blue Cross Plan and the Blue Shield Plan don't operate any differently from a commercial carrier. In some cases, they are even organized as a mutual insurance company.

On the other hand, if Blue Cross were to be taxed, very clearly, it would then have to review some of its underwriting practices, particularly the non-group coverage.

Anyway, we are not jumping in on the basis that if they tax Blue Cross this year, they will tax us next year. I don't think that will happen. We are not jumping in because we've got our own problems. The threat to tax-exempt financing, for example, is one of them -- the major one.

WEEKS:

We have talked around this but the physician glut, as some people call it, how is that going to...

McMAHON:

It is amazing how we use language to send subtle messages, like "glut" instead of "surplus".

WEEKS:

How is this going to affect the health care system?

McMAHON:

It's going to have a substantial effect, Lew. We are going to go -- with only a modest change in population -- from about 350,000 practicing physicians around 1980 to 600,000 by 1995 or 2000, because we are just really beginning to feel the full impact of the increase in medical school classes from 8,000 or 8,500 to 17,000 -- about double. It's going to have all kinds of reprecussions. It's going to make the practice of medicine, on the financial side, much more difficult than it has been in the past. It's going to make physicians more amenable to being on a guaranteed income or a salary. That is going to bring about turmoil as to what is the entity that is going to hire them or is going to guarantee them. Is it going to be a group of physicians? Is it going to be a hospital? Is it going to be an insurance organization? Is it going to be some other kind of commercial organization, like Sears? I wouldn't be at all surprised to see a Sears create a health system, contracting for the hospital beds it needs and hiring the physicians. And there will be some that will be amenable to it.

I don't think, however, that it may happen as fast or be as drastic as the figures I gave you seem to appear. I think the days of a 70 hour medical work week are coming to an end. Many of the medical students that I have seen, and talked to, and residents and interns, don't plan to practice medicine the way their role models have -- the teachers that they have had. A

third of the medical students are now women. They're going to have interruptions of their careers. So the glut or the surplus, or whatever we want to call it, probably is not going to be as drastic as we think. But I do think there will be physicians available for employment, physicians available for administrative jobs.

One of the things I want to do when I go back to Duke is to look at ways to set up some management or administrative short courses, in the continuing education sense, for those physicians who are going to become managers or administrators.

It is going to have all kinds of reprecussions for the health care system, including some that we are now seeing like the surgery that's being done on an outpatient basis by-passing the hospital. We may see doctors making home visits again that may shortcut some of the home health agencies and the hospital-based home health agencies. It's hard to know exactly how it's going to work out because it's hard to foretell the future, but it's going to have a major impact on the way we did things in the 1970s, for example. We didn't see the result in the 1970s, we began to see it in the 1980s.

WEEKS:

There was a great growth of medical schools in the 1960s...

McMAHON:

...after Lyndon Johnson, as I have often said, quoting a dear mentor of mine, "In a happy half hour of concentrated thought, Lyndon Johnson decided we were fifty thousand physicians short." President Johnson didn't understand that if you correct the fifty thousand, you were going to have 200,000 too many at some point.

We went from a class of 80 to 114 at Duke. There were some new medical schools started. Some of the others even doubled their enrollment.

WEEKS:

As you say, a third of the students are now women and in some of the newer schools it's fifty percent or more.

Continuing this a step further. What's going to happen to the hospital administration glut?

McMAHON:

It's already happening. Twenty or thirty years ago, every student we turned out of a hospital administration program went to run a small hospital — first, perhaps to a big hospital as an assistant, then to run a small hospital and then move up. Well, we don't have that any more. So clearly we need to take a look at where the output is going. I have never been satisfied that our hospital administrators understood enough hospital finance, so we may have to strengthen that. Some of them are going to become department heads, and they may spend their lives as department heads. If that's what's going to happen, we need a different kind of administrative course.

I don't know. I'll know better about that in a couple of years because that's the first thing I'm going to try to figure out.

WEEKS:

And you will undoubtedly find that at Duke the women are a big number in hospital administration.

McMAHON:

Absolutely. And you know lots of them at Duke are not going into hospital administration, they are going into consulting work. If we're going to turn out consultants, are we giving them the right education for that?

WEEKS:

That brings us back to the point that you made about your experience in North Carolina. Where are these consultants going to get their experience before they become consultants? I have often wondered about the teaching situation in the HA courses. Many of the teachers may have their Ph.D. but not have any real working knowledge of a hospital.

McMAHON:

Absolutely.

WEEKS:

I have wondered about that.

McMAHON:

So have I. For that reason, I think there has been a movement away at our program at Duke from a real understanding of what a hospital is like and there we are with a marvelous example right in sight. But I don't think there has been enough of the people involved in running that hospital in doing some of the teaching in hospital administration. It has become more academic and, thus, less related to real life.

WEEKS:

The expression used to be, in the early days of hospital administration, we'll have some visiting firemen come in and talk and you'd have a schedule of maybe ten or twelve come in and talk. That was not bad. The only thing is to get the right kind of firemen.

McMAHON:

Yes. We are still doing that at Duke. Bob Toomey has a two hour or three hour class on Fridays and he brings in a succession of people to talk. The question is, is that thoroughly integrated into the rest of the program so

that they are not getting a little episode here and a little episode here, without the continuity to build on. I don't know how he does it. That's one of the things I want to know about. Bob's not going to be with us forever. What do we do? Do we substitute for that? Is that adequate? Am I going to do some of it?

WEEKS:

Undoubtedly you will get your hand into some teaching.

McMAHON:

Absolutely.

WEEKS:

We haven't talked about HMOs except just to mention capitation or something of this kind. Blue Cross is developing 70 or 80 HMOs, a network. Some of the insurance companies will undoubtedly, are or will, develop some. Is there going to be a shakedown in all of these HMOs? Are there going to be mergers?

McMAHON:

I don't know, Lew. It's one of the things that's going to be interesting to watch. I can't tell you how it's going to go. There are two issues here. I think the incentives in the capitation arrangement make it likely that that's the way the world will move, instead of the free choice and the cost reimbursement and the fee-for-service system. There are lots of good incentives for cost containment in the capitation system.

Barney Tresnowski and I had a conversation a couple of months ago. We agreed that we would meet in three years to look back. The world Barney sees is — Barney sees a different world emerging from the world I see — a world where the insurance carrier is going to take a stronger position. The

insurance company can be a capitation arrangement, but it does it through controls over utilization and payment. The Blue Cross people call it "managed care." You can still have free choice or a broader choice, but the choice you make of physician or hospital is limited by what the carrier will do or will impose by way of utilization controls on those providers.

I see more of a provider dominated capitation -- that the providers will take control of the capitation arrangement and decide how it's going to be split up using the carrier just for out-of-area coverage. That, then, retakes control of utilization by the people who know it best, the doctors along with the hospitals.

It's hard to tell, Lew. That's one issue. The second issue is the debate, or the discussion, of the nature of health care itself. Is it a local service? Can it be regionalized? Can it be nationalized? I don't know. I know that VHA is based on the premise that they can have a national HMO because then the employees of an employer in site A will be taken care of by hospital A, in locus B, by hospital B. And they can write a national contract -- what they are doing with the teamsters. I don't know whether you can put that together or not. I know enough about business to know that they don't organize or put their plants where there are going to be members of VHA. They put their plants where they want to, with other things being considered. If General Motors puts a plant in Smyrna, Tennessee and there is no VHA hospital, how are they going to deal with that one? And I really don't know whether or not the idea that some of these organizations have that they can put together a national network and then sell it nationally, versus the way Kaiser goes about it. They decide where they want to put a Kaiser hospital and a Kaiser plan and then they say to the employers in the area, "Give your people a

chance to sign up with us." But they are still local. They are not tying Washington to Portland, Oregon or to Long Beach, California.

So there is a lot of stirring going on. Humana calls all of their hospitals Humana. I don't know whether they can pull that off or not. A lot depends on what employers do. If employers move in the direction, let's say, of a voucher type arrangement -- everybody in the company gets a voucher to take to whomever he or she decides locally meets the health care needs best. If they do that, you don't need a national system. Then it's going to be the strong local system that then competes.

I lean in the direction of the fact that health care is a local service, delivered locally, and that its strength lies in the hospital and the physician team in that location. If that is strong, if quality and reasonable cost are taken together, that team's going to survive regardless. If General Motors says no, we're going to have a national contract, if CHAMPUS says we're going to have a national contract, then, maybe there will be some differences. It is one of those things we are going to watch, because I can't tell you which way it's going to go.

WEEKS:

I think that the argument has been used that General Motors and Ford have said we want a national contract. We want to be able to...

McMAHON:

There are signs that they are moving away from that. The HMO Act itself may have helped because it said you've got to provide your employees with a choice if there is a qualified HMO. I think that would be a sounder direction to move in.

WEEKS:

Aside from employees being scattered around the country, the other thing is what if you are in California and you have an accident?

McMAHON:

That's where the insurance company comes in.

WEEKS:

But the incidence of that would be minor, I would think, and there could be a formula.

McMAHON:

...under five percent. You can handle that any time. That's not where the over-utilization comes. You've got an accident, you've got to deal with it. There may be too much testing, but that's a very minor part of the health care costs.

WEEKS:

I was going to ask you -- did you meet Anna Rosenberg? Did she do consulting for you?

McMAHON:

Absolutely. I knew Anna first, before I came here. I knew Anna, -- because both Walt McNerney and Ed Crosby had employed Anna Rosenberg and Associates to give both of them public relations advice. So I knew her first because she was a regular attender at BCA board meetings as part of the consulting operation there. Ed and Walt agreed on that together. So when I came here, it just made good sense to continue Anna as a consultant to me and to AHA on some of our advertising. We had a flurry of advertising in 1975 and 1976. Then on general public relations advice.

WEEKS:

She must have been a very bright person.

McMAHON:

She was a marvelous person.

WEEKS:

I was trying to make arrangements to interview her shortly before she died.

McMAHON:

She would have been good. I'm sorry you missed that opportunity. I used to go to New York about three times a year. Tom Rosenberg, her son, would set up a series of meetings over two days -- one every two hours -- with some of the health related reporters in New York, the health writing specialists with the news services and of course the Times and the Daily News, the Today show, the CBS morning show. I was once with David Hartman on the ABC morning show, and on the Today Show several times. That continued for ten years until shortly after Anna's death.

WEEKS:

I'm sorry I missed her.

When we were talking about HMOs and hospitals, I wanted to ask, when an HMO contracts with a hospital and a hospital reduces its rate in order to get that contract, that, in turn is going to cut into the finances of the hospital it would seem to me. Unless they could fill a lot more beds than they were filling before.

McMAHON:

Two things, because it's the volume issue. You have two ways to look at it because it doesn't necessarily cut into the hospital's bottom line. You

have to think about two things. If they contract with the HMO and increase the volume by 10%, that 10% is likely to flow to the bottom line. Ten percent is not enough to markedly increase the cost. But conversely, suppose the hospital says, "No, I'm not going to give you any discount," and they lose 10%. That takes 10% away from the bottom line.

I've used, Lew, in this context -- the example given by a fellow that I've played golf and cards with: I talked to his wife this morning about a young person that she's interested in seeing go to Duke. He runs a sweater mill in Mount Airy, North Carolina. When he comes up here to talk to Sears or Montgomery Wards and they start talking about 20,000 dozen sweaters, all of a sudden he gets out the sharpest pencil you've ever seen. Because if he can arrange to sell 20,000 dozen to one customer, it just evens out his production line over a long period of time. He gives them a discount. Our folks say, "If I give anybody a discount, they are going to take away money." Not true. Because if you are at 70% occupancy and you can go to 80%, that's worth a discount. If you don't, and go from 70% to 60%, consider the alternative.

WEEKS:

It's the fixed overhead you have to worry about.

McMAHON:

That's the reason that I think some of my hospital constituents don't know enough about finance to understand this. I remember Horace Cardwell, I could never convince that boy as long as I live. He thought any discount was illegal, immoral and non-fattening. I said, "Horace, you're wrong. You've got to consider the alternatives. And you've got to consider that if you get some more volume as a result what it's going to do. And you've got to think your way all the way through the alternatives."

WEEKS:

There are two things that I see. Some of the smaller hospitals, or the non-cooperative hospitals, will drop by the wayside.

McMAHON:

They may very well. Or convert to save other services.

WEEKS:

The second thing is, what's going to happen at the end of that contract with the HMO when they come back and try to get together again? Are they going to want more?

McMAHON:

What happens to my friend the sweater maker? If Sears says, "You know, Lindsay, we've got somebody else now." There's that side of it too. But that's the real world. All of a sudden if a bank sees that because of interest rates, there is a flight of capital to another institution, it has got to adjust too. All of a sudden our hospital folk have got to live in the real world. A world that isn't going to be dominated, I think, Lew, by freedom of choice and cost reimbursement.

WEEKS:

We can't do it. We can't afford it. There's no question about that.

You served on the President's Commission for Health Education. Is that anything worth mentioning?

McMAHON:

My interest in health education grows out of that. I served on that commission, starting out, as a Blue Cross representative and then continued when I came here. Out of that commission, of course, grew the National Center for Health Education. I have served on the board of that center from the

beginning. I have just written to the chief executive officer to suggest that Carol McCarthy take my place on the National Center board. I found it useful. It translated into a lot of the things that we've done here on the health education side, into our encouragement of hospitals to explore health education as a very useful adjunct to their acute patient services. I've enjoyed it. I think it's been useful to me and to the hospitals.

WEEKS:

Would you care to say anything about the International Hospital Federation?

McMAHON:

Just briefly, in passing, Lew. I enjoyed that too. It did, as I've said to Carol, give me an insight into the health systems in other countries. As a result, I can look a Ted Kennedy in the eye, when he said to me once, "I've been to Britain and that's an excellent health care system." I said, "So have I Mr. Senator, but it ain't worth a damn for Americans." We are not going to accept the kind of regimentation they have in Britain, to limit their expenditures to 6% of GNP. The doctors won't, the hospitals won't, more importantly, the patients won't.

So the opportunity to find out about health care systems in other lands has been useful. In addition, because when they had their biennial congresses, we have always taken a good delegation of Americans; that helped make a kind of goodwill gesture on the private individual side -- the kind of goodwill gesture that I think Americans really need to make to the rest of the world. That we are not a rich, powerful, arrogant nation. We are a nation of individuals just like them, with the same kinds of problems that they have. Problems of how to provide good compassionate treatment of our fellow human

beings.

WEEKS:

I attended a meeting one time of the IHF advisory board. I was impressed with some of the people who sat on the board.

You mentioned the Veterans Administration. How does AHA relate to VA?

McMAHON:

Well, I have served on the special medical advisory group to the Veterans Administration for ten or twelve years. In addition, we have had a number of people from the VA serve on our board of trustees, — Mark Musser, the Chief Medical Director back in the early or mid-1970s. Mark and I were old friends back in North Carolina. Then John Chase, and now, John Gronvall, the Assistant Chief Medical Director.

I hope it has been helpful to the VA to know what's going on in the rest of the health care system of which they are a part. It's been important to me to explain to my own constituents, Lew, that the VA doesn't have the same kind of patient-mix that my constituents have. It has a heavy indigent, older, mental case and drug addiction and alcohol addiction problem -- a peculiar patient load. To say that we ought to close down the VA system and move it into the civilian sector would be bad for the veterans, I'm convinced, that they are taking care of. Because it is not a normal patient load. They wouldn't be comfortable in the civilian sector because we are an acute care, under thirty-day stay, and they've got a much long length-of-stay.

Obviously, as the feds try to squeeze down, Congress and the administration, more veterans may move to the private sector — if they start means-testing all veterans. They haven't had a means test for years for people over sixty-five. I think there are some changes going on there as they

adjust to downsizing. But there is another side to it. They are heavily involved in medical education. Just like that VA hospital in Durham, right across the street from the Duke hospital. It is an important part of our teaching function at Duke because we can then expose our students and the house staff to a different kind of problem, more like the problems they may see in some other settings than the tertiary care patients that become more and more of a high percentage of the Duke patients.

WEEKS:

In our last few minutes here would you care to talk about what you see for the future?

McMAHON:

No. I wouldn't care to do that. I wasn't employed to be clairvoyant. I don't know enough, or maybe I know too much to be clairvoyant. Sometimes it's much easier to make prognostications if you don't know very much.

I would say this, however, about the future: that most of what I see written that forecasts the future is just going to be dead wrong. I don't think we are going to have a thousand or two thousand hospitals close. We may have a thousand or two thousand or three thousand or four thousand downsize. But if they are rendering a service to their community and are supported by the medical staff, they aren't going to go away. They are necessary for the delivery of health services, almost regardless of who they are, necessary certainly to the physicians.

I don't see the ten or twenty super-meds that Paul Ellwood sees. Again going back to my feeling that health is a local service. Moreover, we have capital problems in this country. If you look at other parts of the economy, the bridges, the roads, the ports, the airports that we need, the water and

sewer systems, the street systems, and what business is going to need of its own to expand and provide jobs, there isn't going to be a lot of money floating around for some entrepreneurs to build up ten or twenty super-meds.

We are not going to see all doctors involved in the corporate practice of medicine. I think we are going to see all kinds of arrangements over ten years. I suppose I've got twenty-five years to go to observe the scene, at least I hope I do.

I think all of the forecasts that are being made, both by my unsuspecting constituents and the consultants, are going to be wrong. I do not know how it's going to be. I know that change never comes as fast as we think it will. If Murphy had an additional law, it would be McMahon's law, called "Things never change as rapidly as you think they will." I know how rapidly I thought they were going to change in 1972 and have reduced my rate of anticipation of change markedly every year since.

I think it's going to be an interesting world, both for doctors and for hospital folk. I've got great confidence that they can adjust to it, just the way that I've got great confidence in our educational system and in the way business adjusts to changes. And they'll do it in a peculiar American way that will be more individual than regimented. I hope my successor will have as much fun trying to keep it unregimented as I've had, relatively successfully, I suppose.

WEEKS:

I suspect that you look back on these years since 1972 with a certain amount of enjoyment and satisfaction.

McMAHON:

Absolutely.

WEEKS:

I think that your colleagues will undoubtedly voice that in your farewell dinner, if you have one.

McMAHON:

I hope they will. The one thing that I am convinced that they cannot do is to say anything or do anything that exceeds the joy and satisfaction that I've had. It has just been a great fourteen years.

WEEKS:

I really appreciate the time you have taken for this.

McMAHON:

I've enjoyed it too.

Interview in Chicago

April 3, 1986

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