HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Stanley R. Nelson

STANLEY R. NELSON

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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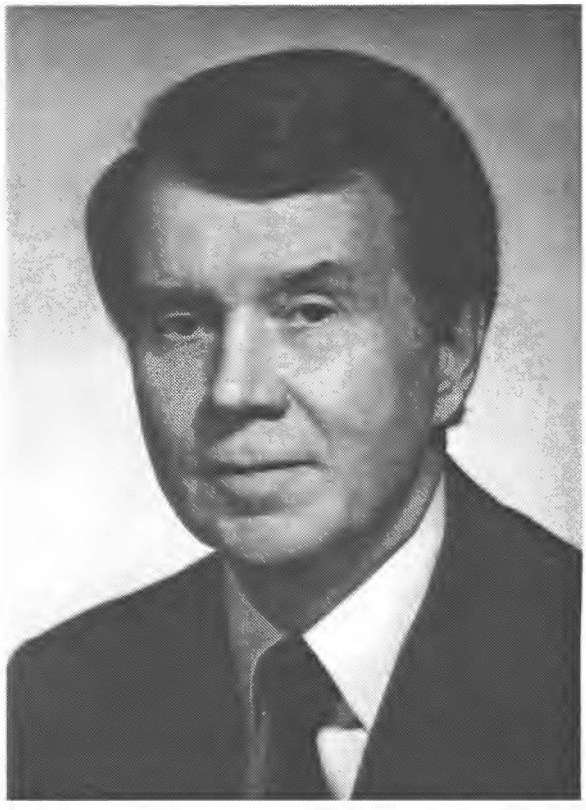
Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298



Stanley R. Nelson

CHRONOLOGY

1926	Born August 12, Chippewa County, WI
1944-1945	U.S. Navy, Aviation Cadet
1948	University of Minnesota, B.S. (Economics)
1949-1950	Northwestern Hospital, Minnesota, Administrative Resident
1950	University of Minnesota, M.H.A.
1950-1952	Butterworth Hospital, Grand Rapids, Assistant Administrator
1952-1955	Parkview Hospital, Fort Wayne, IN, Assistant Administrator
1955-1961	Parkview Hospital, Fort Wayne, IN, Administrator
1961-1968	Northwestern Hospital, Minneapolis, Administrator
1968-1970	Northwestern Hospital, Minneapolis, President
1970-1971	Abbott-Northwestern Hospital, Minneapolis, President
1971-1974	Henry Ford Hospital, Detroit, Executive Director
1974	Henry Ford Hospital, Executive Vice President
1984-	Henry Ford Health Care Corporation, President

MEMBERSHIPS & AFFILIATIONS

American College of Healthcare Executives, Member

American Hospital Association, Board of Trustees

Member, 1977-1983

Chairman-elect, 1981

Chairman, 1982

American Hospital Association, Committee on Licensure of Health Personnel,

Chairman, 1970-1971

American Hospital Association, Council on Manpower and Education,

Member, 1972-1974

American Hospital Association, Council on Financing,

Member, 1975-1977

American Hospital Association, House of Delegates,

Speaker, 1983

American Hospital Association, Life Member

American Hospital Association/Blue Cross Association Committee,

Member, 1975-1977

American Hospital Association/Health Insurance Association of America

Committee, Member, 1975-1977

American Public Health Association, Member

Council of Teaching Hospitals, Administrative Board,

Member, 1975-1978

MEMBERSHIPS & AFFILIATIONS (Continued)

Health Alliance Plan of Michigan (HMO), Vice Chairman, 1978-1981

Lincoln National Life Insurance Co., Variable Annuity Fund,
Board of Managers, Member, 1979

Medical Group Management Association, Member

Michigan Hospital Association/Blue Cross and Blue Shield of Michigan
Committee, Chairman, 1976-1978

Michigan, University of, Lecturer

Minneapolis Medical Center, Administrative Committee,
Chairman, 1969-1971

Minnesota Blue Cross, Board of Directors, 1970-1971

Minnesota Hospital Association, President, 1969-1970

Minnesota, University of, Preceptor

National Chamber Foundation, National Health Care Strategy Task Force,
Member, 1977-1978

Study Commission, Accreditation of Selected Health Education Programs,
Member, 1971-1972

U.S. Department of Health, Education and Welfare, National Industry
Council for Health Maintenance Organization Development,
Member, 1979

Voluntary Hospitals of America, President, 1977-1981

AWARDS & HONORS

American College of Healthcare Executives

Gold Medal Award for Excellence in Hospital Administration

University of Michigan Program in Hospital Administration

Honorary Member

WEEKS:

Mr. Nelson, I have in my notes that you were born in Chippewa Falls County, Wisconsin in 1926 and that you have your bachelor of science degree from the University of Minnesota in economics -- which you got in 1948. The next note is about hospital administration. I wondered how you chose this for your life's career.

NELSON:

If you are a historian, there might be a connection there that would be of interest to you. It happened during my last year in college at the University Of Minnesota, after World war II. I was looking for a postgraduate course of some sort, thinking seriously about law, when I was directed to the program in hospital administration. Jim Hamilton had started the program at the University of Minnesota in 1946-1948. The first class graduated in 1948, so it started in 1946. I was attracted to it instinctively by the need for management skills in the hospital field -- which was apparent even to someone like myself who didn't know much about the industry. Coming out of the Depression and World War II, the needs for health care obviously were growing. Even I could see that there was going to be an expanding need for management expertise. So it had a great attraction to me, and it fulfilled my desire for a graduate program.

The person who really directed me into it was Joe Norby. Joe Norby had run a hospital in Minneapolis. He was a friend of our family, a good friend of my father's. He, at that time, was running Columbia Hospital in Milwaukee. He and my father were on a college board together. He knew of my search for a graduate program. He encouraged me and helped me to get into the Minnesota program. So, I give Joe Norby a lot of credit for directing that step.

WEEKS:

He died before I had the opportunity of meeting him. I talked with his son Maurice, who also was prominent in the health field. He told me quite a lot about his father. In fact, I believe Joe Norby was one of the first persons to recognize the need for Blue Cross.

NELSON:

Yes. Yes. I think he was running a hospital in Minneapolis when the Minnesota program, the Blue Cross Plan, was started. Then, I think, he helped start the one in Wisconsin.

If my facts are correct, the Blue Cross emblem was created in Minnesota.

WEEKS:

van Steenwyk was the originator, I believe.

NELSON:

van Steenwyk first used the Blue Cross symbol. It has become quite a prominent symbol.

WEEKS:

I regret very much that I never met van Steenwyk either.

NELSON:

Nor did I.

WEEKS:

Talking about Jim Hamilton, it might be of slight interest to you to know that I was in South Duxbury, MA, his retirement home, about seven or eight years ago when I interviewed him. He took me downstairs in his basement and showed me a row of four drawer files — must have been seven or eight of them.

He said, "I have information on every one of my students." He kept current on this information, even after he retired. Apparently he would get

information from the school. He had these files all filled with this information. I am sure he had information in there on you also.

NELSON:

He became, interestingly, a good friend. As I grew older I came to understand better his contribution to the field. It was monumental.

WEEKS:

A remarkable man.

NELSON:

We became quite good friends. of course, we were very close to Shirl and Walt McNerney -- and the other daughters as well.

WEEKS:

Shirley wrote me a note after her father's death. I had written my condolence. She referred to the oral history of him. She said they really appreciated it, now that he was gone. They really realized what it meant. It was the only document of that kind that they had. So I sometimes feel that this work, which I do, is worthwhile.

I next have a note of your going to Northwestern Hospital in Minneapolis for your residency. Since we are talking about Jim Hamilton, I wonder what the hospital administration residency was like. He told me that he really rode herd on those preceptors and that he insisted that they be good preceptors.

NELSON:

I think he may have overstated that just a little bit. I guess he had an idea of what he wanted from his preceptors but if you review those early years the residency was quite unstructured. In later years he did bring the preceptors back for conferences and there were some standards established for

residencies and so on, probably at the insistence of the university. In the early years it was pretty informal.

My residency was an example of this. I was the youngest in the class. i didn't quite understand that I was supposed to be out seeking a residency during the year we were on campus. I think I was the last one placed. It was strictly coincidence that I ended up at Northwestern Hospital in Minneapolis. They did not intend to take a resident that year, so no one else applied there. Then they changed their minds late in the game, and I was the only one available. So, that's how scientific the placement was, at that time.

I think in the later years there was a much more formalized process.

WEEKS:

I think so, too.

NELSON:

In the early years there wasn't much.

WEEKS:

Hamilton told me stories about certain persons he placed in residencies. He said some student would want to go to a certain place but Hamilton thought that student would not work out well with that administrator so he would send him somewhere else.

NELSON:

He did a lot of that. I think he prided himself on being able to match people for their mutual benefit, and that sort of thing. I am not sure that it always worked out that way.

WEEKS:

Jim was a great story teller.

NELSON:

Yes, he was.

WEEKS:

Was this hospital residency in between the two years of classes?

NELSON:

No, during the second year.

WEEKS:

Then you went back and got your degree.

NELSON:

You got your degree at the end of your residency.

WEEKS:

According to my notes I have you in your next stop in Butterworth Hospital in Grand Rapids, Michigan as assistant administrator. What did they have you do when you were there?

NELSON:

Butterworth Hospital is a good hospital. It was a good hospital then. Grand Rapids was a fairly sophisticated medical community, three good hospitals, each with medical education and nursing education. Of course Grand Rapids was a very fine community; a lot of substance to the community. Butterworth had an administrator and two assistants, a senior assistant and a second assistant, a junior assistant. I became that second assistant. It was an entry-level position. The thing I have reflected on often was the opportunity for a very young person coming out of a new kind of educational program, entering at the very top level of the management structure in a fairly significant organization. I don't know whether that has ever been possible anywhere else in our society; where you could enter at the top. But

that's what you did in those days.

As the junior assistant I did pretty much whatever anybody else didn't want to do.

One thing I do recall is that I set up a central personnel office at Butterworth. Most hospitals in those days had the personnel function decentralized. Each department handled their own, which caused some problems. We set up a centralized personnel office. I was also in charge of public relations.

WEEKS:

It was all good experience.

NELSON:

Public relations was a new concept, too. I still remember the gentleman who was running the place didn't quite understand what it was but thought we were supposed to have it. So, whenever he ran into something that he didn't want to handle, he would yell at me, "Nelson, this is public relations, take care of this." It could have been medical staff relations, it could have been patient relations, it could have been employee relations, it could have been anything. Because what isn't public relations? His definition of public relations was in the broadest context.

WEEKS:

Was Ron Yaw at Blodgett Hospital in Grand Rapids at that time?

NELSON:

Ron was at Blodgett. Over the years we really became very good friends.

WEEKS:

Everyone speaks very well of him. I don't believe Sister Maurita had come to St. Mary's Hospital yet.

NELSON:

No. I never got to know anyone at St. Mary's. I was in Grand Rapids a short time. Less than two years.

WEEKS:

How did the move to Parkview Hospital in Fort Wayne come about?

NELSON:

It was a combination of opportunity and a desire to get with a different organization. Very candidly, I had problems with the philosophy of the administrator at Butterworth. He was a medical administrator who had come out of the Harvard complex. Quite rigid and traditional in his approach and thinking -- and quite negative. That bothered me a great deal. So, I wasn't particularly happy. It was a wonderful hospital and a very good learning experience. It was an entry-level job. I have absolutely no complaints about that.

I had a chance to go to Fort Wayne where they were developing a program for a new hospital, on a new site. Most important it was to work with Don Carner, whom I had met at Northwestern Hospital. He was on the administrative staff there. he was looking for help. Because of our previous association he offered me a job as assistant.

Anyway, I went down there because, while the situation was less secure in the sense that they were building a new hospital and the position of the hospital in the community was not nearly as strong as Butterworth's, it was much more exciting and I thought it would be a better learning situation.

WEEKS:

Then you stayed on as administrator, didn't you?

NELSON:

We got the new hospital built and occupied. A year later Don Carner, who always wanted to live in California, left Indiana and moved to California. I was appointed to succeed him as administrator of Parkview Hospital. Again, thinking back on it, I was given an unusual opportunity, although at the time I didn't think it was all that unusual. I became C.E.O. of a very significant organization -- and I was 28 years old. Of course, at that stage of my career I knew everything, so it wouldn't seem unusual.

I have always been grateful they gave me the chance. That was the most exciting job change I ever made. Very exciting to have your own place at an early age. I can still remember the excitement of it. I have never had anything comparable to it since.

WEEKS:

That was a medium-sized hospital, wasn't it?

NELSON:

It has grown into a very large hospital.

WEEKS:

Somewhere I saw a note that you had an extended care facility of 100 beds there.

NELSON:

It failed.

WEEKS:

Was that for chronic care?

NELSON:

It was really a nursing home. We received a donation, a sizable donation. We had a nice campus, we had plenty of land to build it. So we

built a nursing home as a separate building on the campus. Of course, we built it first class, all private rooms and everything that goes with it. We managed it out of the hospital. I learned from that experience that hospital people don't know how to manage nursing homes. By the time the nursing department got through staffing it, and everyone else got through staffing it, our costs were so high and our prices were so high that we priced it out of the market. We were competing with people who were cutting down on food portions to save money. It was just a bad fit for the market. Fortunatley we built the building in such a way that it could be used for other purposes. We converted it to a psychiatric facility. It worked very, very nicely. That was an interesting lesson about nursing homes being different from hospitals.

WEEKS:

McPherson out in Howell, Michigan had that experience. They built themselves a facility where, as you said, they priced themselves out of the market.

After Parkview you moved to Northwestern Hosptial in Minneapolis.

NELSON:

Back to Northwestern Hospital.

WEEKS:

You had another building campaign there, didn't you?

NELSON:

A tough one. A very tough one.

WEEKS:

Northwestern -- a community hospital?

NELSON:

A non-sectarian, voluntary, community hospital. First of all, I had my

residency there at Northwestern. I knew a lot about it. As a matter of fact, the administrator who had preceded me had been my preceptor there. He had been asked to leave after 14 years. They had a search. I had been at Parkview almost nine or ten years. I had run the place for six years. It was still growing. It was almost too good. I predicted at that time that it would continue to grow. It was located beautifully in terms of community growth. You look back 25 years later and everything that anyone with common sense would have predicted has happened.

That predictability gave me reason to leave as much as anything else, because it lost its excitement. Right? I sensed that if I was going to get other kinds of experience, I would have to go some place else to get it. We had already expanded twice. We knew that further expansions were coming. That's fun, but, if you do it once or twice you don't need to do it four or five times. So it was a much different kind of challenge in Minneapolis. It had the best medical staff in town. The physical plant had been developed. They had gotten behind in their programming, the medical staff was really getting restless. Northwestern Hospital had a board of trustees of 48 women. By my diagnosis, at least, that was part of the problem, most of the problem. They didn't quite understand what standards to apply to management. So, management had gotten away with some things that wouldn't have been acceptable in some other hospitals.

I saw it as a fascinating challenge. I knew the ingredients were there to make a very strong program. I called them and told them I would be interested in talking with them. They didn't call me, I called them. It turned out that they offered me the job and I went back and took it.

WEEKS:

How did it happen that they had a board composed entirely of women?

NELSON:

It goes back to the origin of the hospital. It was founded by a group of very prominent women back in the late 1880s. Originally it was a women's and children's hospital. That lasted about two years and then they made it a general hospital.

Virtually all of that board of women were very prominent socially and in the community. They were community leaders and their husbands were community leaders -- the Pillsburys, the Crosbys, the Heffelfingers, the Cargills, a very, very strong board.

WEEKS:

Was this a self-perpetuating board? Did they select their board members?

NELSON:

Yes.

WEEKS:

Quite a social plumb to be elected to the board.

NELSON:

Absolutely. They had a lot of pride in being on the board.

One of the things I set about doing was changing that. It probably was a foolhardy thing to do, but we got it done.

WEEKS:

You reorganized the board of trustees?

NELSON:

We got men on the board. More important, we introduced a diversity of experience to the board.

WEEKS:

Did you set up a new pattern of departments and management?

NELSON:

At Northwestern? I am not sure what that reference is to. You see, my predecessor had been there for 14 years. He had a very centralized decision-making style. That's not my style. In the process of changing that we did restructure a number of the departments. We changed a lot of the people, quite frankly. It was interesting to inherit a hospital where all the decisions were made in the administrator's office. We decentralized the decision-making process. A fascinating experience.

WEEKS:

You remarked about your affiliation with the university medical school.

NELSON:

The university was not very much inclined to cooperate with the voluntary community hospitals at that time. In our case, because of the quality of our medical staff, they made an exception particularly in the area of internal medicine. We got strong affiliation going there.

Then we hired a very prominent chairman of medicine from the university to come over to our hospital, Cecil J. Watson. He was internationally known in medical circles. He was the counterpart to Owen WangenStein, who was the famous surgeon up there. Those guys were giants. When we got Watson to come over to head up our program, that changed the whole complexion of the place. He was willing to do it because he was approaching retirement. We were willing to keep him on past retirement, which he wanted to do. We gave him some research support. It was a very good thing. We didn't imagine we could do it. It fit his needs, interestingly, and served our hospital very nicely.

WEEKS:

Did this have an effect on your resident program?

NELSON:

Yes, although we didn't have a heavy teaching program, but, yes, it did affect it.

WEEKS:

You were promoted from administrator to president of Northwestern, weren't you? A member of the board also. This was rather unusual, wasn't it?

NELSON:

I think it was unusual at that time. I think that was about the time we were adding men to the board. I think some of those men had very much a corporate view of the organization. They couldn't imagine the chief executive officer not being a member of the board, bearing the title of President.

I do remember one anecdote about that. I think I was one of the first to get that title in the Minneapolis area. There was some consternation in the county medical society. I don't exactly remember what their concern was. I guess they thought non-physicians were taking over in too big a way. There were some letters to the editor of the county medical journal.

WEEKS:

Did you have any physicians on the board?

NELSON:

At the same time we put a couple on the board. Ex officio, chairman of the medical board. I have always been an advocate of that.

WEEKS:

I have a reference here to a medical complex.

NELSON:

That's the Minneapolis Medical Center. What year was that?

WEEKS:

This would be 1968-1970.

NELSON:

That's about the time we were merging with Abbott Hospital. We had convened a number of institutions to talk about collaborative efforts. Those institutions were Sister Kenny Rahabilitation Center, Abbott Hospital that we ultimately merged with, Deaconess Hospital which subsequently went in a different direction, Mount Sinai Hospital which is still independent and suffering for it, and Children's Hospital which has become the most prominent pediatric center in Minneapolis. We would gather voluntarily on a weekly basis to try to identify what kinds of things we could do better jointly than we could individually. There are two things to be said about it. One is that it was worth doing because today you go to Minneapolis and within that center you will see Abbott-Northwestern Hospital which merged early. Subsequently, Sister Kenny merged into the same corporation. Children's Hospital which has not really merged, as I understand it, is a sister institution and very much a part of that. At the time the Children's opened we closed pediatrics in Abbott Hospital and Northwestern and transferred to Children's. Children's, as I said, has a very strong pediatric program today, probably the leading program in the Twin Cities, certainly in Minneapolis. That would not be the case without this kind of collaboration.

WEEKS:

Minneapolis is an unusual city anyway, isn't it? What are there, about four multihospital systems there?

NELSON:

Yes. This was one of the early ones. You are right, it is an unusual town. Very sophisticated medically, and culturally, socially, and economically.

WEEKS:

It's an unusual town in many ways. I want to ask you about fund raising.

NELSON:

I learned about fund raising from my Indiana experience, from the things we did down there.

WEEKS:

How did the community as a whole work?

NELSON:

We didn't have any capital drives in Minneapolis. This was an ongoing development program. It wasn't a capital drive, per se.

WEEKS:

I noticed in Rochester, NY, all the business powers got together and said that when they have a fund raising program they would have a community fund raising program and allot money to individual hospitals as their certificates of need show.

NELSON:

Minneapolis had a fund raising campaign, a capital drive, prior to my arrival and all the problems and all the joy that goes with it.

WEEKS:

At Abbott-Northwestern were there two separate buildings?

NELSON:

Yes. About two miles apart.

WEEKS:

And it remains that way?

NELSON:

No, since the merger there has been a physical consolidation. That did not happen while I was there. It was after I left. We had been merged only about two years when I left. We were integrating programs but we weren't integrating facilities. An anecdote on that merger, that is interesting to me at least, has to do with how it came about.

Both Abbott and Northwestern were good hospitals and compatible in many ways. One day I went over to my counterpart at Abbott Hospital and said, "Why don't we merge these two hospitals?"

He said, "O.K., why don't we do that?"

That was the beginning. I sensed that he really was serious, and I was serious. So, we started involving some of our key trustees. We found there was a pretty good fit. That fit held up pretty much across the board with the exception of some of the prominent physicians. In retrospect, 20 years later, it had to be one of the best things those two organizations could do. Interestingly, we did it for the right reasons. We anticipated difficulties hospitals were going to have to assimilate technology, limited resources, limited capital resources, human resources. We saw it as a much more efficient way of addressing the health needs of the community. Abbott-Northwestern today is one of the leading cardiac surgery centers in the country. They have done some very, very good things, none of which would have happened without the merger. Without the merger both those hospitals would be struggling. With the merger the enterprise is doing very nicely. In a tough market.

WEEKS:

Did you completely merge your medical staffs?

NELSON:

Yes. We merged the boards, we merged the management, we merged the medical staffs. we kept the women's auxiliary separate. They merged 1Ø years later.

WEEKS:

That's pretty important.

NELSON:

We just didn't see how we could do that at the time.

WEEKS:

You were taking away some of their trustees, you couldn't take away all of that.

Was the planning stage during your two years there with the combined organization?

NELSON:

Not the physical consolidation. The organization was done then.

WEEKS:

How did you happen to come to Henry Ford Hospital?

NELSON:

They were in a big mess. They were desparate.

WEEKS:

Did you immediately succeed Dr. Buerki?

NELSON:

Ted Howell was here.

WEEKS:

That is what I thought.

NELSON:

Ted Howell, whom incidentally I never met, was Dr. Buerki's heir apparent. He had grown up here in the department of medicine. He had an unfortunate experience with a massive computer program. It didn't work. It blew up. As a result, he left. They brought Dr. Buerki back in, as you may recall, in an acting capacity with the assignment to find someone to run the place.

I had been at Abbott-Northwestern for about 10 years. I wasn't the first one he talked to. He talked to several people who didn't want the job because it had a lot of problems. I was ready again and was getting a little impatient. I was ready for another set of problems and I found them.

WEEKS:

I imagine you did.

My neighbor across the street is David Lewis, a professor of business history at the University of Michigan. His specialty is Henry Ford and the Ford Motor Company.

NELSON:

The historian? I have talked to him.

WEEKS:

I borrowed some of his files of clippings on Henry Ford Hospital. One of the things that amused me was that back in the early days of the hospital -- back in 1915 when they originally opened -- the chairman of the board was Henry Ford, Edsel was vice president, and some of the other members of the family were other officers. But he brought in from the Ford Motor Company

Ernest Liebold to run the hospital.

NELSON:

Yes. As Superintendent.

WEEKS:

Yes, as Superintendent. They were using that title at that time.

My understanding of Liebold was that he was a Prussian type character. He had absorbed all the ideas of the production line in Henry Ford's factory. He couldn't understand why a hospital couldn't be run that way.

NELSON:

I have heard some of those stories.

WEEKS:

And do all your appendectomies on one day, that sort of thing.

NELSON:

I am not sure that Henry Ford didn't see some things that way too. Talking about the early days, when I got here and learned and appreciated the role that the Ford family and the Ford Company played in our community, I started doing some reading. I have come to appreciate what that role has been. It is not insignificant.

In order to set some of the flavor of the place, early on, I asked to see the old minute books. I wanted to get some kind of background on what had gone on. The secretary brought out three rather small volumes. I said that I would like to see them all. She said, "This is all."

The reason was that in the early days, as you are describing, when Henry Ford was chairman of the board, there were only five trustees. He was chairman, his wife was a member, his son Edsel was a member, Edsel's wife, Eleanor Clay Ford, was a member, and then somebody like Liebold was the

secretary. They would meet once a year. They would elect officers, and that was about all. Minutes were contained on one page. You could get 30 years in one little book. That was the way Henry Ford ran everything. It was his hospital. As a matter of fact, that was the way it was perceived by him and the community.

The original story is that Henry Ford was treasurer of the citizen's group that was building this hospital. He had given the land, which was the largest single donation. The fund raising effort wasn't going very well. He didn't believe in committees. So, he offered to repay all donors, build the hospital for the community, if they would let him run it. They said, "Fine," and they did and that is how it came about. But it was his hospital and he subsidized it right out of the motor company.

There was an employee here, who had been here 50 years or more when I arrived, who goes back to those early days. He tells about going out to the motor company at the end of the year to get the check to subsidize the deficits.

WEEKS:

As a matter of fact, before World War II, it was rather common, wasn't it, for boards of directors, wealthy people, to pick up the deficits?

NELSON:

I think so.

WEEKS:

I can remember reading one story of the Depression days in which a trustee turned down appointment as chairman of his hospital board because he couldn't afford to underwrite the deficit -- one of the honors that went with being chairman.

When you came here were there a thousand beds or more?

NELSON:

Yes. They were operating 950 beds, and a big multispecialty group practice running through the spine of the place. It was a big enterprise.

WEEKS:

Is your medical staff still full-time, salaried?

NELSON:

Yes.

WEEKS:

I have read some articles about admissions. If a person came from off the street and said, "I am ill" or "I have a pain" would he be assigned to a certain physician?

NELSON:

Yes, he's triaged and put into the system. We have today the most active trauma service in the city of Detroit.

WEEKS:

I imagine your location is a busy one.

NELSON:

We see more emergency room visits than Receiving Hospital. Going back to the early days of the place, the integrated medical staff was a concept of Henry Ford, which I think is remarkable. He had an ingenious mind. Anybody who would devise and implement the industrial assembly line is not an average person. He saw some of the same organizational efficiencies in an integrated hospital and medical staff. The idea of doctors having their offices out in the community and their patients in the hospital -- he saw the inherent inefficiency of that. He wasn't concerned about ethics of medicine, or

salaries, or fee-for-service. Those things didn't enter his mind, I am sure. What he saw was an inefficient system. He said that if you have a hospital and a laboratory and the beds, that's where the doctors ought to be. I think he did touch base with the Mayo Clinic and got support for his idea. He, at that time, went to Johns Hopkins and hired the first medical staff. This was 1918, 1919. That was heresy back then. There are still a lot of people who don't think this is the way for a hospital to behave.

We now see health planners saying physicians and hospitals have to integrate their services and get closer together. Henry Ford was only 70 years ahead of his time, which I think is remarkable.

He also had some other ideas on health, you know, that were right on target. He was very much opposed to smoking. No smoking in his factories. No smoking in this hospital. The doctors used to have to go out behind the garage to smoke. He was very much opposed to obesity. They tell stories, true or not I don't know, that when the word went out that he was in the hospital they would hide the overweight employees because he would say, "Get rid of that one." Also, he was opposed to coffee.

WEEKS:

Alcohol also, wasn't he?

NELSON:

Alcohol. He was a teetotaler. He also had some ideas that weren't sound. He was opposed to refined sugar. He thought it aggravated the lining of the stomach. He was almost a vegetarian.

They tell one story. He had a boat coming back from some place. It was empty and that was against his philosophy to have an empty boat going around. So, he loaded it with bananas and shipped a boatload of bananas in here. This

was during the 1930s. They had bananas coming out of the back door. Bananas didn't last long either so they didn't know what to do with all the bananas. He thought bananas were nutritious. And they are, I guess.

He had a lot of ideas on health, many of which proved to be true.

WEEKS:

Did he interfere with the operation of the hospital?

NELSON:

I think he did. I think he did. He ran everything he had anything to do with. He ran it. He did rely on a couple of leading physicians for advice: Dr. Sladen in medicine, who was a giant; Dr. McClure in surgery, who was a giant. He did rely on them. As a matter of fact, I believe they actually sat with the board of trustees. Nevertheless, whether they did or didn't, he relied on them for advice.

WEEKS:

How is the medical staff organized here as far as relationship with the hospital administration? Do the doctors have a separate corporation?

NELSON:

There is one corporation. The board of trustees of the hospital, on which there are now four or five doctors, is the ultimate governing authority for the enterprise. The enterprise is the hospital and the group practice. To my knowledge, it is the only major, multispecialty, group practice that has ever been founded by a hospital. All the other major multispecialty groups have been founded by doctors: Mayo Clinic; Cleveland Clinic by Dr. Crile; Leahy Clinic in Boston; Ochsner in New Orleans; Lovelace of New Mexico. All the major clinics have been founded by doctors, which stands to reason. This place is reversed, and, for that reason, the board of trustees which is

dominated by non-physicians is the ultimate authority. The rest of it flows down from there.

WEEKS:

Do you take policy ideas to the board?

NELSON:

Yes. The formulation process is all across the organization. That goes up to the board. As you know, in this kind of an enterprise, most decisions are made through building consensus. By the time an idea gets to the board there is pretty much a consensus of support.

WEEKS:

You probably have talked with individual members in advance.

NELSON:

If anything is highly controversial, you just keep talking about it until you reach consensus, or the idea goes away.

WEEKS:

Somewhere I read that Henry Ford's wife, Clara, had a special interest in the hospital.

NELSON:

The family has always had an interest. This building was named for Clara Ford. The school of nursing. A magnificent building. Built in the late 192Øs. A school of nursing named to honor his wife. He built the educational building with classrooms, gymnasiums, swimming pool, squash courts. Every room here is a private room with full bath. That's an unusual dormitory even for an exclusive college in those days. This was a school of nursing. The family has always had an interest in this place. That's one of the reasons I came here.

WEEKS:

The school of nursing has a national reputation, hasn't it?

NELSON:

It has been a diploma school, it is now being converted to a baccalaureate program with Oakland University. Yes, it has had a very proud tradition.

WEEKS:

What do you think the effect is going to be, if the day ever comes when there is a requirement of a bachelor's degree? What effect is there going to be on the profession of nursing -- supply?

NELSON:

That is a question we could talk about a long time. We already see the shortage being created not so much by the baccalaureate degree having become almost a standard, but by the fact that women have so many other career choices. I was over to speak to the program in health administration at Northwestern in Evanston two or three weeks ago. Over half the class was women. You go to a law school and you see half the class is women, go to a medical school and a third of them are women. With those kinds of career options open to women these days, we are seeing a fundamental shortage in the market place for nursing. There are other choices, more attractive choices. We are in a shortage and it will get worse. I think what the outcome is going to be is that nursing is going to become a more professional component of the health care team than they have in the past. Fewer of them. The care givers, I think, are going to go back to the old practical nurses idea again. Maybe a two-year educational program, or some such thing. If you can find the people to fill that. There are just not going to be enough nurses to give care.

They are going to have to supervise care.

WEEKS:

The LPN is still a one-year course, isn't it?

NELSON:

Yes, I guess it is.

WEEKS:

Many of the LPNs are not young women, but some of them are older women, as old as 50, are taking the LPN training.

I think another thing that nurses need is recognition as a professional.

NELSON:

No question. Part of the dilemma is that their role has been difficult to define, because they want to move closer to what the doctor is doing, and the doctors don't want them. For years the doctors have been saying, "If you want to be a doctor, why don't you go to medical school?" So they are. That's creating another set of problems.

WEEKS:

There is no question that all of these things are complicating the problem.

The last figure I saw on full-time, hospital-based practicing physicians and residents here at Ford Hospital was about 800 or 900.

NELSON:

We are up over 900, close to 1000.

WEEKS:

Are you still using the term "intern?"

NELSON:

No. We use "House Officer."

WEEKS:

I noticed in some of the early notes I took "intern" was still in, but now I don't see it. I suppose it is disappearing in most other places. I want to ask you some other questions about the hospital.

Are the fees charged to patients the same across the board?

NELSON:

Yes.

WEEKS:

The same regardless of ability to pay?

NELSON:

Yes.

WEEKS:

I once had a discussion with a physician on the difference in pricing. He said he charged a wealthy man more for an operation than his regular fee because if anything went wrong it would be much more difficult to satisfy a man with power and money than it would be with the average citizen. i don't know whether that is a good argument or not.

NELSON:

I don't think there is much of that around anymore. There may be still some. One of the stories they tell is that Henry Ford's child had a tonsillectomy for which the charge was exorbitant, and that is why Ford built this hospital. I don't think that is true.

WEEKS:

I have heard that kind of story about other members of his family. The stories may not be true of his family, but I have heard of such a case.

NELSON:

I don't think it was uncommon back in those days. It was the Robin Hood principle.

WEEKS:

Henry Ford was operating on the principle that he should sell his product cheaper and cheaper so that more and more people could buy it.

NELSON:

He saw hospital care the same way he saw the Model T. If you price it reasonably, more people will use it, and that's the way it should be. What he did with the Model T, I think he figured would work anywhere.

WEEKS:

I also have come across an idea I can't explain. The philosophy of Henry Ford did not include charity in the sense of giving to people who didn't deserve.

NELSON:

Right.

WEEKS:

But, I have also read that in the early days of the hospital and while he was still alive he used to see that care was provided to say veterans who had no service-connected injury but who had some other illness. Remember Mrs. Ford used to have a house out on Michigan Avenue near Inkster, a home for unwed mothers.

NELSON:

I didn't know that.

WEEKS:

There is a public school at that location now. The way I understand it

is that Henry Ford liked to help people who helped themselves.

NELSON:

That's right. That's very true.

WEEKS:

That was shown by his help in the hospital care.

There must have been a period during World War I when the second stage of Henry Ford Hospital was partly built. The first hospital was opened in 1915, I believe.

NELSON:

It was a small place then.

WEEKS:

Forty-eight beds. Then, the story I heard was that before World War I broke out, at least before the United States got into it, Ford had started construction of an addition to the hospital.

NELSON:

The main hospital.

WEEKS:

The walls were up but it wasn't finished. The Army took it over?

NELSON:

My understanding of that story is that the first four floors of the building you see on West Grand Boulevard were completed and opened just at the completion of World War I. Ford leased the hospital to the government for a dollar a year for use of returning war wounded. So the first year or so of the hospital operation it was used by the government. My understanding was that the building had been completed at the time. That's about when it was opened, 1918.

WEEKS:

That must have been the origin of that story.

We were talking about charity. Henry Ford, according to one story, Henry Ford is supposed to have, during the period 1914-1915, before the first hospital building was opened, was supposed to have supported a mission for derelicts and homeless, people suffering drug abuse.

NELSON:

Here?

WEEKS:

Somewhere in this area. I don't know that it was on this property.

NELSON:

It doesn't sound like his sort of thing, does it?

WEEKS:

No.

NELSON:

I have never heard that.

WEEKS:

There are so many stories.

NELSON:

Oh, yes.

WEEKS:

Another story I have read is of the medical staff of the original hospital forming an evacuation staff for the Army. They were all ready to go to Europe on November 11, 1918, Armistice Day. I don't know whether they ever got to Europe or whether they were disbanded down in Mississippi where they were stationed.

NELSON:

That makes sense.

You remember Ford's famous Peace Ship commissioned in, when was that, 1917?

WEEKS:

I think it was.

NELSON:

I am not sure that the hospital didn't have a medical unit during World War II.

WEEKS:

I am sure they must have. Nearly every major hospital had one in the planning stage at least, didn't they?

NELSON:

They put a team together, at least.

WEEKS:

That undoubtedly had a great effect on the practice of medicine. I mean the war experience of treating the wounded and injured under emergency conditions, and under unusual administrative conditions.

Do you have any particular system for keeping up with technology? I am thinking right now of the lithotripter problem in Michigan.

NELSON:

Well, the explosion of technology makes that task more difficult. I think we have already reached a point where our organization and others are required to make choices. I have been saying for a long time that we can't be all things to all people in depth. So we will have to pick our spots. So, within those channels that we have sort of identified as things we want to do,

it's a continual process of our physicians to make those choices.

WEEKS:

You have a special service named after Edsel's wife, don't you? That's a building, isn't it?

NELSON:

These are buildings. The Eleanor Clay Ford Pavilion is the new wing that replaced the operating rooms and a lot of the radiographic functions, intensive care. It's not a program, it's a major wing. It also includes the trauma service.

WEEKS:

What is the building, and its use, that's named after Edsel?

NELSON:

That's the one in West Bloomfield. That's a major ambulatory center. That's the Edsel B. Ford Center, West Bloomfield. He played an important role in this institution, particularly his wife and widow. Mrs. Edsel Ford -- Mrs. Eleanor Clay Ford -- was a trustee when I arrived and was for many years. She was a remarkable woman. She was the queen mother of this community, as you know, a very modest, very bright, intelligent woman, very gracious, very warm. She was a delight, she was really something special. She was very interested in the hospital, very generous with the hospital for many years. We wanted to honor her. Her husband died as a very young man. He was on the board along with her until his death in 1943.

WEEKS:

I worked in a drug store in Grosse Pointe as a young man. I can remember Edsel Ford coming in there. He was, as you say, a very modest man. He didn't demand special attention, he was unassuming.

NELSON:

From what I have read about him, he was a person I really would have liked to have met and known. He must have been very special.

WEEKS:

I think he was.

You have named something after Benson also, haven't you?

NELSON:

That's the educational and research building. Benson, of course, was the second son of Edsel and Eleanor. He was a long-time chairman of the board. He was chairman when I arrived, and remained so until his death. I think it was 1978 or 1979 when he died. He had been chairman a long time. He succeeded his grandfather I believe.

WEEKS:

I wouldn't be surprised.

NELSON:

I think he did.

WEEKS:

His grandfather died in 1947.

NELSON:

I think he took over after that. Maybe Henry II was in there for a little while, then decided he couldn't do that and run the motor company also. Nevertheless, Benson was chairman for 25 years or more.

WEEKS:

I am sure all the family take a great interest in the hospital.

NELSON:

There were five family members on the board when I arrived, five out of

13 trustees were family members. That gives you a little idea. There has always been a family member as chairman of this board. When Benson died, Henry succeeded him. Henry was still running the motor company. He didn't need any more to do, but there is that family sense of commitment, and responsibility that has been a very valuable thing to this organization.

WEEKS:

The pressure on Henry II was very great, I am sure. He went into the Ford Motor company under very adverse circumstances to run the company. As you say, he had been operating it for quite a few years when Benson died. He must have been nearly burned out.

Just some little historical pieces here: I was surprised to read that Henry Ford Hospital used airplanes to bring patients to William Stout Field. That must be the one out by Dearborn Inn.

NELSON:

That has to be.

WEEKS:

They then brought the patients in by ambulance to the hospital. I can see one of those planes -- the "Tin Goose" — coming in.

NELSON:

The old trimotor? As your friend Mr. Lewis would tell you, there is much written on the Ford Motor Company's role in aviation. I guess I hadn't heard that, but it doesn't surprise me. That field...the Dearborn Inn was the first airport hotel. The first regularly scheduled commercial flights were from Dearborn to Chicago and back. I think he put the first stewardess on an airplane. To hear what you just said doesn't surprise me.

WEEKS:

Somewhere I ran across a 1927 price schedule for Ford Hospital: bed rates, $3 a day; professional medical service, $7 to $35 a week; the first appointment with complete physical and lab, $10.

NELSON:

That was a lot of money. Ten dollars was a lot of money.

WEEKS:

For x-rays: minimum $1.50, maximum $10. Special nurse $8.25.

NELSON:

I think we should do something about health care costs.

WEEKS:

When did you first get the idea of satellites? This came about during your tenure, didn't it?

NELSON:

Yes. The implementation certainly did. It probably had been discussed prior to my arrival. I heard people say they had talked about it. Is the name Ernie Breech familiar to you?

WEKS:

Yes.

NELSON:

You go to our Fairlane Center, that's the Breech Pavilion. His widow has given to it very generously. He was a trustee at one time. I got to meet him and know him a little bit. He was an advocate of branches. He called them "branches." So the concept is not original, certainly not with me. It probably goes back a long way. The implementation took place in the 1970s. To us it seemed a logical extension of what the hospital was already doing in

ambulatory care. The main campus clinic is ambulatory care. We have a big multispecialty group doing 600,000 to 700,000 visits a year. That's a lot of ambulatory care. I think, if I made a contribution, it was in pointing out two things. One is, we are in the ambulatory care business, and secondly, the community has changed. If we are going to continue to relate to the community as we have historically, we would have to change. So bring the ambulatory care service to where the people are, instead of assuming that there is only one way of doing it. It was a very logical playout of a basic strength that the hospital had, that the organization had.

WEEKS:

The staff are all salaried?

NELSON:

They are members of the same group, the same medical staff. A physician in one of our satellites, who is permanently based in the satellite -- some are, and some rotate --, has a dual appointment. He is appointed as a member of the staff of one of the satellites but also as a member of the clinical department of his specialty. So, if you are an internist, the chairman of internal medicine approves your appointment even though you are based in West Bloomfield or some place else. Plus, the director of the satellite has to approve your appointment as well. That's how we try to keep it tied together.

We sensed that one of the problems would be a little less cohesion than we had with everybody in one building. Geography does that to you.

WEEKS:

Do you get much in the way of referrals to the main hospital from the satellites?

NELSON:

We get a significant number of referrals. It's a very important part of our total program. Somewhere around 15% of our total admissions come directly out of the satellites. In addition to that, we think at least another 10 to 15% come indirectly where a person in a satellite is referred to a specialist here on the main campus for outpatient visits and then admitted. That we don't track very well. Admissions directly from the satellites we try to.

If anybody puts up an ambulatory care system to serve as a feeder to the hospital, I think they are going about it the wrong way. You had better recognize that it is a different business that calls for different approaches, management skills, attitudes on the part of the physicians, and control systems. I have heard a lot of hospitals say they were putting in these ambulatory care systems to feed the hospital admissions. The yield is pretty small.

WEEKS:

The type of person who goes to an ambulatory care clinic probably has an urgent, immediate need, and feels that it is something that should be taken care of at the clinic.

NELSON:

Not that there aren't some admissions. That's the common misperception, I think, of what ambulatory care centers do for you. If you don't want to go into ambulatory care as a business, as a service, then you had better not do it at all, because the other reasons won't justify it.

WEEKS:

Can you operate in the black in ambulatory care?

NELSON:

You can if you combine it with a prepayment program. But you really have to combine the two. They are synergistic. The combination is a profitable activity.

WEEKS:

You are associated with more than one prepayment plan, aren't you?

NELSON:

The Health Alliance Plan is really a subsidiary of our corporation. Of course, we work with some others. We work with the Blue Cross network. They have a broad base. I think we work with one or two others. The Health Alliance Plan is our plan. It is the one we promote, prefer. Even that represents only 20% of our total revenues. So, the bulk of our revenues still are fee-for-service and other sources of payment. Of course Medicare is 45%, Medicaid 12%. But it's an important piece of business for us, very important.

WEEKS:

What do you think the results may be of some of these plans that are before Congress now for insuring Medicare patients beyond what they are now?

NELSON:

Catastrophic?

WEEKS:

Catastrophic and other added benefits.

NELSON:

I think catastrophic coverage is a desirable thing to the extent that you remove the catastrophic risk from the individual. If it's truly an insurnace concept. I think it's a good thing.

WEEKS:

Apparently they think that a very modest increase in the Medicare premium would pay for it. They were so wrong in forecasting the cost of Medicare and Medicaid in the first place, I don't know whether an actuary or anyone else can forecast accurately in this situation.

NELSON:

You are absolutely right. They missed the mark on Medicare and Medicaid.

WEEKS:

Your first satellite was in Dearborn?

NELSON:

Dearborn and Bloomfield opened within 60 days of each other. That was the other thing that perhaps distinguished us from others. Others weren't doing it when we did. We did it in a major way. We didn't open a store front. We opened 75,000 square feet in two very different kinds of locations. Dearborn was an established community, West Bloomfield was a growing community. We weren't sure they were going to work.

WEEKS:

That was quite a gamble.

NELSON:

I call it "bet your job time." We have a game around here called "Bet Your Job."

We thought something good would result from it... kind of like that nursing home I built down in Indiana. It didn't work as a nursing home, but it worked as something else. We figured we could salvage it or do something with it. If we were going to do it, we wanted to make a bold statement. We just didn't want to go in the shallow end of the pool. We wanted to go in

with a major presence and a statement that said, "We are here!" So, that is why we built big buildings and made a major commitment. We put a lot of overhead in there. It took a long time to get up the speed. It took us about three years to get up the speed. So we needed some staying power as an organization.

WEEKS:

You have such a large investment in your present campus, main campus. My next question may seem silly. You never have considered moving to the suburbs?

NELSON:

It is not silly because at the time we did the satellites there were two schools of thought in our organzation regarding satellites. There were three schools. A small school said we ought to move out. That was unthinkable -- morally, economically, every other way. We just couldn't leave Detroit. There were two schools of thought beyond that. We shouldn't decentralize because it would divide our resources and focus and detract from our main effort, the main campus. Therefore what we should do is build this center of excellence and people will seek you out. The old center of excellence theory. The other school was people don't want to come to Detroit. They have moved, they want convenience and accessibility. You have got to go where the people are. If there was any genius to what we did, we did both. We didn't deny either.

We rebuilt the main campus. virtually everything we built here is designed for education and research, housing for education, intensive care kind of services. We didn't build any more beds. Then we did the satellite system. So we satisfied both schools. If we had had to do one at the expense

of the other, I think we would have had more difficulty. It's worked pretty well.

WEEKS:

I was going to ask you another silly question.

NELSON:

The last one wasn't silly.

WEEKS:

In your salary scale you, I am sure, make allowance for different specialties and different seniority. How do you arrive at these figures? Do the physicians enter into this?

NELSON:

Yes. They have a compensation and benefits committee. We go on the basis of data, survey data, other clinics primarily. we participate in a survey, salary and compensation survey of 14 major clinics. We have that data. That's a guideline. We use other data bases and guidelines. I used to think there would be the ultimate formula which would perfectly define compensation for the physician group. We have yet to find that formula. I gave up on that about 10 years ago.

WEEKS:

Speaking of research, do you fund your own research?

NELSON:

We have a research budget of something over 10 million dollars a year. Half of that comes from outside sources, mostly National Institutes of Health. The other half we fund internally out of endowment funds, not patient revenues.

WEEKS:

Is your research based on the hospital's ideas of what should be studied or are you doing studies the National Institutes of Health or some other government agency thinks needs to be done?

NELSON:

I suppose if the NIH funds it, they think it needs to be done. That's a large part of our budget.

WEEKS:

Do you go to NIH and say that this is what we would like to do?

NELSON:

We go to them and say, "This is what we are interested in doing. This is what we have the capability of doing. Are there resources for doing this kind of research?" We do not go there and contract to do research.

I think we have come a long way in the quality and level of research around here for a private, non-governmental institution. Ten million dollars a year is not big by major university standards, but it is pretty big by community hospital standards. I felt good the first time the research committee closed down a program. At that point I thought we had things moving in the right direction, when they actually shut down a program because they didn't think it was worthwhile. But research is not our major mission.

WEEKS:

I understand.

NELSON:

It's not our major mission. It's here as an appropriate part of the total.

WEEKS:

You are going to collect inhouse data anyway for your own use and your own guidelines as to where you are going and what needs to be done, and this sort of thing.

As an example, yesterday I talked with Sam Shapiro who was with HIP in New York as a research person and is now at Johns Hopkins. The kinds of research they did got way beyond the hospital. They were studying population figures in general. I suppose it could be applied to their hospital in extension. So I am wondering about what kinds of research you are doing.

NELSON:

I was talking about the biomedical research. We have done some health services research but we haven't had much going in that direction lately.

WEEKS:

The hospital has a fairly large endowment fund, doesn't it?

NELSON:

In excess of 100 million dollars.

WEEKS:

What are you doing in the way of managing other properties, such as other hospitals?

NELSON:

Not much.

WEEKS:

I can remember a few years ago, I don't know how the story came out, but wasn't the hospital at Mt. Pleasant, Michigan...

NELSON:

Looking for a contract? Yes, I think they were. A number of them have

flirted with it. Maybe they got one, not from us. We managed St. Vincent's Hospital in Toledo for three years. At one time we thought that contract management of hospitals might be a good thing to do. We got away from that. It's not a very satisfying thing. The return isn't there at almost any level. There is no big economic return. There is no return in terms of referrals. You can manage St. Vincent's and the doctors can refer to Columbus or Cleveland or anywhere. You are not going to influence the physicians' referral pattern by a management contract.

WEEKS:

A regionalization plan doesn't seem to work either. There is no two-way flow of referrals.

I was wondering what your Fairlane Health Care Corporation...

NELSON:

What they do?

That's our skunk works. That's the barn out in back where we develop things. We develop some home health care programs there. We have developed a very strong dialysis management and ownership program.

WEEKS:

Do you have mobile units for dialysis or is this all inhouse?

NELSON:

It's decentralized, not mobile. The dialysis is not mobile. We do home dialysis. We do a lot of home dialysis. We do acute dialysis in other hospitals, so I guess that is mobile. Then, we have a series of centers of our own. We have actually purchased some centers recently. We have developed what we think are competent management skills in that business and therefore have expanded it. Through the Fairlane Health Services we do that, we do

home health care, as I said, and we are doing some experimenting with other kinds of specialized services. We do some management consulting through there. Some.

WEEKS:

In home care do you use your own staff, or do you use the Visiting Nurses?

NELSON:

No, it's all our own. We have a durable medical equipment program. We have the typical nurse and other health people in the home care program.

WEEKS:

I want to ask you about Cottage Hospital in Grosse Pointe. I was a patient there years ago. Is that totally owned by your corporation?

NELSON:

Yes, it is. That was a merger. The thing we can't do is behave like corporations do when they have a merger. Hospitals are different, as you know. I asked one of our trustees who happened to be a director of the Excello Company. Textron took over Excello. I said, "How long did it take Textron to assimilate Excello?"

He said, "About two weeks."

You look at our assimilation of Cottage Hospital, it's been two years and we are just getting started. The politics are very difficult -- physician sensitivities, trustee sensitivities, management staff sensitivities, their reluctance to merge because they didn't want Big Brother to come in and take them over.

WEEKS:

The hospital was originally built for the people who worked in the big

homes rather than go to Ford, or Harper, or Grace. It developed into a good little hospital. I hope you continue to call it Cottage. The word "Cottage" refers to the English cottage hospitals, doesn't it?

The Kingswood Hospital. I am not familiar with that, but it is a member of your group, isn't it? In Ferndale, Michigan?

NELSON:

A psychiatric hospital. About 100 beds.

WEEKS:

You haven't gone into nursing homes?

NELSON:

Cottage has two nursing homes. So, we have two.

WEEKS:

I didn't realize you had gone into that business.

NELSON:

They have two nursing homes with 500 - 600 beds combined. So, when the merger with Cottage took place, we got in the nursing home business. We are now looking at some other opportunities. We are going to have to find somebody who knows how to manage them.

WEEKS:

This is a big field that is going to grow. If you ever want a consultant, I would recommend that you think about talking with Lloyd Johnson out in Ann Arbor who owns the Whitehall Nursing Homes. He also is on the board of National Medical Enterprises that owns and operates a large number of nursing homes. I interviewed Lloyd a few months ago. I was just amazed at the problems in the field.

Another question to do with the elderly: I don't suppose you have

considered going into congregate living.

NELSON:

We have looked into it. We have had a number of organizations come and ask us about it. We wouldn't rule it out necessarily. I don't think we would try to manage that piece. Congregate living has a nursing home component. That's what I think we would be interested in.

WEEKS:

The Hospital Corporation of America, or a subsidiary, bought one in East Lansing, Michigan. I went up to see it. I was quite impressed. The trouble is, although I am at an age when it would be good to be looking at this sort of thing, I am like nearly everyone else. I say, "I am not ready yet." People don't go in them as soon as they could. Maybe it takes a little marketing here to make it more attractive.

NELSON:

That's fundamental to congregate living -- good marketing.

WEEKS:

We haven't gotten to the American Hospital Association yet. Before we do there is a little more I hope we can talk about.

What is the Vital Care System?

NELSON:

That's a new company, a new program in an existing company, for self-transfusion of blood in a surgical procedure where the blood that is normally lost is cleansed and recycled, during surgery, minimizing the need for transfusions. With the blood scarcity we have today it's an increasingly important thing.

WEEKS:

How are you handling the blood transfusion and the blood purity factor now?

NELSON:

As an institution? We cooperate with the Red Cross Blood Bank. I couldn't tell you more than that.

WEEKS:

Red Cross processes all the screening and testing?

NELSON:

Yes, I think so.

WEEKS:

Today, you would do almost anything to avoid a blood transfusion.

NELSON:

Seems that way, doesn't it?

WEEKS:

Maplegrove, is that a...

NELSON:

A chemical dependency unit on the West Bloomfield campus. Very successful program. Something I brought from Minneapolis, really. Minneapolis was 20 years ahead of the country in this -- in recognizing the problem and in removing the stigma.

WEEKS:

How about insurance on this sort of thing? Some do, and some don't?

NELSON:

Yes. Blue Cross has done pretty well on this. That's important.

WEEKS:

The Howard Johnson building on West Grand Boulevard, I understand that has been taken over by the hospital. What is that used for?

NELSON:

We have our school of nursing over there, for one thing. We have offices there. We have a sleep disorder center there. I always thought that was ironic to have a sleep disorder center in a Howard Johnson Motel building. A perfect place, right?

WEEKS:

Do you do any dentistry other than dental surgery?

NELSON:

We have general dentistry in our satellites. We no longer have general dentistry on our main campus. We did up until a couple of years ago.

WEEKS:

I see that among your other honors you received the Gold Medal Award from the American College of Hospital Administrators -- now the American College of Healthcare Executives.

Shall we talk about the American Hospital Association a bit?

NELSON:

Let's do that.

WEEKS:

You were president -- chairman -- because you came after the change in title. I have a list of councils and committees you served on. Which were the ones that seemed most important at the time?

NELSON:

I suppose the Council on Financing was important. At that time it was

one of the more important and stronger councils. It was during the period when reimbursement and financing were on the front burner.

WEEKS:

What lies ahead for the AHA? The reason I ask this question is that I talked with Kenny Williamson about his days in the Washington office. He is now a consultant to many groups including your Voluntary Hospitals.

NELSON:

No, he is not a consultant for the Voluntary Hospital group.

WEEKS:

Isn't he? I think he is retired now, anyway.

The point he was trying to make was that he was able to set up an office, a consulting office, and represent groups in the health field that possibly were under the umbrella of the AHA or some other group such as that, but felt that the AHA could not be all things to all people. They might have some special problems, as I assume the Voluntary Hospitals feel they have special problems and need to lobby separately. Are these two organizations parts of a problem?

NELSON:

There is a problem all right. It has to do with the dispersion of interests. I think there are two parts to that problem. One is that there conceivably are some legitimate concerns from some constituent groups that the AHA cannot appropriately address. Our whole society is getting cut into smaller and smaller pieces. If you read Megatrends, you understand. There is some substance to the concept that all parts are breaking up into smaller interest groups. That is happening in hospitals too. So, there is some validity to that. There also, in my mind, is inappropriate desire on the part

of hospitals to somehow be represented in Washington. It's strictly an ego thing. It's an institutional ego thing. Do you follow me?

In other words, I had profound respect for the AHA Washington office. I have profound respect for it. I have watched it work and I maintain that they can cover 99% of what most hospitals need, a very high percentage of what most hospitals need. But there are a lot of hospitals that don't understand that -- hospital organizations. They think if they only had their own man in Washington, things would be different. There are enough lobbyists in Washington, people looking for work that know the Washington scene. They can gratify those institutions by saying, "You are right, and I am your man."

One thing Jack Owen has done recently, which I think is ingenious, is that he gathers all these different representatives once a week and they go through the agenda for Congress and the Hill. He sort of gives them the AHA position on this stuff and tries to get them marching in the same direction. This would all be unnecessary if these groups didn't have to have their own representatives down there -- most of which I think are unnecessary -- including the VHA.

When we started the VHA, one of the things we said explicitly was, "We are not going to be an advocacy group." I was the founding president of the Voluntary Hospitals of America. We ran VHA out of Henry Ford Fairlane Services for three years with the standing offer that they could take it when they were ready. About the three year mark I started doing this tour of duty with the AHA, the chairmanship thing, which you know is a three year tour of duty and demanding. I didn't have time to do the VHA thing. Three years later when I got back to look at VHA, they had a Washington office.

WEEKS:

I didn't realize that came about that way.

NELSON:

These are all my friends. I was not going to make a big stink at that point, but I did express myself. It was after the fact. That is a classic example. If VHA has one, AHS has to get one. If AHS has one, then someone else has to have one. There is a lot of ego wrapped up in organizational institutions -- organizational ego. We just got back from a conference. The Cleveland Clinic talked about their man in Washington. Mayo Clinic has their man in Washington. Most of it is just unnecessary.

WEEKS:

As you say, it is just an ego thing possibly.

NELSON:

In large part.

To some extent there probably are organizations that have special needs.

WEEKS:

Your original Voluntary Hospitals setup. I have never seen a list of the hospitals. Were they hospitals of your size?

NELSON:

They were 30 large hospitals congregated in the Midwest and the South -- voluntary, not-for-profit, sizeable, well-managed institutions. Those were the central criteria. We wanted administrators, CEOs who, in our terms, could "deliver" their hospital without going back to get a vote of confidence every time a new program came along. In other words, somebody who was willing to go up front and speak candidly and take risks. By and large we put those kinds of hospitals together in the original 30. We were restricted to 30 members

during the first couple of years because we incorporated as a not-for-profit cooperative in Illinois on the advice of our legal counsel. We told them what it was we thought we wanted to do. We said, "What is the best way to organize?"

They said, "A not-for-profit cooperative." That was restricted to 30 members in Illinois, where we were incorporated. Thirty was probably a good number to start with anyway.

WEEKS:

Was your original goal to exchange information?

NELSON:

Our original goal was to identify programs that kind of an organization could do uniquely or those kinds of programs that kind of an organization could do significantly better than any other organization. If that was one program or two or three, that was fine. That was about the extent of the concept going in.

WEEKS:

What kind of programs...

NELSON:

Would that be? It argues for selective aggregation of purchasing power, insurace, for example. Or maybe the creation of a self-insurance process. That would be a good example. We thought information exchange and data exchange at levels that had never been accomplished before would be beneficial. We saw the whole realm of information systems as an area of huge potential because everyone was going around inventing wheels or reinventing wheels, spending huge amounts of money, increasing amounts of money on information systems. We thought that was an area that had potential.

We looked at a long list recognizing that if we could only find two or three it would be worth our while. Our idea at the time was a relatively small, tight staff, highly focused on a few programs. When I came back from the AHA "wars" they were all over the place, doing multiple programs. They seemed to be swinging at every pitch.

WEEKS:

They had a Washington lobbyist?

NELSON:

They had a Washington guy lobbyist.

WEEKS:

Was this operation financed by dues?

NELSON:

It was financed in large by sale of shares as the organization grew. If you and I form a club and we can take in 10 new members every year and they buy shares in the club, we can live on that.

WEEKS:

I see what you mean.

NELSON:

That's been for the last five years or so. Subsequently they got some things going that are throwing off some money. Their purchasing program has some substance to it now. It's throwing off some money. That is something else we got into because American Hospital Supply -- Karl Bays came to us and said, "What is this you are putting together? we might have some ideas." We specifically said we were not going to be another purchasing group. The world has plenty of those.

We put together with American a concept we thought would do the thing

significantly better. That is to say, it was a partnership with American who was the biggest in the business. That's not the important part. The important part was that they manufacture 50% of what they distribute. If we could give them enough volume guarantee that it would improve their production and marketing and distribution, their planning and manufacturing costs then could be translated into savings. Aggregating purchasing you can leverage just so far. But this was supposed to go way back to the manufacturing process, you see. That was valid. I signed that contract with Karl Bays. That is the one we got sued on for anti-trust. I am sort of proud of that.

Along the way we said that if we didn't get sued, we were not doing anything. We made it. Incidentally the district court found against us, and the appellate court reversed the thing totally. So we were vindicated two and a half million dollars in attorney fees later, which we didn't pay. American paid that. It was a landmark case. Those are some of the things we were talking about. It's gotten a long way beyond that. I am not sure that everything we are doing makes sense any more.

WEEKS:

When you were chairman of AHA, did you go to Washington often to appear before committees or did you leave that to Jack Owen?

NELSON:

At that time Jack Owen was in Washington, Leo Gehrig before him, and Alex was president. Alex, you know, had a very keen sense of the political process, and enjoyed it, understood it, did it very well. I was a trustee at the time we bought an apartment in Washington for Alex.

You go back to Ed Crosby. Ed Crosby didn't like the political process, the Washington scene. He didn't understand it. It was repugnent to him. He

delegated to Kenny Williamson. Kenny would use the chairman and president for testifying and all that sort of thing. Alex preferred to testify himself. He was better at it than most chairmen would have been. So, it was a different game.

WEEKS:

Talking about Alex and Carol McCarthy now. Did you serve on the search committee?

NELSON:

Sort of. I missed a couple of key meetings.

WEEKS:

Why was she chosen? I would ask this question about anyone chosen. Considering the problems that are coming up now, fractionation and all.

NELSON:

Well, as I recall, the search committee came up with a short list of five names. A couple of those people disqualified themselves early so then there was a shorter list. We were supposed to come up with three names for the board. There were some names that I thought should have been on that short list that didn't make it. The search committee was a very large committee. It was wrong to have such a large group in my judgment. When I agreed to serve on it, I assumed it was going to be a fairly small group like it had been before. When Alex was nominated I think there were five former chairmen on the search committee. This time they had five former chairman and a cast -- there must have been 20 people on it. That's a hard thing to manage. It's hard to sort through a long list of names. There were a couple of names that never made the short list, that I felt deserved to be there. But, with that kind of a setting it was very hard to get the kind of outcome you would have

hoped for. So we got down to three names and I think Jack Owen was one of them. He was my candidate on the short list. Then Jack got sick.

WEEKS:

I didn't know that.

NELSON:

He had cancer. He was going through chemotherapy at the time they were interviewing, so then they went down to two names. The board interviewed the two candidates and Carol interviewed much better than the other candidate. That's why she was chosen.

She's very qualified. She's a bright lady. She handles things very well. My question was the degree of relevant experience she had going into the job. She would, as bright as she is, be capable of learning. I am not sure we have time to teach. She had just taken over the Massachusetts job, before that she ran a hospital council in Delaware which had some relevancy. If she had five or six years of successful managing in Massachusetts or California or Texas, I would have felt much more comfortable. Anyway, that's the way it went.

WEEKS:

I was wondering when you were speaking about this large search committee if, looking back at the McNerney-McMahon situation, if the Association was a little bit gunshy and figured they would cover all bases by having many interests represented.

NELSON:

That very well could be. I also think at that time there were some people who have this rather idealistic "democracy works at all levels and in all directions," idea. I don't happen to agree with that. I happen to think

what Ed Crosby and the guys did in the old days where they sort of went into the back room and came out with a candidate, like electing a Pope, worked pretty well. I think it worked pretty well. It was not democratic, but it worked very well.

WEEKS:

Jim Hamilton chose George Bugbee that way.

NELSON:

Is that right?

WEEKS:

Yeah. I know some of the principals who were being considered at that time like John Mannix of Cleveland and O.J. Pratt. Hamilton told the three of them, "We can't take Mannix because he is Catholic. We can't have a Catholic. O.J., you are a friend of mine, but you are too nice a guy. Bugbee is it."

NELSON:

It would be like Hamilton all right. And he would keep the other two as friends.

WEEKS:

He did.

NELSON:

You could be right. Maybe the search committee did look back and decide the way to solve that was have a large search committee. I think they missed it.

WEEKS:

In 1972 after Crosby's death everybody thought McNerney would be a shoo-in.

NELSON:

That was not the search committee's fault, I don't think.

WEEKS:

The search committee reported for McNerney.

NELSON:

I think the search committee did a good job. They were asked to come up with a candidate, if I am not mistaken. Which says something about this process. This search committee was asked to come up with three candidates to avoid the McNerney-McMahon situation. McMahon was not even considered at the time the last appointment was made. He was an afterthought, I think.

WEEKS:

The strange thing is that McNerney thought that if he left BCA to go to AHA that McMahon would be a perfect successor to him at BCA.

NELSON:

It's interesting, and I think a credit to each of those guys that it could have gone either way, and they would have remained friends. Walter is the closest friend I have in this business. I know that he held no grudge.

WEEKS:

He doesn't seem to.

NELSON:

Not at all. He is above all of that, as a matter of fact. He doesn't need to carry any grudges.

WEEKS:

He is a young elder statesman.

NELSON:

I am going back to the time it happened. As a matter of fact, shortly

after Alex got to Chicago -- I didn't know Alex -- Walter wanted me to meet him so he hosted a dinner, for Alex and his wife, and for me and my wife, and so on. It was very obvious that there was no hard feeling.

WEEKS:

I am sure there were no hard feelings.

There are a few more questions I would like to ask. Do we still have some time?

NELSON:

Sure.

WEEKS:

You have been a lecturer at the University of Minnesota, and the University of Michigan also, haven't you?

NELSON:

Yes.

WEEKS:

And president of the Minnesota Hospital Association?

NELSON:

Yes.

WEEKS:

A member of the Blue Cross of Minnesota board?

NELSON:

Yes, for a short period of time before coming here.

WEEKS:

Something I ran across. What is the National Chamber Foundation?

NELSON:

It's part of the National Chamber of Commerce. I think Paul Ellwood got

me into that.

WEEKS:

Wasn't he originally in the Sister Kenny Institute?

NELSON:

When we planned the Minneapolis Medical Center, he was the Sister Kenny representative. He was the CEO. He was an interesting guy. He is a good friend. We spent a lot of time together in Minneapolis. He has one of the more creative minds in that business. I always find him interesting, fascinating, stimulating. He was one of the members of the Minneapolis Medical Center, the coalition.

WEEKS:

Didn't both of you serve on the National Industry HMO Development...

NELSON:

Yes.

WEEKS:

Was that a committee or commission?

NELSON:

That was a commission. We tried to figure out how to promote HMOs in the world.

WEEKS:

He has quite a nice place out at Christmas Lake.

NELSON:

Yes, Christmas Lake.

WEEKS:

I talked with him two or three years ago.

What are hospitals going to do about low occupancy?

NELSON:

They are going to consolidate, they are going to convert.

WEEKS:

What I was leading into was questions about what is going to happen not only in hospitals but mergers in HMOs. Is this going to happen, among other things?

NELSON:

I think what you see is a classic situation of a new industry. Lots of entrants. Look at Chicago. A year ago virtually nothing, today 28 HMOs. Totally absurd. So the situation literally shouts for consolidation. There obviously will be some that will fall by the wayside, others will merge, some will be bought out. If you look at the Twin Cities again, the pattern that has evolved there might be the model for most communities, for they seem to be 15 years ahead of most other communities. There are three dominant HMOs there now. There are a couple other niche HMOs. That probably will be the pattern. I think that will happen in Detroit.

WEEKS:

Do these HMOs in Minneapolis fit in with the multihospital systems?

NELSON:

There is no coordination. It really doesn't because the HMOs run across grain unless consolidation is happening up there. Mostly, I think because the hospitals did not sponsor the HMOs. They just never did. If you go back to the Group Health Plan up there, that's an old, traditional HMO. That's been around for 30 years, and had very modest, slow growth appealing to a very narrow part of the market. In the late 1970s it, along with others, began to grow. It has become a dominant player up there.

In any new industry you see this growth, lots of entrants, consolidation, and a settling down. Another thing I think will happen: first of all, Blue Cross was a little late to the party. They have such a strong base that they will emerge as one of the dominant players across the country in that business. Now that the Plans have figured out they must get in it or they are going to lose their share. So they will be one of the dominant players. Some of the large insurance companies will be as well. It takes the kind of resources those big organizations have: management resources, deep pockets. It is interesting to watch the Aetnas and the Prudentials and the Cignas and those people. They have sort of figured out that if they are going to be in the employee benefits business they have to have this component. I think they will be among the dominant players.

WEEKS:

What do you think the future of Kaiser is?

NELSON:

I have a profound respect for Kaiser. I think it is well managed. I think they have been very, very prudent, cautious in their growth. I think they could have had much more spectacular growth if they had chosen to do so. They have not outrun their supply lines. So, I would put my money on them as one of the continuing major players. I don't know that they will ever reach the level of domination elsewhere that they have in California.

WEEKS:

That's a pretty good situation.

NELSON:

That comes from a 20 years head start. They seem to be doing well in a number of markets.

WEEKS:

They are spread out in eight or ten different markets, aren't they?

NELSON:

Yes.

WEEKS:

I was interested in talking with Sam Shapiro about HIP in New York because I understood that Kaiser had approached them about merging or buying them out, or whatever. Apparently that didn't happen. In reading a little further I discovered that one of the original organizers or incorporators of HIP was Henry J. Kaiser.

NELSON:

I didn't know that.

WEEKS:

That was astounding to me. I didn't know he was one of the first corporate members or organizers.

Does your HMO take Medicare patients?

NELSON:

We have done that. We have done it modestly. We have done it to try to understand that part of the market. I think we have six or seven thousand subscribers. We are not pursuing it aggressively because we have not done real well with it. We are not quite sure where the government is going to go with it either. They do very strange things, you know. I would hate to be dependent on that, for that part of our business, because you know the government can change one regulation and put you into trouble. We have experimented with it; we have done it, and we are still selling it.

WEEKS:

Can you break even on it?

NELSON:

Initially we did quite well with it but there has been some adverse selection in our case that we don't fully understand.

WEEKS:

Maybe you have too good a reputation.

NELSON:

I don't know. If I were a Medicare recipient, I think I would go for it. If for no other reason, just to simplify the paperwork. My parents, both of whom are dead now spent the last years of their lives doing paperwork on Medicare. It was a constant job. Being in the business I was able to refer them to some sources for help. They still had a terrible time. So, if nothing else, if it simplifies that paperwork, it's worthwhile. If you can tie into a good system, then it's worthwhile.

WEEKS:

There have been some unhappy experiences with HMOs trying to take Medicare patients. Some have not wanted to renew contracts.

NELSON:

There have been some disasters.

WEEKS:

One thing I keep thinking about, and I know it is unpopular. I am wondering if we aren't going to have to come back to a means test someday. For instance, if I can afford to pay, shouldn't I pay? I realize there is an insurance type of situation here where if I am paying premiums I should get some benefits. I am wondering if the day isn't coming when we will have some

kind of means test. We will find another word for it. That word would never go.

NELSON:

I wouldn't be surprised, it's obvious we are going to have to find new sources of revenues.

WEEKS:

We are getting a little of that change and I don't think most of us realize it is happening, or what is happening. For example, on the monthly Social Security payments if my other income is above a certain point I have to pay some tax on my Social Security payments. If my other income is below that certain point, I don't pay any income tax on my Social Security payments. This is sort of a means type of thing.

NELSON:

Or if you continue to work after 65 you don't get the total Social Security payment.

WEEKS:

I worked until I was 68 then I left the university. I have been doing things, made a little income here and there, since then so I don't feel badly about paying a little extra in taxes.

NELSON:

Better than not having to pay them. I have always felt that about those people who have tax problems. I always thought those were the kinds of problems to have. Better to have tax problems than income problems.

WEEKS:

I don't know how much you know about it, I know very little, but Hospital Corporation of America broke up last week.

NELSON:

They proposed to sell off a hundred hospitals.

WEEKS:

A hundred hospitals. A new corporation is being set up for certain employees to take over the 1ØØ hospitals they are serving. The money for the purchase of these hospitals would come from an ESOP loan out of the pension fund. I am just wondering how this is going to come out.

NELSON:

Sounds like voodoo, doesn't it? I don't know anything special about that. I have a similar reaction and lots of questions. I surmise that the HCA company is looking to do two things. One, to sell off some of their less attractive hospitals, and secondly, and more importantly, reduce some of their debt. They are highly leveraged. They have three billion dollars in debt, or something. If they could reduce that to two billion and keep their cash flow pretty close to what it is, that's an improved condition on their balance sheet, and on their operating statement. That was my conclusion. That high finance eludes me sometimes.

WEEKS:

Apparently through ESOP they can get a better interest rate than they could if they borrowed it some other way.

NELSON:

I am not sure that is the way I would want to invest my pension money.

WEEKS:

I am not sure how those ESOP funds are insured; I am not certain about that.

We have come to a point now where we have all these HMOs who have

approached hospitals and have said, "We will send you patients if you give us a lower rate." Have we reached the saturation point now, pretty well? How many more hospitals can be helped?

NELSON:

How much help do you need? I don't know that we have reached the saturation point. I think you lose the effect of that process of the HMOs bringing patients here. It's dissipated pretty fast. I was talking to someone recently out of the Los Angeles area. They had something like 5Ø or 6Ø different contracts -- PPOs and HMOs. They will sign up with anybody, obviously. That means there is no leverage, because the market is so divided that nobody has any particular leverage. At the other end of the scale was in Delaware where there was one hospital, and an HMO came looking for a discount. The guy said, "Why?"

They said, "Because we are bringing you these patients."

The guy said, "I have got them anyway. Where are you going to take them if I don't take them?" That's the only restraint.

I would guess that the Minneapolis situation is one that would be the toughest on the hospitals. Three or four HMOs have a big piece of the market, and they can really direct traffic. They are doing that up there. So, that is probably the worst of all worlds as far as the hospitals are concerned. The fact that the providers have lost control, or are losing control, is pretty evident. During the wonderful era of cost reimbursement in the 196Øs and 197Øs, the doctors and hospitals pretty well controlled the system. It is pretty obvious now that Medicare, HMOs, big employers are driving the system. It is not as much fun.

WEEKS:

I don't suppose it is.

You don't have any new ideas on cost containment?

NELSON:

No. I don't think you are going to reduce costs, if that is what you mean by cost containment. I think the system is responding appropriately to economic incentives. That's why we have a third of the beds in this country empty. The system has responded to the economic incentives. I think one thing we have demonstrated in the last few years is that this system responds like any other industry. When based on costs, we expanded the system. The incentives were to expand the system, and we expanded the system. Now we change the incentives and we are reducing the system and converting and shifting care out of the hospitals. I don't think we will reduce the money we spend, the percentage of the GNP, for health. We will spend it in different ways. Our ambulatory care system is a hundred million dollar business. The satellites alone are a hundred million dollar business. I think that is a pretty efficient delivery system. This monster here (the main Henry Ford Hospital) I don't think is particularly efficient. we have all the inherent inefficiencies of a large place, in an inner city, with teaching and research, and all that goes with it. We probably have more security officers here than most cities of 40,000 people. There are social costs that go with a place like this. Maybe this place won't survive as we know it, but the other parts of the system will. That is cost containment, I think. It's driving efficiency into the system. That's probably what changed economic incentives will do. It will drive efficiency into the system, at the expense of something we have known traditionally, and have enjoyed, and we like. I am

trying to remove myself and our institution from the scene when I say these things, because we could be part of this, be one of the victims by virtue of our location.

One of the reasons our satellite system has worked is that they are manageable. One of the classic questions in this business is: What is the optimal size of a hospital? I have said, "I don't know what that is but we passed it a long way back." This is too big. We are too big.

WEEKS:

They used to say that 300 or 400 beds would be a perfect sized hospital.

NELSON:

As technology increased that kept rising. Even so, this place is too big.

WEEKS:

Yes. So is the University Hospital and so are all these other big hospitals.

NELSON:

I would go to the university for a transplant or some exotic thing that they can do better than anyone else. And I'll come here for that. I have told our own doctors that if I need a routine procedure, I'll go someplace else.

WEEKS:

Do you think specialized hospitals are coming back?

NELSON:

They seem to have. Maybe that is part of what we are talking about. Maybe you can do some specialized services in a highly focused way more efficiently. We are looking at eliminating some services. There was a time

in that wonderful era of cost reimbursement when you could do anything and everything for convenience purposes, not for efficiency or economy, but for convenience. Maybe we can't do that any more.

WEEKS:

I am wondering what you see down the line. Someone was saying the other day that we should not forget that national health insurance or service may be just across the horizon. Do you think it is coming back as a serious issue?

NELSON:

You made a remark earlier about missing the mark on Medicare. I think that experience probably shut off the serious consideration of national health insurance more than any other single event in my lifetime. Look at Congress now. They are so gunshy of any new health program.

WEEKS:

We shall have to wait and see how events work out.

Time is racing by. Thank you for the interview. I enjoyed talking with you. I could go on listening to you for several more hours.

Interview in Detroit at

Henry Ford Hospital

on June 11, 1987

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