HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Russell A. Nelson

RUSSELL A. NELSON

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Russell A. Nelson, M.D.

CHRONOLOGY

1913	Born Grand Forks, ND, May 13
1933	University of Minnesota, A.B.
1933-1935	University of Minnesota Medical School
1937	Johns Hopkins University School of Medicine, M.D.
1937-1944	Johns Hopkins Hospital Successively intern, assistant resident, and resident in medicine.
1940-1943	Johns Hopkins University School of Medicine, Instructor and Assistant Professor of Preventive Medicine.
1943-1947	Johns Hopkins University School of Medicine, Assistant Professor of Medicine.
1945-1952	Johns Hopkins University School of Medicine, Director of the Medical Clinics, and Assistant Director of Johns Hopkins Hospital.
1947-1952	Johns Hopkins University and Johns Hopkins Hospital, Assistant to Vice President Dr. Lowell Reed.
1947-1952	Johns Hopkins University School of Medicine, Associate Professor of Medicine
1952-1973	Johns Hopkins Hospital, Director, Executive Vice President, President.
1952-1955	Johns Hopkins University School of Hygiene and Public Health, Adjunct Professor of Public Health Administration.

1955-1957	Johns Hopkins University School of Hygiene and Public Health, Lecturer of Public Health Administration.
1972	American Hospital Association, search committee for successor to Dr. Crosby.
1973	Josiah Macy, Jr. Foundation study of governance of voluntary teaching hospitals.
1973	Nuffield Provincial Hospital Trust, London, Fellow.
1973	World Hospital Federation, Rene Sand Lecturer.
1974	American Hospital Association, Hospital Research and Educational Trust, Commission on Public General Hospitals.

MEMBERSHIPS & AFFILIATIONS

Advisory Committee on Urban Health Affairs, Member, 1963

American Association for the Advancement of Science, Fellow

American College of Physicians, Master

American Hospital Association, Life Member

American Hospital Association, President 1959-1960

American Medical Association, Member

American University of Beirut, Consultant, 1966

Association of American Medical Colleges,

Executive Committee, Chairman 1970-1971

Baltimore Hospital Conference, President 1953-1955

Blue Cross Association, Board Member 1959-1962

Blue Cross/Blue Shield of Maryland, Board of Directors, Member

Commercial Credit Co., Board of Directors, Member

Control Data Corporation, Board of Directors, Member

Federal Hospital Council, 1962-

Free University of Berlin, Consultant, 1958-1964

Hospital Council, Inc. (Baltimore), 1955-1956

Hospital Council of Maryland, Inc., 1961-

Joint Commission on Accreditation of Hospitals, Board of Commissioners,

Member, Chairman 1961-1962

Leiden Hospital, Holland, Consultant

Maryland Hospital Association, President 1956

Maryland Tuberculosis Association, President 1952-1955

Maryland-District of Columbia-Delaware Hospital Association, President 1956-1957

Medical and Chiurgical Faculty, State of Maryland, Member

Mercantile Bankshare Corporation, Board of Directors, Member

Mercantile Safe Deposit & Trust Co., Board of Directors, Member

National Academy of Science (National Institute of Medicine), 1974

Nuffield Provincials Hospital Trust, Consultant, 1973

Office of Emergency Planning, National Health Resources Advisory Committee, Member 1962

Phi Beta Kappa, Member

Phi Kappa Psi, Member

Phi Lambda Upsilon, Member

Pritchard Health Services, Board of Directors, Member

Rockefeller Foundation, Consultant, Bangkok, Thailand 1967

Royal Society of Medicine, United Kingdom, Senators Javits and Anderson's private Committee on the Care of the Elderly, Member

Social Security Administration, Health Insurance Benefits Advisory Committee, Member 1965-1970

U.S. Public Health Service, Study of USSR hospitals, 1965

AWARDS

American College of Physicians

Master's Award, 1973

American Hospital Association

Distinguished Service Award, 1964

Johns Hopkins Hospital

Distinguished Service Award, 1973

University of Miami

Doctor of Science (Honorary), 1975

University of Minnesota

Distinguished Alumnus Award

WEEKS:

Dr. Nelson, as we said before we started taping, this is sort of an autobiography of yours which will probably help a lot of people learn about the hospital business. I note that you spent your first two years of medicine at a medical school at Minnesota and then you came down here to Johns Hopkins. How did you happen to transfer? I am always interested in why people do things.

NELSON:

I was born in North Dakota and had my secondary education there. I went to the University of Minnesota for my baccalaureate degree in chemistry. I had the great good fortune of going to that university in the depths of the Depression -- it was pretty hard to make a go of it. I had my eye on going to medical school for a number of years, though I don't think my father, who was a country banker, thought a whole lot of that idea -- but it stuck with me.

On the advice of some local doctors in my home town in North Dakota when it came time to apply to a medical school -- they just pressured me to apply at Johns Hopkins, which I did in 1933. To my surprise I was quickly accepted, and at the same time was informed that the tuition was $650, which is interesting compared to today. Well, to shorten a long, tough two summer months -- my family and I concluded that was too expensive. So I regretfully declined the appointment here and applied to the University of Minnesota and was accepted there at a much reduced tuition.

I spent two years there, the first two basic science years. There were about six of us in that class that were disturbed by the prospect of taking our clinical education in Minneapolis. As I reflect back on it, it was one of the times when there was a town-gown conflict and the faculty at the

university which was mostly — and few in number on a full-time basis -- were not accepted by the practitioners and there was a hemorrhaging of good talent out of that clinical faculty. So about a half a dozen of us decided to transfer into another medical school. Two of us came here to Johns Hopkins. I started here fifty years ago this fall and got my M.D. degree in 1937.

So I left Minneapolis because of the conditions in the faculty, as I perceived them, and I declined to come to Hopkins in 1933 because it was too expensive.

WEEKS:

I think it was probably a wise choice coming here. You spent all of your professional life here, haven't you?

NELSON:

My entire professional life from that day until now.

WEEKS:

I was interested in reading something about your career. The statement was made that you successively were intern, assistant resident and resident. I hadn't heard the term assistant resident before. Is that different from other schools or hospitals?

NELSON:

No. It was the standard nomenclature of those days. It has now changed. But Johns Hopkins Hospital, although there is some friendly dispute with some of the hospitals in Boston and New York, is credited with starting the residency system for graduate training in this country. It was a progressive set of experiences and duties and responsibilities. The low man on the totem pole was an intern and then the next rank was an assistant resident. Normally that was held for two or three years. Then there was often an interval of

leaving the clinical wards and going into one of the research teams as a research assistant or a fellow. Then capping it with a year or more as chief resident.

As chief resident on the internal medical service in this hospital we really were the number two person in the day-to-day operation of patient care, serving under the one single professor in each department. Professor, chairman of the department -- this was a Germanic hierarchy which this school and hospital adopted. As I reflect back on that -- and I might say I spent a total of six years in that kind of training -- it was the most stimulating and the most rewarding period of my educational life. It was just tremendous. The technology in medicine was just infantile then but it was an enormously profitable and stimulating experience.

We lived in the nature of a monastery almost. For instance, we were not permitted to be married -- by rules of the hospital -- though there were ways as you might expect. But that was the nature and viewing of the setup. That's the origin of the nomenclature. And it stayed that way until maybe the last fifteen years. I think the remarkable feature of the training was that vast clinical resource. The importance of the emerging laboratory medicine -- very early. The commitment by the professor and his associates, who were full time, and the subtle but clear way responsibility was devolved from supervisor to assistant to low man on the totem pole. You were given responsibility just as fast and as much as you could take.

WEEKS:

When you were talking about the laboratory I was wondering whether Simon Flexner had any influence on that in his earlier years -- and some of the other men. But I'd like to discuss with you later -- I've made a list of some

of the men that either were here when you came or you certainly knew about them after you came.

You were also holding several teaching positions. I noticed that you had appointments in both the medical school and the school of public health. And you continued teaching until after you became director. Another position that I wondered about was -- I have you listed as Director of Osler Medical Clinics. Is there any special significance in that other than it was named after Osler?

NELSON:

I think that is a mistake. Let me back up and say that all that residency training was in the Osler Medical Service. It was named for Sir William Osler who originated the service -- a great teacher. That was all in-bed patients and I was not the director of that. The professor/chairman of the department was the director. The later title, and it came quite a bit later, was Director of the Medical Clinics without a personal name on it. And that is really the outpatient section of the department of medicine.

WEEKS:

I see. At the same time that you were the director of the medical clinics you were also Assistant Director of the hospital, weren't you?

NELSON: That's true.

WEEKS:

Was this under Dr. Crosby, or was this before?

NELSON:

The initial appointment was under Dr. Winford Smith and it was about a year perhaps before Dr. Crosby succeeded Dr. Winford Smith.

WEEKS:

Then I also have you listed as Assistant to the Vice President of the University, Lowell Reed.

NELSON:

That's right, sir.

WEEKS:

What sort of work did you do with him?

NELSON:

I think I would like to expand a little on the progression from my clinical and research days into my administrative functions.

WEEKS:

This is going to be an interesting development to me.

NELSON:

I might say that in that entire period it was a slow transformation and all of my professional colleagues I had known in training and on the faculty always thought I was making a great mistake. In those days going into administration was considered careers for people who couldn't make it in clinical or academic medicine. I was unimpressed by the point of view though I didn't like to take the criticism of my friends because I didn't think it had substance. In about 1940, after I had three years in residency training, I made that move into a research structure that I referred to.

I joined the faculty of the brand new Department of Preventive Medicine. I wasn't burning with a future in preventive medicine at that point but I was terribly interested in the research work that one of the faculty members was doing. So I went with that new department to do my research work on streptococcal infections. We moved from the hospital to the School of Public

Health just to get a place to live as a department. Since the curriculum in preventive medicine was being constructed then and it was thought highly desirable that biostatistics and epidemiology be included for the instruction of medical students, we, who were new in the faculty of preventive medicine, were pressured into taking those courses in the School of Public Health. Fortunately, we did it, because I enjoyed it very much. I might say it was the only part of public health that I really enjoyed because it had a logic and science component to it that I liked.

That brought me up against Dr. Edwin Crosby and Dr. Lowell Reed. I had no idea what that future was to bring at that time. Lowell Reed was head of biostatistics and I was impressed with him as a teacher and as a man. Crosby was a young graduate student at that time in biostatistics. That kind of opened up a different area of medicine for me, and I began to accept appointments on small but, seemed to me, interesting committees that were studying this medical records or laboratory reform. You know how they blossom, those committees. I found I liked that work. Ultimately, Dr. Winford Smith, I am sure on Dr. Crosby's initiative, invited me to -- as he said -- do some work in the outpatient department. Well, that led to being in charge of the outpatient department in those days.

The School of Public Health, the School of Medicine and the hospital all have a common name but an individuality which is expressed in their programs and in their feelings about turf and a lot of other things as any university does. But I had the advantage, as I look back on it, of being active in the administration of the hospital, the medical school -- I never was given the title of Assistant Dean -- but I did a lot of that work. And I was on the admissions committee. Then later I was in the School of Public Health, not as

an administrator but as an adjunct professor. So I had those three areas of exposure.

This brings me back to your question about Reed and remind us of the statement of the three independent units here all with the same name and generically identified as one by anybody except those of us who are working here. There was inevitably a difficulty in meshing the programs of the School of Medicine and the hospital on local, national and international issues. The founder of these institutions was Dr. William Henry Welch who was the initial pathologist. He was 'pater familias' for years and years. Don't even know what his title was -- didn't make any difference. What Popsy thought was right, was done. He bowed out of the picture in the 1930s. He died. From the 1930s until the mid-1940s there was no central office here, each was kind of going its own way. It didn't blow apart but it wasn't running smoothly. And Reed was then Dean of the School of Public Health. The president of the university felt that he needed a person down at East Baltimore -- as the medical center is called -- to represent the university interests firsthand. I believe there were considerations of making Reed vice president of the university and the hospital. But Winford Smith was of the old school and he thought there was no point in having a vice president and he felt it wasn't good to have the university get a little bit more power in that hospital. He treasured the independence of the hospital. So Reed started out as Vice President of the University.

He is an analytical kind of fellow. He was also a Yankee who got things done by discussion and persuasion and infinite patience. He would have been a good fisherman. He was a good fisherman, as a matter of fact. He began to pick up the threads of what this whole thing was about. He needed help. He

came to me.

I had just finished my residency and had done some work in the outpatient department. I started out with him as sort of a gopher-boy. Along the way I became -- I have forgotten what my title was, as a matter of fact -- but I became his chief assistant. We were most concerned about developing structures that brought the three institutions closer together primarily for the development of realistic and, hopefully, the best kind of plans for all of them. So it was kind of a planning opportunity.

WEEKS:

Someone has told me that Dr. Reed was sort of the founder of biostatistics in this country. At least he trained a lot of people who became leaders in that field.

NELSON:

I think that's fair. I don't know about the founding -- I don't know much history of that. But he was the dominant person in the 1940s and 1950s.

WEEKS:

You have seen a lot of changes in the hospital's role in the community I am sure. Would you like to talk about those or would it be better to talk about the university and hospital's outreach into Columbia and into East Baltimore prepaid plans. How would you like to discuss those years of change?

NELSON:

Well, I think it will make more sense to me if I go back to the founding of the full-time medical faculty system at Hopkins. As you know, that was started here. It was one of Dr. Welch's contributions, supported for the day -- handsomely -- by the Rockefeller Foundation. The idea was a simple one. The professors that were responsible for the teaching of the students and the

conduct of research should be like professors elsewhere in the university. They should not be diverted from those duties by the necessity to practice medicine to support themselves and their families.

We started here with, of course, the basic science departments. Then it was medicine and surgery and psychiatry and pediatrics as the starters. That developed over the years against considerable resistance by the local practicing profession, by the good clinicians who were bringing patients to the hospital as attenders -- and were voluntary teachers, good ones. They viewed this as an incorrect move. The debate at Hopkins, in contrast to what it was in some other places, was not primarily that full-timers are competitors in an economic sense to those of us who were out in independent practice. There's a few and they were not the kind of people that would be aggressive in a clinical practice anyway. It was an ideological debate. It was based on the premise, really, that medicine is primarily an art which has to be learned at mother's knee, so to speak. And it has to be done by people whose intense commitment is to the treatment of patients. They really were saying that to devote yourself primarily, or maybe even exclusively, to teaching and research was to discard and denigrate this particularly important part of medicine.

Well, that went on and on and on from 1913 until today. Though I must say the full-time system is pretty well established every place now. There is not an argument there. But it colored the development of the role of the hospital in the community in more recent years. Earlier, the hospital was a privately owned, privately financed, public institution. The door of the hospital was open to the poor people. That was its primary function. The pay patient was reluctantly brought in. The history of Hopkins is beautiful in

that sense. Really it is worth a book in its own. As time went on and insurance became available, the hospital began to move from primarily indigent into a mixture -- which it still is. The old-fashioned true, uncovered indigent is pretty hard to find now.

Well the faculty in medicine -- full-time faculty -- was growing slowly. But with the development of the National Institutes of Health it just boomed, boomed. The faculty went from the totals in the forties or fifties into the six hundreds. These brilliant, active, young academic physicians and scientists were competing in this research world. They were driven by their own research impulses. There were a number of us who felt that this was getting out of balance. The total role of medicine was getting perverted a bit. Furthermore, and more pragmatically, the future was going to be pretty hard to support on that basis. We could foresee the drying up of NIH grants. They didn't dry up but they sure slowed up. Once you slow growth, you've got problems.

Then we started to re-examine the role of the hospital among hospitals and among medical practitioners and community and public health. We had the whole bit we were looking at here in Maryland. Maryland had a good public assistance program, one of the finest state health departments at that time. There was a lot of excellent dialogue about what this should all be or where we ought to be kind of moving towards. It sort of capped in my period with the development of the Columbia Project. We saw the great desirability of making an HMO a part of an institution like Hopkins. It would be very good for Hopkins. It would add that piece that we felt was missing. That is of real community care. And we thought it would be good for the community as a whole, not only Maryland but nationally, if a prominent hospital and academic

medical center put its commitment to this development. Well, this all succeeded in part. Nothing ever succeeds in whole. There was a tremendous and profitable debate inside those buildings. Because the more academically inclined members of the clinical faculty -- the researchers -- said no way. There is no university function to go out and just be in the commerce of medicine, as they put it. Which I think was an over/understatement. The public health types were saying oh, it's the future. We had long evening meetings -- open to the whole faculty. In my experience, it was one of the most beautiful demonstrations of a faculty in debate. It was not bitter, somewhat heated. Enough passion in it -- you knew where things were. But it was beautifully done.

In the end the boards of trustees, who were waiting for medical leadership, agreed that they would make an effort but they wouldn't put a whole lot of money in it, because money was hard to come by and it was a risky thing.

It started out like gangbusters. It didn't do as well as it should have done because basically those clinical practitioners on a full-time basis -- even those who were rattling the cages and saying let's go -- turned out that they didn't really put the shoulder to the wheel. You know, it's a good thing for somebody else to do. To my surprise and real regret it got zero leadership from the School of Public Health, which I thought would be just a tremendous laboratory for the school. But that led to an engagement with the local community here, primarily black, who had been agitating in the 196Øs -- as they were in all cities -- and some pretty, shall I say, radical leadership. They had some friends in the faculty here that said you are going out to Columbia where folks can pay for their care. We don't worry about

that. It's the folks who can't pay for it. So we started a little one in town too. Strangely enough that's the one that has been prospering. Columbia prospers and it is doing well but it is not hooked to this place like it should be. It doesn't help this place and we don't help them.

WEEKS:

Did you have a satellite out there?

NELSON:

Yes, we built a hospital out there. But it's an independent hospital. That whole debate and those times loosened Hopkins from its kind of hidebound traditionality. And we started slowly along a path of opening it up. This building was built -- the doctors' offices. We now own the city hospital. We own this medical plant in East Baltimore. We've got a strong affiliation with a new Catholic hospital. We've got corporations upon corporations that are redeveloping parts of the community around here with investment money. So Hopkins is on a path now of being a center force in a greater community than here -- building what I think is going to be one of the medical and health care organizations of the future. It's going to be a group of institutions, a grouping of professions and supporting services of all kinds. I could say it's the hospital of the future but that's too narrow. If that word gets used too much it's going to hurt the development. Similarly, if you say a community health service, it's going to hurt the development. I prefer to say it's a medical and health organization.

Central to it is going to be the practicing professions who are coming more and more into an organized mode. I speak particularly of the physicians and the nurses. If we can keep that moving the way it seems to be moving now and guide it into something other than elitism we will have some interesting

organizations it seems to me.

I see it as the only way we can rationalize health care to the people who have got to be awfully confused now. And the only way I can see any way of achieving some degree of efficiency of economy. If we were permitted to go on the way we're going on it will just be utter chaos. They will all be public institutions. That's the story.

WEEKS:

May I ask you a couple of questions for the historical point of it? Columbia is a community of what, forty thousand?

NELSON:

I think a little more now, fifty maybe.

WEEKS:

And you have gone in there with a prepaid HMO type practice so that they get complete service -- hospital, doctor's office, the whole thing. Now is this a separate corporation?

NELSON:

Yes. There is a hospital corporation; there is medical partnership and there is an insuring corporation.

WEEKS:

Something like Kaiser's set up.

NELSON:

Yes. Hopkins started it all and Hopkins still has influence in it but it is largely a self-going thing.

WEEKS:

How about the board of directors, how are they chosen? Do you have a board for each one of the three groups?

NELSON:

Well the doctors' partnership is their own. The insurance agency, I think was Connecticut General. The hospital has a board and then I think there is something known as the planning board. I don't think it's an authoritative board. Through that the hospital gets board membership from the local community. There is a representative mechanism for appointment to that.

WEEKS:

Then the physicians who work in the medical partnership work on a per capita basis and they have some arrangement of sharing in the profits.

NELSON:

They divide them up themselves.

WEEKS:

Now East Baltimore, is that a different type of set up?

NELSON:

Yes. Right now it is totally Johns Hopkins, owned and managed. As a matter of fact, the seventh floor of this building is being reconstructed now to be the headquarters for something known as the Dome Corporation. That's a for-profit organization, corporation, set up to manage a lot of the outside activities. The Baltimore Health Plan is at this moment under that Dome Corporation.

It started out with the black population saying, "You ain't gonna run my plan. This is our plan. We're gonna build the building. We're gonna get our doctors." We had great apprehensions about this but said okay. We had two seats on a board of twenty-two. That was the black's definition of fairness -- I don't blame them.

But they couldn't manage it.

WEEKS:

The twenty others probably hadn't had much experience in health administration.

NELSON:

Not much -- they were people from the streets almost, there were school teachers. And they got bad staff. The blacks viewed that as much as a job opportunity for the public in this part of town as it was a health care organization. They wanted everybody to get a job.

Well, in spite of federal subsidies and city subsidies, they got bad management and went broke the first month and never got out of debt.

WEEKS:

In the present set up -- what about the indigent? How are they taken care of?

NELSON:

In the HMO here? By capitation grants from Medicaid program.

WEEKS:

You actually worked out a good plan with Medicaid then.

NELSON:

Well, it's all subject to appropriations.

WEEKS:

I know they are trying in other parts of the country to work with Medicaid and I don't know if they have been successful everywhere.

NELSON:

No. Well, they have had a lot of trouble here. But I think it's been going now -- before I left here. It was started while I was still here.

WEEKS:

Do you have large employers who have their people enrolled?

NELSON:

No. There is not much large employment in this part of town, except the hospital. I understand now that the hospital has a labor union, 1199, and the membership there is 95% black and an awful lot of them live here. I understand that negotiations are in process or may even have been concluded that this health plan will be the agency for the delivery of health care to the union members of this hospital.

WEEKS:

Wonderful! I interviewed Leon Davis, the founder of 1199, and I think he's a good man. He's idealistic. But I think he's a good man.

NELSON:

I was here when they organized. We had a bitter time because they brought in a black shouter and hollerer to organize it and he got everybody in East Baltimore mad, particularly the more conservative elements of the hospital. Thank God for a man that was Leon Davis' agent here. I have forgotten his name.

WEEKS:

Would it be Nicholas?

NELSON:

No.

WEEKS:

Nicholas is in Philadelphia now and is the head of...

NELSON:

This man died shortly after he was here. He was an old line labor

organizer from New York City who knew the name of the game and was a fairly responsible guy. And we were able to deal with him in the final analysis. And the organizer who became president, of course, within two years was thrown out because he was corrupting the finances. I think it's interesting that the employees there will become part of the HMO.

WEEKS:

Yes. This is good.

Talking about HMOs and hospitals, maybe this is off the chronology but have you thought much about Blue Cross in Cleveland going to the hospitals and asking for contracts at lower inclusive rates?

NELSON:

No I haven't. I don't know about that as a matter of fact, but I do know that there has been a controversy here in this state. Blue Cross is a development in Maryland in my professional lifetime. It was started as one of the more idealistic plans and the late Doug Colman was the head of it for a long time.

WEEKS:

Before he went to New York?

NELSON:

Yes. He was one of my close friends. We studied statistics with Lowell Reed together. As an aside -- at one point, I guess it was 1970 or 1971, I found myself being asked to give the eulogies of three dear old friends and professional colleagues, Ed Crosby, Doug Colman, and Jack Masur. They called me about Ray Brown's death and the service they had and I said, "Look, I'm kind of drained from eulogies and I don't want to get to be known as the eulogizer of the world and there are others who were even closer to Ray

Brown."

Back to Blue Cross. Here -- I've got to tell you this because it's terribly important to what I saw as what had to be done to try to contain costs. I had to appear on behalf of Blue Cross at a public hearing in 1959 in Baltimore to defend Blue Cross' need for a rate increase and specifically to describe the rising costs of hospital care. The daily cost was then about eighteen dollars. From that point on there was a continual activity. Having had to do this in the public I decided there's something wrong. They have got to do something in our community about these hospitals. They are all independent as they can be and Blue Cross was having an awful time with them.

So that started the long activity of the local hospitals and the local hospital association. Now, there was no state hospital association, there was no city hospital association. There was a regional one that had a convention and didn't do anything. About half a dozen of us started working on it and it gradually went from an informal arrangement to a state hospital association. We did a lot of things. The most important of which -- preceding the most important -- was that we agreed to establish an agency with Blue Cross and the State of Maryland and the hospitals, typical Maryland way, called the Hospital Cost Analysis Service. That was, in bottom line, an agency that would permit the gathering of what was then existing of financial statistics in hospitals.

We gradually began to move them into some sort of rational tabulations and the cost per patient day began to appear in the public. I had to make the decision one day as to whether we would release to the newspapers a listing of all the hospitals in Maryland, alphabetically, with their cost per patient day. Believe you me, I was not going to be elected anything that next week. Well, they got used to that. That didn't bother them too much.

Well, that wasn't enough, ultimately, because the risk wasn't -- people would say, "That's fine. You're publishing all this material, you're gathering it, but you're not doing anything about it. There's nobody that's going to look at all of this." So three trustees and I agreed and we just had to plain get together and plan state legislation. If we don't, we are going to get something from the feds and it's going to be awful. This is 1967-68.

Maryland is the kind of state that governs itself. Hospitals are enough together now that we can set up something here. We went to the state legislature which was holding annual hearings on hospital appropriations and started to work with the powers-that-be in the state legislature. We finally came out with a proposed statute that created what is now known as the Maryland Commission on Hospital Rates, or something like that. Again a typical Maryland thing. The governor appoints someone, somebody else appoints others and so forth. We put certain conditions upon our point of view with the legislature. We'll go with you, if one, you state in that statute that it's the obligation of the new commission to take the total financial requirements of a hospital into consideration when approving a rate. And two, that all payors will pay the same rate.

Well, this is right at Blue Cross' twelve percent discount. And we had the funniest thing you can imagine -- historically, it wasn't but it looked funny -- the hospitals of Maryland, although they weren't real cheery about it, went down to the legislature and urged the adoption of the bill. Blue Cross went down and opposed it. Here's an insuring agency opposing control of hospital costs.

Blue Cross, after that, began to be less and less attentive to the hospital position in things. In the last few years, last year I guess it was,

they established a program of -- what it amounts to is selective hospital identification for their subscribers. I don't know how they do it but the net effect is that they wouldn't pay for you in a costly hospital. If it's another set of benefits, if you buy Plan C you can get a cheaper premium but you can only use these hospitals. Hopkins and a few other hospitals went to court to try to upset that and lost.

WEEKS:

The Blue Cross benefits are set on the basis of the rates allowed by the various hospitals? Which rates are based on just cost or is there a cost plus factor?

NELSON:

There is a cost plus. It's a very complicated, but very effective, formulation that has been developed by this rate analysis service. For instance, they don't pay depreciation. They permit, in the filing, the introduction of capital requirements for that year which has turned out to be better for older hospitals. And they have moved from "bring your budget in and we'll divide it by your patient days" to something now that's very close to the DRG, which we have had here for three or four years. You guarantee, let's say, a gallbladder removal for X dollars.

WEEKS:

How does the physician's fee come into this?

NELSON:

This is only hospitalization.

WEEKS:

This is hospital service for a gallbladder operation and the physician is another story.

NELSON:

That's right.

WEEKS:

Then Blue Cross is trying to steer their subscribers into...

NELSON:

...lower cost hospitals. Or if they have to go to -- we're the only ones that do certain things -- if they have to go in here, they've got a copayment that's pretty high.

WEEKS:

I see. Even though you are furnishing services that no other hospital in the area can furnish.

NELSON:

Yes. The Blue Cross position is...I would doubt that it would be sustained over any length of time. Big employers in town are going to have the backwash on that you know.

WEEKS:

Have they gone into HMOs of Blue Cross?

NELSON:

Yes. As a matter of fact, I think Blue Cross is in partners with Columbia in one now. I think it might be the insuring agency for Columbia. I think Connecticut General kind of bowed out.

WEEKS:

Blue Cross would have claims handling facilities.

NELSON:

I think they sell an HMO policy. I'm not sure of this. This happened in the last few years.

WEEKS:

There are so many heads to this HMO thing it is almost impossible...

One thing that I have been interested in in your life is the fact that you have had so much of your life in hospital management. I've wondered -- I don't know whether you want to express your opinion on M.D. administrators versus non-M.D.s or master's degree in hospital administration. Do you have any feeling one way or the other?

NELSON:

Oh, I guess I have a feeling. I think, as times go on, it's kind of a strong one. I think what is needed is ability to start with, including in that a strong character. You can't be a milktoast in this business. Good education. I think that education needs to have two parts, at least. It needs a lot of parts, but for this discussion one is a study of health care, a study of the institutions, a study of medical care. What is the product? It's kind of a fragile thing, health. It's not like making steel. It's got problems of standards and qualities and ethics and a lot of things like that, which have to be learned. As a student you have to learn that this is something that has to be paid attention to. I don't think you study ethics from a book. You have to say, yes, there is something there and then you learn it as time goes on.

The other is management techniques. I spent a lot of time, because I didn't have any of it, thinking and reading about management. We might want to get into it later -- after my retirement, I am in corporate activity now. I would put financial management at the top of the list of things that have to be learned and are devoid in medical education, in medical practice. My experience with the MPHs and so forth of half a generation ago is that they

weren't any better at it than the M.D.s. I think Mother Nature has made it necessary for everybody to get financial management with a little more poke to it.

Given those two points, I don't think there is a whistle's difference between an M.D. and a non-M.D. with maybe one exception. In these highly complex academic medical centers where interaction with the cutting edge of medical development and the mores of a medical faculty are so damn important that it's pretty hard to expect, particularly a younger person without some medical background to get up to speed with that very fast. Now some of the experienced fellows are super at it. But it's an uphill battle like financial management turned out to be an uphill battle for me. That's about the one exception I would see.

WEEKS:

I can see where it might be difficult for, as you say, an MPH or MHA to really empathize entirely with the problems of the physician or the medical staff -- not just the physician, but the medical administrators.

NELSON:

I don't believe I would use the word empathize. I think "understand." The trouble with the physician and the lay administrative officer who doesn't understand is that the physician gets his way all the time. And he doesn't bat a thousand -- there aren't any people in the world that bat a thousand. That's because he doesn't understand. He empathizes too much in his favor. You see what I mean. No, I don't think it makes that much difference.

WEEKS:

Would you care to say anything about the age old problem of whether a physician should be the member of a hospital board or not?

NELSON:

I think yes, he should be. I have lived all through MacEachern's time and other debates on this matter. I think what you have to be aware of is the self-interest and conflict of interest and just tokenism. I mean a physician ought to be chosen just like anybody else. If you are going to put on the most powerful surgeon on everybody's hospital board, you are going to have a hell of a lot of trouble. But physicians are pretty good thinkers. And they are pretty good in handling people. Let me put it this way, every place I've been -- I used to go to places that said, "Gee, the doctors are raising hell, they want to be on the board. What do you think about this?" And I was kind of inclined to take the MacEachern line -- there are exceptions but in the main it's troublesome. But every place I've seen a move into physicians on boards, it's gone beautifully.

WEEKS:

I think another thing that might enter into this is how the board is chosen.

NELSON:

Right.

WEEKS:

I can think of one little hospital we did a study at a few years back where you could be a member of the corporation for a dollar and it got to be a popularity contest in choosing people -- they weren't chosen for ability but they were chosen -- either those who bought memberships and got proxies or...

NELSON:

Well, I always, and still do, I would oppose the organized medical staff having an election and designating somebody to be on the board of trustees. I

just think that is dead-wrong. Politics are always bad and if they are medical politics, they are awful. The board of trustees should identify among the doctors the person or two or three that they want. They are the ones that know how to pick them.

WEEKS:

I have seen hospitals where the chief of staff would have an ex officio so that at least he knew what was going on.

NELSON:

That's all right. That never bothered me.

WEEKS:

At least you could say this is the line of communication between the board and the staff. Or I suppose that also comes in if you have a joint conference committee between the two. I just wanted to hear what you had to say.

I think somewhere I read something that you wrote, correct me if I am wrong, where you believed that an M.D. should have direct access to the board. Am I quoting you wrong?

NELSON:

I don't recall that. But I wrote so much and spoke so much and I've changed my mind so much, it probably is true.

Well, I don't think I've changed in these fundamentals. One, the physician is the most important character in the hospital. Two, he's individualistic. He is taught to be a doctor to a patient and that is all he is ever going to do, if he is a good doctor. His views should be thoroughly and effectively known and expressed to the management and the board. He should and can be a good board member. He must be selected like other

trustees are selected -- not as a representative of the organized medical staff. I think the days when the insecure, tightfisted, arrogant or dictatorial hospital administrator sat in an office and controlled the board and wouldn't let the doctor's point of view get there must be gone. I don't think they're here any longer. Do you?

WEEKS:

No, I don't think so but you hear some stories. I've been interested in the role of the trustee in the sense that today he should realize that he has great responsibility. He can no longer rubber-stamp what the administrator wants. But a lot of administrators like the idea of having the board kept in the dark a little bit and you didn't tell them any more than you had to and they approved your ideas. Or, if you were a very smart man or woman, you might be able to make them believe that what you wanted was their idea.

I think it was Jim Hague or Norby that told me about the time that AHA started publishing Trustee magazine, back in Kenny Williamson's day. They wanted some means of distribution. So apparently AHA contacted the various hospitals and said please send us a list of your trustees and their home addresses so we can send them a copy of this new magazine. They were surprised that a great number of hospital administrators wrote back and said, "Send us the Trustee journals and we will distribute them." And found that in some cases possibly they would not be distributed if there was an article in there which the administrator didn't want his trustees to read.

NELSON:

I remembered also when the American Hospital Association board of trustees, general council, and others were very negative about setting up a trustee section or get trustee activity going. This is that period in which

there was the paranoia of the administrator about whether the trustees should be involved. I can't help but think that's changed and is changing. You can't pick up a newspaper now -- today, a hospital in Baltimore had a big fight -- doctors, administrators, community, board, all of them at a public meeting. I see that in the papers all the time. I read that, and I know this in some companies, companies are forming task forces to see what they can do to cut down their costs of hospital care. I read about something known as coalitions. Well, with all that kind of thing and Medicare, Medicaid, state legislatures, debates in Congress -- I can't imagine that there are boards of trustees that are just sitting there with their hands folded.

WEEKS:

No. I'm sure that they shouldn't be.

NELSON:

I don't think there are very many of them. I really don't.

WEEKS:

I don't understand Dr. Paul Ellwood's MESH idea very well, do you?

NELSON:

It's an acronym; I don't know what MESH means.

WEEKS:

I'm not sure either except that it's supposed to be a plan whereby physicians become a part of management. When I say part of management, I don't know just what I mean. But in some way he is trying to develop a system where physicians will have more voice in the management of hospitals and will be actively -- not only talk to a point -- but be activists in the management of hospitals.

NELSON:

I don't know what Paul Ellwood's plan is. I haven't read anything about it. It seems to me that I saw a reference to it. Let me say first I think physicians are getting much more involved in hospital management and I'll give you illustrations right from across the street here.

I'll have to do this in a kind of historical, nostalgic sense. When I first became involved, the physicians that were heads of departments -- you ordinarily think that's a kind of management position, in part -- would have nothing to do, just ignore the management sides of things. They'd get irritated and say straighten it out, but you couldn't pin them down to be part of management. They felt that that was not their job. It was their job to do the best they could in the care of patients and teaching and so forth. Management was to make the environment right and the finances solid. Period.

I started some years ago creating what I called budgets for clinical departments. They were not real budgets. They were just sort of an analytical statement about what the financial resources were that were devoted to that particular activity. I gave those to the department chairmen to study and discuss and do something about if they felt inclined. Well, they didn't do a damn thing and some of them got very irritated. "What do you mean? I couldn't stay within that money -- you spend the money. I don't have any control over it." That kind of answer.

Then I put young administrative officers, residents that had finished their administrative training, and said I'm going to assign you to the Department of Surgery as an administrative assistant, the lowest title that will be acceptable. They would say what are my authorities. I said they are no more than mine. That wasn't a very good answer for them. But the good

ones began to ferret out things and bring up some stuff to the people that I wanted to have informed -- namely, the heads of the departments. That's matured over time so that right now there is an enormous activity by the heads of the clinical departments and divisions about the management of the hospital. They don't set nurses' pay, but there will be discussion of nurses' pay. They are pressured tremendously for the use of resources.

I had a physical examination the other day -- routine one. I went in to get my routine EKG -- there is nothing wrong with my heart as far as I know but my doctor says I think we ought to do it. The girl says, "Doctor, I've got to put some diagnosis down now. The head of the department says we're not going to do any more just routine EKGs." I said, "Put down high blood pressure."

But that's how deep the management by physicians is going now. And the threat of diminution in reimbursement under new rules and regulations is so great that the average length of stay in that hospital across the street went down twelve percent last year. Now that's something. That's something in a big institution like that. If you and I had a small hospital we could work that. But you can't work it in a big one without a whole lot of people working on it.

So, I don't know what Ellwood's doing but I do know that there are more full-time medical staff involved, there are new regulations coming in like gangbusters and any moderate sized hospital, if it's going to live, has got to get that medical staff working in the management of the hospital. Use of personnel, use of consumables, use of bed days, use of laboratory procedures, they are all going to have to do it. I don't know if Ellwood's system is A or B or C or D. Each hospital is going to develop its own system.

WEEKS:

Can you avoid an overdose of defensive medicine because of malpractice insurance costs? Or do you protect your salaried people over here?

NELSON:

We protect them. But still we pay premiums. Actually we are with four or five other hospitals in a captive insurance company but it's still money. That is a very difficult one to do to attack defensive medicine. That's going to be very hard, very hard. There is enough physician input to say what do you mean defensive medicine. If my doctor thinks I should have an EKG when we both think my heart's all right, he's got some fairly good reason for that and I'm going to follow it. Is that defensive medicine? I'm not going to sue him but he's defending me against something.

WEEKS:

I suppose that if the physician himself does not pay the malpractice premium directly, he would be less threatened.

NELSON:

I think if he's in a group he's less apt to be.

WEEKS:

I wonder if contingency fees for attorneys were voided some way — this might help. I don't think they allow it in Canada.

NELSON:

I don't believe so. I know they don't have it.

WEEKS:

I think that makes a big difference.

NELSON:

I'm not sure but what we are the only country that does allow it, as a

matter of fact.

WEEKS:

I guess we have all seen the change in physician practice from solo to group to HMOs to PPOs. Some places salary jobs and physicians with fee schedules tied in some way to usual and customary and DRGs coming in now for physicians too. Which brings me up to a point I have here on your ideas about medical education. This being the place of the Flexner founding and beginning, it is quite natural to ask -- didn't Flexner say there are only two schools, or maybe it was Simon's grandson, that there were only two medical schools in the United States at the time of the Flexner Report that required a B.A. before entrance into medicine.

NELSON:

What's the second one?

WEEKS:

Harvard and Hopkins.

NELSON:

I didn't know Harvard did.

WEEKS:

I didn't know either. Then I also read that sometimes those requirements were slackened a bit when they wanted somebody to come in.

NELSON:

They weren't here.

WEEKS:

Well, the whole philosophy of Johns Hopkins was quite different from other schools, wasn't it? Different from Harvard in fact. Somewhere I read that when this university was founded they called on -- the board or whoever

was guiding it -- called on the presidents of various leading universities in the country and asked their advice, including Dr. Eliot at Harvard.

NELSON:

There was a story in the Hopkins little newspaper and the current president of the University made some comments about the origin of the Johns Hopkins University as a research university, at commencement. He tells the story, which to old Hopkinsites is all well-known.

Johns Hopkins was a bachelor, a merchant and a banker, a Quaker, never married, organizer of the B & O Railroad, and when he died he left a fortune of seven million dollars, which was enormous. This was in the 187Øs. He divided it in half. Half to found the University and half to found the hospital. So each of these institutions started with three and a half million dollars. The guiding light in the establishment of the Johns Hopkins University was Daniel Coit Gilman who came from California. And I believe he had been a professor and maybe a president at, I think, Cal Tech. But he had studied in Germany at, I think, the University of Berlin. You recall that the Germans were the ones that established the research oriented university. The English established what was called the arts and letters college kind of things that became a university ultimately.

Gilman, as a young man, had studied one of the hard sciences, physics or mathematics and had a doctorate in Berlin. He came back to the trustees with a proposal that since this is a brand new university they start it on that model of a research university. And that core of direction has remained to this day. As you know, it is a very well-known university. It has no business school, it has no law school, it has off and on had an engineering school -- they are on an on basis now. They've got a music school finally by

affiliation. And there are a number of voids like this in that university. It's not a broad university. It just teaches the hard, heavy classics and sciences. And the medical school -- I've been in many faculty meetings, small meetings, with ultra-classicists who I think today would not vote to accept a medical school. I've heard it referred to as vocational education in these hallowed walls. You can imagine how the hair goes on end in this part of town.

Well, that's the origin of the Hopkins University. When it came time for a medical school -- and we got a medical school because Mr. Hopkins wanted to have a hospital. He said he wanted the hospital to be, quote, part of a medical school of the university and separately endowed. That's a long hard story but that led to the flavor of the Hopkins hospital and medical school. And that led to Abraham Flexner's report, commissioned by Carnegie. He went all over the country and looked at the deplorable state of medical schools. There were seven in the city of Baltimore. He made a lot of fundamental statements. The punch line was that the way to have a medical school is to go to Baltimore and see Professor Welch and see how they have organized and teach medicine in that medical school and hospital.

WEEKS:

They must have been teaching some basic sciences.

NELSON:

Oh, they had good basic sciences.

WEEKS:

Because wasn't this one of the major parts of the report?

NELSON:

Oh, yes. Yes. The chemistry teacher came from that graduate faculty

out at the other end of town. Another man came in anatomy, who was a biologist fundamentally, came down here to be the head of anatomy. They had a lot of money to start a medical school but they were only able to get about four professors and then the B&O went bust and they didn't have any money. This is an interesting little vignette.

The hospital opened in 1889; the medical school didn't open until 1893. The University got caught in the deep recession of 1891. They only had bonds in those days and B&O bonds went to zero or something.

WEEKS:

That's what their endowment was in?

NELSON:

Yes. I have seen some of the old ledgers. So they couldn't open the medical school. They didn't have the money. There was a woman, Mary Garrett, who was the daughter of the Garrett who was Hopkins partner in the B&O. The Garrett family became the drivers of the B&O even after Mr. Hopkins died. Hopkins was really only an investor in it. She was a pistol of a gal, had a good education. I believe at Bryn Mawr or some place.

WEEKS:

That was a good Quaker school.

NELSON:

Yes. She and three or maybe four relatively young women, thirty or so, decided they would raise money to start this medical school. To make a long story short, they raised $350,000. They gave it to the university for the medical school with certain provisos. One, they would accept as students only those with baccalaureate degrees. Two, they would require a reading knowledge of French and German. And three, women would be admitted on an equal basis

with men. And, by God, they had it. There have never been less than about twenty percent of the class in medical school here that were women. Going way back when.

WEEKS:

Marvelous.

NELSON:

That's the thrust of Hopkins and the hospital and the university. The hospital in trapping the university into a medical school and the Daniel Coit Gilman directing the university to be a research university in the German model. That's the story.

WEEKS:

What do they do now for support? Is there a large endowment?

NELSON:

Oh, yes. Very large endowment and, like everybody else, they've got enormous tuition fees. One of the things that I'm troubled about in my advancing period here is that a super growth of the full-time medical practice over there -- millions of dollars in annual income; makes what the University of Chicago did look like peanuts. It makes for a yeasty place to have this all go on but I guess I've got that old traditional stuff in my bones here that in an academic center you don't go to excesses. You don't go to excesses in research and you don't go to excesses in clinical practice, you don't go to excesses in HMOs.

WEEKS:

There'll be a shakedown, I think, in HMOs and there will be a lot of these go out of business. Don't you think so?

NELSON:

I think a lot of them will go out of business and I think the total growth of the HMOs or those covered by the prepaid form is going to increase steadily.

WEEKS:

Don't you think they are going to merge and combine?

NELSON:

Oh, yes.

WEEKS:

I can see Kaiser going all over the country. The last I heard they were talking to HIP in New York.

NELSON:

I think they've got something here in Maryland.

WEEKS:

I'm sure that this is the wave of the future.

Recently I did an interview with a long time secretary of James Harvey Kellogg on the old Battle Creek Sanitarium. The thing that struck me was he had medical training back in the 1870s. He went to the University of Michigan. At that time the University of Michigan medical school had two courses of twenty-four weeks of lectures and he became very disillusioned before the second set of twenty-four weeks was up and he left. And his primary reason for leaving was because there was no clinical experience. He saw no patients. He finally ended up at the Bellevue Hospital where they had a medical school at that time, in New York City, where he could put his hands on patients. Before Michigan, he had been at Dr. Trall's Hygieo-Therapeutic College in New Jersey, which was mostly water cure and vegetable diets and

this sort of thing. But that was the state of medicine back in those days.

Of course, Kellogg later, after he got his degree from Bellevue, went to Europe several times to study for several months at a time so that he became quite a famous practitioner. I thought I would insert that because, if you didn't know it, you might be interested in knowing about it.

One point I'd like to touch before we get into the actual education -- the thing that has intrigued me, and I think you almost implied concern, was the relationship between the medical school and the hospital where the residencies and the internships were being performed. The division of authority. You, as the director of the hospital, must have had that come up many times.

NELSON:

Many, many, many times.

WEEKS:

Is there an answer to it?

NELSON:

No. There is no pat answer. There is no set structure that is ubiquitous -- that would work.

WEEKS:

I suppose it depends on personalities a great deal -- the dean and the director of the hospital.

NELSON:

I think it goes back even deeper than that. It goes back to the perception of the basic mission of the hospital on the one side and the medical school on the other. I could see a theoretical medical school that sets out to be a teacher of practitioners and a developer of research

personnel and they structure themselves to do. Rather small, rigid and traditional departments. Without a hospital of its own. Affiliating with a local good-sized community hospital that already has a staff and has had forty years or more of tradition of taking care of the people in that community. These are two different traditions and two different missions. And that's going to be hard as the devil to keep on track in some sort of a happy marriage.

In contrast to that, in this hospital and medical school and those in Boston, many in New York and Philadelphia, many in the state universities, they more or less start together and they more or less start on the same set of goals. This hospital was set up to take care of people, but to participate heavily in the teaching of the professions. That was stated and it's still part of it. The XYZ hospital of four hundred beds will never have that later commitment. When push comes to shove, they'll say we're not going to do that any more. This hospital and others -- I don't want to identify this one too much -- but the other big established teaching institutions, they'll go down the tube together.

But, given that broad statement, then the two chief management officers have got to be basically tuned in to live with those missions, and basically understand that on a day-to-day basis there is no real rule book that you have to follow. It's common sense and commitment to each other.

There are some broad sweeps here. It comes Tuesday and somebody asks to do something and doesn't have any money in his budget. Or we need more room for nurses or somebody needs more room for students. You've got to hammer those out on a negotiating basis.

Over the years we tried, I think fairly successfully, to say if the thing

we are talking about is service to the public -- that's the hospital's job to doing, do it. The dean looks at me and says, "You do it."

When it has to do with research, and this is a pretty clean one, we're glad to help in any way we can as a hospital but that's your job, Mr. Dean. And he accepts that.

Now there are some interplays between. When you are caring for a patient, you are teaching. And the house staff has been in a kind of middle place all along, primarily hospital identifiable. But the faculty always wants more house staff and the hospital says we don't need them. You have to have understanding of goals and missions, a commitment to both goals and missions, a decent human being reaction to the people you are working with. No place to play games, and be willing to go down the tube together.

WEEKS:

I can see your point. A few years ago I attended a meeting of deans of medical schools founded 1960 or after. Nearly all of them were schools using community hospitals for clinical experience. And I can see the point. That was back in the period when we wanted a lot of doctors in a hurry.

NELSON:

Yes. Shows how wrong you can be.

WEEKS:

It's almost as bad a mistake as the actuaries made when they tried to estimate the cost of Medicare.

NELSON:

Right. I was there too.

WEEKS:

Will you talk about Dr. Crosby?

NELSON:

A dear, dear friend of mine really. I first knew him here in Baltimore when he was a young person -- might have just had his MPH degree. He was an assistant in statistics, teaching assistant. Then he later became assistant director of the hospital -- first, I guess, director of the medical records, then assistant director of the hospital. That was at the time that I had been at the School of Public Health and I had gone back into the hospital here as resident, chief resident, a position in medicine which is, incidentally, one of the two officers specified in the original bylaws of the hospital. There shall be a chief resident physician and a chief resident surgeon.

I had had a commission in the Navy. When I was called to active duty, I was a patient at the Trudeau Sanitorium in New York with minimal tuberculosis. When I came back the Navy threw me out and the Army wouldn't take me and all my friends were going in the service so I said okay I'll work here. I worked harder here than I ever would have in any service. We were shorthanded.

Dr. Crosby lived across the street from the hospital. We were essentially on twenty-four hour duty, on call whenever necessary. Mine was almost all clinical and his was almost all administration. But Winford Smith was really over sixty-five then, hanging on until the end of the war, and Dr. Crosby was really the hands-on director of the hospital. And we had all the wartime problems. But working that way together we got to know one another very well. I got to know his family, he got to know my wife. We almost lived together. I watched all his girls grow up. We were just kind of one family until he moved to Chicago and we gradually — we stayed very good friends -- but gradually drifted apart in that time. But until his death I think he and I talked on the telephone at least once a week. He was a bright man.

I'm thinking now of his younger days -- terribly energetic, very ambitious. As you know his parents were Salvation Army officers, as hers were. So it was a Salvation Army family through and through. He had that kind of commitment to things. Commitment to the little guy. And a terrible curiosity about everything. He got into everything. He never liked to hear me say this but I'd say it because we were friends -- he got too much involved in details and consumed his energy too much that way. He could have done better in some bigger issues I think. He was gregarious; he got out in the community. They knew him, the other hospitals knew him. He became active in the national association, committee of this, committee of that. We vacationed together, traveled together. When he got with the Joint Commission -- I succeeded him at Hopkins -- about that time I became active with the lower structures of the AHA. When he became Director of the American Hospital Association he called me more and more for special things that he wanted me to do. Then that just led to a partnership in a way that was never stated but fully understood. He got me active in international hospital affairs. I enjoyed that. He was a great traveling companion. He was the kind of person that would be an absolutely perfect mess officer. He would take care of everything.

WEEKS:

Did he have trouble delegating?

NELSON:

No. Sometimes he would delegate very much too wholesale, I thought. But then things that really interested him, he would keep his finger on, drop in on you and that sort of thing.

WEEKS:

Somewhere it seems to me that I heard a story that if he were on his way to work in the morning and thought of something that needed to be done and came into the office the first person he saw he would assign that duty to.

NELSON:

He might have. He got into everything. That's what I meant by details.

WEEKS:

How was he during the building of the new AHA building?

NELSON:

He actually turned that over to Madison Brown.

WEEKS:

Oh, did he?

NELSON:

I believe he did. I wasn't close to that operation. I know Madison had a great deal to do with moving into that building. I think the thing that consumed a great deal of Crosby's energy and time is what I'll call without malice the politics of the AHA. There was always a struggling group trying to be in power. How you handle that, the personal reactions to that. Some of it could get kind of nasty. He didn't like disturbances. He wanted them to go away. Disputes. He wanted to get rid of it. He wasn't one of those fellows to say let's get down here and thrash this out. He did spend an awful lot of time on that. He was loyal to the people that he felt he owed loyalty to. I would say to a fault. He brought in some people, he kept people, particularly at the AHA, who should have been moved around. I thought and I think others thought that too. He was just very loyal. I think he found firing a person extremely hard. Extremely. It's a difficult job for anybody. He hated to

pull the string on people.

WEEKS:

Norby told an interesting story about him. When he came to AHA he asked all of the executives of the AHA, head executives, to give him a letter of resignation and Norby refused to do it. Apparently what he wanted to do, what Dr. Crosby wanted to do, was to rehire everybody -- go through the process of rehiring so they would have, I suppose, a personal loyalty to him.

NELSON:

I hadn't heard that story.

WEEKS:

Norby said no.

NELSON:

Ed relied on Norby for a long time. Norby had his personal problems which got worse and worse until he left. But earlier on, he really relied on him.

WEEKS:

Norby is a fascinating character, isn't he?

NELSON:

He is. I knew him pretty well.

WEEKS:

One thing we didn't do was talk about the AAMC -- your experiences with them. Was Dr. Cooper the head of that all the time, or did he come in later?

NELSON:

That's right. I'm going to go way back. When I was in one of those assistant dean-like positions without a title, sort of helping, I guess it was just about the time that I was beginning to be involved with Lowell Reed, he

said I think you should go to a meeting of the Association of the American Medical Colleges and see what goes on. I didn't know anything about the Association. So the first meeting I went to of the AAMC was in French Lick, Indiana. Now if you haven't been there, don't go. That's the place where Pluto Water is. And you can't get there from here.

It was a meeting of about fifty deans. And they had the front part of the small auditorium of the French Lick Hotel roped off for deans only. There were probably thirty of us hanging on the side. I emphasis this because it was just a dean's club. They just got together and talked about the quality of the students and they had the inevitable curriculum committee. There wasn't much talk about financing. That wasn't a burning issue in those days. The recruitment of faculty was another one. For me, a young fellow, it was a dead bust. Because they were very closed. They would not fraternize with anybody. So that was the AAMC that I knew first.

Then as I got active in the AHA and on the board and committee and ultimately the president, it was inevitable that we had something to do every now and then with the AAMC. It was still a deans' club -- though it was bigger. There were more assistant and associate deans around. I got active as kind of an AHA person with the Council on Medical Education of the AMA which approved internships and residencies and was a partner with the AAMC in the liaison committee which approved or disapproved medical schools -- had been doing that for fifty years. I got on that internship review committee so I had a lot of meetings with that. It was kind of a tough thing. You were setting standards and you had to approve or disapprove. It's not too tough to approve but to disapprove is a miserable thing.

I got to know some of the AAMC people. The director then was Ward

Darley, who was a fine, fine man and who had as a long term goal bringing the AAMC out of the woods. I believe he would even have approved of that statement. He had been a dean of a medical school, he had been president of the University of Colorado. He had terrible arthritis but did an awful lot of work with the AAMC. The AAMC then got some grants from Carnegie or Rockefeller or some foundation to hold institutes for deans, associate and assistant deans and they gradually began to bring in the hospital directors because some of the subjects were these very things we were talking about earlier -- how do you live together. I was on the programs of a number of those. I got to know a number of the deans that way.

At the end of Ward Darley's period I believe he established the committee on the future of the AAMC to be headed by Lowell Coggeshall who was from the University of Chicago -- just retired. And Cogy, as we knew him, with the assistance of the then dean of the University of Michigan, Bill Hubbard, made quite a study and a rather punchy, tough report of recommendations. The essence of which was broaden thyself and bring in all the elements that are interested in medical education, not just the deans. So that led to a restructuring of the AAMC into its Council of Deans, Council of Teaching Hospitals, and Council of Academic Societies -- that's the faculties. I had been active on the committee that was set up to implement the Coggeshall report. It fell to me to make the organizing recommendations for the Council of Teaching Hospitals, which we did. We decided how many, what size and so forth, what criteria -- which I understand remain pretty much the same after fifteen years.

From that I was put on the Executive Council of the AAMC as a representative of the hospitals. In those earlier days, we were always kind

of -- the deans come first and the faculty second, and, oh yeah -- hospitals. But, if you don't have too much paranoia you would handle that all right.

Then, it became obvious to the then leaders that the present -- Ward Darley's successor, who would have been the Dean at Denver and his name was Burser, was just not adequate to implement the plans so some skillful shifting of positions was established -- that same committee of implementation became the search committee for the successor and we selected John Cooper. John Cooper came in at that point. That was probably 1968 or 1969, something like that.

WEEKS:

They were still in Chicago then were they?

NELSON:

Yes, they were still in Chicago -- or, no, they had just moved. I think that was one of the moves that Coggleshall's committee recommended and was implemented pretty quickly.

But John Cooper was then at Northwestern University when he became Director. Well, I continued to be active with the AAMC and I was nominated and elected to be Chairman of the Executive Council. That's the top non-paid position. In that I was the first and only person since Bachmeyer who had held both presidencies of the AHA and the Council of the AAMC.

WEEKS:

Is that right?

NELSON:

Yes. There have only been the two of us. It's just a fluke, of course. And I worked on that. The heavy things at the AAMC then were restructuring this approval process for residency training and internships -- pulling it

away as far as we could -- it wasn't too far -- from the proprietorship of the AMA and the specialty societies and make it a conjoint thing. And it's working, but it has had its ups and downs. Then, we had a great deal to do during my period with the legislation that lead to the federal aid to medical education. I am guilty, with others, of that expansion in the medical school classes.

WEEKS:

Well at the time it seemed to be the thing to do.

NELSON:

Oh, yes. All the studies showed it -- seemed to show that.

So I had that wonderful experience and as such I got to know a great deal about the medical schools of the country and the deans and faculty members and whatnot.

WEEKS:

Did you get into the foreign medical graduate problem too?

NELSON:

Yes, oh, yes. And they are still struggling. I guess the increase in output of our schools is going to probably take care of that to some substantial extent.

WEEKS:

Yes, because there won't be the residencies open. Did you work with Jack Millis?

NELSON:

Yes. I surely did. He was the head of the AMA thing on graduate medical education. I have forgotten the title of it.

WEEKS:

He has done quite a lot of studies in various fields.

NELSON:

This is a sideline, I presume, but Jack and I were at a meeting -- I think at Montefiore Hospital in New York. Something about graduate medical education. We were having lunch. Jack's a fine man and he was kind of puzzled about how did it get this way. He is a physicist, I think, isn't he?

WEEKS:

Yes.

NELSON:

He turned to me and he said, "Russ, what do you think is the real objective of this whole medical business?"

Well, that's an awful question. Like a flash it came to me and I hushed him up right then. I said, "Jack, I think in the final analysis it's to improve the quality of life of the human being."

If he wanted to ask me a global question, I'd give him a global answer.

WEEKS:

I like him very much.

NELSON:

He's still kicking around isn't he?

WEEKS:

Oh, yes. I saw him -- time passes so fast -- it's been about a year and a half since I talked with him last.

NELSON:

Is he still in Cleveland?

WEEKS:

Yes. He still has an office in the university to which he goes I guess when he wants to do some work. But very active, a fine mind. And I like him very much.

NELSON:

I thought that answer I gave him was very flippant. But when you think about it's not too bad.

WEEKS:

No. It covered the situation, I think, very well. The only trouble I have is thinking of that kind of answer at the moment.

NELSON:

I would too. It just flashed.

WEEKS:

Somewhere I have read about your interest in nursing education.

NELSON:

Oh, Lord yes. I have struggled with that for all my professional life.

WEEKS:

I have talked about nursing education with Faye Abdellah and with a lady who used to be head of the Michigan Nurses Association, Joan Guy. I don't know whether you ever met her or not.

NELSON:

I think all the ladies I know are probably nicely retired someplace now.

WEEKS:

Well, you may disagree with me but I have come to the conclusion that the nurse is not quite sure of what her role in life is. She is not quite sure of what she can or cannot do, or what she should or should not do. I suppose

part of it comes from the different levels of training that we have. It seems to me that you made favorable comments on hospital nursing schools as far as the product they put out versus the two year....

NELSON:

I did.

WEEKS:

Has it been basically financial need that's made the hospital nursing schools disappear, or is just a new feeling?

NELSON:

I think, in retrospect, it's a combination of the rise of the ambition of women and I suppose you might call it the status of women who are employed in the professional world which is affecting everything. That started probably in nursing before it did in many other areas. Because the nurses have always had that feeling in my experience, and I think justifiably so, that irrespective of their training they have never been able to achieve the status that would permit them to do the things they could do. And therefore they were dissatisfied. And that's part of that feminist movement. I say it's one of the origins of it. And the second thing -- it was the growth of commitment to higher education among the United States people. You know, go to college, go to college, go to college. Everybody's family was beginning to say you've got to go to college. I think those two things, among others, made it say that nursing ought to be at the college.

I don't have such a hang-up about that thought as I do about what began to be structured under what that concept meant. I think they got off base and they became not oriented to what I would call the mainstream of caring for people. They got into partially-trained psychologists, partially-trained

sociologists, to some extent spiritual leaders, advisors. I think they lost sight of the basic nature of medicine. God, they don't like me to say this because just as soon as I say medicine -- I mean medicine in a big, broad way -- they see medicine as a physician activity.

As a younger person, I remember very well -- I don't know if you ever met Martha Johnston?

WEEKS:

No.

NELSON:

She was a nurse at the AHA for a long time. She was here before that. When I was the Director of Medical Clinics Outpatient Department -- you know outpatient departments are terribly difficult to run -- she was the nurse. We always had a nice graduate nurse in every clinic. I'd go up there and I would see patients as well as be a director. I got to know Martha fairly well. I'd have three rooms and she would bring patients in and fluff them up and give me the records. And I was seeing patients who had been there last week and two weeks before and three weeks before.

I finally said one day as we were sneaking a cup of coffee -- we weren't supposed to do that -- I said, "Martha, this is wrong. You ought to be in that room talking to these people and I ought to be down at the end of the hall waiting for you to come down and say what do I do about this." And I said, "If it works right you won't have to see me very often. I know you."

You know what I was talking about. I was talking about the nurse practitioner. Nurses fought that. Can you imagine? That's why I guess I felt that the nurse oriented to the hospital practice was more apt to evolve into the thing I had kind of visually in mind. Because I worked with nurses

over there with sick people. They saw those people all twenty-four hours. I saw them for four hours. They were doing things all day long and all night long that were very important to those patients -- and never calling me. Right? I'd think they had good sense.

WEEKS:

But do all physicians feel the same as you do?

NELSON:

I think the last statements I've just made, yes. I think doctors feel that nurses can take care of patients and trust them to take care of patients. I think doctors would sympathize with the statement that I make that they got off base in their college curriculums. I think when you get to nurse practitioners and independent practice by nurses, I think doctors kind of choke-up on that. It's new and different and it's kind of in their turf. I can't believe they are worried about it economically. I really can't. I think some of the more thoughtful doctors would say, we've got to watch that. That might get off base. It's like chiropractors practicing.

Well, that's rambling thoughts on nursing. I think, as you say, they don't know what they want to do and that's part of it. I think they are not given much chance to do. I think that's another part. I don't think there is very good leadership. I used to respect some of those tough old gals that used to stand up and say, "This is what nursing is." But now they are kind of whimpish, it seems to me.

WEEKS:

They need a sergeant at the head.

NELSON:

I do too. I used to have an awful time with some of them. When I

disagreed, they were tough.

WEEKS:

I have been impressed with visiting nurses.

NELSON:

Do you mean home visitors?

WEEKS:

Yes. Home care. A little hospital we did a study in in Michigan had a home care department and I spent a couple of weeks just riding around with the nurses and visiting the homes. I was very impressed with what they brought to those patients. It wasn't only what they could do for them physically, but it was the fact that they were there.

NELSON:

You earlier said, and I think this is where I'd like to bring it up, what am I doing now that I am retired and living in Florida. There are two different career paths, other than playing golf.

One is, I have been a director of the Control Data Corporation which is a computer company. For some years I have been working with the appropriate groups there and trying to devise something that is other than selling a hospital a mess of computers. And we have started a program in health maintenance for industry with an education based on a computer way of doing it. Because there is nothing more deadly than a class in health education. And this is public health in privies. But if you've got your own computer and you can learn how to make it begin to answer some of your questions. I think that's good. We have established a claims management computer-based data base system. Particularly for companies that will self-insure for their health benefits. And we are going to do more. You have no idea how lousy the

insurance industry is in claims other than processing the money out right away. We did it at Control Data. We wanted to get our insurance carrier's tapes about what the claims were. Over fifty percent of the diagnoses were miscellaneous.

The third thing we're doing is going out with computer services for hospital and health institutions in a different way than it's been done. The ways it's been done we think are not cost-effective. Buy five million dollars of computers and turn on the juice and start working. And you don't know what you're doing. The basic issue is you have to train the employees of the institution to use and develop the computer services that they want. That's a big education job. And we're building pieces of this. We've got a nice one for laboratory service reporting. This is very successful. We are going now into a logic system. We're trying being the doctor so we can get the necessary information from his work into a data base so he can retrieve it and it can be accumulated and become adaptable.

That's my computer business. It just turns me on.

The other one is more recent. It's a small company that a friend of mine here in Baltimore established. Now it has been merged with a subsidiary of an English company called Pritchard Services. In England and across the world they provide food, housekeeping, security and similar services to institutions -- colleges, prisons, hospitals. This little company that was based in Baltimore started out to develop for-profit ambulatory surgical clinics. And we've got four or five of those.

The Pritchard group picked up a company in Kansas City which had Kelly Girl service for nurses and a home nursing service. We put this together and we are going to develop it into a home care program. I'm terribly excited

about both of these.

So I have moved from the non-profit side to the profit side. I have moved from in-hospital activity to out-of-hospital activity. The reason for out-of-hospital is so evident that we don't have to discuss it. The move from non-profit to profit is a little more subtle. I don't think the hospitals by and large are going to be able to develop these out-of-hospital services of this size efficiently. It gets wrapped up in the bureaucracy of the hospital and requires a good deal of investment capital. And though it is growing, there is darned little entrepreneurship in the management of a hospital. You don't get out on the street at six o'clock and sell the stuff, you know. So that's what I'm doing in the home nursing service.

Now we are talking about home care in a very broad way at this point. We are attentive to the point that you make that it is a comforting presence. And I've always thought that the nurse was the best home-caller -- much better than the doctor. But there are a whole lot of things that are done in a hospital or in a clinic in a hospital on a repeated basis that can be done at home. Like giving injections, diets and a lot of technical things. You can do EKGs and blood tests and you don't have to have the overhead of those institutions. So that's what I'm working on.

WEEKS:

I think that's a big field.

NELSON:

Yes, sir. I do too. It's not so global. I can get my hands around it.

WEEKS:

We haven't completely left nursing yet because we are still talking about visiting nurses. How about the other nurse specialties like midwives and

clinical specialists in the hospitals?

NELSON:

Midwives, I think, are easy. A properly trained nurse midwife is an important, terribly important, professional component. The time is going to come when the obstetrician is going to be a highly specialized character. And there ought to be more and better nurse midwives, and more widely distributed. There is always the need -- and it's not because they are nurse midwives -- but, you send a doctor out to Timbuktu and let him practice there for ten years and he's going to get sloppy. So are the nurses. There's got to be some kind of a knitting together here.

Clinical specialists in nursing -- they've got to be. The technology of the hospital care is growing. There are going to be very few ordinary GNs or RNs, GSNs, controlling the floor. They are going to be highly specialized. There is no way you can stop it because of the technology. I hear people say I want the same old nurses to come in and see me every hour. There is no way you are going to do that. Technology won't permit you to do it. The young women won't permit you to do it. Given the choice of patrolling the floor and running something in the intensive care unit, I know what that young girl is going to take. You do too.

WEEKS:

This is one of the points -- we had a woman in Michigan, a young woman, who later went somewhere else. She was a little bit upset because practicing as a clinical specialist in the University of Michigan Hospitals, she was not allowed to do what she was capable of doing. I think this is going to be difficult until everybody learns how to accept them for what they can do.

NELSON:

Yes. But they will accept them. Probably the big university centers will be the last to accept them because there are so many young physicians that want to get into the act anyway. But you take that out to the St. Somebody's Hospital where there aren't those people, where the surgeons and the others are in their offices in the middle of the day -- those girls are going to be doing it. They are going to be doing all they've ever been taught to do.

WEEKS:

I have often wondered too about screening work. Ever since I read about Grenfell's stations in Labrador where a British trained nurse would be in charge of a little station there and she could do lots of things. What she couldn't do, she could get on the radio and get somebody to....

NELSON:

This company I am with -- this Pritchard Associates -- they have got a small program which is really paramedical examiners for insurance companies. The physical examination of thumping and listening and poking and measuring this and that. It's fun to do. And you get that kind of feel -- I've got my hands on it. Nurses can do that just as well as physicians. Now they can't do the pelvics and the rectals and probably some of the esoteric things in the eye and they probably would need some help on the cardiac work. But if I were practicing medicine, with all the degrees I've got, I'd want -- I'd take my wife because she is a damned good nurse -- and say these are your patients. I'd do what I asked Martha Johnston to do. I'd say, you examine and tell me what you found. I know a good nurse will say, she's so fat I don't feel anything. Well, that's important. I'll go feel. I don't think I'll feel a

hell of a lot more. But I would have a good nurse run my practice. I don't mean fluff. I mean really do it.

WEEKS:

This is it. There's ability there and nurses are going to demand the right to do this sort of thing because they can go into a dozen professions now. It isn't like they have to make a choice between nursing, office work or teaching. Now they can get into anything.

NELSON:

The only thing that hangs me up is that this is all directed at colleges now. And I'm not sure the colleges are going to put this kind of thing in with the nurses.

WEEKS:

Do you still have a nursing school here?

NELSON:

We just started one again. We had a fine nursing school in this hospital for years. It turned out a lot of the nursing leaders of the world. But it got to where the quality of the girls went down because they couldn't get a degree. We started a degree school here about three times in the past but that university is so research and Ph.D. oriented. As I said, they wouldn't buy the medical school now and they certainly don't like to have nursing schools. So we closed our hospital nursing school about ten years ago. But recently three hospitals, two with Hopkins, have combined in the running of a consortium school with the university giving the degree. But right in your recorder I am going to predict that it isn't going to succeed.

First, this university is not the kind of university that will allow a nursing school to thrive. Second, I think that the requirements for nursing

in the future are such that they are going to be a lot more heavily oriented to the medical centers rather than to the university centers. You notice I said medical center. I didn't necessarily say hospital.

The world knows Johns Hopkins as that bunch of buildings over there. And the world knows it as a medical school and hospital. You know it as a medical school and hospital. If you try to separate these two, you get into all sorts of trouble. Most people will say what are you talking about?

WEEKS:

They are separated corporately, but you can't tear them apart.

NELSON:

Oh, sure. Never.

WEEKS:

Maybe we've got to take a look at our nursing education. Most of the leaders I've talked with want a baccalaureate degree.

NELSON:

I don't mind a baccalaureate degree. I just don't want one that's so heavily oriented to psychology, sociology and what I call the soft, almost non-medical affairs -- or disciplines.

WEEKS:

But I don't know what the pool of applicants is out there today for nursing. Whether they can get people to come four years to school or not. I'm not sure that they can fill the nursing need.

NELSON:

Nurses are still underpaid, I think.

WEEKS:

In Michigan we've gone very heavily on LPNs. I don't know whether that's

a good thing or not.

NELSON:

It's better than aides.

WEEKS:

Yes. I sat on a board for about three years of an LPN school and I thought they turned out some pretty good graduates. But they had pretty high standards.

NELSON:

Most of the floor nursing in most big hospitals now is done either by LPNs or just home-trained aides -- just trainees. That's what patients see.

WEEKS:

The body care maybe the professional nurse doesn't want to do that. I don't know.

NELSON:

Well, if she's got a choice between intensive care and doing that she'll take intensive care.

WEEKS:

Yes. I am sure she would.

Let's see, you were president of the Hospital Association in 196Ø was it?

NELSON:

That's right.

WEEKS:

One fact I ran across, I think it's a fact, is that you have some ninety-eight assignments, appointments in AHA committees in total. I don't know who compiled that statistic.

NELSON:

I don't either. Well, I was on a lot of committees. In any organization you start out in the minor leagues.

WEEKS:

I have a few here listed such as the Council on Professional Practice.

NELSON:

Yes. I had a lot to do with that.

WEEKS:

Is that hospital administration professional practice?

NELSON:

No. That's a council that AHA had to discuss the concerns of the professional practices in hospitals -- medical practice, laboratory practice, nurse practice -- not nurse education. For instance, I think one of the first assignments I had was to be chairman of a committee on the infant formula room -- the sanitary standards of the room that prepared the infant formulas in hospitals. That's an illustration. We had a lot to do in that council with the relationships that existed in hospitals between the hospital board, the hospital administrator, the whole medical staff, and the hospital-based specialists -- the radiologists, pathologists, anesthesiologists, physiatrists. This was a heavy series of debates.

WEEKS:

Did you go through that period when they were wanting to bill direct themselves?

NELSON:

Oh, yes. There was constant controversy over that. Bad blood for a long time. It was very difficult to get any resolutions. Corporate practice

raised a big red flag.

WEEKS:

I have heard -- I don't know how true it is -- that that very point of the pathologists and the radiologists and so forth billing directly was finally settled once and for all when Medicare came in. I think Wilbur Mills and his group approved that rather than hold up the passage of Medicare. I think the AMA and the colleges --

NELSON:

I don't remember it as being that precise but what I do remember about Wilbur Mills and the AMA and Medicare is that the AMA would back down in its traditional and severe opposition to Medicare hospital insurance if they would take the Kerr-Mill's physician portion which was Kerr-Mills physician for indigent care and add it to Medicare and that got us part B. So it's all physician services, surgeons and everything. I think Medicare's impact on the specialty disputes was great because it greatly increased the flow of money. And when that money got bigger and the hospital was more and more in a position of being reimbursement oriented -- before that we were casually billing, as you know -- and more citizens were being covered, the doctors said we don't want to be at the mercy of those hospitals in collecting our bills, in setting our fees, or splitting our fees. We want to be physicians. We want to be treated like all other physicians. And it became very heated. I put the fact that there was more money in the system as a big issue. It didn't take too long for the anesthesiologists to win. They were more hands on. And they got direct billing, a separate structure. The pathologists and radiologists were harder to come by. The pathologists moved in a little ahead of the radiologists. The last to move strongly was the radiologists.

I think in the last twenty years the argument has largely become moot. I don't know who bills or how in many places, but in essence the doctors' piece of that is separate from the hospital's piece.

WEEKS:

I think it ends up sometimes with two bills, one for each of them.

NELSON:

Whatever. But the hospital is out of the physician component of those.

WEEKS:

You were a committee chairman of the nominations committee too weren't you?

NELSON:

Yes, that's traditional that the past president -- I don't remember whether he is the immediate past president or a year or two later -- becomes chairman of the nominating committee. That's still going on.

WEEKS:

And I have you down for Preparedness Planning Committee.

NELSON:

Yes. I was. A terrible job.

WEEKS:

What were you planning?

NELSON:

Oh, catastrophe, civil defense, emergency services. It was a strong civil defense kind of thing. I served with White House commissions on this and other things that related to it.

WEEKS:

Then there is registration and approval -- what was that?

NELSON:

I don't recall that. I think that's a misnomer.

WEEKS:

It could be, because I got these from several sources and I find that...

NELSON:

The AHA has a program of registration of hospitals and approval for registration of hospitals. Sort of a technical thing. It may be that the senior officer is chairman of that. I don't know. If so, it is a nominal appointment.

WEEKS:

The most controversial thing I could find about your committee appointments was the search committee for Dr. Crosby's successor.

NELSON:

That's the way it was.

WEEKS:

The stories you hear about McNerney being the favorite character for a while.

NELSON:

I think this needs to be put in the record. When Dr. Crosby, who was not well, decided to resign or retire, he informed me and said, "I have talked to the presidents officers -- there were three of them -- and we'd like you to be chairman of the search committee for my successor."

I said, "My God, you're a great friend."

WEEKS:

This all happened before he died? I didn't know that.

NELSON:

Well, the appointment of the committee. I think he died in midstream.

Finally I said, "All right, but my experience on the university side and my knowledge of the politics that can sweep the AHA leads me to request of you and the officers and the board that this committee have a good, good deal of independence. And I'll be glad to negotiate with you and the officers as to who the members should be but I want to be part of that."

I said I would like to have it come to the point that we will bring a name to the Board of Trustees. That's how much delegation I would like to see it have in the interest of getting the job done. They agreed. I guess that was probably a mistake.

The committee members were several previous presidents -- George Cartmill, Stanley Ferguson, Frank Groner and Nathan Stark. I think that's all. I said I want one staff member from the AHA assigned to this and I want your most discreet person because I want a lot of leg work done. I went about it and the committee thoroughly approved. The way I would do it here. You consult widely. The last thing I wanted to do was to get nominations from the state societies and things like that. I issued a general invitation to the membership and the board, to anybody that was in the hierarchy to communicate with me about any recommendations they had. There were lots of them; files and files.

Well, we had a number of long meetings trying to decide what kind of person, what kind of future we were going to go at, and so forth. And I think my committee was in agreement. We then began to get feedback from two of the president officers at that time, kind of on the side, saying you know it looks like its too closed book here. Maybe some people were saying that. And there

is no dialogue. I said we had set up a great, big subsidiary committee, an advisory committee to the search committee and put everybody on that and have meetings and talk about what we're doing and how we're going about it and get their recommendations, get their concurrence or contra or complaints or whatever. We did that. And they met and so forth.

Well, we decided we needed strong leadership. We could see then that we were going to have turbulent times. We thought we needed someone who could command a national audience and a national presence. Someone who was very articulate. Experienced, but not too old. And, of course, I am describing a person like Walt McNerney or Ray Brown. And we conferred at length with Ray Brown. And Ray was very helpful. We finally said, "Ray, how about you? How about you coming back?" We said, "We're not offering it, but would like to give you high consideration."

"No."

Well, Walt McNerney was a name that came up and up and up. So we finally said that looks like our number one. Let's go back to the president officers and see how that flies with them. Ed had died in the meantime.

Well it's hard to read people sometimes but it looked like that was probably all right. So we said okay, the committee would then like to meet with the board at your convenience and make our report. Which I did and I said we have one recommendation, Walter McNerney. And I asked each member of our committee to comment at the board. Obviously there had been rump sessions in that board and they took it upon themselves to start all over again. I never really wanted to dig in to see where we stood. But I think they were afraid of Walter McNerney. I think he was "Mr. Blue Cross" and they didn't want "Mr. Blue Cross" in the hospital business. That's my assessment.

It was not my happiest day.

WEEKS:

No. It put you in a bad situation. I'm sure there was some politics there within the board or some personal feelings because I'm sure that Walt has stepped on toes.

NELSON:

Well he has. He is a vigorous fighter. Their choice turned out to be a good choice, McMahon was a good choice.

WEEKS:

Yes. Now they are going through the process again.

NELSON:

I say lots of luck.

WEEKS:

I haven't heard. I am waiting to interview McMahon after his successor is appointed. I also have the same situation with Dr. Affeldt. They want to wait until their successor is in.

NELSON:

Of course, John Cooper's too. He's retiring too. They are all retiring on July 1, 1986. Every one of them.

WEEKS:

I have a tentative appointment with Cooper sometime in July. I didn't realize that it was July 1 that he was retiring.

NELSON:

A year from now.

WEEKS:

Well, I am going to interview him in July of this year. I don't think

there is anything particularly controversial anyway.

NELSON:

Another controversial committee, that's not the AHA, that I was a member of is the Javits/Anderson committee on Medicare. Have you got that down there?

WEEKS:

No, I didn't realize you were on it.

NELSON:

Sure. Oh, yeah. I guess this was 1961. But Senators Javits and Clinton Anderson of New Mexico...

This was a private committee. They did it in a private capacity. It was not a committee of the Senate. It was privately financed by groups that Senator Javits was able to get out of New York. I don't know who put the money up. It didn't cost a lot. There were about twelve of us on the committee -- ten or twelve. Arthur Larson, who had been in the government and was then at Duke -- Dean of the law school or something -- was the Chairman.

We labored and came up with what became known as the Javits report. And it was pro-Medicare at a time when the debate was getting kind of heavy. I haven't read it for a long time but my memory says it was a pretty conservative statement. The needs for old folks and the importance of a federal program -- something that would look way too Republican for the present days. I was off the AHA presidency but still heavily identified in public with the president of the AHA. The anti-Medicare forces in the AHA and in Blue Cross -- and I was on the Blue Cross Association board at that time -- thought it was pretty bad. They were vocal about it, that I would, from my position in the AHA, join the national committee and go out endorsing

Medicare. I thought that was a bunch of poppycock. AHA or nobody else owns me. But they were kind of nasty about it, including some of the Blue Cross plans.

That was another real controversial committee.

WEEKS:

They were going to tack that on a bill in the Senate, were they?

NELSON:

No. There was no specific legislative recommendation. We gave the report to the senators and the senators gave it to President Kennedy.

Incidentally, on the side, it was one of the most impressive periods or episodes in my professional life to meet with President Kennedy in his oval office. There were about six of us -- on this report. Impressive, because the President had our report in his hand and he had it dog-eared and he spoke to us with knowledge about our report. You know, some staff man probably did it -- but here's the President of the United States meeting with six of us, knowledgeably, about the report we produced. And I'll never forget one of his comments. He said, "Now, what are the chances of getting something done in the Senate at this time?"

Javits and Anderson were there and I've forgotten which one said, "Well, we hope that we can get Ribicoff [you know, Ribicoff had been at HEW and had come back into the Senate] to join us."

President Kennedy said, "I'd never trust Ribicoff in anything." A fellow Democrat!

WEEKS:

I think he was a lightweight.

NELSON:

Oh, very much.

WEEKS:

Out of that...

NELSON:

It was one of the forces that moved Medicare through Congress, yes.

WEEKS:

But they tried to put some kind of an amendment on a bill in the Senate, didn't they?

NELSON:

I don't remember that.

WEEKS:

I think that was a Javits bill -- a result of your committee work probably.

NELSON:

Probably.

WEEKS:

But it failed. By the way, I think that Gary Filerman once studied that and wrote a monograph on the failure of the Senate to pass that amendment.

NELSON:

Oh, I know Gary very well. He was here you know. He was probably here when I did that. 1961, I guess he came later.

WEEKS:

I am trying to think now. He came to AUPHA about 1963 or 1964. So he could have been here then.

Do you want to say something more about Medicare?

NELSON:

Medicare came about because of the needs of the elderly and the political reality that compulsory health insurance was not to be in any reasonable future. The needs of the elderly kept getting worse with inflationary costs and increasing longevity and medical technology. Hospitals for a decade or more were moving -- although slowly -- to support some national action; the medical profession was adamantly opposed. The AHA house of delegates in 1960 or 1961 approved -- after spirited debate and a split vote -- a statement of support for a national program.

In 1964-1965 during the Johnson Administration. Congress acted to create Medicare and placed it under the Social Security Administration. A year or so was left to tool up. I, along with a dozen or so others -- doctors, nurses, union leaders, knowledgeable scholars of health care -- served on the Health Insurance Benefits Advisory Committee (HIBAC). We really worked for a little over a year in helping set up procedures and rules, reimbursement, quality of standards, and the relation of Part A to Part B -- these all being difficult to resolve and fit the great variations in our 50 states.

The job done was remarkable. Much of today's administration is as laid down in 1965-1966 -- a tribute to the HIBAC group and especially to Bob Ball and Arthur Hess of the Social Security Administration.

WEEKS:

That brings up a question about the university's interest in hospital administration education. You tried a couple of times here. Is there still a program going on here?

NELSON:

It's the same thing as when we talk about nursing. It was located in the

School of Public Health and it never had the kind of, shall I say, health or scientific cut that stimulated that school to do something about. It was there by sufferance. It was kind of a patched together curriculum I thought. A cookbook -- how do you do that sort of thing.

I guess I sound kind of arrogant but the setting here is such that if things are going to go it has to have a reasonable amount of intellectual content or challenge. This education never took off in that way here. Chicago always has had it. But it never took off here. It took off as a kind of implied thing. It was a bastardized thing. It wasn't management, it wasn't public health, it was a little of both.

WEEKS:

I can see where the university would need a high caliber course in order to really support it with full heart.

By the way, do you still take residents in hospital administration?

NELSON:

Yes, I did.

WEEKS:

Do you think that's a valuable part of health administration education?

NELSON:

Yes, I do. The ones I saw come through here were most of them pretty young. And they're bright, bushy-tailed, but they hadn't really lived much in the world. I think they really need to rub their nose for a while in what the product is. How the product is made.

WEEKS:

When I was at Michigan I interviewed quite a few of these young people coming through and it seemed to be that most of them were right out of their

baccalaureate and right into this. They saw a career opportunity here. But now and then you would get someone who had been out working and had come back and you would see all the difference in the world.

NELSON:

Yes. I had a nun once. She was out of twenty years in hospital work. I asked her to make a report to the Board of Trustees one time, which I usually did because they ought to see what that process is like. And she went on and on and on and on and on. I said, "Sister, one thing we've got to learn is we've got to learn how to turn it off." She smiled.

WEEKS:

You said you were a member of the BCA board as well as the Maryland Blue Cross board.

NELSON:

Yes indeed. As a matter of fact, it may not show there, but I was on the BCA board selection committee that selected Walt McNerney. I wasn't chairman but I was the hospital representative on that with van Steenwyk, Colman, Jones, Jeb Stuart.

WEEKS:

Was Rufus on that too?

NELSON:

No, but he met with it.

WEEKS:

Walt McNerney told me when he was talking about his selection that he had been making speeches and one time he made a speech somewhere and he looked down and he saw Colman and van Steenwyk and Rorem and someone else sitting down there in the front row. And a short time after that he got a call --

would he be interested. He said, "I thought they were casing me."

NELSON:

Probably.

WEEKS:

But I said something to Rufus about that and he said, "Nah, we were just sitting there listening to him." Of course Rufus might say that anyway.

I wonder what you think about the direction of health insurance now -- the old Blue Cross service.

NELSON:

That's gone.

WEEKS:

And the indemnity of the commercial insurance?

NELSON:

That's gone.

WEEKS:

Now, what about the options? I realize that self-insurance by group employers must be thirty or forty percent.

NELSON:

Is it that high? I know it's growing.

WEEKS:

It may be just partial. They may be self-insuring up to a certain level and then beyond that have some insurance company back them up above that level.

We talked a few minutes ago about HMOs becoming national systems. Do you see any voluntary hospital merger chains that will ever become national?

NELSON:

Yes. I think the answer is that. I don't know if there'll be a lot of it. The voluntary hospitals of America, they are not merging but they are sure doing a lot of business together -- more and more all the time. And putting money into it. Like banking, I think regional is about as far as it will go.

WEEKS:

I noticed the Supreme Court handed down a decision on that didn't they?

I talked with Dr. Frist, Sr. of the Hospital Corporation of America -- he's a very impressive man. He's about our age. When I stopped to think of in fifteen years building up to 400 hospitals either owned or operated and the tremendous amount of cash that's flowing through that outfit and the buying power they have and, of course, the recent merger in taking over the American Hospital Supply Corporation....

NELSON:

Foster McGaw is turning over in his grave.

WEEKS:

I talked to Foster McGaw a day or two after this happened.

NELSON:

Is he still alive?

WEEKS:

Yes.

NELSON:

I thought he was dead.

WEEKS:

No, he is still alive. I did a paper on him. I can't call it an

interview but it was a question and answer which he responded to in writing. He's up in his high eighties, but he is still alive. I think he's taking very good care of himself because he doesn't get out much.

Dr. Frist has had a heart attack and a stroke, on separate occasions. He was in an automobile accident where he was very badly injured and yet he's trying to make seventy to eighty hospital visits a year and make a speech in each one to the trustees.

NELSON:

That's an entrepreneur, you see. He's had that in his blood since he was a boy.

WEEKS:

Oh, yes. He told me how he worked his way through college. You'd be amazed at what he did.

NELSON:

I know he sold books or something.

WEEKS:

He had all kinds of things going. The man is amazing. As you say it is in his blood.

His argument is, 'We can do it cheaper; we can borrow money cheap; we can build hospitals faster. We can still make a profit and do it for less money than ...

NELSON:

I think he's right.

WEEKS:

And Kaiser. I interviewed Dr. Garfield shortly before he died. When you talk to these men that have done all these things -- gone off in the desert, build dams — nothing is too big for them. It just seems to me that someone of that caliber is going to begin to set up national systems of one kind or another.

NELSON:

I think so. But I think the nationalization, if that's the word we should use here, is going to happen but I don't think it's going to be through the hospitals. I think the hospitals are going to just be part of it. The HMOs will nationalize things. The national HMO will make the contracts.

WEEKS:

And the hospital will be the provider, period. And they'll have to live according to the demands of the HMO.

NELSON:

Of course they will.

WEEKS:

Another thing that Dr. Frist was interested in was homes for the aged. He has one in Michigan now.

NELSON:

Homes or ...medical things or...

WEEKS:

What he's interested in is building three levels of care into one institution.

NELSON:

Zero care to full care.

WEEKS:

Yes. So the people who are ambulatory or need just a cane to walk and can go to their meals and so forth -- they can live pretty nice, if they can afford it. What are we going to do with all these people? A lot of people our age are in nursing homes. It doesn't take long to use up your capital when you go to a nursing home.

NELSON:

That's for sure. As you say, you do the best you can.

WEEKS:

Do you think it's a federal problem -- that the federal government should...

NELSON:

Minimally. After my years in professional work, I believe the federal government can't run things very well. And when it gets too heavily into the financing of things political realities are such that they are forced into running it. And they don't run human services worth a hoot. We give lip service to an old fact, but we don't really mean it, and that is that there's a hell of a lot of difference between New York City and Meridian, Mississippi.

WEEKS:

The very fact that Medicaid has failed, more or less -- Kerr-Mills failed because you can't....

NELSON:

....you can't dictate the standards like that. You really can't. I don't know what's going to happen with the care of the aged. It obsesses me a little but it will you too. I think nobody has solved it, no country has solved it. I'm familiar with England and that's one of their biggest

problems. I would forecast a combination of things evolving. One is it might become even more of a charity thrust through churches. Churches are still able to raise a lot of money. And it's that kind of a compassionate thing that the church can do pretty well. They don't run hospitals as well as they can run some other things. But that's because it got too technical and scientific for them. That's one thing.

Another thing is more services delivered in the home. Whether that be a family in a home or whether it be an individual in some kind of an institution that's a home. I can foresee that. I can perhaps foresee a federal role in some financing that gets it as far away from operations as possible. Hill-Burton wasn't bad when it was first started before they started requiring too many things.

A federal role, too, in the establishment of the broadest kind of standards, not hygiene standards but the broadest kind of standards. Which means they'll probably be pretty minimal standards.

I see industry having to put money up like they are doing in pension plans over the lifetime of a worker to protect to some degree. I think we are going to have to patch it all together. That would be my guess.

I used to say that's a good thing for hospitals to do. Uh uh. Not now. I think hospitals have moved to the point where they are technological shops now and will not do a good job. They traditionally have never done a very good job because it has always been a second rate activity to a hospital. And even more so now.

Churches...I'm not very close to any of this but it seems to me that churches are -- what I read -- I won't say constantly because that's pretty flat but they are kind of searching for missions from time to time. Things to

do other than preach to the flock.

WEEKS:

Since we started talking about this, the thought crossed my mind I wonder what the Mormons do.

NELSON:

I don't know. I think they do their own welfare. I bet you the care of the aged is a family phenomenon with the Mormons. They are back doing like our grandfathers did it.

WEEKS:

Most of us are pikers beside them when it comes to taking on responsibility.

When you were here in your hospital, I'm sure you noticed a great deal of difference before and after Medicare and Medicaid. What were some of the things you noticed? Did you have an increase in admissions?

NELSON:

This hospital was usually so full it's hard to tell an increase. I think more the increased money flowing in changed the hospital as much as anything. The first thing it did was raise wages which were tragically and disastrously behind the times. That, strangely enough, led to unionization. Because it suddenly became something.

WEEKS:

It was the result?

NELSON:

No, we started that before. The union, as it always does, increased the pace. But that's the principal thing I think. Of course, ours was so different because we got a good Medicaid program at the same time. That took

the load of the indigent — financial load. I think the statistics would show an increase in the admissions of those over age 65 but I didn't feel it as such. I know the ophthalmology department had a lot more cataracts for instance.

WEEKS:

Probably a lot of the older people had let things go.

NELSON:

That's right. They just couldn't afford it. I think another thing is it began the process of decent accounting, financial accounting. Most hospitals were in deplorable shape in the 1950s and early 1960s in accounting. it often wasn't existent. It started that and it started improving the personnel associated with the financial operations.

WEEKS:

So many things. Physicians had higher incomes. They were able to treat things that they weren't able to treat before and this may have made a difference in the way they practiced too.

I mentioned before that I would like to have you talk about your experience in Berlin.

NELSON:

I'd love to do that.

This came about through our State Department and I owe that experience to my late good friend Jack Masur. Do you remember Jack?

WEEKS:

I remember the name, but I never met him.

NELSON:

He was head of the clinical center over here. A fine, compassionate

clinical administrator. He had been a general officer in the Public Health Service and he was asked by the State Department to make some suggestions because the State Department wanted to make a hospital and medical effort in West Berlin. When Berlin was partitioned, West Berlin inherited the worst of the hospitals. The youngest hospital there was built in about 1907. Terrible old institutions.

The Ford Foundation had led the charge to build a free university in West Berlin. West Berlin had a lot of well-trained, academic kind of doctors that had come over from East Berlin -- escaped as soon as they could with their families before the wall went up. So there were a lot of energetic people who wanted to do something. Of course the basic reasons for what was going on were political -- to beef up West Berlin as a showcase. And we used what's known as counter marks. They were Marshall funds. When we sent all our billions over there they kept book and said we owe you so much and we'll pay you in marks in due course. So we were able to spend West German marks. The West German economy in the mid-1950s was beginning to move.

I went over there as the medical advisor to a team of architects out of New York, New Orleans, and West Berlin who had been commissioned to do this. The instrument that was doing it was a foundation that was set up, a German foundation, called the Benjamin Franklin Stiftung, which is German for foundation. That was set up to short-circuit or evade the bureaucracies of both foreign ministeries. So that all the foreign ministeries did in the State Department and their foreign ministry was punch the money into this foundation.

Then we started working with the West Berlin government. Willy Brandt was mayor. It was great. Just great. He was the kind of guy -- like a

Kennedy or a Humphrey -- great compassion. And he had power. He said, by God, we'll do this.

For instance, one meeting -- we had been laboring to design a hospital and the German appetite for a hospital was enormous. They just thought two thousand beds was a minimum. So the architects designed a beautiful plant that permitted itself to be cut in half -- for political and financial and a lot of reasons.

So we went forward -- the Stiftung went forward with a plan for half. Right then, by God, Willy Brandt said, "We'll build the whole thing." And we did.

It was terribly interesting to me to deal with the German medical academic mind and culture. It was no problem with the architects or the politicians. They were understandable. Remember the German university is a very hierarchical affair. There was one chief professor and all the others were underlings. Some of the immediate underlings called docents had been in that position -- roughly equivalent to our associate professors -- for twenty-five years. And the chief had everything, including a private practice. And they always had their own nurses and their own beds and their own lives. There was no real general hospital. Despite the good German name of the general hospital. And they were very possessive of their turf. A lot of them didn't get along too well either -- medicine and surgery.

It was agreed that we would produce for that a teaching hospital on the American model. And the catch-word for the Germans was "under one roof." Their vision was literally that. A whole series of hospitals under one roof.

So I had a fine time dealing with those men. A memorable time, I laid out for them the need for what in this country would be called a medical

board. I pointed out that this is a place where medical policy, overall policy, was set. Where standards and appointments were made. You know what I'm saying. They had never had any thing like that! As they saw the logic in this, they began to come along. And then they said but who will be the chairman of that? They were very afraid of a dictator. I said you could do that in a number of ways, you could elect your chairman from among you, you could take a chief medical officer physician full time who might be the director of your hospital and let him be chair, you could ask the president of the university to chair. Well, it took weeks to thread this through. Surprisingly, they finally agreed on a general medical director.

I might say that I think some of them didn't trust any one of the others to tell you the truth, but they didn't want the university involved.

Well, it was just a wonderful experience. I had a great time. The hospital was built pretty much on schedule. It took about eight years from the first meeting until it was opened -- just because it takes a lot of time. And it's a thriving institution.

WEEKS:

How many beds did they finally build?

NELSON:

Fifteen hundred! I got five hundred out of them.

WEEKS:

And it's still operating well?

NELSON:

Yes. And it's a very fine medical school too.

WEEKS:

That's wonderful. That must have been a great sense of satisfaction to

you.

NELSON:

And I got all sorts of scrolls and what not and we became very, very good friends. I once brought over to this country, I think it was about twenty medical professors and two nurses. I said you've got to see -- now we've got an examining force -- you've got to see how these things will work. I took them to about five academic centers. We spent about two months traveling. I said don't hurry yourselves. And I met them here and said this is the first one -- I'll take my time, you know me, we trust each other. I'll take my time and go over it slowly -- meet over in our board room to listen to our board meetings -- medical board meetings and so forth. And I never will forget that one night in one of these dormitories, I said to these professors, "You've got to see some of our medical students and graduate students and see how they react to teaching and academic life."

I said I'm going to be there and I'm going to introduce you and I'm going to ask these students -- I had picked them carefully; I knew them -- I'm going to ask these students -- I'm going to ask you to talk, the Germans -- some of them couldn't, they couldn't speak English -- and describe what you are doing over in West Berlin and so forth and then I'm going to stop that and I'm going to ask the students to interact with you. I said now don't be alarmed or offended if some of these students get up and ask pretty pointed, difficult questions. I said that's not a matter of disrespect in our university or in the United States. As a matter of fact, it's a matter of respect. They think you might know the answer to a difficult question. I said don't take it as impertinence.

Well, some of them were a little too old to accept it. We had a lively

night.

WEEKS:

It was good both ways wasn't it?

NELSON:

Yes, it was.

WEEKS:

Why did they call this the Free University? Was it free of tuition?

NELSON:

No. I think it's like it's used in other settings -- you've seen the word autonomous university? It's the same thought. It's not part of a church, it's not part of another organization.

WEEKS:

Like a free city.

NELSON:

Right. It's a free-standing university.

WEEKS:

I have you noted here as going to Leiden Hospital.

NELSON:

Yes. I went there for a shorter period of time at the invitation of the medical director there whom I had met at some international meetings -- on a somewhat similar mission to the West Berlin. Leiden University is one of the old, fine universities in Europe. And they had the misfortune in their medical school of rebuilding the whole thing, hospital as well, in about 1915. And it had just frozen since that. Old-fashioned. Much like Germany's. And they were just trying to bring it together and get rid of this madness and so forth. They needed some help, they thought, from the United States. Exactly

what we do.

I went there maybe half a dozen times in a year and a half.

WEEKS:

Now your Nuffield Study in Britain -- was that a comparative study?

NELSON:

No, it wasn't as formal as that. The Executive Director of the Nuffield Trust was Gordon McLachlan -- a good friend of Ed Crosby's of the American Hospital Association. The two of them concocted the idea that there would be an exchange of what they called 'fellows' for a number of months. The time to be negotiated.

Gordon had asked me to be the first American fellow. So I went over with my wife and had a wonderful time -- given an apartment.

When I got over there Gordon said, "What do you want to do?"

I said, "Well, I'd like to look at the hospitals and the system here from a different point of view than some of us had looked at it in the past." I wanted to look at it from the standpoint of their graduate medical training. Because I knew if I did that I'd get into all sorts of worms.

So I went through pretty much all of England and some of Scotland. I was looking at the educational process -- training of doctors. Not too different from ours actually. But they've got a little of that German docent thing. They've got more troops than they are prepared to offer as generals.

WEEKS:

They call their specialists consultants, don't they?

NELSON:

Yes.

WEEKS:

And isn't there a limited number of those who can be appointed?

NELSON:

Yes, that's right.

WEEKS:

So that's what you are referring to. You might be in the stream for twenty-five years before you got it.

NELSON:

That's right.

WEEKS:

I was impressed -- I was there in 1964 and visited a few hospitals -- I was impressed with what they had done with some 200 year old buildings. Some of them were fixed up pretty nicely.

NELSON:

Sure. I've seen those too. As a matter of fact, some of the older ones are nicer than the new. The brand new structures they've built up, they are kind of ordinary.

WEEKS:

I think my favorite story is in going to Guys Hospital and a young man, an assistant administrator, was taking us about. My wife and I were there together. We were out in the courtyard and he said, "This whole wing was bombed during the war and so we rebuilt it. We rebuilt it out of the same kind of material, the same architecture, everything was identical."

I said, "I can't see where the old is and where the new part started." He said, "We were faced with a problem. We were wondering what to do, whether we should sandblast all of the building so that it would look all new. We

finally decided to soot the new part."

NELSON:

That's very practical, isn't it?

WEEKS:

I thought, that's cricket I guess.

What did you do in Russia?

NELSON:

This is an Ed Crosby story too. This was in 1965. This was the first year of the cultural exchange that was agreed to by the two countries when they were sending scientists of certain types and cultural things first. The Russians wanted to have a medical and hospital visiting team sent there and they were going to send one over here. The Public Health Service organized it. Five of us went -- Crosby, Nelson, Bonnet, Graning of the Public Health Service, and Masur. We spent, I think it was five weeks there. Wrote a report, by the way, which is gathering mold someplace.

We traveled from hospital to hospital, from big cities down to the very small places. We were just looking at the hospitals and finding out what we could about how they were operated and something about the professional structure of them, something about the educational process. We were shepherded around by two people. One was a woman who was a translator for us. She was an officer in the National Medical Library. She did the translations from English to Russian. Another was a radiologist who was also the medical director of a small hospital.

We saw all sorts of things I'll tell you. Learned an awful lot about Russia. Traveled all over the place. We went from Leningrad in the north down to Tashkent in the Asian part.

WEEKS:

That's very unusual that Americans would have that much freedom. You were quite privileged in that.

NELSON:

Yes we were. And we were treated absolutely first-rate too.

WEEKS:

That's wonderful. Did you find a high percentage of female physicians?

NELSON:

Yes, quite a few. They are very wasteful by our standards. I say wasteful in their staffing. They had one doctor, usually a woman, permanently established on every floor of the hospital -- like a ward officer. They had lots of M.D.s, you know.

WEEKS:

I suppose patients coming in didn't have a physician, they just came in and were assigned to whatever floor?

NELSON:

Just like Bellevue. No, there is no physician assignment except the very upper, upper echelons. No, there is no choice. Everything was about thirty or forty years behind us. I felt comfortable on some of the floors because that's the way they were here when I was in medical school.

The Russian people that were patients -- I saw patients and examined them -- I thought as long as I'm here I'm just going to go right at it. They were nice. They were terribly interested to see an American. But the Russians are very docile patients. They'd let you cut their fingers off, I think. I saw meals now and then. They were dreadful. They were gruel, with bowls of kind of soupy stew. So they don't do much on the amenities, I'll tell you that.

One interesting sidelight, because this is where I guess some of the fun comes out. We were always conscious that we were being supervised. Those two people with us were there for reasons other than just helping us -- though they were darn nice people. One night in Tiflis, which is in Georgia where Stalin was born -- and that's really not strictly Russian. They are Mediterranean types -- like Greeks or Armenians. They've got a lot more life. You can see it on their streets and their buildings and in their faces and everything. Our guides said tonight a journalist would like to meet with you and take you up to the Terrase. They always have that -- the Terrase Restaurant -- on a hill. Okay. We were experienced enough to know that the journalist was obviously a KGB kind of guy.

So we got up on this mountain top -- hilltop. There was this great big structure. It looked like a restaurant for people on a party and that sort of thing. We looked at the city. We walked around. We learned a little bit about handling this surveillance. That if we went to a hospital we could find ourselves separating a little. And we were five and they were two. So you could get off a little bit by yourself. So we did that.

One of us --I've forgotten who it was -- said there's a lot of laughter and music going on over here -- let's see what it is. I think it was Phil Bonnet. We walked in. And we walked into a banquet that was being held for a graduating class from the local medical school. Talk about fortuitous occurrences. And the professors were presiding. We had learned how to behave at banquets by this time too. There were about between 75 and 100 students there -- most of them girls. We were no more than introduced than we were grabbed, literally grabbed, by groups of eight or ten students -- come on over here and sit down by us. We were brought some kind of food. We didn't want

any food. They just gathered around us. And they wanted to practice English. They studied it and they listened to the BBC every morning. Some of them were pretty good. They asked us to talk about medical students over here. We got them to tell what they did. Their's wasn't too different. Their experiences as medical students -- a lot more of them in a class. But it wasn't that much different. Wasn't that funny?

WEEKS:

That was a wonderful experience.

NELSON:

Yes, it was.

WEEKS:

Not many people have that privilege, I don't think.

Well, we can't go without talking about the Joint Commission. I have often wondered if Dr. Crosby has some hesitation about leaving Hopkins and going to Chicago.

NELSON:

Oh, yes. He had a lot of soul-searching to do that day. He was devoted to this place and a lot of the people here. But in the end -- well, I was going to make a pronouncement but I don't think that's right. He had been here a little short of twenty years -- fifteen. I never really put it this way and I don't know that it's right -- but having gone through a little of this myself and recognizing that he was a restless soul -- I think in a way he might have been in tune to take on something new. But then, I think, something like a Salvation Army mission was in this pie too. Something very important to get done. And I think George Bugbee was a hell of a good salesman. George had a lot to do with persuading him. But he never had a

regret. Never, never expressed a regret to me. I think if he had had a regret he would have said, gee, I wish I had not done it.

WEEKS:

It probably made it easier for him to move to the Hospital Association after having been in the Joint Commission.

NELSON:

Yes. That was a pretty easy move. He liked the Joint Commission and he had a great respect for Gunnar Gundersen, who I believe was the first chairman of the Joint Commission. He had a great respect for him.

WEEKS:

They had to break a lot of new ground didn't they? Because what the American College of Surgeons had done was not the same as what the Joint Commission finally did.

NELSON:

No, it wasn't.

WEEKS:

Did you ever go on one of those inspection tours?

NELSON:

For the Joint Commission?

WEEKS:

Yes.

NELSON:

Yes. I had one of the first ones here. I tell this story -- it's apocryphal, but also has some meat to it.

You know the ground rules were not laid out. I got a call from Colonel So-and-so, who said he was from the Joint Commission and was coming over to

inspect our hospital and would like to meet me at nine o'clock. I said fine. He came into my office and sat down and said, "What are we going to do?"

I said, "We're going to inspect the hospital. What do you want?"

He said, "Do you still have a good pathology department over there in the corner?"

I said, "Oh, yeah."

He said, "Do you still do most of the posts on the dead?"

I said, "Yeah, we still do that."

"You need a larger laboratory."

The inspection was, I think, one day. Finally I took him out and said, "At least walk through the hospital."

He said, "I'm sure your kitchen's all right."

I said, "I guess it is." But then I said, "Let's go up on the floor" -- he was a medical colonel, this guy — "let's go on the floor and see patients and see the nurses." But that was it.

I went to some of the trouble spots. I was in Utah, I believe, when Ken Babcock was there.

WEEKS:

He's retired now in Florida too, isn't he? And there is one other in there.

NELSON:

Oh, he's out in California — Porterfield.

WEEKS:

So you sat on the board of directors of this did you?

NELSON:

You see, the commission was set up with three commissioners from each of

the participating groups. Initially it was the AMA, AHA, College of Surgeons, College of Physicians. Three each. And I was one of the three. Then, they elected the chairman from among those. I think I was the chairman the last year of my three year appointment.

There were a lot of big issues -- a lot of work to be done to set the standards and the process. But there was a hell of a lot of jockeying in that commission because the AMA board of trustees -- it's typical of a kind of conservative, neanderthal way of looking at things -- were nervous about things. What's this startup outfit getting in? And, of course, something I didn't know as well as I began to learn is that there never was 100% real good blood between the College of Surgeons and the AMA.

WEEKS:

I suspected that a couple times too.

NELSON:

And so here was the AHA and the College of Surgeons. Well, the net result is that the AMA was not willing to let their own commissioners make decisions on their own. It would have to go back to that board of trustees. I'll never forget one meeting where a practitioner in Lancaster, Pennsylvania was the leader of their group. He was a good man. He had been president of the AMA. A pretty reasonable fellow. We had agreed on something -- it had to do with either psychiatry or nursing homes which was all the buzz at the time -- and took action. We had to meet the next morning and clean up the agenda and he came back and said, "I've got to raise this issue again and tell you that we cannot support that." Overnight the AMA board of trustees had pulled the rug right out from under its own representatives.

Well, everybody was upset and felt terribly sorry for him. That was, I

think, the biggest difficulty we had. Oh, we had difficulty with some hospitals suing because they were disaccredited and so forth but all in all we did pretty good.

WEEKS:

Basically wouldn't the AMA prefer to have been the sole...I heard the story that George Bugbee was approached by the American College of Surgeons when they could no longer afford it and then AHA offered to take it over.Then AMA heard about it and rushed in, so they finally decided to do it together.

NELSON:

It was all decided at some meeting of, I think, the AMA in Atlantic City in 1950 or 1949.

WEEKS:

We were going to talk about Winford Smith.

NELSON:

He was director of the hospital when I was appointed intern in 1937. We sort of perfunctorily met the director at that time. That was just a how do you do. Later when I became the chief resident in medicine, I was called to his office and he made quite a point of the importance of that position. He pointed out, as I said earlier, that there were two resident officers noted in the original bylaws. He said the hospital will pay you as chief resident $500 a year so that you can take emergency calls for anything in the hospital, like fires or whatever, on nights and weekends. And you'll rotate with the chief surgical resident in that job. This had gone on for years.

Well, he made a great point of that. As I recall, that was the only salary I got as chief resident from the hospital. But I did get about $2000 from the medical school because I was teaching students.

I subsequently got to know Dr. Smith better when I became more active in committee work and particularly as I got into the administration of the outpatient department. When he offered me that position, he then called me down to his office. He was quite a formidable person to meet, his office was rather formidable -- in the old-fashioned ways. There was no levity in Dr. Smith, at least in dealing with me.

He said, "I want you to go see some other outpatient departments and I want you to visit some of my friends who have big hospitals." I was sent to Lakeside, to Strong Memorial, to Mass. General, and of all things to Boston City because he knew a Dr. Melaney. So I had kind of a junket seeing outpatient departments. They're all the same mess that everyone knows.

I occasionally had contact with Dr. Smith but mostly I did my reporting to Dr. Crosby who was the senior assistant to the director. I got to know him a little bit after his retirement. He and his wife lived in the same apartment building that we did for a while. I watched him grow into his eighties. Just a fine man of high integrity. To me, extremely old-fashioned. I was forty and he was eighty-five.

WEEKS:

That's quite a gap there isn't it?

Are there any other persons you have worked with that you'd like to comment on? You went to AHA after Jim Hamilton was gone.

NELSON:

I worked closely...I don't know that I want to or could comment about my contemporaries. I'm still good friends with all these fellows. I did mention Doug Colman.

WEEKS:

Yes. I'd like to know more about him.

NELSON:

I was close to him. I believe his father was a clergyman. His dad died when Doug was fairly young. He was from New Jersey originally and after graduating from Cornell, I believe, in the 1930s I believe he worked for the Welfare Department in the state of New Jersey. And from and around that got interested in Blue Cross and ultimately came to Baltimore in, I think, 1936 or 1937 to be the organizing executive of the development of Blue Cross here, and subsequently Blue Shield. A very energetic, very able person, well educated and brought people together. He got a good board for Blue Cross -- developed a very good Blue Cross plan, a conservative one. I challenged him about the fact that he wouldn't pay adequately all the time. And he said, "Well, I'm perhaps not fully adequate but I'm always there." He had visions of doing things that he never could get done in his Blue Cross plan which would be to develop what we now call a real data base on utilization. He wanted to do that and research for a while. He never could get his board to appropriate the money to hire the folks for that. He had good relationships here with the hospitals. He had a hankering to be in the academic field somehow. He would go into the school of public health and take courses. And at one point, Johns Hopkins University went to him and offered him the vice presidency for fund-raising and development. He took it. I told Doug he was just crazy -- that's not your kettle of fish. Well, it was attractive. That didn't last but a couple of years.

Then the position in New York became open. George Bugbee was living in New York then. He was working for that drug company.

WEEKS:

HIF -- Health Information Foundation.

NELSON:

That's right. And he was on the Blue Cross board and was chairman of the search committee or on the search committee, I have forgotten which. He called me several times about it. He also wanted to know whether I was interested.

I said, "No, I'm a hospital fellow."

He said, "What about Doug Colman?"

I said, "I think he is just the kind of person you want. If you act pretty quickly you can bring him out of the job he's in because I don't think he likes it." Then that happened.

Doug had a great deal to do with the development of national Blue Cross, commission efforts and that -- trying to bring the Blue Cross plans together. He was a doer. I was very fond of him and we worked together a lot.

WEEKS:

He was relatively young when he died wasn't he?

NELSON:

Early sixties.

WEEKS:

I never had the pleasure of meeting him. Of course, I've heard a great deal about him. It's strange isn't it, in those early days, very few of the promoters or entrepreneurs of Blue Cross plans were trained in any of the health professions -- every thing else. vanSteenwyk was a builder. But they had to have that entrepreneural spirit, I guess, in order to get into it. It was quite a challenge.

Did you know van Steenwyk?

NELSON:

Yes. Not as well as I know some of these others. I served on that infamous search committee that found Walt McNerney and I think Van was chairman of that.

WEEKS:

That's right, you did mention his name.

NELSON:

McNary was on it.

WEEKS:

From Michigan.

NELSON:

Jones from Massachusetts. I can remember those three.

WEEKS:

Did you work much with Walt McNerney himself?

NELSON:

No. Our paths have crossed a great many times, but we've never really been that much together. I was on the BCA board when he was president -- for a short time.

WEEKS:

When was that? It was 1961, I guess, when he came to BCA.

NELSON:

Yes. About that time. I know because it was right after the Javits report. They had a meeting down in Florida and boy, did I ever take the hot tomatoes from those conservative Blue Cross fellows, including Walter.

WEEKS:

There must be a lot of pressure in BCA -- political pressure. I have never been back to talk with Walter about how he was really forced out but it may have been the big building they took over. Have you been in the new building? It's a twenty-some story building and they took all the floors but two. Now they are down — I haven't been there in a few months — but I think they are down to about half the building -- gradually shrinking and trying to cut expenses.

I think we should talk about your awards now. I have some listed. I'm sure you must have some more — the AHA Distinguished Service Award. That's a pretty nice honor.

NELSON:

Yes. I feel it was.

WEEKS:

And the American College of Physicians' Masters Award.

NELSON:

That was even more of a thrill to me. The AHA award was while I was sort of in the stream of things. The American College of Physicians represents my early beginnings in academic and clinical medicine you see. And after all of those years to have been found pleased me immensely.

WEEKS:

They still think of you as a physician then.

NELSON:

They did. I don't think I got many other awards. I'm reminded of a fine old physician over here who said, "Awards, awards, sure. I got third in shot-put once."

I am a Distinguished Alumnus of the University of Minnesota and I got a medal for that.

One of the most pleasant things that's happened to me is that they named a building after me over here, shortly after my retirement.

WEEKS:

Did they really? That's something that will be there a long time.

NELSON:

It was a real surprise. I just have to say it warms your heart.

WEEKS:

Especially when they do it while your still alive.

Does Johns Hopkins have satellite hospitals? You said you own City Hospital now.

NELSON:

That's a satellite.

WEEKS:

Do you have any others?

NELSON:

Well, we've got a pretty strong affiliation with the Good Samaritan Hospital out here. It's a new Catholic hospital. We don't have a formal affiliation, but we work pretty closely with that one up in Columbia. There are a number of affiliations on the level of graduate medical education -- for information exchange. Two hospitals in Baltimore and Hopkins are affiliated in the nursing school. But these aren't in the mold of the real satellite. There is a lot of thinking and planning in this direction.

Right now there's a good healthy debate as to whether the way to go is to merge and or buy or whether to structure a looser consortium. My guess is

it's going to come out both ways. We're going to have some of each. But there's a move to network.

WEEKS:

Henry Ford has a couple of satellite hospitals and they are also trying to get management contracts, I understand.

NELSON:

Well, Hopkins had a management contract with that City Hospital for a couple of years before the city and Hopkins decided that we ought to buy it -- take full control of it. Maybe some management contracts end up that way.

WEEKS:

It seems to me that since we are moving in that direction, since the investor-owned and some of the voluntaries -- other voluntaries -- are moving in that direction, I don't know what kind of general statement you could make about university medical school hospital medical centers -- about them associating with others. Like the Hospital Corporation of America now has at least one university hospital connected with a university medical school under management contract.

NELSON:

I know that's going on. I don't know whether the view I have on this is old-fashioned and traditional or revolutionary, but I am a little bit doubtful of the wisdom of big centralizing moves for management. I've seen it in corporate work. I see it in my computer company. And at a certain point it's negative. When you get to a certain size or reach, it doesn't work well.

I think that's going to be even more so with some hospital conglomerates and especially so if the university is involved. I would hope the world would go in such a way that policy and standards and joint venturing can go on

without total control and that managements can be decentralized. This is human services we're in and I'm just afraid that the hospital system won't be any better than the federal government when it gets running things that are too big for it.

WEEKS:

I think there's a lot of truth in that. But you see in our commercial corporations where they are merging disparate kinds of ventures under one umbrella and after a while you will see that they sell off or dispose of units. Somebody's good idea to build a strong company that was merged and then is cast off and is worth nothing and is gone. It makes me feel badly just to see it.

NELSON:

Sure does. I think it is likely to be even more true in the hospital/medical field. I don't know enough about how HCA or Humana or so forth operate but if they are highly centralized with their authorities, I think they are going to have trouble. I guess they are wise enough to have foreseen this or lived through it and are giving their local units a lot more leash time and distance.

WEEKS:

Yes. They have their own local boards apparently and they are trying, I think, to give them as much authority as they should have -- and trying to make them community connected, to get the community spirit into it in other words. How successfully they can do that I don't know.

NELSON:

The test is going to be when times get tough. For all hospitals times have been lush for fifteen years -- cash has just rolled in.

WEEKS:

I think you struck the point there that they haven't been tested yet. Our whole country hasn't been tested very much in the last generation. We who have been through the Depression -- I know our kids and grandchildren probably hate to hear us talk about the Depression but...

NELSON:

I'm sure they do too. It's a good testing time, isn't it?

WEEKS:

We've not forgotten the lesson at our house. Although we didn't suffer or go hungry or anything, we didn't have much. I think you are right. This testing period is going to tell the tale.

NELSON:

Maybe I shouldn't say but I've been expecting the evil day for a long time and it never did come — the evil day being the testing time. I really think it's here now. Our federal deficit, our tax rates, our wage rates, our dollar price, decaying manufacturing plant and operations, and this frightful spiral in cost that we went through in health care. There just has to be some kind of tighten down. And I think it's starting.

WEEKS:

So many people, most everyone has been born since the Depression, so to them this is just something you read in the history book and it doesn't mean very much, but when we see,as you mentioned, our smokestack industries going down, competition coming in from abroad and all these things we've got to do something to stand up and fight this off. We've got to pay our own way. You or I cannot go on deficit financing in our private affairs for very long -- we can for a while maybe but not very long. There is always a reckoning day and

there will be with this.

NELSON:

And we're not quite ready for it -- in total in the nation. I think the hospitals are getting ready for it. But everybody's got to take his bite in this.

WEEKS:

But the very fact of competitive bidding for hospital stay is coming in now in this northeastern Ohio thing where Blue Cross went out for competitive bidding and three or four hospitals were not given contracts, they almost faced bankruptcy. So they are starting to sue to try to overturn the thing. So, as you say, the hospitals are facing it now, maybe before anybody else.

What else do you see down the line in the way of the future?

NELSON:

I think the biggest change is going to come in the way the physicians organize themselves to practice medicine, rules under which they are going to be practicing. That's still pretty loose. And you are going to have a surplus of physicians. The market's going to change. Doctors are going to have to really now practice in organized groups. And there are going to be constraints put on the economics of their practice. This is going to impact hospitals and other institutions substantially, some for the good, some not for the good. Doctors are going to have to choose what organizations they belong to, more than they ever have. I think that's probably the biggest change I see.

I really do believe that out-of-hospital, out-of-clinic health services by others than physicians is going to develop pretty rapidly. It's going to be troublesome and I don't know that it's going to save that much money

because although its unit prices lower, the need and demand out there is going to be fantastic. You know there are people who need help now all over and they are sitting at home. So I don't know if it's going to save much but I think that's going to happen.

I believe we are going to go through a generation here with less government intervention and government sponsorship. I wouldn't have said that a few years ago but it seems to me that we're on track for that. In such a way that it's not going to change in the next twenty years probably.

As I said earlier, I think business and industry are going to get more into this process for the purpose of getting more rationality into the dollars they have to spend and therefore put into the cost of their products. I don't know what form that's going to take. My experience, limited experience, with industry is I don't think they are very attracted to get into the process of health care delivery. They know it ain't easy. But they are going to be calling the tunes a little bit more.

I think the individuals are going to have to put up more of their resources at the time they get care than we were brought up to believe. They seem to be able to find the money to do it. You and I thought if they have to pay anything they won't come in. Well, that's not true in this economy and this society. They'll cough up.

I believe the cost curve is going to moderate in the next decade. It's starting already. I think the principal reason is: I believe the economists who say we are going to have a more steady stage of inflation than we have ever been through. I think this country is pretty hypersensitive to any more inflation. So that's going to moderate costs. Wages aren't going to rise as fast. These are all going to impact.

WEEKS:

The insurance principle has probably made people unaware of the rise in medical costs because they haven't had to pay out of their own pockets in most cases.

NELSON:

Absolutely. I don't know whether you have had a major episode that you have had to go through. I had to lose a gallbladder a year ago, all of a sudden. When they ran the cash register on what I had, I guess I had six or eight thousand dollars for just a short stay and a snip out. I call it a simple thing. Do you know what it cost me? I guess it was twenty percent of some of the fees for radiology that sort of thing. I've got a supplemental insurance and that covers my Medicare deductible.

Well, I enjoyed that, but I'm not sure that's right.

WEEKS:

No, it isn't right in proportion to what we're...

My wife lost an aunt not long ago who had been in a nursing home where it was costing her between $20,000 and $25,000 a year just to stay in this nursing home.

NELSON:

Scares you doesn't it?

WEEKS:

It certainly does because she didn't require much care -- but she had to have care so she had to be there. Luckily she had enough money to pay her way.

NELSON:

Family after family after family faces this.

WEEKS:

These things have got to be faced. We've got to find some better way of doing things, it would seem to me. The hospitals are facing the fact now that they can no longer get the prices that they used to get. Somebody comes in and says do you want to enter into competitive bidding with other hospitals for your services? At first a slick salesman can say, if you go into the competitive process instead of operating at sixty-five percent occupancy, we'll send you a lot of people and you will get that up to ninety or ninety-five percent occupancy. Some of them will go for that.

The same with physicians if they enter into some kind of contract. That can only go so far.

NELSON:

I don't know what's going to happen. I doubt there is anything sweeping going to happen. I think there's going to be a lot of patches here and there, here and there.

WEEKS:

I think the warning should be try to live healthfully and drop all your bad habits.

NELSON:

Or hope when you get to the point where you're supposed to be through that something awfully heavy falls right on the top of your head.

WEEKS:

So they don't keep you on life maintenance.

NELSON:

Well, I think that's about all I know about the future, sir. I think there is quite a bit in there that we went through.

WEEKS:

Yes. I'm sure there is. Thank you for this oral history. I am sure this has been truly worthwhile.

An Interview With

Dr. Russell A. Nelson, Baltimore, MD

June 11, 1985

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