

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

James Hague

JAMES HAGUE

In First Person: An Oral History

**Lewis E. Weeks
Editor**

**HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series**

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1959-1974 editor in chief of Association
1962-1977 corporate secretary of Association
1967-1974 associate director of Association
1977 secretary emeritus of Association

MEMBERSHIPS & AFFILIATIONS

American Hospital Association
Life member

University of Chicago
Program in Hospital Administration, guest lecturer

National Association of Science Writers
Life member

National Society for Medical Research
Member of Board of Directors

Northwestern University
Program in Hospital Administration, guest lecturer

Society for National Association Publications
Member of board of directors

Washington University
Program in Hospital Administration, guest lecturer

Who's Who in America

Who's Who in the Midwest

AWARDS & HONORS

American Hospital Association
Trustees' Award, 1974

American Hospital Association
House of Delegates Special Citation, 1977

WEEKS:

You started out in your work life as a newspaper man.

HAGUE:

I was born in England. I came here first when I was 10 and then I went back and forth because my dad couldn't make up his mind where he wanted to live. We went back in the depths of the Depression in 1932 when I was 16 years old, 17 years old. I got myself into the position of an indentured pharmacist, studying to be a pharmacist. I didn't like it, but in those days one didn't quarrel about jobs. For this I was paid the glorious sum of six and four pence a week from which they took health insurance and unemployment insurance. Six and four pence a week at that time was probably about three bucks a week. Of course, I was going to school.

I came back in 1933 and got a job as a newspaperman in Connecticut. I had made an impression on the editor of one of the Bridgeport, CT newspapers. I worked there for eight or nine years, too long, really. Then I went to the Hartford Times. I stayed there a very short time, about a month. I got a call shortly after this from the Associated Press budget bureau chief in Baltimore, offering me a job, and I took it.

Because Baltimore was a very important medical center we had quite a few

scientific-medical stories out of Baltimore. Al Blakeslee, who became the medical editor of the Associated Press, was in the bureau when I joined and did most of them. I did some and when Al left to go to New York, a plum appointment in AP, I became more concerned with science writing. In that capacity I had a fair amount to do with Hopkins. That was even stronger after I came back from the Pacific where I was in the Marine Corps.

I got to know Ed Crosby. He was then the first assistant director of Hopkins, a titled job: the First Assistant Director of Johns Hopkins Hospital. The director being Winford Smith. Crosby became the director when Winford Smith retired. He was the third director of Hopkins. He offered me a job as Hopkins PR director. I was very happy with him but like many long-time newspapermen there was a real pull on me to go back to the newspaper business. I went to Ed and said I thought I would be going back to the newspaper business. I was so-called Director of Public Relations, a title for which I have little use.

Hopkins was just south of the Mason-Dixon line geographically but it was utterly south of the Mason-Dixon line philosophically, and professionally. Those guys didn't have too much of a feeling for publicity or public information, as I would call it. I really became an executive assistant to Ed Crosby. I wrote his letters; I handled chores for him. I was a good generalist. That's what a newspaper makes of a guy, a very broad knowledge, very shallow. I was indeed the epitome of that. Shallow as hell, broad as hell.

So, I decided to go back to the newspaper business. I went to the Washington Post as assistant city editor during the days when it was in a bitter fight with the Washington Star. This was long before it became the

eminent newspaper it is today. It had a marvelous editorial page. It was short on staff, short really on news space. It had tremendous competition in news and every other way from the Washington Star. The Times-Herald had the sensational market to itself.

WEEKS:

Was that Cissy Patterson?

HAGUE:

No, I guess she had just left when I went there. I went there in 1949.

Ed Crosby and I kept in touch. They had a tragedy at Hopkins. He called me for advice on how to handle it. I said, "How you handle it is keep your mouth shut. Maybe nobody will ask you. Don't you go spouting off!" Good advice then, good advice now. I cite that as an indication that we kept in touch even while I was in Washington and he was in Baltimore. We would talk every two or three weeks.

He kept on saying, "If you ever want to get back to the health business, let me know. I have some influence." He was on the rise in the AHA at the time. As a matter of fact when he took the Joint Commission job we talked about it and I wrote a couple of speeches for him at the Joint Commission in 1952. I told him late in that year that I would like to go back to the health business. I had had enough of my return to the newspaper business. He was then the incoming president of the AHA. George Bugbee, then the AHA's chief executive, had hired a director of public relations who was a real misfit. Bugbee knew it. The guy went back to Minnesota to nobody's unhappiness: the guy's or Bugbee's or anybody's.

Bugbee was looking. Crosby spoke in my behalf. Bugbee and Maurice Norby interviewed me in Washington and I was offered the job of director of public

relations here (Chicago).

Russ Wiggins was the Post's editor, the predecessor of Ben Bradlee--Ben Bradlee working for me at the Washington Post. In those days, 1953, they offered me a thousand bucks more to stay, which, you know was a big deal. I had made up my mind. The dough mattered but it was not prevailing.

So I came to Chicago. I went to work for Bugbee. His last major appointment was my assistant, Dan Schechter, who became my successor. Crosby and I stayed in touch all this time. The decision to hire me was made while they were attending an International Hospital Federation meeting in England. He was living in Winnetka at the time and said I should live in Winnetka. At that time there was a brilliant man on the staff in charge of professional relations. He turned out to be an extremely controversial figure, Charlie Letourneau. Letourneau had a former student of his living in Winnetka, working for the Board of Methodist Homes, who had just been given the top job at the Methodist Hospital, now the Riverside Hospital, down in Columbus, Ohio. He was renting a house in Winnetka, Letourneau found out about it, and so I got a house in Winnetka. It relates to this because Crosby was then at the Joint Commission as director. He would drive down--one or the other of us--we started a car pooling and kept on until his death. I started to work for him--no money--at the Joint Commission. I wrote the quarterly bulletin, wrote his speeches, things like that.

Then Bugbee upped and resigned. I have my own notions on why, all favorable to Bugbee. I think he built the organization beautifully. He was a small organization man. He built a beautiful foundation. The personal control and involvement in every detail was obviously going to get beyond him as AHA grew. It was going to be impossible. I think he felt he would hold

the organization back if he stayed. So he stepped out.

I have an interview with Norby about how Crosby got the job. When Bugbee told him, Norby has told me, he said to Bugbee "OK. I don't want anybody to consider me to be your successor. I won't accept it. I want a letter to the board saying that--and going with your letter telling the board that you resign." So he ruled himself out of the picture, and I believe him.

He (Norby) tells me that Ritz Heerman was the AHA officer coming in, and close to Crosby. Different backgrounds, but both of them imbued with the sense of the spiritual element in hospital care. Heerman surprisingly so because because he went around with a pair of dice in his pocket, shooting dice at the drop of a hat. But he had a true sense of the spiritual contribution of hospitals. That got him close to Crosby. Crosby was an M.D. Buerki wanted an M.D., and he thought he could get Heerman's help by suggesting Dr. Black from the West Coast. According to Norby, Crosby was not an M.D. type in the normal sense, he was a hospital administrator. That was his background. He was, according to Norby, a clear choice. There was talk that Kenny Williamson wanted it, but Kenny didn't have a chance against Crosby.

Crosby was of two minds about the job. He thought that the AMA needed a moderate in the leadership position to get rid of the last vestiges of Fishbein, and there an M.D. was absolutely sine qua non. He thought he might be the guy who could fashion the AMA into a really public service organization, one with vastly more power than the AHA. Indicative of that is a remark that I ran across just a couple of days ago, looking over some index cards I have. In 1916 the AHA board asked the editor of the journal of the AMA to list the AHA in its directory. The editor said no he didn't have space. So, while the AHA had grown enormously in power by the fifties, it still was nothing like

the AMA in public affairs.

Crosby thought he had got the Joint Commission on a good going basis even though he had been there only a short time. He and I talked about this business, the offer of the AHA and his desire to give leadership to the AMA. He finally decided that he really had to act. The AHA was an offer that had to be acted on. The AMA, he decided, would never go as liberal as he was. So he decided to take the AHA. He joined it in 1954. I think in June, about a year after I joined the AHA. Most people think he brought me. He was instrumental in it but he didn't hire me.

C. J. Foley, who was then the editor of Hospitals, hated the job. He really did. He used to take me to Ballantines, a restaurant, a favorite luncheon place for AHA when we were on Division Street and asked me for advice on running an editorial shop.

I used to tell him, "You have got to be boss! You have just got to be boss!"

He said, "Well, in this situation I think I am right and my staff is wrong. What do I do?"

I said, "I don't give a damn whether you are right or wrong, you are the boss. You tell them this is the way they do it. If it's wrong, it's unfortunate. In my view you are right, but I would give you the same advice anyway."

He just was uncomfortable, so he told Ed so. A short two months after Ed had taken the job, he said he wanted to work directly for Ed as sort of an executive assistant, and he wanted out of the magazine, Hospitals, the journal. Crosby asked me, with my background, if I would take the editorship, and I did. I still kept my public information hat.

From them on I was in various positions. As I have described it, I was the vice president in charge of the written word. That is a reasonably apt description of my functions.

Crosby wanted me to be fairly close. We talked. We shared philosophy. We shared strategies and things. I wanted some sort of official position so he made me Assistant Secretary around 1960, I think. After Norby resigned the secretaryship in 1963, I was made Secretary in 1963 retaining the jobs of public relations, and publications.

When McMahon came in 1972, he suggested that I give up the publications and devote myself to the corporate secretaryship. I did that until I retired. I am sure that I would not have been terribly happy because, under Crosby, I was given free rein, absolutely as much free rein as any editor of an association publication could have. The new administration saw publications as part of the whole association to be used to further what were perceived to be the goals of the association and of its member hospitals. Objectivity came off second best. I remember writing later a story of one of the American Medical Association House of Delegates wildest meetings in which there was a revolt against the Board of Trustees. This was covered accurately and importantly in the AMA's own publication. When I wrote my story it was cut to ribbons because one of the AHA officers thought it might make things a little more difficult in the relationships with the AMA. All my story did was tell what happened from the viewpoint of someone quite favorably inclined toward the AMA. It was a much kinder story to the AMA than the one AMA published in its own periodicals. This was a different approach, a different philosophy and I would not have been happy with it. So I was just as happy with my exclusive secretaryship.

Around 1976 I decided I wanted out. Take early retirement, that is the best thing to do, to get out of the secretaryship and take sort of a sabbatical and interview some of the leaders of the field, get it on tape, and get it transcribed and get it in the library. Some day perhaps, write a history of the AHA.

That sounded like a good idea to Larry Hill, a nice solution to all the problems. So I stayed on for a year, did a great deal of traveling, did those interviews. On December 31, 1977 I retired. I have stayed reasonably close to the AHA, covered stories for them while I was living on the West Coast. I would like to work for them here on the publications side.

That's it. There you are up to date.

WEEKS:

Would you like to go back and tell us about the beginning of AHA?

HAGUE:

The AHA really started as an offshoot of a commercial venture, the National Hospital--something or other--published by a guy in Detroit, I think, Michigan somewhere. With him as a fomenter--that's quite the wrong word, instigator perhaps, certainly I don't want anything pejorative here at all--a group of superintendents got together in Cleveland in the Colonial Hotel in 1899. Somewhere it says that it was 1898. That's wrong. I had something to do with the error, but the actual founding date was 1899. A group of them got together and there have been meetings ever since. It started, of course, as the National Hospital Superintendents Association. It was a personal membership group, limited at first to superintendents of hospitals, by whatever named called. I think interestingly that at time the Cook County Hospital chief executive was called the warden, and was the warden until a

decade or so years ago. When Jim Houghton took the job he succeeded a warden. They finally opened it (the association) to assistant superintendents. That made, obviously, a membership consisting of doctors or nurses or an occasional accountant, not many of them though, and very few laymen running any hospital of any size.

They did some good things. For one thing, they got the very best people to serve as president. They were really first class. You look at the people who were the presidents of the AHA. That's a Who's Who of hospital management. There were the Goldwaters, the Winford Smiths, Henry Hurd, Ed Crosby, Jim Hamilton, Russ Nelson, Ray Brown, Al Snoke. They are all there, every key guy. They maintained that excellence much longer than the AMA. In the early days of the AMA, then a reasonable organization politically and progressively, they had everyone. Their presidents were all outstanding men: Popsy Welch and other topflight scientists and teachers and whatnot. It fell off in the AMA but the AHA maintained that excellence longer than the AMA. Maybe there aren't as many luminaries around as there were then. In the beginning, it was basically a correspondence club with a meeting once a year. They do have the "Proceedings" of the early years in the AHA library. They knocked that off, I forget just when. They are really fantastic things to go into. Have you looked into them?

WEEKS:

No, I never have seen them.

HAGUE:

They are verbatim records of the annual meetings. They are questions and answers. In 1913 one question was, "How do you get a cup of coffee to the patient before it gets cold?" A sort of indication that problems are not

easily solved. It's a mirror on the people who were running hospitals.

WEEKS:

The priorities.

HAGUE:

Yeah. There was some concern in those years with the care of the blacks, but not much. I am reading a book called Simple Justice, a story of the Brown v. The Board of Education case. The first third of the book is a history of race relations. The author says that the worst period for race relations for the blacks in this country were the first fifteen years of this century, not slavery. Wilson was a dreadful segregationist.

WEEKS:

A Southerner all the way through.

HAGUE:

Taft wasn't a Southerner. Neither was Theodore Roosevelt and they both were antiblack. You can't fault the hospital people for not worrying for that was the climate of this country at that time.

The first significant date in the American Hospital Association was 1899 when it was founded. A few years later it changed its name and that was significant of course. The giant step that made it possible for it to grow was in 1917 when it abandoned its personal membership orientation and became an organization of institutions. There aren't many organizations of institutions in this country, even though as de Tocqueville said we have more organizations than any other country on the face of the earth. We have organizations for everything. Usually they are individual. Oh, we have the Association of American Railroads, we have the Association of American Medical Colleges, but if you take a look at the vast majority, you find they consist

of individuals. So, this was a significant and extremely difficult move to make, to go from the trend of individual membership to institutions. However, the dominance of the organization by the chief executive officer, by whatever name called, was retained because from the outset the voting representative of the institution was the chief administrative officer as it was called in the bylaws.

The goal of the association remained quite constant in that as it moved from sharing information among superintendents, the group quickly focused on bettering care for the people. That was a constant. The last change in 1972 or 1973 really reiterates it. I don't think it has been fulfilled of late. There is a far greater cash register approach than the early leaders ever contemplated. Maybe it's necessary.

I think about that time, World War I time, or just after, they were talking to Dr. Walsh about setting up a secretariat. Not a full-time secretariat, a paid secretary on a part-time basis. I think the pay was to be a thousand dollars. Along at that time came Ohio, easily the most organizational minded of any of the states when it comes to hospitals. Thus the influence of John Mannix, and thus the influence of hospitals in Ohio on the state legislature. As Mannix says in my interview, the hospitals got money for accident victims and showed the hospitals they could do something with the legislature.

Ohio was the first state to be recognized as a section of the American Hospital Association. Shortly thereafter a group of Protestant hospitals, the American Protestant Hospitals asked to be recognized as a section. The association said "No." They thought that a section of hospitals, could not be based on religious affiliations. There was a section on TB sanatoria and

geographical groupings as in the case of a state or province-- Canada being a very important part of the Association in the early decades.

Canada contributed many leaders among them MacEachern, Basil MacLean, Agnew, Letourneau, George Graham of late, lots and lots of them.

Ohio was the first of the states sections. The others came in quickly, Wisconsin was second, Michigan, I think, was third. Then there was a man, whose name I can't remember, who was the chief executive officer who was replaced by Walsh.

Walsh's great contribution it seems to me, being only partly facetious, was the seal of the association. He designed the seal of the association, really. There was a committee on the design of the seal which reported in 1927. There is only one thing wrong with the seal, it's full of errors. It really is. As a matter of fact, we used to have a picture of this that we sold with a description of it. I stopped the sale of it because it was wrong. The cross in the upper right quadrant is supposed to be a Maltese cross. It isn't. It's a cross formee, it isn't a Maltese cross. You see a sign in France or Europe of a Maltese cross and it's a Maltese cross. The caduceus should really be off the vertical. The cross of Lorraine, the quartering device, the bars, are reversed. The maple leaf, I am told, is not the true maple leaf of Canada. But worst of all, before we added the error of 1898, was the nisi Dominus frustra. That famous Latin phrase, variously translated, but the people dimly know what it means...that scroll was supposed to have contained the words "The American Hospital Association," when used by the AHA. When the association gave permission to others to use it, then, of course, it couldn't say American Hospital Association, so they were to put nisi Dominus frustra in there, but not when it was used by the AHA.

Then it was discovered, this is how these things happen, that on the accreditation certificate of the Joint Commission there were five seals: the Canadian Medical Association, the American College of Surgeons, the American College of Physicians, the American Medical Association, and the American Hospital Association. They were on the top of the accreditation certificate. You could identify all of the organizations except the AHA. There was no name so I determined to correct it. Having been told that it was founded in 1898 and the 50th anniversary of the association being held in 1948, I encircled and got the board to approve this: Let the errors alone. You would have to change all the Blue Cross certificates, because at that time they were using this and just encircled the legend "American Hospital Association, Founded in 1898," another error on the seal.

Somewhere along the line, 1928 or 1929, Dr. Bert Caldwell came into the picture. A nice enough man, a gourmet I'm told, and apparently a gourmand also, a farmer, an army doctor, a colonel who served in Panama on his major tours, I believe. He took over the association. By this time they had 18 E. Division St. I think they had a staff of two or three and he kept it that way all the time. He liked it, didn't want to rock the boat. The association really consisted of a letter answerer, Dr. Caldwell as the organizer of the annual convention which was its major activity, and, eventually in the mid-thirties, a journal which he did. Pretty lousy.

He obviously had a hard time even in his own do-nothing way because of the Great Depression. People weren't paid. They mortgaged 18 E. Division St. (They got the mortgages back, of course.) Even despite the Depression, there were those who thought the association should be doing things. There was an occasional committee. Rufus Rorem on the accounting committee,, that was his

first AHA activity. They were looking at national health insurance, as was the AMA. There was a lot of favorable view on both sides, at North Dearborn and over there at 18 E. Division. I remember, and this indicates the political feelings at the time, when a committee was suggested. The board was informed that the likely candidates for that committee would be: Goldwater, whose political philosophy was very liberal; Winford Smith, who was for national health insurance (turned against it later); and Michael Davis. Can you imagine Michael Davis...anyway, that was the tenor of those times.

I think it was in 1932 that the association made its first pronouncement on prepayment, in support of it. It has been unflinching in favor of prepayment ever since. I think Rorem agrees that without the AHA there would be no voluntary prepayment. There would be prepayment, but it would be government.

As an organization it was do-nothing, it wasn't a no-thing organization. There were some very good brains, thinking and worrying. You should look at these index cards and see the vast range of things with which the association concerned itself.

About this time guys like Mannix were really getting awfully restless and thought that the AHA needed fundamental shifting. Under the institutional membership arrangement, as I have said, the chief administrative officers had the votes. Obviously the selection of the convention city determined the policy making of the association, because, if the convention were in Philadelphia, then the chief administrative officers of Pennsylvania hospitals or New York hospitals or New Jersey hospitals would obviously outnumber the chief administrative officers of California and Oregon, who wouldn't go to the meetings or wouldn't go in sufficient numbers. You might get a Ritz Heerman

or George Wood. It obviously was not representative of the government of the AHA, and they were making decisions both positively and negatively. They were concerned with the Wagner Act, Social Security, obviously. The hospitals of the country were not represented properly. I don't think the architects of the shift, as it came about, were as philosophically wedded as were the founding fathers in Philadelphia to the theory of representative government versus democratic government, republican versus democratic government. But what they were fighting for was the same thing: representative government. You couldn't have representative government unless you had a body...and don't forget that the nominating committee was chosen by this body and they chose the Board of Trustees and the board continued and the House of Delegates continued. For example, I think in 1927 or 1929, I am not sure which, a very active, good hospital administrator, Frank Chapman, John Mannix' mentor--he was one of the few laymen who was running a decent sized hospital, Mount Sinai in Cleveland--he was nominated. He was closely associated with the Modern Hospital. The people who dominated the AHA, doctors, didn't like even that touch of commercialism. Although Chapman was the choice of the nominating committee, they beat him with Dr. Joseph Doane.

Mannix got them to organize a committee on membership structure. I think they got it through the House in 1937. That was the great watershed mark for the American Hospital Association.

WEEKS:

How did that change things?

HAGUE:

It created the House of Delegates. Every state had a representative or representatives chosen by the institutional members within the state.

They created a council structure, and the House of Delegates, and another body called the Assembly which was a nothing. The House was the key thing. They also gave Caldwell more money to operate: but he didn't spend it.

There was a real push on the West Coast especially for a Washington bureau. It went sky-high, of course, when the war came. The Wartime Service Bureau was founded, basically to answer questions about linens and this thing and that thing, but not really lobbying. There was some lobbying, but not much. John Hayes testified on Taft-Hartley, for example, but it was done on a volunteer basis out of Chicago, dominated out of Chicago, and as little as Caldwell could get away with. The Wartime Service Bureau was under a guy from Brooklyn. Everett Jones was in the War Production Administration. He was the administrator of an Albany hospital. He knew the needs of hospitals and knew they weren't being represented. He was very influential in getting a hospital voice. That was the first voice of the hospitals in Washington, the real voice. It was basically over Caldwell's inertia.

I was told by someone who really should know that Caldwell was satisfied with the way things were. He didn't want to spend the money made available to him. He was really fighting guys like Mannix and Hamilton, the people who were coming up. Hamilton, of course, came out of a business school background, Tuck School at Dartmouth.

I was told what he (Caldwell) would do. He would say, "I think I am going to retire." So, he would quiet down the efforts to oust him. Then another year would come, a new set of officers, and he would say the same thing.

They would say, "Let's not do anything. He has been around a long time. He is a very nice guy. He knows all the right restaurants. Things are going along nicely. We have big crowds at the convention. It's good."

Then a new face came on. That was Jim Hamilton. This changed things in administration. Don't forget that Hamilton got great support from guys like Mannix, but Hamilton did the hatchet job. It needed doing, he did it. As I understand it, he went to the nominating committee and said, "Look, I am going to be president of the AHA some day, I'd like to get it behind me, so I want you to nominate me."

I think Agnew was chairman of the nominating committee. According to Jim Hamilton, Agnew said, "You are going to be president, but it's not your turn yet."

Hamilton said, "I don't care whether it's my turn. I want to be nominated. If you don't nominate me, I will have the votes."

Jim Stephan recalls that he was nominated, and of course, he was elected. He made it his business to make the change. That was fairly dirty.

Caldwell apparently aroused a great deal of sympathy among Catholic hospitals and among the hierarchy. I do not know whether Caldwell was or was not a Catholic. I would like to digress here because it's pertinent--but at one point in time, the AHA set up a joint committee of associations with the Catholics, the Protestants, and the AHA, deciding political and legislative questions. Each group had equal voting strength. That obviously was an abandonment of the AHA's power because here were two much smaller and religiously oriented groups with the power to override the AHA. Also, the Board of Trustees should be acting for the American Hospital Association, as the CHA board should be acting for the Catholic Hospital Association and the APHA board should be acting for the Protestant Hospital Association. They had abdicated power to this three-man group. Father Schwitalla saw in the elimination-- I understand, I don't know this at first hand, but it makes

a good deal of sense to me--saw in the change of direction as leading inevitably to the formation of an independent Washington activity by the American Hospital Association. Hamilton was pushing for it. He was spending his time in Washington. Basil MacLean who was then the president, had taken a leave during the war and Hamilton, the president-elect, really was in charge at this point. He was spending half or 60%, 70% of his time in Washington, with and without Caldwell's OK, much of it apparently at his own expense. I don't know that, but I am pretty sure of it. Yale was willing for him to do it. There was a suggestion that he be given the Washington job altogether on a leave from Yale.

As I look at the history, this presented a real threat to Schwitalla who had more power in the joint commission than his 800 hospitals entitled him to. Get rid of Caldwell and put some one else in there, let Hamilton win, and the Washington Bureau would be established just as sure as hell, and then AHA would act independently of the joint committee. That would deprive Schwitalla of a big power. Anyway, Schwitalla fought, and wrote a letter--a blatant power play--to all Catholic hospitals saying that Catholic hospitals should vote against any move to create a Washington office. Hamilton blew his stack and wrote a stinger of a letter to Schwitalla and to Monsignor Griffin and said by damn it was going to happen. All of this creating some effort on the part of the bishops' representatives... I don't know whether you know the bishops' representative structure.

WEEKS:

No, I don't.

HAGUE:

You ought to put that down. It's an interesting tale, aside from the AHA

but it has a great deal to do with the Catholic Hospital Association. I don't think you get a fair shake on the significance of the bishops' rep versus the nuns' situation from St. Louis.

There was a lot of pressure on the board to not fire Caldwell. Hamilton said, "At the first meeting of the board at which I preside, he's going to go." Period. They were meeting at the Drake Hotel. Hamilton recalls that he was in his room when John Mannix called him from down below. He said, "Jim, I am here with Monsignor Griffin. Come on down, will you please? We would like to talk with you."

Hamilton said, "Look, I just got to bed. It's been a tough day."

John said, "We have lived together for a long time. Come on down."

So he went down. It was nothing but a straightout appeal for delay in firing Caldwell.

Hamilton said, "Now look, I have had it." (Here we are, John is a good Catholic, as you know, and Griffin is obviously a Catholic). He said, "I am up to here with the pressure from the church on this. Now I am going to tell you then I am going to leave. If Caldwell resigns, I will see to it that he is taken care of (a pension or something). If I don't have his resignation tomorrow morning, he will be fired and that will be the end of it. I have the votes and I am going to do it."

He went out of the room and the next morning he had the resignation. That was the end of that.

Mannix was the logical choice to run the organization, if he would take it, because of his historic fight for a strong American Hospital Association... He had fought the good fight, had been influential, had been effective, and would have been a fine exec, but I am told by people who were

there that his Catholicism did in Mannix. It makes sense, although it's an evil thing.

WEEKS:

Because of the circumstances at that time of the Washington fight?

HAGUE:

No, I think there was an anti-Catholic sentiment in hospitals. How many hospitals--you have been around quite a lot now--how many hospitals do you know before 1950 that were run by Catholics?

WEEKS:

You mean outside the orders?

HAGUE:

They were all nuns. They were religious. I am talking about Catholic laymen. How many?

WEEKS:

I don't know of any.

HAGUE:

I don't know of any either. There were some good Catholics around, obviously, but it was like the insurance industry--Catholics...

Like Bob Buerki. He said, "I am not a biased individual but I know a Catholic would not be acceptable in the job." So that did it. The other third candidate was O. G. Pratt.

Bugbee was the dark horse. No one really knew him, although he had been chairman of a council, and thus was on the Coordinating Committee, which was quite important. It isn't so important any more. Thus Bugbee was a very key guy and was an ally of Hamilton's. He got the job.

They raised the dues fourfold that year. Bugbee went to work and he hired

staff, good staff. When I said before we started recording that he kept his hands on everything, he surely did. He approved the design of the poster for National Hospital Week. He approved the theme of National Hospital Week. He approved every article that went into Hospitals. He approved every manual. He went to every council meeting. The guy was fabulous, but he didn't delegate. He did get good people and he did set the association on the right track. The three or four key staff: C. H. Foley, Maurice Norby, Kenny Williamson, and Bugbee met in what Bugbee calls a "retreat" in the Hotel Churchill. In these days you talk of retreat in Aspen House of Colorado. This was around the corner just across the street from the Ambassador Hotel in Chicago, not very far from AHA headquarters. They came up with what the association should be about.

Representation. You think of representation in more recent years with emphasis on Washington, you think that's all we are talking about. Actually there was far more to representation. Representation also means the AMA, the pathologists, the radiologists, the anesthesiologists with which we have done very poorly since the forties.

The second had a double name: research and standardization. The AHA was influential in the study of the anesthetic gases, and the mixture of nitrous oxide and ether, and the things that made it almost impossible to mix the two gases.

The other one was education: publications, conventions. George thought of the commercial aspect of conventions as a necessary evil. He wouldn't give the exhibitors the time of day if they interfered with an educational program. He would take their money, but that's it. He ran damned good conventions so they came. Now the national conventions are weaker than they

ever were.

Those three--basically three, because research and standardization could be considered one--dominated AHA. George Bugbee went down the line and he gave great power to council chairmen. Council chairmen were given these three goals and then he asked what these councils should be doing and thinking about to further AHA toward these goals. They came up with some very exciting things. The first thing they did was a series of manuals, the best the hospital field had every had, and there were lots of them. They were of uneven quality, because, while he had expanded the staff as sharply as possible, it was as he said, "You may raise the dues four times but I may not be able to spend it wisely. We don't want to spend the money simply because it is there."

We had a lot of committee-written manuals. Writing and editing by committee is a horror. Committees are good for thinking. It's a marvelous device to get thoughts in order, to winnow things out, but when it comes to putting things on paper, throw the committee out the window, and hope it's a very high level so they don't come back to bother you. He didn't have the staff to do it, so committees did it and they did remarkably well. They really did. Some of those early manuals are still damned good. They have been revised.

The manuals were a part of the education thing. Then they started a whole series of institutes. Another facet. He added people in various areas. Oftentimes the first thing they would do was run an institute. He got himself a personnel gal, Ann Friend, Ann Saunders when she was hired. She ran a couple of personnel institutes. I was at Hopkins when she started a public relations institute, and I went to it. It was interesting. It was at

Westminster Choir College.

Going on at this time was Bugbee's great dream for an Institute of Hospital Affairs. Westminster Choir College was one of the places he had in mind. He got Ray Sloan and the Sloan Foundation interested. Ann Friend did some writing of a proposal for it, but he never could swing it.

WEEKS:

Didn't the college change its mind about selling at about that time?

HAGUE:

Yes, but I don't think the Institute was fixed on the college. It was a nice place to be if you were going to have it, but it was independent of that, because I know he was looking at Hopkins and the University of Chicago. But that didn't come to pass. Then when Ed Crosby was chosen (to succeed George Bugbee) he was far more a pragmatist than George and he saw that the hospital field needed something more concrete than scholars sitting with other scholars and figuring out what to do with the world. Again, you should remember what I said about Crosby and his business of the AMA and the power. He could not see the AHA competing on anything like an equal footing with the AMA from 18 E. Division St. Bob Cunningham once described it as a gallimaufry, a very fancy word.

Crosby decided that this building in Chicago was more attainable than the Institute because it could and would be bought by the membership. You wouldn't have to depend on others.

WEEKS:

Before we leave George can you say something about his other activities, commissions and so on?

HAGUE:

One of the first things that George did was get money for the Commission on Hospital Care. As I understand it, the Public Health Service recognized that the hospital situation in this country was abominable. The war was going on, there was no construction at all of civilian hospitals. I think it was Parran who was surgeon general at the time. He had a notion of a big program, that finally turned out to be Hill-Burton. He needed data to sell it to the Congress. The same thing seemed logical (to George) but I think he realized damn little was known about the hospital situation in the United States of any validity. So George went to various people, got money, put together a very independent commission, chose another Ohioan, Bachmeyer, to be the director. (Bachmeyer was at the University of Chicago at this time, of course.) Norby was chosen by Bachmeyer. Norby was then on the AHA staff, having come here from Pittsburgh. After he left Rorem he went to Pittsburgh and had the Plan there. He came back not to the Blue Cross activity, which surprised everyone in Blue Cross, but to AHA.

Norby was chosen as number two. Bachmeyer was running the Chicago hospital administration program and the University of Chicago clinics. According to Norby he said he would spend half time in each job: three days a week there and three days a week at 18 E. Division, where the Commission was housed. Except in the presence of an absolutely horrifying emergency he was not to be bothered by one side or the other on the off days. This gave Norby a great deal of influence in this thing. Parran couldn't really wait for the Commission on Hospital Care to digest all of its data, publish its report, give its report to the foundations and the members of the commission: the whole schmear. He had a political, legislative problem on his hands and he wanted those data and he wanted the fact finding well done. He thought it

would be well done. So, the Public Health Service was the hidden financier of the whole thing. Norby was on the payroll at a dollar year. Dave Wilson, who became the president of the AHA, came to Chicago on leave from PHS. All the statistical work was done by PHS people. As the reports came out, they went to PHS so PHS was privy to the data before those data were public. That work, of course, made the Hill-Burton legislation possible. PHS sent Vane Hoge to the University of Chicago to take the course in hospital administration so that he could be in charge of the program when the legislation passed.

The Commission on Hospital Care maintained arm's length from the AHA. It made reports to the AHA board, but gave the AHA board absolutely no control over the Commission's activities. So, while Bugbee had basically created it, it was doing its work away from him. This was Bugbee's big thing -- Hill-Burton. More than any other nonlegislative person, and I think this is true, and I broaden it, more than any nongovernmental person, including the PHS, because the PHS was significant-- a guy like George Perrott was very important--but I don't think in the legislative situation, the actual power play, anyone was as powerful as George Bugbee.

He got along with Senator Taft. Again Ohio. I know George was from Michigan but he had strong Ohio connections. As I am sure you know, Burton is just a name on Hill-Burton. But it's Taft, also Ohio, belongs there, because it was Taft who did the work, who came up with the grant-in-aid program. The insistence that Hill-Burton be really seed money, and it surely was... I have seen charts of the money that went into hospital construction during the Hill-Burton years. Hill-Burton was a substantial fraction, but it was a minority of the funds that were spent. Taft insisted on local control. That's why there has been no scandal. I know of no Hill-Burton scandal.

That's because individual hospital boards had to raise local community money. Their reputations were on the line. Unlike the Interstate Highway Program where the states got 90% of it from the feds and the rest of it came out of state coffers not directly from a community. Those guys were lined up to get their hands in the boodle right up to their elbows and all sorts of scandal. That did not happen with Hill-Burton because of Taft's careful draftmanship with Bugbee. I am sure Bugbee deserves a lot of credit for such a good piece of legislation.

Then I think the PHS was responsible for devising the early formula which made the initial beneficiary the rural community. That meant the rural South. That meant Lister Hill. Lister, of course, in a Democratic Congress was Mr. Health on the Senate side; John Fogarty was on the House side.

Do you have any questions?

WEEKS:

I think the Hill-Burton Act and the formation of the Joint Commission are the two big things.

HAGUE:

It's strange. Norby played an important role in the accreditation as well. Incidentally I have his interviews. I know he would be delighted to have you look at them if you want to.

WEEKS:

I would like to.

HAGUE:

The College, The American College of Surgeons, was running out of money. Their inspection program was really focused on surgery and on medical records as an outgrowth of its concern with surgery, because the surgeon couldn't

prove that he had done an adequate number of surgeries properly unless there were medical records to back up his claims. Therefore the College couldn't say to a surgeon we require that you do 100 operations of thus and such nature before we let you into fellowship. Nobody could prove that he had done a hundred operations, well or any other way, in most hospitals.

I think it was the financial burden on the College. I don't know where the records of the organizing committee that led to the Joint Commission are. I have not seen them. I have talked with Norby who is very familiar with it.

The American College of Surgeons came to the AHA, not vice versa, and asked the AHA if it would take it over. Bugbee thought it was a hospital program, as it was, and belonged in the broadly-based hospital organization, the AHA, which it did. It was an appropriate thing for the AHA to do, and the AHA had a relatively painless way of raising money. The AHA dues are not a big factor in an individual hospital's budget even today. So the AHA could slip a hundred dollar levy in the way of dues to hospitals a hell of a lot easier than you could slip that hundred dollars on the backs of a lot of surgeons who were already paying a lot of money in various professional organizations. It made a lot of sense. The AHA board decided to do it.

The AMA got wind of this and showed up furious in Atlantic City to tell the AHA that they had no right to be involved in this situation. AHA was not impressed. Strangely enough, neither was the American College of Surgeons, which, I think it is now clear, at the outset did not trust the AMA sufficiently to give that organization any role, let alone the dominant role, in the standardization or the accreditation program, as it came to be called.

As people began to talk, a broader approach seemed to be the only way to go. They did start this approach. I am not sure of the year, but it's in my

card file, and I think it's in the Norby interview also. Norby served as secretary. I did very extensive interviews with Norby. He was a significant number two man. He was number two to Rorem in Blue Cross after having been number two to van Steenwyk. He was number two to Bachmeyer on the Commission on Hospital Care. He was number two to Bugbee, and he was number two in the accreditation activity. I forget who was chairman of that committee, it could have been Gunnar Gunderson, who was the first chairman of the Commission.

Anyway, they rassled and rassled. The five body commission was the result, The Joint Commission on Accreditation of Hospitals. The Canadians were on it, as you know, at the start. I think I was told that the decision to let the Canadians bow out of membership was made by one vote on the board. That's no way to make major decisions. When you are that close, you throw them in the hopper for a while and let them marinate. Eventually you will get a surer vote.

The Joint Commission took over, as you know, and Crosby was its first director. Bugbee, through Norby, was a pusher for hospital representation. There is no doubt that today no one disagrees with the notion that hospitals have the right to an important role in the accreditation function.

I think it was unfortunate that the votes were set up the way they were. We had found, at least in my look at the Commission, the AHA commissioners voting the merits. You wouldn't find all the hospital people on one side on any one standard. The AMA, with as effective power as the AHA, has effective veto power or did have, I don't know what it is now--the AMA commissioners voted the party line. The AMA House of Delegates decided what the policy should be and those commissioners carried the water. That's not the way I think it should be, but it is the way it is. I, for one, would have been more

pragmatic about it from the AHA standpoint. I would have played the same power game. My set of votes would have been cast for what our Board and our House deemed to be the best interest of hospitals, and just played politics.

I believed that both Bugbee and Crosby took the wrong stance of doctors on hospital governing boards. Right philosophically, perhaps. But wrong programatically. I would have given in on it to the AMA. I would have exacted a high price.

I remember in one of the revisions of the standards, George Graham was the senior member of the committee from hospitals. Dick Palmer was the chief spokesman for the AMA. The story is that he told George one evening over at the Drake at a dinner at Dick Palmer's invitation, "Give in, George, on physician membership. Let's have a standard on it and you can have anything else you want in the set of statements. Gives us that and you can have yours."

I would have bought the deal. I really would.

WEEKS:

They wanted it mandatory to have...

HAGUE:

They wanted a physician on the board. It make sense to have a physician on the board anyway.

I think that's about it for the Joint Commission, because Bugbee left two years after the Joint Commission was formed. There was an advisory board; he was on that advisory board. He was there during the formative days. He and Crosby were very close, so undoubtedly they were very, very influential in charting the course that the Joint Commission took. The importance of an administrative type was shown by the selection of Babcock to succeed Crosby, and it wasn't until Affeldt came on board that an actual practicing doc had

anything to do with the direction of the Joint Commission. John Porterfield was not a practicing doc.

WEEKS:

Is the Commission on Financing of Hospital Care worth discussing here?

HAGUE:

Yes. The Commission on the Financing of Hospital Care was an outgrowth of the unwillingness of the Commission on Hospital Care to tackle the subject of finance. They were going to be at loggerheads. They just weren't going to get anywhere, so they decided to put it aside. Then Bugbee again created another commission on the same basis as he did with Commission on Hospital Care. I think there was more AHA influence through Norby. I think largely because they didn't have a Bachmeyer running it.

WEEKS:

He had died in the meantime hadn't he?

HAGUE:

He died at the Washington National Airport. A massive heart attack. I don't think he would have taken the job anyway. I think Gordon Gray of the University of North Carolina...or was he the commission? They run together. I think Norby is a better source on this.

The Commission on the Financing of Hospital Care did do one thing. It focused the attention of the AHA on health care for the aged. A committee was appointed by the AHA board to study the Commission on Financing of Hospital Care. What should the stand of the AHA be in that section having to do with the health care of the aged? van Steenwyk made the recommendation and the board adopted it. From that point on, it seems to me that the AHA debate was more methods than anything else.

The AHA quickly accepted the need of the aged for health care help and the need for federal assistance in the solution.

The AHA's approach to care for the aged was to be via a Blue Cross card for everyone, destroying the differential between those who could pay and those who could'nt pay because everyone would have the little old Blue Cross card. It would base a person's contribution to that premium to some income basis but applied with some humaneness. No hardbench means test approach.

The hospital powers are a relatively conservative lot. They are not Neanderthal, but I am sure that 95% of them voted for Reagan.

Anyway, such a lack of entitlement was attractive to many of the hospital conservatives. It's an acceptable thing if done properly, to liberals such as I. I found, despite my liberal beliefs, and I am much more liberal than most people in the hospital people, that I could live in this AHA climate. I couldn't live in the AMA climate, obviously. They came up with that suggestion. It was--and I usually use the very earthy term--it was urinated on by everybody in sight, from the left to the right. It just got absolutely nowhere. AMA came up with Kerr-Mills as a way of stopping Medicare. It didn't stop Medicare, of course.

The AHA, because of its position, had real influence on Part A of Medicare. Of course, everything hit the fan when Mills came up with Part B. Guys like Wilbur Cohen were perfectly willing to settle for the hospital part of the package as a beginning with hospital physician specialist--radiologists, pathologists, etc.,--covered. It wasn't a total health care program. It was exactly as it set out to be: a program to remove the financial barrier to access to hospital care for the aged of the country. Obviously he (Cohen) was delighted when the medicos came in with Part B with Wilbur Mills.

AHA was part of the drafting of Part A. By this time AHA was very much into the Washington scene, very important. It had a lot of influence. It was only when Part B came in that things got extremely difficult for AHA, largely with the specialists. Buerki was the leader of the early AHA efforts in the late 1930s and early 1940s to get some harmonious relationships between hospitals and the various hospital specialists. You wouldn't know it today but one hospital specialty group after another thanked Buerki for working with them to get approval by hospitals of a statement that permitted just about any arrangements. They all backed off very quickly once they got the power and recognition that they were seeking. Hospitals realized, certainly Buerki did, that hospitals had to have a reliable source of specialty services.

The specialists were all delighted with what Buerki had worked out because they wanted recognition as something closer to the internists and the real doctors, the laying-on-of-hands doctors. Once they got most of that they quickly went for the dollar. Some time someone should take a really close look. Some of that hospital-physician relation background seems very unsavory. Some of the anesthesiologists' tactics against salary. Their statements are ridiculous on their face. They were tough on those who didn't believe in them.

WEEKS:

We were talking about Bugbee's tenure, then we talked about the Commissions. I think we went from the Commission on Financing Hospital Care into this last discussion.

HAGUE:

Yeah, because of Part B. We got to Medicare. In Medicare, as I said earlier, and this is on the tape, the debate was about how to do it and not

about whether it should be done. The special meeting of the AHA House held with the Blue Cross Plans at the Drake Hotel in 1962 or 1963 in Chicago to establish policy on it said nothing more than to say we don't want Social Security administration of Medicare. I am sure that's what it would add up to. The AHA, by and large, prevailed on removing Social Security from the active administration of Medicare programs--through the intermediaries. We fought for them and won. The AHA staff did the scut work that led to the nomination by an overwhelming majority of hospitals of the Blue Cross Association, revitalized--revitalized by this time--as the intermediary. One, saying there had to be an intermediary; two, naming Blue Cross as the intermediary. By and large, it's worked quite well, I think.

WEEKS:

It's doubtful if Social Security would have been able to handle that tremendous mass of data when Medicare was activated.

HAGUE:

No, it couldn't have done it initially but it could have done it later.

There was one other thing that the AHA did in the Medicare thing. The Surgeon General announced that under Title VI of the Civil Rights Act of 1965, I guess, hospitals that showed discrimination would be denied federal funds. That would have meant that in the South Medicare wouldn't have worked, at least in the beginning. I think the Moses H. Cone decision was in by then, I am not sure. I think it was. That was the decision where the Supreme Court held that Hill-Burton was a state action and therefore the Fourteenth Amendment applied. In any event, William Stewart, the Surgeon General, really issued a tough, tough statement on discrimination. But in the opinion of the Southern hospitals, the Public Health Service was enforcing Title VI in some

sort of a numbers game. They deemed the methods extremely unfair. Jack Masur was the first true government officer to be the president of the AHA and in the chair during some of these tough policy decisions and voting his desires, his own philosophy. A marvelous man. He came to Ed Crosby and said, "We've got troubles. Medicare goes into effect on July 1, 1966. It would be just catastrophic if those civil rights rules prevented taking care of the vast numbers of elderly patients under Medicare when it goes into effect. What can you do?"

John Gardner was Secretary of Health, Education and Welfare at the time. I got to know one of his assistants, a staff assistant, not a line type guy. I got in touch with him and said that HEW was responsible for this whole Medicare program, and that we have got some problems. This may not go, because of this civil right situation. We at the AHA will do what we can. So what we did was we got--with HEW paying the bill--representatives of state associations of every potential trouble spot in the United States, took them to Washington and had two days of air clearing. It cleared the air. There was little problem. As a matter of fact, when you think of it, July 1 came and went with hardly a ripple. That's pretty good for hospitals in this country, it seems to me.

WEEKS:

I would just like to add a little subhead here. Not long ago one of the black graduates from Michigan sent me a compilation he had made of the number of black hospitals that went out of existence and the fact that there are only two black medical schools of any size left. They attribute this, sadly enough, but gladly enough, to the fact that civil rights has made this difference. Where before they were trying to build a system of black

hospitals, now this is practically gone.

HAGUE:

It was one of our hopes, obviously, that Title XIX would eliminate the public general hospital as the only place for the poor, not just the blacks, to be cared for. Certainly in California the reasonable leaders had hoped that the county hospital system would disappear. As you know, maybe you don't know, in California all the people who couldn't pay their bills had to go to the county hospital. That was it. There was no other way. A guy like Bill Stadel, who was the medical director of San Diego County, the second largest county in the state, was the director, in that capacity, of the county hospital. As soon as possible he sold the bloody thing to the University of California because he wanted it gone. He wanted everyone to go to their own hospital. It isn't working and it's too bad.

The AHA in Medicare...there were endless task forces in that year (before Medicare was implemented). Without AHA and its ability to mobilize resources, hospitals would have come out badly although I don't think they fared as well as they should have. That was largely because of the specialist problem. The victory which is related to it of the AMA was in the preservation and extension of fee-for-service. Its total dedication--no matter what word you use, it's there--to the fee-for-service system is in my view understandable economically, arguable socially but may well cost us the system of health care as we know it in the end.

WEEKS:

I just had a nice interview with Dr. George Crile, Jr. He is a great foe of the fee-for-service for surgery, as you know. Ford Hospital, Cleveland Clinic, and Mayo Clinic all operate on a salary basis, don't they?

HAGUE:

Yeah. Mayo's is unorthodox operation. It has no hospitals, just a medical partnership. But certainly Henry Ford, and certainly Cleveland Clinic, certainly the University of Chicago, prime examples of high-class salaried practice.

WEEKS:

I think we have covered Medicare pretty well. Would you care to sum up your opinion of Dr. Crosby?

HAGUE:

Ed, no doubt, was a manipulator of people in the good sense of that word. He was not a medical scholar; he never saw himself as a good physician at all. He said he wouldn't treat someone's cat. He brought to the AHA his belief in doing good for as many people as possible. In the field of health, except for the classic public health things like sanitation and immunization, the hospital was the major agency of doing good for people in the time of disease. The hospital had, indeed, supplanted the family physician. It was in the hospital and through the hospital that sickness really could be controlled. I am not talking about immunization or pure water supplies and pollution in the air, and so on. I am talking now about what we see as routine health care in this country. The hospital is the place where it is given. The hospital is the place that trains the givers. Therefore, someone who is dedicated to doing good for a lot of people, if in the health field, should be working in and for the hospital.

I think he held that. He had an amazing personality. He knew everyone and everyone liked him. The Bob Buerkis, the Herman Hilleboes, the Howard Rusks, the head of the WHO, the Ray Browns, the Mike DeBakeys--you name them,

he was trusted by them, and he could get things done through them.

He was a Salvation Army child. He married a Salvation Army woman. He quickly went into public health in New York state, basically in New York. Union College, Albany Medical school. The New York State Department of Health had a habit of choosing the brightest young men and sending them on to Hopkins for further schooling in public health. He did his work for his master's and his doctorate in public health at Hopkins where he came under the strong influence of a man named Lowell Reed. He was a very important man, later, the president of Johns Hopkins. Lowell Reed was not an M.D. type doctor. He was a Ph.D. type doctor, a biostatistician. At one time every chair of biostatistics in the country was held by a graduate of Reed's. Not only of Reed's but the Hopkins program. Raymond Pearl, who did some of the early studies on tobacco, was one of the early biometricians, as they called them in those days. Lowell was a statistician. He liked Crosby. Crosby apparently did very well. Crosby did his public health doctorate on a study of syphilis.

The school of public health at Hopkins is right across the street from the hospital. Until recently Johns Hopkins Hospital had at once no relationship and every relationship with the university. The only thing that held them together was one sentence in a letter from John Hopkins to both the university and the hospital saying that he wanted them to work together. That's all, and, by God, they did.

The hospital was an independent corporation and got an equal amount of Hopkins benefaction as did the school. It was opened long before the school. It was the great enticement of the great, early physicians. It was the early interest of the Rockefeller Foundation through Gates, I think his name was, and through the Flexner study. The hospital and school were separate, but the

chairman of the department of surgery at the school of medicine had to be the chief surgeon of the hospital. But that's all there is to it.

Crosby was sent over to the hospital to work in the vital statistics area, working with early computers, and adding machines. He tried to teach me a little vital statistics, little stuff, not enough.

Unlike most institutions, Johns Hopkins Hospital had great reliance on statistical reporting to judge the quality of its care. Its annual reports were just chock-a-block with statistics from the hospital. Not enough attention is paid to that these days. That led Crosby into a broader field of hospital administration. He became a certified medical librarian. He went into administration and became Dr. Smith's chief assistant, and then became the director.

Later he took over the Joint Commission, came here to Chicago, built this AHA building and the one next door (840 North Lake Shore Drive, Chicago). He built the organization into what it is today, or just about what it is today, on the foundation that Bugbee had left him.

He ran into problems on this building. Obviously, we needed a building. He knew that, so he went to noted hospital architects, noted architects not just hospital architects, Smith, Gardner, and Erickson. They told him what it would cost to build this building. John Hatfield, Sr. was chairman of the building committee, treasurer of the Association at the time. On this they settled on what it would be, went to membership and said they would have to double the dues. The Association had, as I said earlier, a nice way of getting money, but when you are talking about five or ten million dollars and you double the dues, that's the limit. The AHA didn't have any capital. Then they got the sad news that the 17 stories that were to be built for 5 million

they could build 13 stories now for 12 million. A little difference! There wasn't enough money. So within a year Crosby had to go back to the House of Delegates and ask them to double the dues again. It took some doing.

The building was slow. There was a big hole where this building is now, filled with water all the time. Some people irreverently called it "Crosby's Ditch." I remember I once was in a night club in San Francisco--I am a jazz fan--and Muggsy Spanier a hell of a cornetist, now dead--they played on a band stand behind the bar. Between sets we started talking. He found out I was from Chicago at the American Hospital Association and he said, "Did they ever fill that ditch in?"

I said, "What the hell do you know about it?"

He said, "I used to walk by it every day. I wondered if they would ever fill it in."

They did fill it in, obviously.

This was to be the institute that Bugbee wanted. The American College of Hospital Administrators was to be here. The accountants were to be here. Blue Cross was to be here. Chicago Hospital Council was to be here. The Illinois Hospital Association was to be here. All sorts of things were to be here. They all were at one point. Then with growth pressure on their part and on ours, they evaporated. Oh, one of the things Crosby did was persuade the Continental Illinois Bank to take a mortgage on this building. That's not easy for a nonprofit organization to do. As it was said it was risky but he went and persuaded a resident of Winnetka, who was the president of the bank, and other people to give the AHA a loan. We got a temporary dues assessment to pay off the mortgage. Everyone said, of course, that you put in a temporary dues assessment and it's engraved in concrete and will never go

away. It did go away after four years. They paid off the mortgage and stopped the dues assessment.

Then they needed another building and his credit was good, both with the membership and the banks. He could build it, and he did build it.

WEEKS:

Is this on Northwestern University land?

HAGUE:

Yes. This piece of property came from a trust. It was given to Northwestern by Colonel McCormick. He had a medical writer, a physician. He said that if Northwestern didn't use this for their own purposes, they had to pay a certain income to the Fuller Fund or Tucker Fund, or whatever, named after this guy, this physician. We took on that burden, I think it was \$4,000 a year, obviously nothing for this property. We had difficulty getting zoning because the zoning did not permit an office building, so we had to go down town and play politics.

WEEKS:

Did it get by because it was health related?

HAGUE:

No. You could build a hospital here. You could build a library, but you couldn't build an office building. Dr. Crosby talked to the mayor and got his variation for next door, too.

WEEKS:

Before we started taping I suggested you might want to discuss where the revenues of AHA come from, whether is it the real estate, the convention, the publications, membership dues... Is there a principal source?

HAGUE:

I don't know. For a long time by far a majority of the funds came from dues, institutional dues. The personal membership societies...There are two kinds of personal memberships: regular personal memberships, and then a membership in one of the organized societies. As a life member of the Association I am one of the regular personal members. Gordon Davis is a member of the Public Relations Society. The aim was always that much more than 50% of the Association's income come from dues so that the Association would not lose its dependence on its members, and, therefore, the members would not lose their ultimate control over the Association.

The AMA, for example, was just the opposite. That's what gave Fishbein his great power. I don't think the American Medical Association had real dues until the middle 40s. They were supported entirely by their publications and their convention.

What the total AHA income is, I don't know. We can get you a report, we can get you the figures, very easily. I think the emphasis has been to developing sources of revenue, to increasing the revenues from other than membership dues. Membership dues are increasingly threatened by the multihospital system.

Many years ago the AHA set up a special membership arrangement. It couldn't be called membership because laws often prevent government hospitals from holding membership in things. They were called contract hospitals--or something. Some camouflage is all it was. Everyone knew it was a camouflage. Every Army hospital, every Public Health Service hospital, every VA hospital, is a member of the American Hospital Association. The largest institution in that system pays maximum dues, all others pay minimum. Rationale: If you charge everyone in the federal government hospitals (the

regular rate) they would all be paying the maximum, spending large sums of money. They would all quickly come to the conclusion that one membership would suffice. They would get one member in, and then they would distribute all the materials to the other members of the system. Therefore you might as well take them all in straightforwardly on the dues schedule I mentioned.

The chains didn't do it that way. They took just one membership. AHA is now changing their tune because the multihospital systems are becoming a real threat. I don't know how many Derzon said were in the chains but a very large proportion of our American hospitals are in the chains now. With only dues, that is a real problem for the American Hospital Association.

Another problem that Kenny Williamson saw was that eventually an unfriendly government might say, "Why the hell are we paying through Medicare and the like to support an organization like the American Hospital Association that does nothing all day, six or seven days a week, but kick us in the teeth." This is a conclusion that someone could draw at sometime.

In Canada the federal government will not pay for AHA dues paid by hospitals out of their reimbursement scheme. They will pay dues paid to the Canadian Hospital Association through the provinces. They recognize the value of the association. They have a little different setup, however, in that the federals are paying much of the bill and have very little to say in Canada about how it is spent. The provinces are fighting tooth and nail to protect their own turf.

I think the relationship of the AHA to the Reagan administration is probably pretty good. Al Manzano, who now is the Washington director, was in the early Reagan governments in California, and is of a conservative ilk. Therefore, probably pretty good relationship. But it seems to me Reagan has a

very short temper for those who oppose him, and certainly has ways of getting at them. I think that if the AHA is perceived eventually as an opponent of the Reagan administration, there might be financial difficulties ahead.

WEEKS:

This is a good point you bring up, when you speak of Manzano. We haven't come to McMahon yet. I was wondering this one question. It seems to me both Mr. McMahon of the AHA and Walt McNerney of Blue Cross have been public figures, have been more active, it seems, in the public forum and in representing the associations than they have been as operating officers. Is that a fair statement?

HAGUE:

I think that in the later years of Dr. Crosby's life. Let me see if I can go back. Doug Colman--this is going back quite a few years--Doug Colman, a very perceptive individual, said, when he was sitting on our board, that it was time to look at the American Hospital Association because of the incipient, vast changes coming through the dominance of government. They weren't here yet. The board appointed a committee with a distinguished membership. Ray Brown was chairman. Ray Brown, Mark Berke, I forgot who else. A good committee. I served as secretary. They wrote a document called The Changing Hospital. They looked at the AHA and the hospital. A good committee. They said things were changing like crazy. Then in 1965 we got Medicare. The percentage of money paid by government went way out of bounds, not out of bounds, but it went...it escalated enormously. The hospitals had ceded, at the AHA suggestion, an intermediary role to Blue Cross--this is by and large, there were some hospitals that chose other than thus, of course, government hospitals...

WEEKS:

A small minority.

HAGUE:

A very, very, small minority. They ceded that intermediary role so that they were not directly related to the provider of vast amounts of their funds. Blue Cross was moving clearly into more of an adversarial position than it was. As Mannix may have told you, he disagrees a bit. He thinks they made a great mistake. But that was a fact of life. Insurance commissioners all over the country, especially Pennsylvania, wanted real arm's length negotiations. The Pennsylvania guy had some ideas that would save vast amounts of money, but that was crazy, but that was what he thought would happen, whether it happened or not was the fact of life.

So, hospitals were becoming increasingly restless and demanding. They wanted a vigorous spokesman to speak loudly and clearly at every possible opportunity in behalf of hospitals. That role did not fit Dr. Crosby. I think he would have been effective at it, but he didn't like it. Anna Rosenberg, whom he hired, after McNerney did, kept on arguing that the guy who should be talking to the Warren Magnusons, and the Wilbur Mills, was not Kenny Williamson, but Ed Crosby, and that his role as spokesman was more important than any other role.

He saw it differently. He was one of the early apostles of utilization review in hospitals. It speaks kind of loudly for the man he was, that he proposed utilization review as a method of improving the quality of care. He couldn't get to first base with that notion. They wanted no part of it. The government didn't see much sense to it. It would cost some money. Only when it became a cost control did utilization review come to pass. He had seen it

as something important to do for quality of care.

Kenny, who believed in working very, very quietly was very, very close to Lister Hill. Kenny was close to Wilbur Cohen, was not as close to John Fogarty. Fogarty was perhaps just as powerful, or almost as powerful, on the House side as Hill was on the Senate side.

It's all mixed in. The state associations were becoming strong. They had very powerful organizations. They were charging far more in dues than the AHA was. They were building very strong empires. Their guys were talking to their state legislatures. They were hammering. They were, by and large, more conservative than Kenny Williamson. Kenny wasn't a flaming liberal, but he was perceived as such by many. He believed in speaking quietly. The combination of a political philosophy that didn't sit well with some, and a lack of public statements and public attention added up to a serious dissatisfaction. Dissatisfaction with Crosby, as well as dissatisfaction with Kenny. Crosby did not heed Anna Rosenberg's suggestion that the time had come for him to talk. He wasn't comfortable in that role, there is no doubt about it. But he had to assert more control over Washington.

He appointed Alanson Willcox, the general counsel of HEW under Lyndon Johnson, and a liberal, as the general counsel of the AHA. That rubbed people, not me, but it rubbed people who were paying the bills the wrong way.

Williamson had--I was going to say "thinly disguised" but I don't think he disguised it at all--distaste for Richard Nixon. Jim Cavanaugh--did you know him?

WEEKS:

I know who he is.

HAGUE:

Jim Cavanaugh was close to Richard Nixon. He was an appointee of his. More importantly from the standpoint of the AHA, his preceptor in hospital administration was Jack Kauffman, who was about to be the president, or chairman of the board, of AHA. So the jokes that--Williamson was a good story teller--he told lots of stories about Nixon, none of them friendly. He told one of the toughest before the House of Delegates of AHA and that did it. It got back to the White House. Cavanaugh called Kauffman and said, "What the hell are you doing to our friend? You are a friend of Richard Nixon's (and Kauffman was). We are trying to do things for you and you have got this Williamson ranting and raving and telling nasty stories about Nixon in front of your House of Delegates."

A lot of people thought that Williamson had had much too free a hand. It wasn't as true as most people thought because Crosby used Norby. Norby tells a story about testimony written by Williamson to be given on something or other by Frank Groner, a wheel, but a very conservative Baptist, a good man, a real fine guy, one of the dearest people there is in the hospital business, but a conservative guy. Norby had seen it and Crosby had seen it. It was going to be absolutely unacceptable to Frank. So Norby went to Washington and rewrote it. After they had rewritten it to Frank's and Norby's satisfaction, Williamson had to be ordered to go to the Hill with Groner to introduce him, which is the standard course.

That control was not known on the outside. The Washington function was becoming more and more and more important to the point, you may know, that this Association considered seriously a move to Washington, move the headquarters, the whole thing.

I insisted to Crosby that he have control, that he show control. There

was a teletype system between the two offices. Williamson didn't like it. I told Crosby at a luncheon at the Lake Shore Club one day. (We had lunch together almost all the time.) I said, "Put the monster back." (That was Williamson's name for it.) He said "We don't use it much."

I said, "I don't give a damn. The thing should be back there to say that Chicago is in charge."

I was secretary of a committee called the Special Committee on Leadership. John Stagl was chairman; it led to his presidency of AHA. The committee vetoed, and I was for the veto, moving the Chicago office to Washington. We would have a hell of a lot better perspective if we stayed the hell away from the Potomac. A lot of people don't think so.

The Washington office was first called the Wartime Service Bureau. Then it was called the Washington Service Bureau. I persuaded the Special Committee on Leadership to change the name from the Washington Service Bureau to the Washington Office of the American Hospital Association, to take away the separateness of the Washington Service Bureau and to put it in a subordinate role to headquarters. There's a New York office, there's a San Francisco office, there's a Washington office, much bigger, much more powerful, much busier, obviously. But it is an office, not a separate entity standing out there alone.

Some states started sending their own lobbyists, opening their own offices, Massachusetts for one, in Washington. John Harty and a group of hospitals he was very active in, unhappy because of the lack of visible activity in Washington. This was a very dangerous situation, obviously. Then the House of Delegates episode came up.

Kauffman who was president then, or president-elect, chairman-elect, got

Crosby aside, upstairs in a room at the Hilton, the Washington Hilton, and said, "You've got to fire him. That's all there is to it. He's got to go."

Then Crosby got sick. Steve Morris, then in one of the chairs...I am not sure whether it was just before Crosby's death that Morris was given the task of firing...resigning, retiring. It was dismissal for a change in attitude and philosophy in the Washington office. They got Leo Gehrig as a director. He was more conservative than Kenny, but not as conservative as some of the people who were after Kenny's skin. But there was no doubt that as the Leadership Committee had stressed, there was going to be a president of the Association, the chief executive officer, and he would be the spokesman. It would no longer be a Kauffman, a Steve Morris, or a Frank Groner. The spokesman would be staff, McMahon mostly, others sometimes. McMahon carried that out. That is where the AHA stands today.

WEEKS:

One thing I have heard, I don't know whether it's true. When Crosby died and a successor had to be chosen that the search committee recommended Walt McNerney, but the Board of Trustees chose McMahon. Is that true?

HAGUE:

That is not quite true. There were two search committees. There is no doubt that the first search committee chose Walt McNerney. I got some interesting tales on it, not cleared by the authors, but interesting to read. I talked to Groner about it. I talked to others about it. I haven't talked to the guy really...but I'll tell you my understanding of it. The search committee was a powerful search committee. Russ Nelson was the chairman. Russ was chairman. Frank Groner was on it, and George Cartmill, I think. All past presidents. Then there was another, an advisory committee to the search

committee, headed by Horace Cardwell, who was to be the leader. He was a man I got along very well with. He was a conservative as I am liberal.

McNerney was the final committee choice to be the president. I talked to you about the increasing adversarial position of Blue Cross. This was especially true in New Jersey. Deep-seated dissent against the Blue Cross plan. Jack Kauffman, who was on the board, the chairman, was then the president of the Princeton Hospital, deeply involved in this situation, unhappy as could be about Blue Cross and any of its devices. A hell of a lot of other people on the board felt the same way. Only one name was presented at a special meeting of the House. The House told the Board to appoint another search committee. They appointed another search committee consisting of members of the Board. Here is where the story gets a bit messy, not messy, a bit unclear. One tale, perhaps apocryphal that the search committee, as I recollect, presented two or three names to the Board, needed a majority.

WEEKS:

Was this the first search committee? Or the second one?

HAGUE:

The first search committee is gone. The second search committee brings in multiple choices. It takes a majority. I am told that one member of the Board was asked, because of a foulup in dates, when the Board was starting. He thought it was starting at eight o'clock on Saturday morning, in fact, I am informed--no staff was present during any of this--he and his wife were shopping in Chicago Friday afternoon. He had a few hours to while away, didn't know the Board was in session, wasn't present when the first vote was taken. According to one of the members of the Board, and a brilliant one, Martin Steinberg, McNerney failed to get a majority by one vote. The missing

trustee was a McNerney vote. This was the story. Sister Marybelle of Duluth say she dosen't think it happened that way. She was chairman of this second search committee.

In any event, McNerney's name was back up and didn't get the necessary majority. The Board asked that McMahon be asked to come to Chicago. He came to Chicago, was interested, made an immense impression on the Board. He was offered the job, and was hired.

So, we had a couple of interesting accession situations. Now, I am just as sure as can be, had Crosby been alive, say he had retired, and they were looking for a successor, he would have had a hell of a lot to say about who the search committee recommended. If he thought the search committee's recommendation wouldn't go, he would see to it that it wouldn't present it. Having presented it to the Board, the House would have accepted it.

WEEKS:

The method was...?

HAGUE:

It's a Board appointment. It isn't the House.

That's the story of the McNerney...

WEEKS:

You were going to say something about the bishops' representatives?

HAGUE:

Yes, and the regional advisory boards. I'll take them one at a time. The bishops' reps won't take as long.

As I understand Roman Catholics' canonical law, there is one single boss in every diocese, just one. He has an unusual name. He is called the Ordinary. Why is he called the Ordinary--I once asked this of a priest who

should know.

He said, "It's because it would be ordinary for him to do things that would be extraordinary for anyone else to do."

As the Ordinary he had complete power. He equals in matters of authority over his diocese, he equals the power of the Pope. He is the equal of the Pope in certain matters. I am told the title of the deed, the true ownership of the Catholic hospitals in this diocese (Chicago) belongs to the various orders, some instate, some outstate. Legal ownership is Cardinal Cody's, he owns it all. They call it, "ownership in corporation sole." An individual person owns the whole body. It's a problem. He can, never does... he can say to an order, "I find Sister So and So repugnant. Get her out of here." She has to go.

As hospitals grew in power, Catholics had a lot of hospitals, 850 of them--they became a very important part of the apostolates of the Catholic church, as of other churches. The bishop decided he needed someone to watch over these things. He appointed a bishop's representative in each diocese. For many years the representative here was a very powerful guy, Monsignor Barrett. Some of them were very bright, some of them dumb. In the final analysis, because they spoke for a bishop, the big authority came from them. The bishops' reps used to meet once a year. I have spoken at a couple of them. The bishops have a national organization now called the Catholic Conference. It used to be called the Catholic Conference of Bishops. Obviously, the hospital man there--and there was one, Luke McGowan was one--spoke from the viewpoint of the bishops. He worked for the bishops in Washington and was allied with the bishops' reps around the country.

The Catholic Hospital Association was founded to give some voice to the

people who run the Catholic hospitals in actuality, and those are the Sisters. As you know until a few years ago they really did. Some of them had an assistant with considerable power but the basic power was the administrator who was always a nun. Anyway, a priest, a Jesuit, up in Milwaukee, Molinier I think his name was, organized the Catholic Hospital Association of the United States and Canada--they are split now--to give a voice to the Sisters. Really it didn't work out that way at all, not at all. They went from that Jesuit to another Jesuit, Schwitalla, a powerful man, to another Jesuit, Flanagan, to another Jesuit, Casey, and that was the end of the line. Literally, St. Louis, under the control of the priest, had the veto power over Catholic appointments in the AHA. In later years no Catholic nun was ever put on the board of the AHA. The Catholic representative was always the choice of the Catholic Hospital Association. We had a few miseries. We had a Monsignor who didn't care about hospitals. He was a school administrator. He was interested in running the parochial schools of the diocese of Milwaukee and couldn't care less about hospitals and hospital problems. He never showed up. I don't think he attended more than two meetings in three years, maybe three. Mother Loretto Bernard, for example, one of the really brilliant administrators among the female religious, was never approved by St. Louis and, thus, was never elected to our Board.* Then it all culminated in a dreadful situation.

The bishops' reps had a candidate for the presidency of AHA, Tim O'Brien, a beautiful guy, a beautiful guy. As a matter of fact, when my daughter was

*She had served as a vice president early on, before St. Louis took charge.

married in a Catholic church, he was then president of the Catholic Hospital Association. He arranged a trip to St. Louis so he could make this short jaunt up here and marry my daughter. That's how close he was. Obviously, I was on his side. He was the priests' choice to be presented.

The nuns had their choice, Sister Marybelle of Duluth. A wonderful person. Who, in his right mind, would get involved in a fight like that? George Graham, chairman of the nominating committee, did not. They put in someone else.

That sounds like politics, but there is more to this than politics. I saw in the AHA's account of the Catholic Hospital Association's meeting that a theologian or representative of the Conference of Catholic Bishops--I don't know who he is but he's a priest-- talked about the moral obligation of hospitals to recognize the right of people to bargain collectively, to have decent jobs, everything a labor organizer would say. He put it on moral grounds.

The nuns, who try to balance the budget and run a hospital and keep it going are not as friendly towards unions. They don't take this high ground that the bishops' reps do. They are much more concerned with paying the bills, about strikes, about their moral responsibility taking care of patients.

Things were coming to a head. They got themselves a president, a nun. There had been nuns who were president. Finally they appointed Sister Maureen as chief executive of the Catholic Hospital Association. Sister Irene Kraus, subsequently, was the first religious to ever be the president of the AHA.

Now the Catholic Hospital Association had made turns just like the AHA--changed its name. It wants to be more adversarial with government, wants to be more representative of management. They now have a layman as president

and chief executive officer of the Catholic Hospital Association.

WEEKS:

You were going to say something about the regional...

HAGUE:

Yes. Let me say one more thing. I think that it's important because the Catholic Hospital Association is a tightly knit group. Their views are important. Their views now will be more management oriented than they would have been if the bishops' reps had maintained their dominance. That's how I see it anyway.

The regional advisory board was related to the growing concern of the membership and some of the state hospital association executives to the increasing importance of the external forces on the AHA and a demand, I guess, of more of a role in policy determination. It didn't really start that way. It actually started when Maurice Norby, who said he would retire at 55--a funny guy, he was going to retire and wanted to ease himself into retirement. He thought it might be a nice idea to set up a regional office, and he did so, I think in about 1963. Some people mix up the regional advisory board and the regional office. I am a strong believer in the regional office as an extension of the AHA staff into some of the far reaches of this wide country. I became opposed to the regional advisory board concept. I am in a very small minority. Almost everyone thinks that the regional advisory boards have been the preserver of the American Hospital Association, that it would have melted away, that we would have had a Massachusetts lobby, and a community health organization, and what not. AHA was losing touch with its members. That is the prevailing argument.

Let me tell you what the regional advisory board is. The regional

advisory board is a board set up...basically it's a small House set up in each of the nine regions approximately the same as the HEW regions. You know them: New England is one; Mountain States another; Pacific states another. The regions make sense.

Norby's idea was to get an office out in San Francisco and go around to western hospitals and help implement AHA programs, help in the understanding of AHA programs, help AHA in understanding hospitals problems. In a very busy association, all very desirable objectives it seems to me.

The regional advisory board, however, was to be a part of the policy formation.

Here are some of the things I believe about the RABs: That the RABs tend to find the lowest common denominator, and I don't think that's good. When Mannix set up the councils, when Mannix devised the council structure...he didn't do it alone by any means, but he was sure a powerful guy, under Bugbee, carrying them out. Good people put in charge, really good people. Ed Crosby was chairman of the Council on Professional Practice, so was Russ Nelson, so was Stewart Hamilton, so was Al Snoke. The Council on Administration, Jack Hahn. The Council on Planning, Frank Groner, Jack Masur. The Committee on Insurance, Ritz Heerman.

WEEKS:

All top men.

HAGUE:

All top guys. They got that way by what Russ says is the democracy of pick and choose. A policy would be established by a reasonably complex process. Not many policies have to be made in haste. There is time for things. That it has to be done yesterday is a lot of nonsense. Anyway, the

thing would go to a committee. A committee on planning would be asked to study the appropriateness of mandatory planning and develop a statement and send that to the Council on Planning. It would be changed very, very substantially. Then the Association had a very neat device called the Coordinating Council, another one of Mannix' plans, consisting of the chairmen of each of the Councils. There was the chairman of the Council on Blue Cross, in later years the chairman of the Council on Finance. The Council on Professional Service talked about the serological test for syphilis. Is it really necessary? Some committee in infection would say...they would say, yes, it was necessary. I know a better example: smallpox vaccinations. Should...I can give you even a better one: the use of Social Security numbers in medical records. First the question goes through a committee on medical records. Lo and behold, they say it's a lousy idea. The Council on Administration gets it. They say it's a pretty good idea. They have statements on it. Then it goes to this Coordinating Council. The chairmen of the Council on Administrative Services is there, of the Council on Professional Practice is there...each of the chairmen. Then the basic issue of Social Security is argued. We now have a recommendation from the Council on Administrative services (to use the Social Security numbers in medical records). The Council on Professional Services says, "O.K., fellows, you say use it because it's nice and easy. It sounds so nice and simple. What do you do when you get someone who's unconscious in the emergency room, and they don't have a Social Security card on them and you want to start treatment. You are not going to have the patient in the emergency room very long. You can't wire Baltimore, yet you have got to start treatment. Somehow the patient has to be given some sort of a number. What do you do? Set up a

double system?"

This argument would go on. Then when it got to the Board, most of the arguing was over. The Board audited the Coordinating Council meetings and the Coordinating Council audited the Board meetings. By the time it got to the Board it was in pretty good shape. It was argued about by the best people the Association could get, experts, many chief administrative officers, but many others too. Then it would go to the House of Delegates. In most cases the House accepted the leadership of the Board. There would be a preconvention conference to review the various subjects, to tell the delegates what was coming up in a couple of months, that's all. Let them ask questions. There would be top people from the offices and staff there to answer their questions so they would be ready, and the officers would be ready in case they came up on the floor. The membership of the House was satisfied with the leadership of the Boards as shown by the recommendations it made to the House.

Come the Regional Advisory Boards. The Regional Advisory Board consists of all the delegates in a state or region. If there is only one delegate, as there is in many states, then both the delegate and the alternate are voting members in the Regional Advisory Board. All statements now go to the Regional Advisory Board. I always took the position that the Board should not send these things out without action. The Board should do something with them. They shouldn't just throw them to the winds and say, "Let us know."

I think they have devised a system now whereby they go to the General Council, the new name for the Coordinating Council, the RABs get them, and then on up to the Board, which is better than the way it was where they would go to the Board, go to the General Council, the General Council would go to the Board. The Board would not make a recommendation but would consider it

and send it on to the RABs. The RABs would meet in a couple of months, or a month later, and have at it.

The selection process for the House of Delegates is not designed to bring the same quality to the surface as the Council and committee and Board selection. It is just a fact of life, in my view. People would argue with me.

The Regional Advisory Board chairman sits as a member of the Board, enlarging the Board from 15 to 24, with the president making 25, although he usually doesn't vote. One of the problems with these Regional Advisory Boards is the membership of the chairmen on the Board as a whole. That creates a different class of trustee. I refuse to call them regional trustees, or the others at-large trustees, because I say they are all trustees, they all have the same fiduciary responsibilities. When a man came from a region he was to represent the hospitals of that region. While he was bound to present any recommendation voted by his regional board, once he made that presentation, then he was a member of a 25-man board, and he should act as a member of a 25-man board for the common good.

They actually had some meetings of the RAB trustees. I just thought that kind of caucussing was inimical to the kind of leadership that I thought the Board should give. It, obviously, delayed things. When a guy could go to his delegates and say, "Look, we think the AHA is a socialistic organization. If they issue a statement on national health insurance, we are going to resign and we want everyone else to resign in this region, in this state (because it's usually done on the state level). The delegate, impressed by the screams of his closeby neighbor, then goes to the Regional Advisory Board, and is a hell of a lot more effective there than he is in a House of 150 or 155. So you get a lot of regional view magnified or overemphasized and a lack of a

national approach. Over my objection they finally seated the delegates from region together in the House. I said, "This is wrong. Alabama should sit next to Alaska." It is not only a sensible thing on the basis of the alphabet but it would be nice for D.O. McClusky, a swell guy, to know that everyone does not think the way he does about going out to the Philippines and recruiting nurses. Alaska or New York sitting next to Mississippi, or something...The RABs go over every document with a fine tooth comb. Instead of staff you have got elected delegates, and that's different. A guy who is appointed treasures that appointment, is more influenced by expert opinions than the elected delegate.

If often becomes, I think, more a matter of policy formulation by regional referendums than by national debate. I think AHA has enlarged and weakened the Board of Trustees. I think it has put an unnecessary delay in the council process. I think it has weakened the councils because they know their work is going to be subject to the delegate from Opelousas chosen because he is a good friend of somebody, or chosen now because he likes the three or four trips a year he gets paid for by AHA, including two meetings of the House of Delegates. I think it has weakened the councils and thus the policies of the AHA. It has brought a regional approach to the House of Delegates, or has exposed the House to the danger or peril of the regional approach. I think it is unfortunate. They did write the worst possible scenario and said the AHA could have gone down the tube without them. I am not so sure.

In any event, the state exec, who has a hell of a lot to say about who is going to be the state delegate, and sees those delegates all the time, now is in a position to dominate the AHA's House. Frank Groner sees this as a serious setback.

WEEKS:

I am a little confused about one thing. On your local level, is this through the state associations.

HAGUE:

The state associations. Let me tell you how the delegates are chosen. As I think I said off the tape, delegates used to be chosen by the members of the American Hospital Association within a state. The election could be conducted by the state hospital association or, in the event of no state hospital association, by the American Hospital Association. Very cumbersome operation, obviously. So the states took over the election process, through this Mickey Mouse of recessing and reconvening, and things like that.

In the reorganization--I forget whether it was Special Leadership Committee or the Regional Advisory Board--in the regional reorganization we gave the power formally to the states, which they pragmatically had. Although the AHA is not a federation, the state hospital association selects the delegate and the alternate delegate from that state to the American Hospital Association. So the power of the selection of the House is in the various states. You and I both know that the chief executive officer of any association is the most important person in that association, not the president who has a year or two of glory and then good-by.

Steve Morris. I asked him a question. In 1932 the Board of Trustees of the American Hospital Association came out in favor of hospital prepayment. My question: Could that policy statement have gone through the RABs? He said, "No way. No way."

Every administrator would be fearful of his trustees, of the insurance executives on his board, of all sorts of problems, socialistic accusations.

He said it just wouldn't fly through the RABs, but the board of twelve, as Rorem says, voted with their hearts as well as their heads.

WEEKS:

It has tended to make AHA more conservative.

HAGUE:

Oh, sure. Again, this is all my opinion, others disagree with me. The vast number of the members of the American Hospital Association think that the RABs have been a magnificent contribution. I disagree.

WEEKS:

From a management standpoint, from the management of an organization, it must be much more difficult than it was before.

HAGUE:

You have nine individual RAB staff directors out there. They all, as everyone does who works in an organization, want direct access to the boss. No doubt about it. These nine equal individuals...he never would put one individual in charge of all nine, which is what he had to do. He believed that he would be going against the disseminated nature of the beast. Actually it just emphasized the cellular structure imposed on the organization. You had a New England cell, and they had a boss reporting directly to Crosby. Talk about the Regional Advisory Boards, this is one example: When Regional Advisory Board #2 was created--it consists of Jersey, Pennsylvania, and New York, reasonably large collections of hospitals, and of wealth, and of strong people. Three of them: George Allen of New York, Jim Neely of Pennsylvania, and Jack Owen of New Jersey, these are strong guys. If you think that some hired hand sitting in Princeton is going to tell them what to do with their hospitals, you are crazy as hell, and I don't think you are. They see the

Regional Advisory Board as their own thing, and it is.

WEEKS:

Will the RAB concept ever be reconsidered?

HAGUE:

I don't think I'll be around to see it at all because it's too firmly entrenched right now. The delegates love it. The execs love it, and the members apparently do too.

WEEKS:

I was going to ask you about Rufus and John Mannix disagreeing on the splitting of AHA and Blue Cross. I don't know as they had direct confrontation, but they had differing views.

HAGUE:

They did.

WEEKS:

I don't know what your views are.

HAGUE:

I thought Blue Cross divorced itself from the AHA because people were complaining about the appearances of Blue Cross and hospitals being in each other's back pockets. I didn't think they were. There was enough evidence to indicate that they weren't. It seemed to me that the combination of...that a very close working relationship between the moneybags and the provider, between the purse and the provider, was very good for the patient. I don't think any one of the insurance commissioners or politicians has proven any evil results.

Given anyone who believes in the voluntary aspects of society, certainly such a person could not say anything but that the relationship between

hospitals and Blue Cross contributed significantly to the success of the Blue Cross movement and its benefits to the American people. I don't think that's a very arguable point of view. If it is indeed so, then before you divorce yourself, before you sunder that relationship, it seems to me you have to show some malignancy, some malevolence. Neither John Mannix nor I has been persuaded that any such showing was ever made.

I think there were some staff who had had some uncomfortable moments with regulatory authorities about Blue Cross and AHA. Newspaper people...I remember Bill Hines interviewing me once. I said, "Look, the fact that an insurance commissioner here or an insurance commissioner there says that there is something evil in this relationship, doesn't make it so, Bill. I think that it is a good relationship for the public and it can be shown that I think that Blue Cross and AHA should thumb their noses at those that say it is bad, if it is indeed good." I said "I think we are knuckling under to a storm. I think the dimensions of the storm were exaggerated. In any event, I think we knuckled under."

Would the Blue Cross Plans at this date have any standards if the hospitals of this country through Rorem hadn't forced them on them?

WEEKS:

I agree with you. Another thing I found ten years ago when I was doing studies in hospitals, I found that when I would go in and talk to the financial man I didn't get any feeling that there was any hand in glove with Blue Cross, I got the feeling that there was sort of an adversary...

HAGUE:

Absolutely! I told you what I think is a major reason that McNerney isn't the chief executive officer of the American Hospital Association is the deep

animus of some people against Blue Cross. And yet McMahon came from the Blue Cross setting but not with the same kind of baggage.

WEEKS:

On the other hand I would say that Blue Cross has been a wonderful thing for hospitals.

HAGUE:

Of course! Mutual benefits don't make it evil.

WEEKS:

The final test is: What does it do for the patients?

HAGUE:

I remember Russ Nelson on the subject. Somebody said it was illegal to pay medical residents out of Medicare funds or out of Blue Cross because it was a corporate practice of medicine. The AMA passed resolution after resolution. Russ Nelson said to me, he said, "Jim, once they can prove that it is bad for my house staff and bad for the patients that house staff takes care of, I'll stop it. Until they do, they can go plumb to hell. The AMA can resolve, and resolve, and resolve, I am not going to change."

To me that's the right approach.

WEEKS:

You were going to make some further remarks...

HAGUE:

You suggested we talk about the Special Committee on the Provision of Health Services, which became generally known as the Perloff Committee for its chairman, Earl Perloff. That committee was an important mark in the history of the association. Some people thought it was a low watermark and others, including me, thought it was a high watermark. It put the Association in a

very progressive situation, a position that they lost precious little time in retreating from. It reminded me of another key episode in AHA's life and perhaps this could be a digression here, before we go to Perloff, the thought of retreating from a position reminded me of a key thing in the whole business of hospital/physician relations and the relationship of the AHA and the AMA.

As I said in the earlier interview, in the late 1930s Dr. Robin Buerki led an effort at codifying relationships with the so-called hospital specialist groups, radiologists, pathologists, etc., largely at their instigation. As I said, earlier the hospital-based specialists were not treated as equals of the laying-on-of-hands or the cutting-with-the-knife physicians. And they didn't like it. So they were anxious to get help. The three statements that were developed were almost identical and were all approved by the AHA and the specialist societies. The anesthesiologists were quickly disenchanted and the pathologists and radiologists soon joined them in abandonments of these statements. But abandonment didn't make them go away.

And then a famous character in the modern history of the American Medical Association, a guy named Elmer Hess, a urologist from Erie, Pennsylvania, came up with a report that was all intertwined with a revision of the AMA's code of medical ethics.

There was one ethic in there having to do, if you looked behind the fancy language, with hospital/physician relations, dealing with under what conditions a physician shall dispose of, and I think I'm quoting it correctly, his professional attainments.

Under the Hess statement, which I think was dated either 1950 or 1951, it really ruled out anything that smacked of hospital involvement in these relationships. Well, that could never prevail because, as you know, then in

the late 1940s and 1950s, radiology and pathology certainly and they were the big ones, and physiatry to some extent but that wasn't a very important one at all any way, radiology and pathology were considered to be hospital services and in most cases they were paid for by the hospital, in one form or another. Obviously, a pronunciamiento from the American Medical Association wasn't going to change the reality of life.

Realizing that some reasonable solution, something acceptable to both groups, had to be sought, the AMA and the AHA set up a joint committee of the two boards of trustees and in 1953 they came up with this statement, adopted in June 1953, by the AMA's House of Delegates. And in August or September of that year, August I believe, in San Francisco, by the American Hospital Association's House of Delegates.

This was a document agreed to by the joint committee. Ritz Heerman was chairman of the committee from the AHA side and presided at the AHA's House for Ed Crosby, then AHA president, who had a horrible case of bursitis out there. Anyway, it did go through. And it basically said, that if a patient, physician and hospital were not exploited, and I'm quite sure of that verb, that any relationship, any arrangement was satisfactory. The arrangement could not exploit any of the three parties concerned. That seems to make a good deal of sense.

In December of that year, the AMA retreated. The meeting of the AMA's House, the clinical meeting, was in St. Louis. They wanted no part of something they'd thought was o.k. six months ago. And they wanted to go right back to the Hess report of 1950, that for all practical purposes put every arrangement but fee-for-service beyond the ethical pale.

The radiologists, of course, argued that no one would come into radiology,

that their specialty was dying, that people were badly treated, and that public welfare was being horribly abused because radiologists couldn't bill directly. Well, that to me was and remains, nonsense. I told my good friend who was Executive Director of the American College of Radiology that it was arrant nonsense, that the whole business that quality was affected by who billed for the services never made any sense at all. I thought then, and I think now, that the method of reimbursement had no effect on the professional quality of the services rendered. I think that there are good radiologists, as there are good in all things, and there are bad ones. Paying them directly on a salary doesn't make the bad ones good or the good ones bad.

I think an example of that is the fuss being made at the moment by the pathologists...and the AHA has gone along with them on this, and I disagree with the pathologists, that one of the points in the proposed Talmadge amendments to Medicare was that under part B, and as you know, part A originally covered hospital-based specialists' services as a hospital cost, but part B pushed them into a separate professional service. One of Talmadge's points was that part B should pay for professional services by physicians, that included them all, and certainly that as part of his work a physician undertook certain administrative costs, just as a physician had to maintain a private office--that that is part of his professional thing is quite separate, but that was allowed. That was under Talmadge's amendment a perfectly proper thing to do.

Where the rub came, and it did come and it's still there, because it is logical. What Talmadge proposed was that a physician was entitled to a professional fee where he did something for an individual patient and entitled to a salary for administrative services. With all the automation in the lab,

it's very difficult for a pathologist to show that in those cases he is in any way directly concerned with professional care for an individual.

Now when the pathologist looks at...when I had a little wart...when he looked at that wart to see if it were a malignancy, then indeed he was. When he was looking through that microscope, he was rendering a personal professional service. But can you imagine what this would do if a pathologist could not be reimbursed under Medicare for blood studies or urinalyses that go through by the thousands! Obviously, the reason they opposed this change has nothing to do with the quality of care. It has to do with the amount of money that the pathologist is going to get paid out of it. And that's all.

The AHA, unfortunately, has not taken, in my view, a strong enough position. Because, to me, it's logical that a physician should be paid for the things he does for a patient. Whether he does it at the bedside or in a laboratory, he's got to do it for a patient. There's got to be an individuality there.

They talk about the professional patient/physician relations, Nelson Cruikshank always said that the pathologist had a patient/cadaver relationship. I don't think the AHA is strong enough in its position on that, because I think that it is to the benefit of the patient, as long as you don't hurt quality, to keep costs down as low as possible.

There's a little book out--have you seen it?--on negotiating the hospital/physician contracts. Do you know Aaron Cohodes? He used to be managing editor of Hospitals, and managing editor of Modern Hospital. He has a thing in town called Teachem, Inc.

WEEKS:

Yes, I've heard of the outfit.

HAGUE:

He's been quite successful. And a guy that used to run the Alexian Brothers hospital here, or in Elk Grove, did a book for Aaron called, How to Negotiate a Physician Contract. He lambastes the AHA for not taking a strong stand on the subject of hospital/physician contracts, as the AMA does on the other side.

Well, that's a substantial regression and has nothing to do with the thing we started talking about and that was the so-called Perloff committee.

The Perloff committee was a document of great leadership in the hospital field. Just as the AMA's House of Delegates ran for cover on the Joint Statement on Hospital/Physician Relations, so not quite as hastily but quite substantially, the AHA backed off from this. This report was sent to the Board of 1970 and in 1971, at the January meeting, to the House of Delegates with a recommendation to appoint a committee composed of members of the House to take the recommendations, those that were essential, and bring them back to the House and to do so this fall, no delay, because universal health insurance was really up for grabs at that time, as you know.

The committee approach did two things. One, the members were a lot closer to the membership who would have to live with this than the members of the Perloff Committee. Also, what the House committee did would have the imprimatur of the House, if the House approved it, which it was likely to do. D. O. McClusky, Jr., was chairman. A nice Tuscaloosa, Alabama guy. He got the Distinguished Service Award basically for his work on that. It was a solid committee of good delegates. It was a well thought out committee. McMahan, then a delegate at large, was on it, as I recall.

The Perloff Committee, itself, really grew out of a staff meeting in the

board room that used to be down here. The statement on financial requirements of health care institutions was being argued. It had just come out. And, of course, when you get into that you are really into the life's blood of a hospital, from the standpoint of the administrator, money.

During that discussion, someone, it may well have been Kenny who said, "You know we really ought to take a look at this whole damn system. No one has looked at our system. And here we're talking about financing it."

I think it was he who said it, but anyway this was the thrust of the discussion at that staff meeting. So it was agreed that a very powerful, as strong as possible, committee would be named. And the general outlines of the committee structure were established almost immediately. The charge was an extremely broad one: just look at the system.

Take a look at the people on that committee. Perloff, a civic minded guy who had been the Chairman of the Board of a public hospital, Philadelphia General, and also Chairman of the Board of the Albert Einstein Medical Center. A truly civic-minded guy. There was a practicing surgeon. There were hospital administrators of various political and philosophical colorations. There were two attorneys, again of different colorations, John Horty and Sherwin Memel. Sherwin really represented the for-profit hospitals and his political beliefs were as you might expect them to be coming out of a Southern California organization of for-profit hospitals. But Sherwin was a powerful and good member on this committee. Another was president of a board of trustees, there were three practicing physicians, a surgeon, the head of a group of surgeons, a chairman of a department of medicine, Northwestern University Hospital of Evanston, and then R.R. (R-square) Hannas who was an emergency physician and one of the leaders in the fight to get recognition for

the emergency physicians. A marvelous committee, and they did come out with a really great report.

WEEKS:

What point of their suggestions was different from what had been suggested before? Didn't they suggest some kind of a health corporation?

HAGUE:

Philosophically, the big thing they said was health care was an inherent, legal right of each individual in the United States. That has not survived. In the House adopted statement, the inherent right survived, but the word legal was dropped. The argument was that it gave it too much of a legal standing and that the legal implications were implicit in the word right anyway. If I have a right to something, it is fulfillable in court.

There was one other philosophical thing the committee recommended that hasn't gone anywhere. That is that eventually the fee-for-service system might not survive, that capitation might have to come if the committee's goals, the objectives, were to be attained. That, obviously was an anathema to 535 North Dearborn, the AMA. Even the suggestion.

The House of Delegates committee realized that the whole report just took too big a bite. So the House really dropped all of that part of the report out for later implementation.

Certainly to go back to your question, the health care corporation was the key to this. There is no doubt about it. The committee met every month, two weekend days every month, and they had damn good attendance, all the time. They looked at an HMO and they realized, the fault with HMOs, a fault with the Health Maintenance Organization, is that it is a vertical structure, really an industry-oriented structure, that it provided no method of comprehensive

coverage.

I would like to be in an HMO right now, I cannot be in one. I cannot be in any prepaid capitation group. There is nothing available to me. And this is ten years, a decade later. The Health Care Corporation would have carved up the country into areas for which a hospital would have responsibility and in which it would have rights. It would be protected within that area and for that protection it had to do certain things. It had to offer everybody in that area an opportunity to be part of it, if they wished. Pretty far reaching, very progressive. And when you look at this committee again, you wonder how the hell could they adopt it--and there is no minority report, you know.

WEEKS:

How could they come up with consensus on that?

HAGUE:

Everything in here is approved by the whole committee. They fought hard but they agreed. Father Tim O'Brien was the moralist. He wouldn't let them get too far off from doing the right thing. He kept their shoulder to the wheel and burned their ears when they started getting too commercial. I sat in on certain meetings. I remember Steve Morris, who after all had a system out in Phoenix, a quite a successful operation. He said, "You've got St. Joseph's, a fine hospital, and Good Samaritan spreading around, doing some things." This plan was designed to make the net of health care a very tight mesh.

WEEKS:

In other words, starting out with their preamble that everyone has an inherent right, all this was patient-oriented, all the way through. I heard

someone say that there was a meeting not long ago of multihospital groups in which all the talk was about the finance, about the business, nothing about the patient.

HAGUE:

This is my terrible feeling about the people who are in charge of hospitals and of hospital organizations. They feel that the primary client is the hospital management. That wasn't the case then. And here, don't forget, the Health Care Corporation survived the review by this House of Delegates committee.

Within its geographic area, the Health Care Corporation (this is Perloff) would have to demonstrate its potential to provide care for all who would voluntarily register during regular periods of open registration and agree to maintain their registration for a fixed period. Then the State Health Commission, if people didn't register, would assign people to this, so that everyone was covered.

"Within its geographic area [this was approved by the House] the Health Care Corporation would have to demonstrate its potential to provide care for all who would voluntarily register during regular periods of open registration"...this is from the policy statement. The sequence was, the special committee reported on the problem of provision of health services, the House of Delegate Committee studied that special committee's report, recommended to the House a policy statement on provision of health services. That statement was approved by the House in August 1971, and was until 1976, the basic policy of the Association on the provision of health services.

Representative Al Ullman was not Chairman of the Ways and Means Committee at the time but he was the number two Democrat and introduced a bill

incorporating most of basic Perloff. As a matter of fact, he had enough clout that he introduced it as H.R.1. that year. So it was an attractive thing.

It was far more forward looking than any alternative to all-out national health insurance than had been offered to that point. It kept it within the voluntary system. It proposed substantial changes but it went nowhere and that's unfortunate.

Then in 1976, the American Hospital Association--I think it's fair to say--redid the 1971 policy statement. Remember that, in the documentary history of the Association, the special committee report has no formal standing as approved policy or principles. The only thing that has been approved was the actions taken by the House of Delegates on it. Obviously, the Board would never act independently of the House on a subject of this great importance. And didn't.

So this was the policy statement until 1977, when after long discussions and thorough laundering by the regional advisory boards and revolts in some conservative areas about this statement, it produced another statement called "Statement of Provision of Health Services, Under Universal Health Insurance". The inherent right, legal or not, was gone.

WEEKS:

That is no longer in there.

HAGUE:

No longer in there. The Health Care Corporation is gone. The substitute was comprehensive health delivery systems, like the business of....

WEEKS:

In other words, they have taken away some of the specificity and gone to more general terms.

HAGUE:

Yes, they took away a system and recommended broad principles in which the health care needs of the country should be met.

It is completely different, obviously.

Any questions on this?

WEEKS:

Do you think that the Perloff idea is dead?

HAGUE:

Yes.

Ullman is no longer in the Congress. He had studied it very carefully.

One thing that the AHA did before this change in policy, and I consider this a change in policy, definitely a more laissez faire position than the position of 1971, or the position of Perloff.

WEEKS:

Are you speaking of the 1977 statement?

HAGUE:

The 1977 statement was certainly more laissez faire than the others seem to me.

Ullman's H.R.1., Universal Health Insurance, was based on the Perloff Committee and had the guts of the Perloff suggestions in it.

But to me the Health Care Corporation, you'd never get through the RABs. No one in the Congress, well...it would be a much more expensive system than we have right now, because it would provide care for everyone. Provide good care for everyone. And those things don't happen without costing money.

Obviously, the Reagan administration would not touch this with a ten foot pole. I think if there were revulsion against the Reagan philosophy, it would

probably be easier, from a legislative and political standpoint, to go the whole-hog of national health insurance. And that's just about dead in the water. Perloff was a complicated system. It would take a lot of state legislation. And so if there were a movement for national health insurance, which I doubt, I think the Kennedy-Corman approach would be the one to go, certainly the one to be pushed. I doubt that anyone would take it on possibility of the degree of change that would be necessary for the AHA to reverse itself again and go back to the Health Care Corporation, the Perloff scheme.

WEEKS:

AHA by definition has to be conservative, because they have so many conservative members.

HAGUE:

That's right. As we said in the report of the special committee on leadership, it has to be a trade association, because if it isn't a trade association, it doesn't have any members. And if it doesn't have any members, it doesn't exist. But the special committee said that it had to be a public service organization as well. That was the thing that ran through this and ran through much of the AHA's statements that the AHA represented....I've written this phrase for the speeches of various people, mostly Crosby, a million times, the AHA is the representative of hospitals and the people, the patients, they serve. And that coupling is the key. We didn't represent just hospitals, but also the patients they serve.

WEEKS:

After all, any farsighted trade association should be thinking of the public it serves. I mean even if its's selling nuts and bolts.

HAGUE:

Unfortunately, I think that the history of most of the associations of industrial-related things do not have a very good public service record.

WEEKS:

I agree with you. But I think if they were farsighted, they would.

HAGUE:

I certainly agree with that, and I think that what I see as a diminution of the public service philosophy in the AHA's program will be hurtful to it in the long run. I don't think you could persuade the Paint Producers Association of the United States to support rigid rules, to have advanced the proposition that you ought to have rigid rules on the lead content of paint. That's something that is pushed down their throats, although it's in the public interest. By government. And it's unfortunate, but I think it's true.

I think that in your own state, the automobile industry fights every inch of the way against regulations that people have shown are in the public interest. The Japanese can do it, without destroying the industry, and I don't know why we can't. And I don't think that the American automobile manufacturer's association, if there is such an organization, would support mandatory restraints in automobiles. One reason they wouldn't is that they would lose their members. Then there is no more association.

And that's the difficult thing for an organization like the American Hospital Association. It's a very sticky thing.

When you get a situation like out in California, the Intercommunity Hospital in Whittier, the administrator either lost his job or was threatened with the loss of his job because of his support, and I don't think he was a real supporter of the AHA. The Board of Trustees of the Intercommunity

Hospital of Whittier didn't want any part of the organization, largely because of the policy statement on provision of health services.

Anything else on that?

WEEKS:

No, I think that pretty well covers Perloff and the offspring of it.

HAGUE:

I think it does.

WEEKS:

I think it was Rufus Rorem who said that the hospitals don't realize that they don't own the hospitals themselves, the community owns them. That they are there to serve the community. They should belong to the community. He brought this up on the depreciation idea should.....

HAGUE:

I think it was Bob Sigmond who was always talking about pooling of depreciation in a community fund. Which, basically, is what Rufus was saying. Obviously, Bob and Rufus were very close. So I'm not surprised.

Certainly the Perloff Committee Report, and to a lesser degree but to a very significant degree as well, the policy statement of the House were documents with clear community and public orientation. Clear, no ifs, ands, or buts. If a hospital got in the way of doing something, the state health commission would come in and do something about it. Oh, to me that was fun! That was a joy.

WEEKS:

Well, I hope it stays a part of the literature and people don't forget what some of these people were thinking back ten or twelve years ago.

HAGUE:

And I hope they don't forget that the American Hospital Association had the courage to come out with something as forward-looking as that.

WEEKS:

And publish it and distribute it.

HAGUE:

And send it to trustees and take the whacks... and they took whacks.

WEEKS:

I asked you if you would discuss the overlap among AHA, ACHA and AUPHA.

HAGUE:

I'm not the best witness on that. It seemed clear to me that the decision in 1917 to go institutional in the AHA, long before there was an ACHA, was a step it seemed to me led from the individual grouping that was the AHA at the beginning, concerned with the superintendents, concerned with the operation of hospitals, but through the eyes of the superintendent, to an organization of institutions. In happening that way then, it gave the association, the AHA, the turf. It was the dominant organization.

I don't think the ACHA came along until the late 1920s or the early 1930s.

WEEKS:

They celebrate their 50th anniversary next year, I believe.

HAGUE:

The AHA, and this is important, had clearly established squatters rights on two major items of income, the convention and the journal. It had, also, established as the source of its dues income, an institution with far greater financial resources than an individual. How would it be possible for an organization of hospital administrators, I don't care how far down the line you go, to come up with a budget of \$35 million based on membership dues?

It's just not there.

So the AHA was clearly the dominant figure. No doubt, when you go to conventions with people, the vendors want to talk to two kinds of persons only, administrators and purchasing agents. They don't care about social workers, or directors of volunteers, or directors of public relations. They want the administrator and the purchasing agent.

There were people, I think Ray Brown was one of them, who said that the ACHA could have been the dominant figure, organizationally. I just don't see how it could. The AMA does it with dues now, but they've got a hundred thousand members. That's a lot different. How many members does ACHA have, four thousand?

WEEKS:

They have more than that, I think. Their journal has about a 12,000 circulation.

HAGUE:

Well, 10,000 then.

As I said in the last interview, the AHA established that education was one of its basic functions. And they were the only ones doing it, really. The ACHA may have had some meetings, but as for regular educational experiences, the AHA really began them. They were the only ones. If an administrator wanted to know something about public relations, if he wanted to learn something about hospital public relations, he had to go to the AHA's institute on hospital public relations.

Years ago, the College thought that it should be in the business of educating the administrator. It makes a good deal of sense. And so the administrators going to AHA programs, were unhappy about it, then they talked

about having programs for trustees and trustees really aren't hospital administrators. To have the hospital administrators have programs for the trustees, to me is antithetical with the whole idea of separation of administration and governing body. But they were doing that and so there was a conflict.

Now, and here again, there was a "white paper," setting a line of demarcation in the educational enterprise. I don't think it was scrupulously obeyed. I think that's the best way of putting it. I think there were attempts. I think they were people of good faith.

The AHA, for many years, was scrupulous in its avoidance of things that were basically related to the administrator and his job....his salary, his perks. I believe they refused to take position on a World War II bill, although they thought it was a sound bill, thinking it was the ACHA's problem, that the hospital administrator should have a commission in the armed services, like all doctors have a commission in the armed services. The AHA and this was before my time, believed that this was the sort of thing that was better in the hands of the College. With the one caveat that the well-trained, well-paid, well-respected administrator was essential to the proper operation of the hospital and therefore essential to the goals and objectives of the American Hospital Association.

And as for AUPHA, the association was always on the fringes. I think there was inevitably some conflict. But the AHA, when they built this building, the first pledge was that there would always be a home here for the College. Are they still here?

WEEKS:

Yes, they just moved, I think they're in this building now.

HAGUE:

It was a clear understanding of great affinity. And as you know, the real shining lights in the College have always been shining lights in the AHA. One of the founders of the College never made it very far in the AHA. But a hell of a lot of them did.

WEEKS:

Many of those early, well the founders of the College, were physician/superintendents or administrators, many of them.

HAGUE:

Oh, sure. Except for some of the diehards, the really progressive physicians were the charter members, Bob Buerki was one.

WEEKS:

People like Claude Munger. There are quite a number of them. Harley Haines from Ann Arbor was a founding member. When you look at the pictures.....

HAGUE:

There were a lot of physicians. Munger was an extremely important guy in the AHA.

WEEKS:

And I've learned that Munger was one of the first to be interested in measuring the quality of care.

I interviewed Karl Klicka, I don't know whether you know him or not, and he was in New York and was sort of a protege of Munger's at one time. His statement is something to this point, that if he had known as much then as he does now, he would have paid more attention to what Munger was saying. Because he didn't realize what a good source of advice there was right there.

But he didn't take advantage of it nearly as much as he should have, or could have.

HAGUE:

So, as you can see, things went rather smoothly. There was an occasional worry between the two groups.

WEEKS:

How about AUPHA?

HAGUE:

As I say, I certainly was on the fringes of that, never really got involved. We didn't do much on the AUPHA at all, supported them sometimes, with money. But that's about it.

WEEKS:

Filerman has been a very aggressive Executive Secretary. He has had a lot of problems on his hands with all the new programs coming up. I think that he's always felt that the AHA and the ACHA should enter into the accreditation processes and things of this sort....accreditation for their schools. Doesn't the AHA sit on the accreditation board?

HAGUE:

I think so.

WEEKS:

They've developed since he became full time secretary. The point that I'm wondering now in looking ahead, I'm wondering what the future holds because ACHA, you have pretty well explained, is being left the professional side of the administrator, and that AHA is leaving to ACHA the job of continuing education for those people from a strictly professional standpoint. Correct me if I'm wrong, AHA's efforts in education are more at the level of the

operator.

HAGUE:

No doubt about that. They're at the level of the operator or the external influence, the lawyer, the chief of staff, who is not an operator, if he's a practicing physician, the trustee. The AHA sees great responsibility for that.

I've always thought, for example, that the joint code of ethics between the two groups was nonsense. That you can't have an ethic for a building. An ethic is a personal thing and the College should have one, and the AHA should have rigorous standards for hospitals. But to call it a code of ethics is crazy. A code of ethics is something absolutely personal. And the College is the one that should be doing that.

WEEKS:

When I was at the Press I was always interested in trying to find somebody who could write a good book on ethics for our hospital field, other than the normal things that you think about. I mean sort of a philosophical approach in layman's language. But I never found anybody who could write it.

HAGUE:

To me, you've got to be a professional or close to being a professional to make an ethical code of any sense. Ray Brown and I have had a go at this idea that hospital administration is a profession. I don't know it. I find it wanting in several things.

WEEKS:

Well, the word "profession" has been misused so much, all the way from baseball, football and basketball, that....

HAGUE:

A pro is a guy who makes money rather than being an amateur. A pro is

someone who is very good at something rather than bad. So it's a terribly misused word. But trying to use it in our sense, it's a very difficult word to define. There are certain components to it.

A profession has to consist of those persons with a special body of knowledge, a code of ethics, and a profession for the public welfare.

WEEKS:

This is one thing. A good professional should put the welfare of his patient or client above his own. This is the thing we are forgetting in hospitals today, is the patient.

Do you think we've covered the field?

HAGUE:

There was one point that I think shows a change in philosophy.

Some years ago, and this is an indication of a change, and I think this is somewhat to the good...I think it's important to be on your toes, to protect your rights but there's something about ethical constraints that ought to be sufficient but sometimes they aren't. Anyway, in Kansas City, Sue Jenkins was there, that's how long ago it is, they had a nonprofit blood bank supported by the Kansas City area hospital council. They rejected the blood from a skid row outfit, well it was not a skid row outfit but it had a bunch of skid row providers, on the strict basis of quality control.

The excluded bank sued them on the basis of restraint of trade and did it under the Federal Trade Commission. And the Federal Trade Commission upheld the excluded blood bank. Dreadful, awful thing. And the nonprofit blood bank, the white hats, took the case up to the Circuit Court of Appeals for that district.. This was an expensive proposition. Sue pleaded for money from the AHA. It seemed to me that it was an extremely important case because

the issue of the right of a nonprofit organization to serve the public interest by protecting the patient from substances of poor quality was something that ought to be defended, the pro bono publico principle that was upheld in a similar case in New York, where the courts there said we don't care, this is good for the public to do, so that's it, period. And I thought this was the case down there.

But the AHA refused to participate in any significant way. There may have been some small participation, there may have been some help, but not really much. So it went to the Court of Appeals and they won. The good guys, the guys in the white hats. I've always regretted that I didn't fight very hard for it, didn't go to Ed Crosby and pound on the table and say, my God I know you don't like to get involved with the "legal-eagles" but you've got to put this down.

Now, the Association is in court on everything. It spends a small fortune and apparently it has to do it. But it seems to me that the customary objects of the litigation in which the association participates in the protection of management prerogatives or the enhancement of or protection of hospital revenues.

WEEKS:

So we should add a fourth dimension here to education, representation, research, and now litigation.

HAGUE:

I don't think I would grant it equal status with representation, research and standardization and education. Giving it equal status, making it a fourth leg is attractive in this day and age but it gives it an emphasis.....A helluva lot more lawyers are interested in protecting the property rights of

their clients than there are public interest lawyers.

WEEKS:

One thing we haven't talked about. I don't know whether you have time to say anything. Does the AHA ever act as a policeman? Does it ever police its members? Does it ever try to enforce, in any way, good behavior, let us say?

HAGUE:

A couple of times. It denied membership in a couple of cases. A hospital in Southern California... It did have a policing role, still does.

WEEKS:

Will it expel a member?

HAGUE:

A policing role is not necessarily connected with membership. In 1945, the AHA took over the census of hospitals from the American Medical Association. A hospital had to be AMA registered to be listed in the census. The AHA took that over and that was the beginning of the Guide Issue. It accepted the census but then began its own listing program. It had its listing requirements. Hospitals were surveyed. There were minimal requirements, ten beds or six beds or something, medical staff or physician. What it really did was to separate the wheat from the chaff, the hospitals from the nonhospitals.

It went a little more than that. They had to have medical staff bylaws. And that's going beyond...that's a quality control. And the AHA could or could not list. At one point it was a prerequisite for accreditation by the Joint Commission. The Joint Commission would not survey a hospital for accreditation unless it were listed by the Association.

Russ Nelson, among others, believed that that was an incorrect thing.

That an accrediting body should not abdicate part of its responsibility to another organization. He was perfectly willing to insist that a hospital, to be eligible for an accreditation survey, must meet the listing requirements promulgated by the AHA, but it didn't have to be accepted. The meeting of the listing requirements had to be in the mind of the Joint Commission and not in the mind of the AHA.

Also, the AHA would not admit to membership a hospital that couldn't meet those requirements and did that regularly. Throwing them out, I only know of two cases. In the bylaws there is a hearing provision. We went to court with the Rockford Blue Cross Plan on membership.

But as a policing body, no. The Association's position has always been--and this is why some people think it was wrong, and I know Ray Brown thinks this--the position that the Association held for years, refusing membership for nursing homes was wrong. It was better to take people in and see if you could raise their standards and raise the quality. You had a better chance if they were in the fold than if they were outside. So that has been the general policy of the Association. Minimal standards, then do the best you can to raise them.

Now, as you know, many state associations, I don't know whether it's many, but some, require accreditation. Some hospital councils require accreditation. AHA has never done that. It has been talked about. There was discussion. I know John Flanagan and I discussed it, should the AHA limit itself as some organizations do to not-for-profit hospitals. I am sympathetic to that approach. I see more problems with it, though. So in the whole, I would say no. But basically, my druthers are that way.

So really it is not a police organization. It has been, basically, an

uplift organization or tried to be.

Note by Mr. Hague: This is being dictated in response to a note from Mr. Weeks observing that we had not talked in our earlier interviews about the history of Hospitals, the Journal of the American Hospital Association, during my years at the AHA. In his note, Mr. Weeks asked several questions, and I shall dictate this in narrative form.

HAGUE:

For many years The Modern Hospital for all intents and purposes was the official journal of the American Hospital Association and its publisher, Dr. Otho Ball, had an immense influence not only on the hospital field but also among the power structure of the association. I don't have the records with me, but it is my recollection that the AHA began its journal in 1936 in response, a rather belated response, to a petition signed by some of the leading lights in the AHA hierarchy. It was, as was most everything else in the AHA at that time, almost a one-man operation by the then executive secretary, Dr. Bert Caldwell.

Among the many other things that George Bugbee did almost at the outset of his tenure as the chief executive officer of the association in 1943 was to hire an editor for Hospitals, a newspaper man he had gotten to know in Cleveland named John Storm. One interesting note. George Bugbee retained the title of editor for himself, not wanting to have the AHA journal catapult someone other than the chief executive officer into the dominant power position as had happened with Morris Fishbein at the American Medical Association.

John Storm knew what he was up to and started moving very firmly to make the journal a really important publication, worthy of the AHA. However, it should be stated that George Bugbee maintained a close watch over, and kept his fingers in, Hospitals as he did with just about every other aspect of the operation of the AHA.

John Storm died in the late forties, perhaps forty-nine, or perhaps 1950. C. J. Foley was appointed by Bugbee to take over the editorship. He had assembled by this time, largely the doing of John Storm, a quite competent although a quite small staff. In 1952 the AHA hired Newton Jacobson as a production manager. I mention this as an indication of the state of the art on the journal at that time. The production manager for Hospitals was, for all intents and purposes, the account man from the printer, the Neeley Company. I think that the Neeley Company started printing Hospitals when it was founded and at this point in 1982 is still the printer. The account man for Neeley, a John McCorkle, was the nearest thing that the AHA had to a production manager for its monthly journal.

Newton Jacobson brought the necessary production skills to the AHA.

Foley was never comfortable as the editor and after I joined the association in 1953, he would take me out to lunch quite frequently at the then favorite watering hole of the AHA staff, Ballantine's (now gone) to have an audience for his various unhappinesses at running what was becoming quite a substantial and respectable editorial operation. When Crosby (Dr. Edwin L. Crosby) took over from Bugbee in June 1954, Foley went to him promptly and asked him for a change in assignment. He told Crosby he was not comfortable in his ability to make of Hospitals what ought to be made of it and said that he wanted to keep on working for the AHA but perhaps in a position of

executive assistant to Dr. Crosby. He persuaded Crosby to relieve him of this assignment during the AHA convention in Chicago in September of 1954, just a couple of months after Dr. Crosby had taken over. I had known Crosby since the early 1940s, I had worked for him in both an editorial and executive assistant role at Johns Hopkins, and had remained quite close to him during my years at the Washington Post before I joined the AHA. He, basing his decision I am sure on his long association with me, asked me during the convention at the Palmer House if I would take over as executive editor. I did and although the appointment had the earmarks of a non-kindred nepotism, if there is such a thing, it didn't take me long to establish reasonably good rapport with the staff I inherited from Foley. Foley was around and we were close so the transition wasn't too difficult. At Crosby's request I retained my assignment as director of public relations, as it was called, although as soon as I could I changed the title to Director of Communications, and I combined those functions, adding the secretaryship in 1962, until 1973 when Alex McMahon asked me to give up the editorial assignment (by tht time I had become the editor of all association publications and mass communications) and concentrate on my job as Secretary. I did so.

Now back to AHA. AHA's journal became Hospitals. I was determined to carry out Crosby's key desire to move Hospitals into a leadership role. He did not like being second best in just about every way to The Modern Hospital, although he had then and maintained for the rest of his life a boundless respect for Bob Cunningham, then the editor of The Modern Hospital. I knew Bob rather well then and shared that respect, a respect that grew by leaps and bounds throughout the years. We were the warmest of friends and the keenest of competitors. My background was, of course, editorial and I had inherited a

thoroughly competent sales director, Bremen I. Johnson. I also had a staff of quite good salesmen. My own long editorial background made me concentrate on the editorial side as one would expect, and having confidence in both Johnson and Jacobson, I let them run their own shops rather completely. Editorially I wanted to try for a balanced "book," as all magazines are called by those who work on them, and that balance, it seemed to me, should bring in every issue if possible something professional, something practical, and something popular.

Crosby came as close as an association executive could ever do in giving the editor of his journal a free hand, free from the band of strictures of association dominance. I established my own belief early on that the journal should get strength from the fact of its being the association journal. This belief was not shared by all, especially the salesmen who thought that the association journal was a burden on their selling efforts. This feeling of theirs was strengthened by the reactions of many of the buyers of advertising space. But I insisted throughout that the connection with the association was the journal's greatest strength and had I had my way, I would have changed the name Hospitals, too narrow a one, as it turned out, to The Journal of the American Hospital Association, and the AHA's name is also too narrow.

The journal under Storm and Foley (and Bugbee, of course) had made great strides and had become an important second ranking periodical to The Modern Hospital. But the disparity in popularity and in one extremely important aspect, in advertising pages, was marked. Cunningham's Modern Hospital was clearly superior. With Crosby's complete backing, we made, and I hope my judgment isn't too biased, substantial and quick progress on the editorial side. I kept our advertising/editorial ratio quite close to the fifty percent point. This is not a good money-making breakdown. The Modern Hospital, for

example, ran about thirty-five editorial, and sometimes dropped as low as thirty-two percent. This is a solid profit-making ratio and the value of The Modern Hospital stock proved it. We were willing to spend some money. We covered things. We employed the capable AHA staff to render good judgment on manuscripts. When The Modern Hospital started to play down contributions from the field, I played them up, thinking then, as I think now, that practitioners in the field need an outlet for their thinking and that the field needs constructive efforts to improve the practice. This idea is losing popularity rapidly.

On the commercial side, I think we carried something like eleven hundred advertising pages a year against a thousand or better than that for The Modern Hospital at the beginning of my tenure. The cover was stodgy. The layouts were stodgy, not all that bad, not all that good either. Something dramatic had to be done if we were going to make real strides in our attempt to become the number one "book." Crosby was enamoured by the frequency of the publication of the Journal of the American Medical Association, a weekly, and we thought that we could serve the field more promptly by going twice a month, and, not at all inconsequentially, come up and make the kind of dramatic splash and lift Hospitals into a much more commercial contending position against The Modern Hospital. So there was a good deal of money-making motive in the switch to twice a month, but it wasn't entirely that by any means. We continued to give our readers far more editorial material than The Modern Hospital in our twice-monthly publication, just to emphasize that. Also, after much thought, we decided to go to a picture cover. We would have liked to have gone four-color then but I thought that would be beyond our budget and decided to go for high class black-and-white covers rather than smidgy color

covers. Our shift did force some changes on The Modern Hospital side and they started using color covers but in a half-hearted way. They produced a composite page of four colors then cut it into quarters and then used a small color cover photograph. I thought the move rather inadequate.

Our big strength, no doubt, was in our willingness to spend money as a major source of information for our membership. The journal went to every member as a nondeductible part of the membership dues. A captive audience certainly, not so captive as when we finally became totally controlled. That was a straight out commercial move. But the going to twice a month was not strictly a commercial move. We did not change our circulation pattern at that time. We had a very substantial number of direct subscriptions and then, of course, we had the membership subscriptions. We out-subscribed The Modern Hospital and our contest against The Modern Hospital was helped by the ownership changes there. F. W. Dodge first brought it from the Otho Ball family, and then McGraw-Hill took it over. McGraw-Hill was interested in the bottom line, the profit-margin, and while we were providing an outlet for membership contributions and providing prompt and good coverage of our field, the editorial screws were tightening on Bob Cunningham. Not that Bob didn't continue to speak out forthrightly. He did.

As I have already noted, we did decide to go to controlled circulation to answer the increasingly demanding requests of our space salesmen that we give them targeted circulation. They were interested in getting our journal into the hands of the purchasing agents, the administrators, and a few other groups, the so-called major purchasing points. The space salesmen couldn't care less about getting it to directors of public relations or directors of social work. I did, and when we went to controlled circulation I insisted

that the controlled circulation be extended to these nonpurchasing pressure points as well. Gradually we moved ahead of The Modern Hospital in editorial. By the time The Modern Hospital went out of business in 1971 or 1972 we had turned the situation around completely from what it was in the early 1950s. We had two thousand advertising pages and they had eleven or twelve hundred.

The demise of The Modern Hospital was a sad event in hospital affairs in this country and it was due, entirely, in my opinion, to the ironclad belief in the McGraw-Hill board room that the only thing that mattered was the return on the investment. I was not privy to their corporate decisions but I certainly sensed that McGraw-Hill was insensitive to and the directors would not be persuaded by the service rendered by Bob Cunningham and his staff to the hospital field. As a matter of fact there was an unusual episode that is not written anywhere but there is no reason for it to be held quiet at this time, and that was a proposition, amazing though it sounds, from McGraw-Hill that the American Hospital Association and the McGraw-Hill Publishing Co. join hands in the combined publication of a single journal. I was covering the American Medical Association's House of Delegates meeting in New Orleans late in November 1971 when I got a call from Dr. Crosby who was in Chicago telling me to come back to Chicago but to hold my hotel room in New Orleans because I would be returning there after a one-day meeting in Chicago. It was on a Saturday that he called and I got out of there on Sunday after major meetings at the AMA and checked into the Lake Shore Club late Sunday night. At a breakfast the next morning I was briefed on what was up. Crosby, John Sullivan, AHA's treasurer and more importantly Crosby's strong financial man on the staff, and I were to meet with a senior official of the McGraw-Hill

Co., the one with the responsibility for The Modern Hospital, and with Bob Cunningham to go over a proposal. The proposal was that The Modern Hospital go out of business and that the McGraw-Hill Co. publish a journal for the American Hospital Association. Obviously a thunderbolt suggestion. McGraw-Hill would be responsible for all the business side and the AHA would take over editorial control completely. Crosby and Sullivan seemed quite receptive of the idea. I expressed very serious reservations about it. Crosby said that this was not the time for me to express a yes or no on the whole idea, but that he wanted--of course this was such a novel approach--he wanted Bob Cunningham and me to put together a fair blueprint of how such a scheme could be put into effect. Scores of problems come to mind. What would the title of the book be? What would happen to the employees of the AHA on the commercial side of our journal? What would the percentage of editorial to advertising matter be, and who would be responsible for that ratio? Anyway, it was decided that Cunningham and I would spend as many days as necessary putting down possible answers to the multitude of questions. I took a suite at the Drake, and we met there for, I think, three days. Bob and I agreed that the first sentence in the memorandum would state clearly that my participation in the formulation of the memorandum would not be in any way construed as indicating my support of the whole idea. I said that I expected to write a separate memorandum formally opposing the suggestion. We went through many, many things. Title was decided on. If this came to pass, it was to be The Journal of the American Hospital Association. I got Bob up to about thirty-eight or forty percent on the editorial/advertising ratio, with advertising having the major part, of course. We came up with a relatively reasonable compromise on who would control that ratio. We agreed, it came

largely of my doing, that Bob Cunningham's famous column, "Looking Around," would be continued. He would have complete editorial freedom in that column.

While the memorandum was in the process of being prepared and I had seen a copy, and I think Crosby had seen a copy too, but I am not sure... Anyway the work was done in January of 1972 and Dr. Crosby died in February of 1972, and the project died with him. I don't think it would have worked. It seemed to me that it was just an act of desperation on the part of McGraw-Hill. It certainly was a novel approach. Bob and I both had fun trying to make a sensible blueprint out of such weird lines.

I remained as editor of the journal throughout 1972. One of the more unfortunate episodes had to do with something that happened after I had left the directorship of the journal. I continued to cover the meetings of the AMA's House of Delegates for a couple of reasons. I found them fascinating as episodes in the health field's goings on, fascinating is perhaps too weak a word, unbelievable may be more apt. One meeting in Seattle, or it may have been Portland, was a shambles from the standpoint of the AMA's Board of Trustees. The Board faced a revolt of great magnitude. I had much respect for the AMA and liked many of the things that its House did, but some things didn't make the best of all possible readings. Certainly, as the editor of or the reporter for the journal of the American Hospital Association I would hardly be inclined to indulge in tabloid sensationalism. As a matter of fact, I thought I was far more friendly in my reports on AMA proceedings than were many others. I submitted what I thought was a balanced, and in view of what had happened, an extremely mild account of the goings on during the revolt against the AMA's Board. The next thing I knew, I was called in and was told that one of the officers who had been present at the AMA meeting had asked to

see my account of the meeting. He found it objectionable. He didn't find it incorrect, but in his judgment he didn't think the journal of the American Hospital Association should carry such an account no matter how accurate. It turned out that the American Medical Association in its own periodical carried accounts far more blistering, and they were still quite objective, than mine. I thought that mine was quite pabulum, but, of course, tht isn't the point. The point is that for the first time since I had had anything to do with the journal an officer of the association had asked for the opportunity to review a report of an event. This reflected the philosophy that every publication issued by the association should serve the political purposes of the association. My point of view is, of course, that truthful reporting services, in the long run, the goals of an association such as the AHA. I don't think that point of view is generally held now. I know it was held by Dr. Crosby and a review and censorship of a news report in our journal by one of our officers would have been unthinkable to him.

I told them to take my name off the piece and do what they wished with it.

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