HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Avedis Donabedian

AVEDIS DONABEDIAN

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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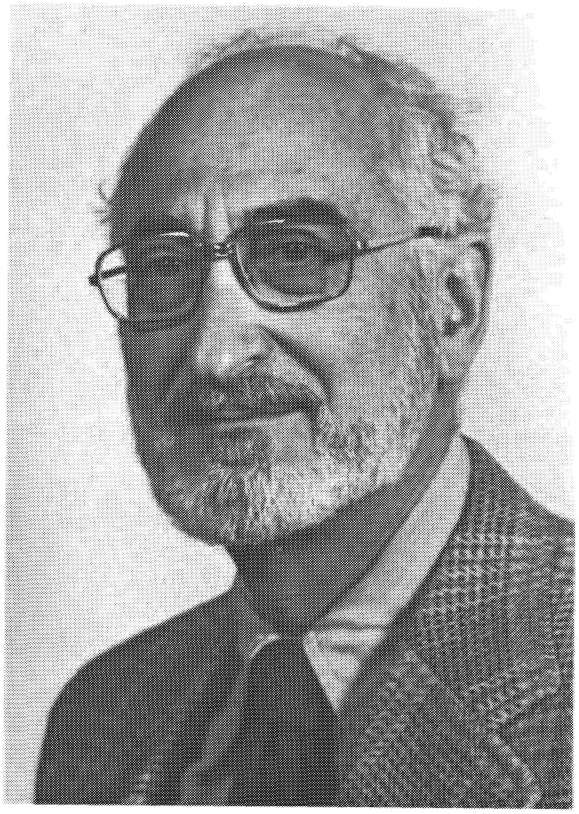
Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298



Avedis Donabedian

CHRONOLOGY

1919	Beirut, Lebanon, born January 7
1938-1940	American University of Beirut, Internship equivalence
1940	American University, B.A. (with distinction)
1944	American University, M.D. (with distinction)
1945-1947	English Mission Hospital, Jerusalem, Physician and Acting Superintendent
1947	University of London, Hospital for Sick Children, Institute for Child Health, Postgraduate course
1948-1950	American University, Instructor in Physiology, Assistant in Dermatology and Venerealogy
1949-1951	American University, University Physician
1951-1954	American University, Director of University Health Service, and Clinical Assistant in Dermatology
1955	Harvard School of Public Health, M.P.H. (magna cum laude)
1955-1957	Harvard School of Public Health, Research Associate in Medical Care
1955-1957	United Community Service of Metropolitan Boston, Medical Care Evaluations, Studies, Medical Associate
1957-1958	Harvard School of Public Health, Visiting Lecturer in Medical Care
1957-1961	New York Medical College, Assistant Professor Preventive

Medicine (1957-1960), Associate Professor (1960-1961)

1959-1960 Office of Vocational Rehabilitation, Traineeship

1959-1961 New York Medical College, Department of Physical Medicine and Rehabilitation, Consultant

1960-1961 New York Medical College, Department of Physical Medicine and Rehabilitation and Preventive Medicine, Study of Rehabilitation Potential of Nursing Home Population, Research consultant

1961- University of Michigan School of Public Health, Associate Professor of Public Health Economics (1961-1964), Professor (1964-), Professor of Medical Care Organization (1966-), Nathan Sinai Distinguished Professor of Public Health (1979-)

MEMBERSHIPS

American College of Hospital Administrators, Honorary Fellow

American Public Health Association, Fellow

Association of Teachers of Preventive Medicine, Member

National Academy of Sciences, Institute of Medicine, Member

SPECIAL SERVICES

Association of American Medical Colleges, Longitudinal Study of Medical Students of Class of 1960, Consultant, 1974

American Public Health Association, Committee on Evaluation and Standards, Member, 1968-1970

American Public Health Association, Governing Council, Member, 1970-1973

American Public Health Association, Medical Care Section, Program Committee, Chairman, 1964-1966; Member, 1963-1964

Exerpta Medica, International Editorial Board, Section 17, Member, 1971-

Inquiry, Editorial Board, Member, 1979-1982

International Journal of Health Services, Editorial Consultant, 1971

Medical Care, Editorial Board, 1970-1973

Medical Care Review, Editorial Board, Member, 1963-1977

Michigan Association for Regional Medical Programs, Task Force on Methods and Evaluation, Member, 1967-1969

Michigan, University of, Honorary Degree Committee, Member, 1982-1984

National Academy of Sciences, Institute of Medicine, Senior Member

National Academy of Sciences, National Research Council, Policy Committee for the Study of Institutional Differences in Post-Operative Mortality, Member

National Academy of Sciences, Panel on Health Services, 1970

National Center for Health Services Research and Development, Research

Scientist and Fellowship Review Committee, 1970-1971

National Center for Health Statistics, Standing Committee of the Public Health Conference on Records and Statistics, Member, 1970

National Institutes on Rehabilitation and Health Services, Advisory Committee on Health Services Rehabilitation and Research, Member, 1969-1971

National Research Council, Committee on Health Care Resources in the Veterans Administration, Member, 1974

Social Security Administration, Advisory Committee on Health Insurance Benefits Research and Statistics, Member, 1965-1967

U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health, Advisory Panel on National Insurance, Member, 1975

U.S. Public Health Service, Bureau of State Services-Community Health, Community Health Research Training Committee, Member, 1965-1969

U.S. Public Health Service, Research Resources Administration, Bureau of Health Services Research, Review Group on Quality of Care, Member, 1974

White House Conference of 1970, Forum II, Delivery of Child Health Services, Consultant

AWARDS AND HONORS

Delta Omega

Honorary, 1955

American College of Hospital Administrators

Dean Conley Award, 1969

National Association of Blue Shield Plans

Norman A. Welch Award, 1976

American Risk and Insurance Association

Elizur Wright Award, 1978

Delta Omega Society

National Merit Award, 1978

Medical Group Management Association

A Review of Some Experience with Prepaid Group Practice

cited as one of the "75 most valuable books in print for managers of group practices."

American College of Hospital Administrators

Honorary Fellow, 1982

BOOKS

Medical Care Chart Book

First Edition (with S. J. Axelrod) Ann Arbor: Bureau of Health Economics, School of Public Health, The University of Michigan, 1962

Second Edition (with S. J. Axelrod) 1964

Third Edition (with S. J. Axelrod; J. Agard) 1967, 1968

Fourth Edition (with S. J. Axelrod; J. Agard) 1968

Fifth Edition (with S. J. Axelrod; C. Swearingen; J. Jameson) 1972

Sixth Edition (with S. J. Axelrod; Gentry, D. W.) 1976

Seventh Edition (with S. J. Axelrod; Leon Wyszewianki) Ann Arbor: AUPHA Press, 1980

A Guide to Medical Care Administration. Volume II: Medical Care Appraisal--Quality and Utilization. New York: American Public Health Association, 1969

Aspects of Medical Care Administration: Specifying Requirements for Health Care. Cambridge: Harvard University Press, 1973

Benefits in Medical Care Programs. Cambridge: Harvard University Press, 1976

Explorations in Quality Assessment and Monitoring:

I-The Definition of Quality and Approaches to its Assessment. Ann Arbor: Health Administration Press, 1980

II-The Criteria and Standards of Quality. Ann Arbor: Health Administration Press, 1982

WEEKS:

Well, we always begin at the beginning and I notice you were born in Beirut.

DONABEDIAN:

I was born in Beirut; I would have to get you the dates for other events later because my memory for dates is very poor; besides you have my curriculum vitae so that should verify that.

WEEKS:

We haven't in any of my other interviews mentioned the American University of Beirut, but I had a friend years and years ago in Detroit, a Dr. Kassabian who was educated at the American University of Beirut and the only person I know, besides you, who was a graduate of that university. I have often wondered about how that was supported...why was it called American University.

DONABEDIAN:

I think it first began as a mission school. It was founded by people who were interested in bringing both education and religious enlightenment, if you wish, to the Middle East in the late eighteen hundreds. I don't know exactly when, maybe 1860-1870 something like that, and it had a different name which I don't remember now. And so it began, in a sense, as a missionary enterprise.

Later it became gradually more and more secular. When I went there in 1935, I believe, as a sophomore student, we still had to go to chapel. They had a chapel on campus and we had to break classes at maybe 10 o'clock everyday and everybody went to chapel and then we went to classes again. Attendance at Sunday chapel was mandatory, so there was this kind of religious background, except by the time I was there it was mainly moral and ethical and much less evangelical because the school had Jews and Arabs and Moslems and Christians and Armenians and all kinds of people representing a good cross-section of Syria and Lebanon and the Middle East.

I think around that time or earlier the name had been changed to the American University of Beirut. Because it began as an American enterprise and then the school was incorporated in New York. It has its Board of Trustees in New York and provides degrees under the auspices of the State University of New York. How that works exactly, I don't know.

My father had come to Beirut to study medicine. I don't know exactly when, but prior to the first World War. He was caught, fortunately, in Beirut when the war started -- when Turkey entered the war. We come originally from Turkey -- rather the Turkish part of Armenia. My father was a teacher there. He had been educated in another American college -- the Euphrates College, but had gone into teaching and decided to study medicine so he came to Beirut to study medicine. The war began; he was therefore safe from the Turkish massacres as a result of being there.

And then my mother was deported by the Turks during the war with millions of others. But through some fantastic adventures and tremendous grit and enterprise, she was able to come to Beirut and rejoin my father. I was born, therefore, in Beirut when my father was a medical student. I was born in the

American University Hospital and the Professor of Obstetrics and Gynecology who delivered my mother of me continued to be there so when I came back to medical school about twenty years later he was my professor of obstetrics and gynecology. I was the second person he had attended to during delivery who was a student later on in medical school.

WEEKS:

There must have been a lot of satisfaction from that.

DONABEDIAN:

He was a wonderful man. We were essentially friends. This is the Beirut part of our family.

WEEKS:

Was English the language used?

DONABEDIAN:

Yes, English is the language used in everything. Of course, they have a good department of Arabic and they teach Arabic as a language. It is not the language of instruction. It is a field of study.

WEEKS:

Where does the faculty come from?

DONABEDIAN:

The faculty is mixed. It had when I was there a fair number of Americans who came in for three years, four years, five years. Some came in and settled and stayed there and became, in a sense, native. There was a tradition of certain families producing a fair number of faculty and senior people -- presidents and so on. For example, the Bliss family and the Dodge family and so on. Several of their members and relatives and in-laws and so on had a long-standing association with Beirut and they constantly came back. Some of

them lived on and lived on into retirement and then came back to the United States to retire.

Most of the faculty was local. Some of the key people were American citizens. However, the president was always from the United States. Most of the Deans used to be from the United States. The department chairmen of the medical school used to be from the United States. So citizens of the United States had kind of the key positions.

Gradually as the natives, the local people, became more educated and more and more, in a sense, demanding and more aware of their own identity, I think they demanded more and they got more. I think the university rather willingly relinquished more and more control; had more members of Lebanese origin or Middle East origin on the Board of Trustees in New York and gradually the University is becoming more and more controlled by local people but still with very heavy ties to the United States. And there is a great deal of sympathy I think for the United States by and large.

WEEKS:

Was the medical school one of the major components?

DONABEDIAN:

I think the medical school was probably the major component. It's like many other universities, the medical school becomes very large, has a very, very large budget and is the tail that wags the dog, attracts a lot of attention and financial support. I think the University, around the time that I was there, was heavily supported by the Rockefeller Foundation. I don't know who else.

You see when you are a student you know none of the politics of the university. Then later on, is it Point Four -- the International Aid agency

in Washington -- poured in a lot of money and I think more recently some people said that was really because the political significance of the university was, I think, very much recognized. Especially around the second World War and the post second World War period, by the United States.

Recently I think there is more varied support -- oil money, contracts with Arab governments. I have a feeling the United States continues to support it through various international agency grants.

WEEKS:

In happier days, Lebanon was supposed to have been sort of a Switzerland. A place of exchange, a neutral spot where all peoples could meet. I suppose it is very important, politically, for the Americans to support an effort like that even though I am sure, in the beginning, it was not a political gesture.

DONABEDIAN:

No, I am sure that in the beginning it was mainly humanitarian and religious. I think many of the personnel continue to be interested in the humanitarian and a kind of international friendship but I think the political factor is very significant. The university has produced lots of leaders in general who have a leaning towards democracy and the American view of things.

But the university has also produced some opposition figures and has been a place where students have agitated for more local control and autonomy. But that is understandable, I think, the two are not opposed to one another. One can be, like a child in a family, he wants to be independent but it doesn't necessarily mean that he is going to break away from the family. He wants to make his own decisions. I think that is the kind of situation....

WEEKS:

You can't expect students to be docile. Otherwise we are not doing a very

good job of educating them, are we?

DONABEDIAN:

By and large, I think, when graduates of the American University have to oppose American policy it is somewhat in sorrow because they would like not to have to do that. But they may feel that the United States is wrong or that this particular policy is wrong or that they would like to see more attention to Arab interests and so on.

But recently, of course, everything is different because the local interests have been so splintered the university really doesn't talk now so much of Arab interests as sub-interests as well -- Christian versus Moslem and various other political subgroups. So it is very fragmented.

WEEKS:

There has always been a very tenuous balance there between the Christians and the Moslems too, hasn't there?

DONABEDIAN:

I think in Lebanon, you don't have racial differences. We don't have dark skin/light skin, blond and so on. There is no racial prejudice, and there is really no religious prejudice in the sense of apartheid or in the sense of hotels only for Christians. There is no social stigma attached to being either a Christian or Moslem but there is certainly a very heavy political and social identification with, first family and kin and tribe, if you wish to call it that, and then, second, with religion. At the very last, I think, there is identification with country such as Lebanon as a country, Syria as a country, as a political entity -- Jordan as a political entity, Palestine as a political entity. All of these countries are of recent vintage. I think they date mainly from the first World War. The national identity is much weaker

than religious identification and, of course, the most important thing in the Middle East is family and friends. Look after yourself, look after your family, after your religious group and your village and things of this kind. There are lots of loyalties but they tend to be local rather than national loyalties.

There are national loyalties but they kind of come way down on the scale of things.

WEEKS:

I was just recently reading about Gandhi and the situation in India when he was trying to secure independence for the country and I am amazed at the hatred there was between the Hindus and the Moslems and the butchering and the needless slaughter of actually millions of them. I guess the total during that period of maybe ten years or so, in the late 1940s and early 1950s -- it just doesn't seem possible when these people are all of the same racial stock, basically. It is very hard to understand.

DONABEDIAN:

When I was in Lebanon, there was some tension between religious groups. There was a tradition of enmity. But all the other people, Moslems and Christians who were of Arab origin or spoke Arabic -- we don't know what Arab origin is -- we know identification, using the Arabic language and identification with Arab culture -- but racially, who knows where they come from -- the people who call themselves Arabs, at least in the Middle East. But the young Arabs were hoping that finally religious divisions were going to be healed and they were being replaced by consciousness of being Arab people.

Others felt, and I think they were the fewer, they felt that there was emerging a Lebanese identity, A Syrian identity. Some people were thinking of

a Greater Syrian identity that would include Lebanon, Syria and Jordan, in a larger Syria. Certainly everybody was hoping there would be an Arab identity that would submerge everything else, and there were hopes that this was happening.

Some people were skeptical -- I was skeptical because I was not an Arab. Therefore I always felt that there was going to be trouble. One of the reasons I left was that I felt there was never going to be peace in this part of the world so I might just as well leave. But most people were very optimistic.

Then I think the recent events kind of put us back maybe two hundred years or something by reviving all the old enmities and creating deeper splits than ever before.

WEEKS:

It is really a tragedy what is happening.

Many of these graduates then spread all over the Middle East, in fact all over the world, wouldn't they?

DONABEDIAN:

Yes. First of all, many of the people who study in Beirut come from outside of Lebanon. Lebanon does not or could not then accommodate all of the educated people it produced. So it exported brains, it exported trained people all over the Middle East.

Many came to the United States because of the American connection. The fact that the diploma of the University was recognized in the United States, and the language was English. Graduates of the American University of Beirut could do well here. They had no trouble passing the exams and doing well. And some got married and stayed.

Many Armenians, particularly, came to the United States because they all felt the same way I did, in a sense. Their parents had been through a tremendous experience -- Turkish genocide -- they felt there was always going to be trouble and they wanted to be out of it. When they came to the United States to study they just stayed on.

WEEKS:

I don't think most Americans realize the importance of the American University. Was it Presbyterian originally?

DONABEDIAN:

I don't know. I think so.

WEEKS:

I remember talking to a man who had some connection with the Presbyterian church who was leaving for Beirut and he was going to the American University for some sort of business. I just assumed that maybe the Presbyterians were either alone or one of several who were supporting it.

DONABEDIAN:

It could be. There is a tremendous network of people who have had associations with Beirut or members of their families have had association with the American University of Beirut. Or they know somebody. So wherever you go you are likely to meet some person with a connection to the university.

For example, here at the University of Michigan, there are several people who have been associated with Beirut. In my department Professor Bashshur, Rashid, is a graduate of the university. For example, Professor Schorgar who used to be Chairman of Middle East Studies or Anthropology -- I forget which -- he taught at Beirut, and there are probably others.

Two or three weeks ago I went to New York to talk at the HIP workshop.

Somebody came up and spoke to me and said, "I am Dr. Nute. I was in Beirut, I had a family in Beirut, or my father was in Beirut." It goes on and on and on. Wherever you go, you find it.

The other day we received a letter from someone in North Carolina, I believe, who said "I was a teaching in Beirut and you were my physician when I was there. (I used to be a university physician.) You treated my family -- I saw your name in the Grand Circle Tours brochure -- you took one of the tours, you were very happy. Could you tell me some more about it?"

WEEKS:

In a way being at Beirut studying at the American University was sort of like being in London, in the international sense. People come from all over the world to study and then go back home or go somewhere.

DONABEDIAN:

When I was there, there was a fair number of United States citizens who could not enter medical schools here or had family there; or they were of Arabic extraction who would come to the University to study up to their last year and then come here and finish their studies here and get a degree from an American university. The university was producing foreign medical graduates in the more narrow sense of American citizens who go off and get a foreign degree and then come back and continue here.

But then that stopped because the University felt that it should not be educating United States citizens. But the university still lost a large number of its students. This is true only for the medical school, I think. It is a little different for the other branches. None of the other branches really was, I think, as prominent as the medical school.

WEEKS:

I had that impression but that's why I asked. I wasn't sure.

You did get your M.D. degree there.

DONABEDIAN:

I got a bachelor's degree there and I got my M.D. there later.

WEEKS:

I noted that you went, then, to Jerusalem then Palestine.

DONABEDIAN:

I was born in Beirut but I grew up in a small town north of Jerusalem which is now very often in the news, called Ramallah.

WEEKS:

I didn't realize that.

DONABEDIAN:

It was then a small town. It was a town of about 3,000 exclusively Christians, surrounded by Moslem towns. This was a pattern, I believe, in Palestine in the smaller villages -- some were Christian, most were Moslem. And they were separate. It wasn't as if the Moslems and the Christians were mixed up. Even in the cities there were quarters. In Jerusalem there was an area where its Christians were. Nobody spoke of them as ghettos really, but they were concentrations of similar people -- you know Jerusalem has an Armenian quarter, a Moslem quarter, a Christian quarter and then had two Jewish quarters, one inside the walls and one outside the walls. So there was a certain amount of segregation in that sense.

Ramallah was a very small town where I grew up. I was taken there when I was six months old by my parents. When my father finished his medical degree, he went to practice in Ramallah and stayed there all his life. So I was taken

there when I was six months old and I grew up there. Then I went to Beirut where most people from Palestine went to study. And afterwards came back to live in Palestine. I was a Palestinian; I was not Lebanese.

WEEKS:

This was a British protectorate at that time?

DONABEDIAN:

At that time they called it a British mandate. I don't know the difference between a mandate and protectorate.

I did not want to work with my father in his little village practice where he did everything under the sun, including obstetrics, gynecology, minor surgery. I mean general practice in its widest sense. Sometimes people would even bring their animals. There were no vets so they would bring in an animal and my father knew something about even that. He even did dentistry for a while until a dentist moved into town and the dentist objected and said, "Look you are taking all my business." So my father gave up on the dentistry. By dentistry, I mean basically pulling teeth, not repairing but just pulling teeth. Lancing a gum abscess and things of this kind. He also did lots of tonsillectomies in his office.

It was just a remarkable kind of rich, varied practice. I've seen diseases there in my father's clinic I have never seen anywhere else: relapsing fever, leprosy, tetanus in infants. He had a very, very, varied and big practice. People come from villages all around. In the morning his office was just like a bazaar. It was crowded with people sitting on the street waiting to come in and be seen. It was a remarkable, remarkable practice. He was a remarkable man.

WEEKS:

What did he do for hospital facilities?

DONABEDIAN:

Well, people didn't really go to the hospital. If they were very ill they might be sent to the government hospital in Jerusalem. There was no hospital in Ramallah. So they had to go to Jerusalem. It was not terribly far away. I think it was maybe sixteen kilometers away. What is that, about nine or ten miles?

That was a big distance at that time. Today we would think of it as nothing. But there were cars, there were buses. People had mules and donkeys and horses -- mainly mules and donkeys. There was transportation, but still it was far away. I don't think people wanted to leave home, certainly the villagers would not want to. They went to the hospital to die, essentially. It was still that kind of mentality.

So, my father would send them either to the government hospital in Jerusalem or to some other hospital. The German hospital was very well known and so was the French hospital. There was, I think, an Italian hospital as well. These were established by missions generally -- the French mission, the German mission. The government ran its own hospitals but they were not very highly regarded.

Later on, of course, there were Jewish hospitals. There was a Wallach Hospital run by a Jewish physician, and then, of course, the Hadassah Hospital, much later on. Then that became essentially, the dominant medical institution in Palestine -- probably much of the Middle East.

WEEKS:

They had several Hadassah hospitals.

DONABEDIAN:

But there was little hospital care. Most of the care was given in the homes by my father and by the family.

WEEKS:

He went to his patients many times...

DONABEDIAN:

Oh, for heaven's sake, most of his practice was in home visits. It was a major part of his practice. He made night visits. He got up early in the morning, around 5 a.m. and made home visits. By 8 a.m. he would be in his office and the villagers would have arrived on their donkeys and mules that would be tied outside his office waiting. Even camels, I've seen. There would be a big crowd waiting for him to see them. He would finish and then in the afternoon he would start visiting again. And at night. Some nights he would go out two or three times. He wouldn't get much sleep. He didn't get much rest. He never had a vacation, I think, in his life -- maybe once or twice.

WEEKS:

Did he like it?

DONABEDIAN:

He liked it. He never complained. He loved his work. It didn't seem likeable but... He was a very unusual man.

WEEKS:

Was you father's practice segregated also or did he treat anyone who came?

DONABEDIAN:

No. There was a residential segregation in that certain villages were Moslem. Other villages were entirely Christian or, if they were mixed, then they were basically two villages close to each other: In a sense, a Christian

and a Moslem segment. But there was no social segregation in the sense of people having separate facilities or things of that kind. So my father's practice was mixed. He treated the local people who were Christians and people from some nearby villages, which were almost adjacent to Ramallah, who were Moslem. Then he treated the Moslems from all the villages in the district.

WEEKS:

I was wondering if he established a reputation. If there might not be Moslems who would want his service so...

DONABEDIAN:

There was no call for it. There was no institution that had that kind of segregation. Doctors were not known as Christians or -- that is, excluding Jewish doctors. I think Jewish people were seen as different, as separate. We had only one Jew who lived in Ramallah when I was there and everybody wondered what he did. "He's a strange person; you shouldn't go near his store," we were told. I don't know what he did. But the kids would go there and look at the store and say, "There's a Jew there." So that was unusual. But otherwise, not.

WEEKS:

How did you get your appointment to the English Mission Hospital?

DONABEDIAN:

Well, when I finished medical school, I didn't know what I was going to do. I didn't want to join my father because, frankly, I wasn't good enough. To practice like that you have to know everything. You have to be willing to do anything and everything, and work in very primitive conditions -- without a lab and without hospital support, without nurses, without anything at all. My

father did remarkably well.

I couldn't do that. It had been trained out of me. I was overtrained for that kind of practice. So I wanted to work in a situation which was somewhat similar to the one under which I had trained. I was not a specialist but I needed a laboratory; I needed nurses; I needed hospital beds; I needed to observe patients. I couldn't make snap judgments and diagnoses so I didn't know what to do.

I didn't want to stay at the university, although I had been asked by several people to intern and become a resident, because I felt they didn't teach very much there. The residency and internship programs were very elementary at the university then, and physicians were used mainly as assistants to the senior doctors. There was no adequate, formal training. Soon after that everything changed. There was a major reorganization and the United States system of internship and residency training was introduced. But when I was about to graduate it was still very much you stay there and work with the doctor, do his bidding. You are in a sense something of a servant to him and you learn as much as you can as you go on. I decided that wasn't for me. So I was going to think of something else to do.

Then there was a vacancy at the English Mission Hospital. I heard about it through Dorothy. We were then engaged. We hadn't been married yet. She was a teacher at a mission school in Beirut. She was a graduate of the British/Syrian Training College, as it was called then. She was teaching at the school which was run by missionaries. It had a very heavy religious orientation. It was still really a mission school even though it had lots of Moslem girls studying there. It was purely a girls' school.

She told me, "Hey, look, I hear there is a vacancy at the English Mission

Hospital. They are looking desperately for a physician."

I applied. I was interviewed by the physician there whose name was Dr. Politeyan. His father happened to be a Greek who had married an English woman and settled in England. He was the most English person I have ever seen, in spite of his name. He had gone to Cambridge and after Cambridge he had trained at St. Thomas Hospital.

As I was saying, I was interviewed by Politeyan. He asked me one or two questions -- about Cooley's disease, I still remember. What do you know about Cooley's disease? Which wasn't very much. Anyway, I knew it had something to do with the spleen -- got enlarged or something. He said, "That's enough, you're hired." Actually, I think they were desperate for a physician.

I had been a brilliant student, always at the top of my class. I knew a lot of theoretical medicine -- not much practice, but I was a very quick learner. So I don't think he was disappointed.

It was a very small hospital -- about 20 beds. Actually, it had lots of beds but they were not occupied. The hospital, which had once served a very important purpose, by the time I was there had kind of lost a great deal of its usefulness because the Jewish community had developed its own services. I don't know when it was established but I think before the large Jewish influx, and it was a mission to the Jews. Its mission was very specific. The intent was to serve the Jews and to convert the Jews to Christianity. To make Hebrew Christians, as they called them. Its success was extremely limited. There were a few Hebrew Christians but not many -- a handful...five, six, ten. Something like that. The hospital which had been very busy and, I think, had lots of patients, gradually as a kind of Zionist or national Jewish awareness and Jewish services were introduced, particularly the Hadassah hospital and

other Jewish hospitals, this particular hospital declined; had fewer and fewer patients. When I was there it served, mainly, rather poor Jews because it charged very little and had some special functions like treating anybody who had worms -- the doctors there were thought to know everything about treating worms so for deworming people would rush there. They also came for tonsillectomies -- one of the physicians was very good at tonsillectomies. This hospital had these subspecialty areas of a minor kind.

And they had a very busy outpatient practice. Lots of people came in for outpatient care.

WEEKS:

Were there several doctors there?

DONABEDIAN:

There was always a chief English doctor sent by the mission from England, and one or two others. When I was there there was an English doctor full time who was my boss. I was there full time as a junior doctor and there was an intermediate person, an older person who was kind of inbetween and he worked there part time. He had his own office part time. He was not a Hebrew Christian-- he just worked there. And the hospital had a small nursing school. It gave a diploma in nursing, and it had about 20 - 30 beds that were not always full -- most of the time they were not full in any case. There were lots of wards that had been closed.

They had quarters for the doctors on the grounds and I was given a place to stay, and I lived there. Soon after I joined, the physician -- the chief physician -- got ill. He had some problem with nerves, neuritis. He had to go back to England for treatment and I became Acting Superintendent just scarcely out of medical school. So you can imagine what a situation that was.

WEEKS:

Well, that was your first administrative experience.

DONABEDIAN:

It was my first administrative experience and I was not prepared for it. I think I made a total mess out of it. But of course we had a matron. That was the British system. Really the matron did a lot of the administrative work. She told me what to do. Also, there was a pharmacist who had been there for many, many, many years. He was a very important part of the administration. The overall supervision was in the hands of the local pastor -- the Anglican minister. There was a board of Anglican missionaries, I think mostly from England. The hospital was part of the Anglican community and, I guess, with regard to local affairs, was run by the minister. To what extent the bishop was involved in this I don't know. Then, of course, eventually the hospital answered to home mission in England.

Again, I don't know the details because I was kept isolated in my administrative position answering to the local minister mainly for broad administrative affairs.

WEEKS:

You mentioned the Zionist movement. The Jewish people had begun to move in before the establishment of Israel, hadn't they?

DONABEDIAN:

Oh, yes. But this was not that long ago. I was there in, what, 1945-46. Soon, a year or two later, everything came apart. By then the Jewish community was not only very well established but very highly organized. The Jewish Agency was running a lot of the internal affairs. The Haganah was established. I was studying Hebrew with a teacher, a tutor, who said he was a

member of the Haganah. He knew all that was going on...

WEEKS:

That's the revolutionary underground?

DONABEDIAN:

The Haganah was the unofficial army of the Jewish Agency.

I was there about the time Israel was going to emerge, about that time I got out. Up to that point the Jews had been coming in fairly large numbers between the two great wars. After the establishment of the Jewish National Home by the Balfour Declaration after World War I the Jews started coming in, buying land, developing their own communities and settlements, and their own apparatus of community control and self-government.

WEEKS:

This included their health care system...

DONABEDIAN:

All the development of their health care system. I'm not sure when the English Mission Hospital was formed. I don't know whether it was formed before the first world war or soon after. When it was built and started the Jewish community was much smaller. I assume they saw themselves as people living in somebody else's country. They were dependent to some extent on this mission hospital. I am sure they had their own hospitals as well.

Then as they grew in numbers they came to identify themselves not as guests in the country but as people who were coming to establish their own national home, and eventually their own country, and the whole thing changed.

The hospital was in a Jewish community. It was very close to the Jewish ghetto, Mezh Shearim, outside the walls. I guess it drew for its patients mainly from this old Jewish ghetto. But then all around it had burst open and

the Jews were developing the city like mad. Everywhere. The hospital was surrounded by the Jewish community which had spilled outside the ghetto and had occupied a large part of Jerusalem, outside the walls.

WEEKS:

Did that hospital eventually close?

DONABEDIAN:

The hospital got into trouble. Towards the end of the period there was a breakdown in law and order. The British pulled out essentially and said, "Do what you want," and the Israelis took over.

During that takeover period the hospital was in difficulty. I had already left. I felt that I would leave, go back to Beirut, spend a little time and then come back and the troubles would be over, but, of course, it didn't work out that way.

So, the hospital had to be closed. It was turned over later to the Hadessah organization and they ran it, I believe, as an obstetrical hospital for a while. For a while they lost the use of their own Hadassah hospital outside Jerusalem on Mt. Scopus and they transferred their services to the city, I believe, and this particular hospital became one of the Hadassah institutions. The buildings were taken over and used.

Then, I believe, later they built their own hospital on the other side of Jerusalem. But then, of course, they reoccupied the initial Hadassah Hospital. I don't know what they are doing now. I guess the Hebrew University is back in its own campus. I am not sure. I have lost touch with what happened.

But the answer to your question is, "Yes". The hospital closed down, the buildings were leased to the Hadassah organization, being used for a while as

part of the Hadassah hospital. Then, when they didn't need it anymore, I believe they gave it back. I am really out of touch with the hospital. I am sure it is not a hospital. I don't know what it is. Maybe it just closed down, or maybe it is a community agency, I don't know.

WEEKS:

You were there during a very fevered situation weren't you?

DONABEDIAN:

Soon after I joined the hospital, things got bad and there was a lot of civil unrest. The local Jewish population was up in arms against the government. There was a lot of bombing of buildings. The King David Hotel was bombed when I was there. There was a lot of shooting. We had a police station adjacent to the grounds of the hospital and the Jewish -- I guess you would call them terrorist organizations, whether they were or they were Haganah, I don't know -- but they would come in and they would shoot at the police and the police would shoot back. And the bullets would be all over the hospital and I would have to get up and go to the wards and calm the patients. Tell them, "Doctor's here."

I couldn't do anything but I felt at least I had to be there. But the hospital was built very well. It had very high stone walls surrounding the grounds. All the buildings were made of very heavy stone. So we were very well protected by the way in which the hospital had been built. Like somewhat of a medieval fortress. I don't think anybody was ever hurt in the hospital. But we did get stray bullets and we did have to go under the beds when the shooting started.

WEEKS:

Was this due to the fact that the British were trying to limit the

immigration?

DONABEDIAN:

There was the immigration limitation at that time and frankly, I don't remember exactly what was happening. I think the Jewish community wanted to establish, to progress to, autonomy and self-government. The British wanted to keep the status quo. They wanted to maintain the mandate and keep the Jews and the Arabs more or less fighting each other so they could stay on. I don't know exactly what it was the Jews then wanted. I think they wanted the British withdrawn and independence. And the British were hanging on. But then they gave up.

WEEKS:

The British had a lot of trouble after World War II.

Did you marry before you went to London?

DONABEDIAN:

I married soon after I started working there. I was engaged before I went to the English Mission Hospital. Soon after that the physician was going to go home to get treatment. He said, "You know, Donabedian, we would like to see the doctor of this hospital a married man."

I said, "Fine, I'll get married." I was already planning to get married, so...that may have hastened it a little bit. We were planning to get married in any case. So I got married and Dorothy came to live with me at the mission hospital.

Although she was a nurse, she did not get to work there. I tried very hard to get her to start working but she said, "No, I don't want to work."

So those were the early days of our married life. I spent most of my time with the patients or in the laboratory and she would get very angry with me.

We had a little morgue which was seldom used because we had very few very serious patients at this hospital. If someone was really ill he went to the Hadassah hospital or to some other hospital -- some of the other Jewish hospitals. We had the simpler cases so the morgue was almost never used. I made it into a little lab with a microscope and a centrifuge and I would go there and do my blood tests and urine examinations and blood counts. Other lab work we used to send to the government lab and get free services from the government laboratory. I did the simple stuff, the urines, the blood counts and things of this kind...looking for fungus. It was fun. I really enjoyed clinical practice at that lab.

We had consultants if we needed them among the local Jewish medical people. They had by then a fantastic assemblage of experts from all over the world, mainly from Europe, Germany and Central Europe. We didn't lack for expert consultants, surgeons, anything we wanted. We had a core of people associated with the hospital.

Still, looking back on it now, in terms of quality I think it left a great deal to be desired.

WEEKS:

Comparing it to present standards, possibly, but was it much different from what could be expected from other hospitals in the area?

DONABEDIAN:

I don't know. Of course I couldn't compare it with the Hadassah Hospital which was an extremely modern hospital with a great deal of organizational control, I am sure. In this little hospital there really wasn't much organizational control on quality. We were at the mercy of the individual consultants. I didn't know enough medicine really to monitor what they did

and I didn't even have the notion of monitoring. I had never been taught anything about quality control, quality assessment and accreditation and tissue committees. There was none of that, and if there had been I don't think I was really qualified to implement these. I was just a year out of medical school. I was a very young and inexperienced person.

WEEKS:

You really learned the process yourself.

DONABEDIAN:

I had neither the clinical background nor the kind of prestige that I could use to impose on my consultants so they pretty much did what they wanted. Fortunately, we didn't have many serious patients so I don't think it mattered much 90% or 95% of the time what was going on. I did the best I could. I did good work. When I didn't know I always called in somebody I thought knew but I'm not sure that he always knew. I didn't know enough to know whether he always knew that much better. I felt that way.

These were the consultants who had been chosen by the mission physician. They were there already and I was instructed to work with them. I didn't stay long enough to really develop anything of my own there. And I never thought of myself as staying for a very long period of time and becoming a permanent member of this hospital.

WEEKS:

Your next move was to London...I wondered how that came about.

DONABEDIAN:

I was at the mission hospital and I told my boss, the mission physician, that I would like to go and study some more, that I really don't know enough. I would like to study pediatrics. "When you go to England," I said, "Find out

for me. What is there? What can I do?"

We looked to England then because, although I was trained at the American University of Beirut, you always thought England was great as the center of medical education and since we lived in a British mandated territory we naturally looked to England for everything, rather than the United States.

He wrote back and said "Yes, there is a program of study in pediatrics at London University, centered at the Hospital for Sick Children, Great Ormond Street. That is one of the premier children's hospitals in the British Commonwealth. You can come and study there.

That wasn't really what I wanted. I really wanted to go and be an intern and learn by doing, but apparently there was nothing like that available.

I said, "Fine. I will go and study at London University and the Hospital for Sick Children."

That was, I think, a six month course. So I was a graduate student.

WEEKS:

Did Dorothy go with you?

DONABEDIAN:

Dorothy went with me. We stayed at a hotel for missionaries. We were in essence considered to be missionaries although the reason I joined it was to be a physician. But as I said, Dorothy had been associated with a missionary school -- was teaching at one. My father had been educated at a missionary college and had been a teacher and a preacher. So there was a kind of religious background there. I was religious. I was interested in religion. I was part of a community of people -- I guess now you would call them "born-again Christians". They were the Plymouth Brethren, a group of English fundamentalists. The mission was Anglican but they pardoned the fact that I

was part of the Plymouth Brethren. In fact, I had been baptized an Anglican, strangely enough, because the Anglican church was the only Christian Protestant church in Ramallah where, as I told you, I grew up.

They got me a dispensation from the bishop to be able to take communion or something in the Anglican Church. I'm not sure whether I got it or not; I wasn't sure I wanted it. Anyway, the bishop said, "It's okay. He can serve in the hospital as a religious teacher as well."

So I took prayers. We had prayers everyday and prayer meetings once a week, and, of course, there were Sunday prayers in the church. I participated and I preached and I read the Bible. I read the Bible to patients in Hebrew and sang in Hebrew. I did participate in all the religious activities for which I was, to some extent, prepared by virtue by this kind of background. My function was basically to be -- I was interested mainly to be a good doctor, and then a missionary. I was interested in being a good Christian. I wasn't interested in making anybody else a Christian. I was interested in my work and my life and in my ministry to patients being a Christian type of thing. But I found it really very difficult to tell people "Now you become a Christian". I tried to stay as far away as possible. I was willing to say "Now look, I am a Christian and I am doing what I am doing here because I am a Christian, and I am doing a good job because I think it's the right thing to do. I want to serve you and be a good man and that's it, period." It was a kind of self-centered Christianity, if you wish.

WEEKS:

You were in England just before the national health service went into effect, weren't you?

DONABEDIAN:

I think so. No, I think it had been already in force.

WEEKS:

I think it had passed, legislatively it had been passed but they were in the process of setting it up....

DONABEDIAN:

Well, you see, my knowledge of medical care organization at that time was zero. I was so uninterested in health care organization, I knew so little about it. I don't think that I was even aware of the British National Health Service or what was going on in England. I didn't know whether National Health Service was started or not, and I couldn't have cared less.

I was very much interested in clinical medicine. I wanted to be a good doctor. I didn't care about running the hospital, didn't understand it, and I wasn't interested at all in the administrative aspects. I did as good a job as I could of everything I tried. I taught the nurses a little bit. Whatever had to be done, I did to the best of my ability, but my interest was in patients and diagnosis and in treatment and in learning medicine and in being a good doctor.

So when we went to Britain, I wasn't aware of what was going on in terms of the organization of health services.

WEEKS:

You didn't know how people paid for their care or where they came from or...

DONABEDIAN:

I didn't care how they paid for their care. I was very much interested that when they go to the clinic we were nice to them and treated them well and did good work. I would be terribly outraged if somebody couldn't get care

because he didn't have money because my father did a lot of free work. He never denied care to anybody because they had no money. If they didn't pay him with money, they paid him sometimes with eggs, sometimes with a chicken. Sometimes my father would come home with a little lamb or send somebody home with a turkey -- things like that. He took anything and everything that the villagers brought him. That was, in a sense, the general tenor of medicine for me. It was a service. It wasn't a commerce, it wasn't a business. It was a scientific and intellectual exercise. It was very interesting as an intellectual pursuit. It was a puzzle to solve. That kind of thing. It was a challenge intellectually and it was, in terms of values, a service to people. Money was subsidiary.

I grew up in a family that was reasonably comfortable. My father was a doctor. He wasn't rich but we always had enough of everything we really needed and money was totally unimportant. I knew that I would always have enough and that was all I needed. I didn't want money, I wasn't in it for making money. So I didn't understand the social aspects of the organization of health services or the administrative aspects. I saw it mainly as a humanistic and intellectual effort. I still do. I haven't changed my mind.

WEEKS:

Things have changed though, as you know. The attitude of the physician towards...

DONABEDIAN:

Even then I think, in the Middle East it wasn't the good old days. I think in the Middle East medicine was a business for most people. Perhaps because society was not so diverse and not so highly urbanized there were still more personalistic relationships between some patients and their

physicians. But I still think people were in medicine to make a reasonably good living. That was modified a little bit by the fact that if you worked in a small village you knew your patients socially and had known them for long periods of time so it was inevitable that a more personalized or humane aspect crept in just by virtue of the other part of the relationship. But that was not found everywhere. I think in the city it was not as in the little towns. That was, of course, much less evident for specialists than for generalists.

The pattern that we now see here was evolving in the Middle East at that time and to a large extent had become established in cities like Jerusalem which had super-specialists and specialists of a modest type, but mainly generalists. We had a whole hierarchy that was already established and developing.

WEEKS:

You did decide to go back to the American University after...

DONABEDIAN:

I didn't really decide to go back to the university. I was kind of driven to it. My plan was to go to England, study pediatrics a little bit and then go back and start my own private practice. Perhaps go back and work a little bit at the hospital and then start developing my own practice and then break away from the hospital entirely and be on my own as a general practitioner with interest in pediatrics. I never wanted to specialize.

When I finished medical school, I was invited by the chairmen of several departments, since I was one of their best students, "Will you come work for me, be an internist, be an otolaryngologist, be a pediatrician, be this or that?"

I said, "No, I want to be a general physician."

So I wanted to establish my own practice as a generalist with, however, a particular sub-specialization in an informal way. The course in pediatrics I took at Great Ormand Street certainly didn't prepare me to be a specialist. It just gave me an additional interest in and knowledge of pediatrics. But I wanted to come back and be a pediatrician on my own and a generalist, a family physician. I guess now you would call it a "family physician."

But because of the troubles and the shooting and the bombing and general unrest, I decided to take my vacation and go to Beirut where my in-laws, Dorothy's parents, were and stay with them for a few weeks until the fog lifted and smoke cleared away and then come back. Of course, then the Arab/Israeli war developed. There was a partition of Palestine, the Arab/Israeli war, and there was no way of going back. It was impossible to go back. So I started looking for a job.

I latched on to my old friends at the university of Beirut and did whatever was available. I had basically lost my turn in the mill that produces the medical leaders in the university. I had not gone into the internship and residency and so on. I was a Palestinian. I had no license to practice in Lebanon, neither a medical license nor any of the other kind of permission. So the university had to get permission for me to go in there and I did things that nobody else wanted to do for which they were looking for people. So I taught a little physiology and I worked in the dermatology clinic and in the syphilology clinic.

I was a physician for the nursing school, took care of the nurses when they were ill. Everybody envied me that. They thought that was really a plum. I was the physician of the women's hostel -- that's where the coeds lived. It was a tremendous responsibility morally. I taught nutrition. I

taught -- what else did I do? Lots of things like that -- all of them were kind of little bits and ends of things.

Later on I became the college physician at the university health service. Still later I became director of the University (student) Health Service, but I still kept some of these other things going. Mainly, my interest in dermatology and syphilogy continued and I worked in the clinic.

I think if we can go back a little bit since you probably are interested in the social medicine aspect of all of this... You see all of this has a very heavy clinical orientation and that was really basically my orientation. I wanted to be a non-specialized, generalist clinician -- a family physician. It was what I had always wanted to be because I guess that was what my father was and I liked that. I wanted be that. I never wanted to be a specialist. It was just too confining. I was foolish enough to think that a specialty had just not enough interests. I wanted to be a master of all of medicine.

When I was in London at Great Ormond Street, their course in child health had a very strong orientation to child health. It wasn't simply clinical pediatrics. It was really child health and therefore had a lot of emphasis on the organization of health care services for infants and children. They took us around the various institutions for child care, for chronic care, for preventive care, for infectious disease care. You got some of the social background for child health there. Still this wasn't my interest. I still was more interested in the clinical part of it. But I began to have a broader understanding of the relationship between community organization of health care (if you wish, governmental organization of health services) and the practice of pediatrics, when I was in London.

The other stream in my background which we haven't mentioned so far was

the interest in basic medical science. When I was in medical school I got ill and spent one year away from medical school. I also spent two years teaching pharmacology. I stopped my medical studies after I finished the first two years of medical school because the professor of pharmacology called me in and said, "Look, you seem to be good at pharmacology, would you like to work with me in research and teaching pharmacology for two years, and get a kind of fellowship? You will be paid, and so on."

I was very young then. Had I gone on studying, I'd have finished medical school at twenty-one. And I felt I wasn't ready. I felt in some kind of vague way that I wasn't really mature enough to be a doctor. Although, in retrospect, I think I should have gone on perhaps. I consulted my father. There were troubles in Palestine then, there was a strike or something -- and I think his income was going down and he felt my getting a fellowship in general research and science was really attractive and would be useful. So I agreed. I worked with this man for two years as a teaching fellow in pharmacology. So I had that kind of background in teaching and research. I didn't do much research but I did a little bit.

So that when I came back to Beirut much later on, this person now had become dean of the medical school. He was professor of physiology and he took me back, in a sense, into the physiology laboratory with him. I taught physiology and picked up the threads of this basic science which I had.

WEEKS:

You were all of the time broadening your knowledge...

DONABEDIAN:

I didn't know I wanted to do. It wasn't really a question of broadening my knowledge in any systematic way. I was interested in many things. I think

like many bright people I liked all kinds of things and I didn't want to be confined to anything. I liked pharmacology. I enjoyed working in the lab. I liked physiology very much and it was available and I needed work. So I was able to do some more of it. In retrospect it was very helpful. Because it does give one a kind of more disciplined view, a more scientific view and more experimental interest in approaches to acquiring knowledge. I taught bio-assay. There are a lot of things in bio-assay which have to do with the relationships between doses and results which are not very different from the relationship between inputs and outputs in medical care. One acquires in time a kind of insight and ways of looking at phenomena, ways of looking at nature, ways of looking at knowledge that somehow one uses later on without even knowing that one is using them. It's like growing up and developing muscular skill. You develop finger coordination, foot coordination, hand coordination, eye coordination. You don't know how you develop it but then you use it all the time in a million things. When you get a new task, you use these things without knowing that you use them.

I think my experience shows that, in a sense. The clinical background, the background in physiology, in pharmacology, in dermatology, syphilology and nutrition, and so on. I am not referring to the content of these fields although sometimes the content is also relevant but mainly in terms of the intellectual perspective and some intellectual skills. I am sure I use them all the time now. Sometimes I actually am aware of it. I am conscious of it. I say, "Gee, this looks like a curve I saw in my bio-assay course."

It all gets into that pool of skills, knowledge and orientation, a kind of feel one has when one is dealing with intellectual material that needs to be arranged and put into a certain kind of format.

I also read a lot on my own. I was terribly interested in English literature. Had there been no medical school -- well, actually, let me put it the other way -- had there been any future in English literature other than teaching which was obviously a profession which made very little money and didn't seem to have much of a challenge -- I would have probably studied English literature. Because that was my first love. I read endlessly when I was young. I used to spend all my time reading English literature on my own.

I used to go to a book shop in Jerusalem and buy books. At that time we had the Collins Library: little red volumes, hard bound. Very difficult to find now. Sometimes I see them in second hand stores. The book store had them, the entire series, and I would just go and buy them without knowing what they were. I knew I wanted to read Victor Hugo. I knew I wanted to read various authors, Alexander Dumas. I went in heavily for novels and romances. But they happened to be literature. We didn't have pulp. If we did, I was unaware of it. I don't think it was available. I would have bought it, I think, if we had comic books, pulp, magazines, novels and stuff, I would have read it. I was protected from all of that by the fact that the book store had only the Collins Classics in anything that was financially possible for me to buy. I think I used to pay a very small amount: ten piasters per book.

I had a tremendous collection of that stuff. Also there was the Modern Library Series, "Everyman I will walk with you and be your guide.

WEEKS:

There was an Everyman's Library, too. It was English. The Modern Library was American.

DONABEDIAN:

It was the Everyman, I think. It had the motto -- where did that come

from? Pilgrim's Progress, I think. "Everyman, I shall go with thee to be thy guide." It was a beautiful motto. That also was available. So I read extensively on my own.

Then later I got into reading some philosophy. In my typical fashion, I began reading philosophy with Kant's Critique of Pure Reason. From nothing, from zero philosophy. I went to the bookstore and said I want to learn something about philosophy. Here was Kant's Critique of Pure Reason. You buy it, you read it and you read it again, twice, three times. It was a fantastic revelation.

What did I get out of it? I don't remember anything except some of the words. But you get, I think, an intellectual something. You build up intellectual muscles.

WEEKS:

I think that's a good way of describing it because so much of what we read we forget. We can't recall verbatim but we don't lose it.

DONABEDIAN:

No, we don't remember. I don't think I remember the essence of his philosophy about time and intuition and what is noble and what is not noble, but I do remember the fantastic intellectual structure, (this guy really took something and put it together) and the development of it. One gets a passion for intellectual order, intellectual design, for symmetry. It's beautiful. It's not simply an intellectual achievement. It's an aesthetic, it's an artistic achievement to develop this beautiful, elegant picture.

I think one should have that in one's self. I think I began with an interest of that kind. There is an affinity, there is some kind of something inside you that you don't know is there. Then when you get exposed to

something like Kant's Critique of Pure Reason, that something inside you responds. You say, "Gee, this is something I've been looking for. Isn't this exciting?"

I guess in somebody who has musical skill, not skill but talent, when he hears music, a new world opens to that person. I like music but I don't have that much musical talent. But I do have, I think, a tremendous interest and affinity for logical construction, for logical intellectual structure and intellectual relationships. Just as an architect builds a building and has all the pieces together and it is a functional thing but also it has tremendous aesthetic value. Similarly, I think, when you work with a problem you begin with information, with data, it's like rubble. You go there, it's a quarry, it's rubble. I often use this metaphor. You put this stuff together. You want to put it together in some kind of structure. I think I have an affinity for that. I think I love that. And I think also that I have a skill for that, an unusual degree of skill.

Anyway, whether I have the skill or not -- of course other people have to judge -- I love doing it. I enjoy doing it and I see it not only as an intellectual experience but truly as an artistic thing in terms of the beauty of the various parts fitting together. The terrible agony of one part being missing. Why isn't there something here? I also love the language part. I really enjoy being able to say it in a nice, interesting way.

So that comes from my reading of English literature, my interest in poetry which has been going all the time. The aesthetic part is to say it in a nice way in terms of language but the structure itself has an artistic, aesthetic property, as well as the intellectual aspect also.

Frankly, as I go on, I find I am more and more interested in the aesthetic

properties of what I am doing -- both linguistic and intellectual -- more interested in that, relatively and less and less interested in the substance or even the usefulness of it. This is a terrible thing to say but I am very self-indulgent in that way. I like my book to be beautiful intellectually. I think I kind of assume it is going to be useful, but if it is beautiful, I think it means that it is going to be more effective, more arresting when it is read and has a much more lasting impact than if it is dull.....And also, it means that it is really clear because the aesthetic part is related to the lucidity of the logical structure. When the logical structure is really clear, when it is like a crystal and you look at it and you can see all the little pieces, even though it is difficult and it is complex, if you pay enough attention everything is in place. If there is something that is not in place then I tell the reader -- I try to say, "Look, I am sorry. This piece is still murky, still muddy, it doesn't really fit together completely. We are going to work on it. You have to work on it; I am going to work on it."

WEEKS:

This clear, lucid, beautiful, simple language is the hardest to write but it is the most useful and the most beautiful, I think.

DONABEDIAN:

I was talking now about the lucidity in terms of the logical structure.

In terms of language, I am an Armenian after all. I grew up with Arabic which is a very flowery language and I grew up reading mainly the nineteenth century novelists and reading the Bible. So my language is rather old-fashioned. I read the King James version. My language is Victorian and I love flowery language. I have to really work very hard to make it more spare and less flowery and less poetic, in the old sense, in the sense of being a

little bit schmaltzy. I am somewhat sentimental, in that sense, and that goes into my language and it does tend to be overly flowery sometimes. But I love it. I learned English from books. I didn't learn English from talking to people and therefore my English tends to be stilted.

WEEKS:

The written word is so much different from the spoken word. I have noticed this in the talks I have had with various persons. When you hear your tape, your tape is going to be quite different from many I have taped because you talk more like you would write than many people do. Many persons' oral delivery is very different from their written delivery.

DONABEDIAN:

That is because I learned English from books and writing. I have no verbal recollection of English. I wasn't taught through my ears. I was taught through...

WEEKS:

What did you speak at home when you were a child?

DONABEDIAN:

At home we spoke Armenian. Outside the home we spoke Arabic of a special kind -- village Arabic. That's really quite different in intonation, pronunciation and structure than city Arabic. So I started with village Arabic, the local Ramallah Arabic. Then when I went to high school it was shameful to speak like a peasant so I had to become more citified and adopt the more elegant forms of Palestinian city Arabic. That was really put-on. It was a veneer on top of my initial Arabic. Of course we also studied classical Arabic.

I took all the Arabic courses that all the other students did, and did

reasonably well. I wasn't brilliant at Arabic. That was my poorest subject. I took the matriculation in Arabic and passed and I was okay in Arabic. I knew as much Arabic probably as most of the Arabs there, but not as well as the better Arab students. Then on top of that, when I went to Lebanon, I had to learn Lebanese Arabic, which is different again. So I have problems with Arabic, I think because I have acquired layers of Arabic. Now I find it very hard to speak because I don't know which Arabic to speak and if I am really pushed hard to speak Arabic, I'll speak classical Arabic or some Arabic closer to book Arabic. I am now trying to revive my Arabic by reading books and I really find it easier to speak classical Arabic and speak it reasonably correctly, grammatically, because I don't know what Arabic I have to speak. Whether I have to speak Ramallah Arabic (peasant Arabic), to speak Palestinian city Arabic, to speak Lebanese Arabic.

If I am in any one of these settings, I can quickly adapt and within two or three weeks I can speak Lebanese Arabic with, of course, a strong Palestinian tinge -- from Palestinian city Arabic. I suppose if I went to Ramallah I would speak the dialect -- except that Ramallah is very much changed now. It's full of all kinds of people who have come in from other parts of Palestine. It is no more what it used to be. But I could probably regain that Arabic.

WEEKS:

Where did your English begin?

DONABEDIAN:

My English began in grade school. Then from grade school...well, I went first to kindergarten and maybe another one class after that at a nuns' school, at a parochial school. We had a nuns' school adjacent to the house

where I lived. We never owned a house in Palestine. We rented a house. Right adjacent to it was a convent, a nuns' convent, and children went there to kindergarten.

After that I went to grade school, again in a parochial school, a Catholic parochial school -- a priests' school. That was very close to our house also. I grew up in the shadow of the Catholic church and went to Catholic school.

Then after finishing grade school or near the end of it, there was nowhere else to go, and I went to the American school. So my American education starts way before the University. It starts at the Friends' Boys School in Ramallah.

WEEKS:

They had a Friends' school there?

DONABEDIAN:

The Friends' Mission, the Quakers. I think from one of the Carolinas, I forget whether North or South. The Friends established two mission schools there, a girls' school and a boys' school. They were high schools and grade schools and were reputed to be amongst the best, if not the best, in Palestine. They had one or two rivals. The rivals were English schools run by the Anglicans and one -- I don't know by whom. But these were the best. They were private schools.

So I went to Friends' Boys School in Ramallah. A superb school. Here, I think, it would be like going to prep school. It was that kind of place. It catered to wealthy people and had a boarding school, good teachers. English was taught by either Englishmen or Americans. I've had American teachers of English and English teachers of English. It prepared students for the

Palestine matriculation or the London matriculation, or the Cambridge matriculation, after which you would go to the University of Cambridge, for example, if you were admitted to an English university. Or to the University of Beirut at the sophomore level. And that's what I did.

At the Friends' Boys School, the instruction in high school, at the higher grades, is all in English. So I started English very young, probably around twelve or thirteen.

WEEKS:

You have certainly had exposure to many languages, many dialects.

DONABEDIAN:

The teaching in English at the school was very, very rigorous. Advanced grammar. When I was maybe around fourteen, the Palestine matriculation that year required Shakespeare, every year they required Shakespeare. We took Julius Ceasar one year and King Richard the second. The following year the matriculation was in King Richard II, and you had to know it. Know not only the language but also the characters and the plot. Questions would say, "Discuss the following about King Richard II, the role, his character." You would have to be able to write a very demanding kind of analysis of King Richard II as a dramatic personage in a play.

Remember, a school in a small village in Palestine where the spoken language is Arabic, required the students to have a knowledge of Shakespeare which is comparable to the knowledge of Shakespeare of an English student in an English school because they have to prepare to enter an English university. And we did it. We worked very hard.

WEEKS:

I have a soft spot in my heart for the Friends because three or four

generations back my family were Friends.

DONABEDIAN:

Yes, they are fabulous people. My last two years of being in the Friends' Boys School I was a boarder. They required it even though I lived in Ramallah and I didn't want to be a boarder. We had chapel there, as well, or assembly. I don't know what they called it. We had to go to church every Sunday. Every Sunday everybody would be in their Sunday best and we would march down -- something like maybe a mile or a half mile -- to the little meeting house. A nice little, American-looking meeting house in Ramallah. You walked all the way down, double file, in your Sunday best. I think the girls used to come too.

They were separate. I'm sure they came because it had to be. We would file in and sit in these pews. Imagine yourself in a small American meeting house sitting there in Ramallah. There would be a Friend's meeting.

WEEKS:

Was this silent worship?

DONABEDIAN:

I think probably it was a little modified for us. Maybe it was. I don't remember the details but there were messages and people would preach and there was music and singing. It was not the real thing -- I think the real Friends probably had their own meeting and they would probably sit down and each could stand up and then say something. But, no, ours was not like that. We were not called upon to stand up, or be silent, or say something and then sit down. It was more conducted like a Protestant meeting, more traditional.

We, of course, had Bible in school as a subject of study. I really don't remember what there was in those messages but I keep thinking, "Where did I

develop my interest in social justice? Where did I develop a social conscience? Why am I interested in values as they apply to policy and to problems of access to medical care, and in some of the social and ethical problems related to the organization of health services?"

Sometimes I think probably a lot of it came through this association with the Quakers, even though I am not aware of it. And, of course, part of it may have come through a general Christian upbringing in my family and through the Plymouth Brethren. Although that is a very mixed bag, because the Plymouth Brethren are not terribly interested in social issues. They are more interested in the born-again, pietistic kind of Christianity. Still I think social consciousness permeates even the pietistic approaches to Christianity. Probably the most important kind of religious influence where social issues are at the forefront comes from the Quakers. I can't really remember anything they said. I think it probably insidiously crept in.

I know the Quakers had a big influence on me because when I came to this country I decided to take the Pennsylvania boards -- the Pennsylvania state boards -- so that I could be licensed to practice in Pennsylvania because at one point I thought I would go to work for the United Mine Workers. Go back to my old missionary roots -- go and work in one of these little towns and be a country doctor again. Dorothy wouldn't accept that. If she had said yes, I would have gone I think. She would be a nurse and I would be reenacting my father's life but this time in Pennsylvania which wasn't very different in some ways from Ramallah, really, in terms of the kinds of social problems there.

Anyway, then I went to Philadelphia to take my examination, the first place I went to was the Friends' meeting house. You know, they have one of

the old meeting houses. It was a very emotional experience because I went there alone. I got in and all around the walls they have memorabilia, historical documents, including the letters written by Quakers who had liberated their slaves. For example, a letter said, "Today, I give freedom to Mary Smith and John X in the hope that God may....so and so."

That was fantastic. I was really deeply touched. So there was something of a Quaker in me.

WEEKS:

Yes, I feel the influence although I have no direct connection with it. When I go somewhere I find myself looking for a Quaker meeting house. I have been in the one in New York. I have been in the one in London. I visit a little meeting house whenever I see one. Down on the Eastern Shore of Maryland there is one. I feel a kinship toward it someway.

DONABEDIAN:

I do too. Maybe not as much, but I still do feel it. When we came to Ann Arbor, in fact, we considered joining the Quaker meeting. We did go the Quaker meeting once or twice but the silent prayer, silent meeting, and then somebody gets up and says whatever crosses his mond -- somehow I wanted something more directed than that. We joined the Congregational Church. But I did consider the Friends and I still have this tender spot for the Quakers in my heart and in my mind.

It was a superb education at the Friends school.

I think religion is really a very important thing in life. I am not now actively in an organized religion and there are aspects of religion such as religious bigotry and narrowness and being doctrinaire and religious dogmatism, which really are terrible. But the humanizing, humanistic, even

pietistic aspects of religion, I think, are very important in life. I think they do color my view of health care and health care organization and social values, and I think even my writing. I think it's a very important part of my life even though I am not an active Christian. But I do think that I am a Christian.

WEEKS:

It would be wonderful that a person working in the health field had some sense of social consciousness through religion. It would make health care much more effective, I think.

DONABEDIAN:

Many people do but they don't know it. Probably many people of Jewish faith bring something from their parents that they aren't even aware of. It isn't formal Jewish religion. Most of the people in medical care that I know to have a Jewish background aren't really practicing Jews. But I think the ethic, something there, which we can't place our fingers on, is working and giving us a kind of moral foundation which resonates well with social responsibility for health care.

WEEKS:

They can't completely divorce themselves from the background no matter what.

DONABEDIAN:

When we talk about the right to health care, about social responsibility for health services, whether the philosophy or the rules, against one kind of philosophical background or other, there often is this business of human beings wanting to be treated as human beings. And I think this comes through very heavily in certain interpretations of Judaism and Christianity. There

are, of course, other interpretations too. There is much in Judaism and Christianity that is rather harsh and punitive and doctrinaire and that, in a sense, is dehumanizing. But I think this latter is a distortion. I think the other part is the more prominent and I think that it is the more valid.

WEEKS:

The next big question, of course, is how did you happen to come to the United States and come to Harvard?

DONABEDIAN:

I've told you that I became director of the student health service at the American University of Beirut. Now this really was not a student health service, pure and simple. In retrospect we would call it an HMO. The University initially provided only care for students and had only one physician who was mainly for emergency care.

When I was there--I don't think due to my efforts, probably due to the efforts of my predecessor and for other reasons of which I was not aware then because I was a little cog in the machinery -- there was an interest in expanding the student health service and making it more comprehensive. Besides being a service for students it was to include non-academic personnel, instructional staff and faculty, and administrative staff, so that it would take care of the entire community under a kind of prepayment system. I don't believe that when I was there people actually contributed to their care financially in prepayment form. But I think the university, in essence, paid a certain amount of money on their behalf partly from student fees and partly from other sources.

We were supposed to provide rather comprehensive care. Ambulatory care and laboratory services were available through the university. Inpatient care

was available in the infirmary, to students and to staff who lived on the campus, if they didn't have homes but were in dorms and campus buildings. Care was available to others, in their homes. We made home visits to see patients in their homes. So we had home visits, we had infirmary services, and we had the inpatient services of the university hospital. I don't recall the details of how the hospital was paid, whether it was entirely paid for by the university or whether it was a paid for in part by the person and in part by the university. But certainly the services of the health service in the office and in the infirmary and the home visits, were free. There were no out-of-pocket payment for these. So it was an HMO.

I didn't know that it was. I liked it, though, because I thought that was really what I wanted. I wanted to take care of people. I didn't want to to be paid fee-for-service. I hated fee-for-service. I don't think I'll ever work fee-for-service. I just couldn't see it. Medicine, to me, was something too sacred t be sold. It was a service. You couldn't really be paid for it. It's ridiculous to take care of somebody and say, "Now you pay me money." It was, for me, inconceivable. Even though my father worked that way it was unacceptable. So we were paid a salary and the patient paid nothing for these services. We didn't care. It was wonderful. I loved it.

I had access to the laboratory services. I did not have hospital privileges because I hadn't had enough training. I hadn't gone through the residency and so on. But I could visit my patients in the hospital. Once a person was in the hospital, he was cared for by the hospital staff.

WEEKS:

Much as they do in England.

DONABEDIAN:

Much as they do in England. But I was there. I visited, I talked to the people, I talked to the staff, I reviewed the record and I was involved in the care, and when the patients left, they came back to me.

So to me that was an ideal arrangement, and I liked the clinical work. I then began to realize something that I had not realized before, namely, the importance of epidemiology. I became aware of mass phenomena and patterns, because I could see that we had lots of patients of a certain kind during certain periods of time. I could see not simply one patient, but twenty patients of the same kind coming to see me. Now, obviously, we know that in winter there will be lots of influenzas and in the summer there lots of diarrhea. Obviously you see that in any kind of practice. There was more to it than that. There were patterns of disease that were much more subtle than just lots of coughs in the winter.

There were people who came with certain kinds of sore throat, a kind of sore throat that didn't fit anything in the books but which all these patients had. There were certain kinds of earaches. Some sore throats had associated earaches, and some did not. There were certain kinds of ear infections. There were all kinds of very clearly discernable disease syndromes with very strange and peculiar clinical characteristics and laboratory characteristics which probably even to this day have not been fully elucidated.

This was so the extent that we would label a disease with the name of the person who came first to see me with it. We would say, "This is Mrs. Smith's disease -- this person has Mrs. Smith's disease."

Then I became aware of the fact that I didn't know how to run the student health service. I didn't know how to budget. I learned how to prepare a budget because the financial officer told me how to do it. But I didn't know

how to run the place. I was terribly upset that I didn't know how much soap we ought to have; and where the soap went. I didn't know inventory control. I didn't know personnel management. It was a very small infirmary. I think it had about twenty or thirty beds. We had one or two beds for staff. We had three physicians and two or three nurses and three or four orderlies.

The entire university community was maybe something like five thousand people. We had a kind of mini-HMO caring for about five or six thousand people.

But still there were very interesting administrative problems. And I knew I didn't know how to administer. I just didn't understand. There must be a way, I thought, of making this health service run like a machine -- smoothly -- so you knew at all times what was going on everywhere, at all points, had control over it, understood what went on, what was happening. I didn't know anything about keeping statistics and records although I developed my own records. I developed a clinical record form and I think it was a very fine one. But then how to take that information and use it statistically, that I didn't understand.

Although we did some work with the statistician and I began to gain glimmerings that, "Hey, this is really something. We can take these data, store these data and use them to understand what goes on, as a matter of practical research."

So I decided that I had to get more training. And also I guess, frankly, more training means more prestige and more training probably means a higher salary and maybe more promotion or whatever. But mainly I think it was that I needed to do a better job and to understand this thing I was working in. I thought I knew enough clinical medicine to understand the clinical part. And

besides I could teach myself clinical medicine. I could read; I could attend clinical conferences. I knew how to be a better clinician. But I didn't know how to be the other things.

For example, here is a little problem. I was interested in growth charts. We had collected over the years a very large body of information about heights and weights of children. The university had associated with it an elementary school, a high school, a "community school", and a French school. We had information on children from rather young ages, something like ten, into adult life. Then some students stayed with us for long periods of time so we had longitudinal data on the same persons for a long period. The same boys and girls, mainly boys. I wanted to pull this information together. I knew this was interesting and important but I didn't know how to do it. I didn't know anything about statistics. I didn't know about means, standard deviations, and frequency distributions. I talked to a professor of mathematics at the university and he hadn't the vaguest idea what to do. But when I got to Harvard I soon knew what I should have done. I decided that when I got back that I would know how to handle that material. I knew something about statistics.

So I came to the United States essentially because I wanted to do things in the infirmary that I felt I could not do well without additional training. So I spoke to the Dean of the Medical School. I told him what my problem was and he approved; he understood the problem. He said, "It happens that Dean Snyder -- that's John Snyder of Harvard -- is going to be in Beirut. He is on a trip of some kind. I will arrange for you to meet him and let's see what happens."

I met Dean Snyder. I told him what I was interested in. I told him I was

interested in learning about diseases in population groups. (I suppose I knew the word epidemiology; I may have used it.) And I wanted to know how to run the student health service. I did not know about medical care organization and I certainly was not thinking of hospital administration. That I knew. That was not what I was talking about.

And he said, "Oh, yes, you want medical care organization and epidemiology."

I said, "If that's what you say I want, that's what I want."

He said, "Fine, we will take you"....or words to that effect.

There was no problem about grades and stuff like that, that was all right. The only obstacle was financing, and apparently the medical school was able to get a grant for me from Point Three or Point Four; I don't know what they called it...AID, I think. I remember that it was about five thousand dollars, I think.

Through very careful management we felt we could make that do for both me and Dorothy. Whether that was without tuition or included tuition, I really don't remember. But anyway, it was enough so that Dorothy and I -- we left our children with Dorothy's parents -- we came to the United States. Actually we went to Italy first, spent a week in Rome and a week in Paris. We came to the United States, went to Boston, we rented a room at the home of some people that friends of ours had recommended. They turned out to be also very good friends of ours, and so we went to school. I went to Harvard, to the School of Public Health and Dorothy went to Boston University School of Nursing and got her master's degree in nursing administration. I went to Harvard and got my MPH and we had a truly wonderful, wonderful year.

I did study epidemiology. That part I learned. I was taught epidemiology

by John Gordon. He was a remarkable epidemiologist who had moved away from the old infectious disease orientation and saw epidemiology more as a method of understanding health phenomena in general, including infectious disease but also including suicide, accidents, chronic illness. He offered a truly progressive and exciting view of epidemiology, and I just drank it in. I though this was just fantastic.

I was also introduced to cultural anthropology and the cultural bases for health behavior and the organization of health services. Benjamin Paul happened to be there. I think he later went to Stanford. He was an anthropologist; a superb lecturer. It was absolutely the most fascinating thing I had experienced. At that time I began to understand that people were not just crazy because they didn't accept health services but they were very rational. They were following the dictates of their culture in terms of viewing health one way or another way. That was an entirely new view to me. Imagine someone who has grown up in what is called an undeveloped part of the world in the midst of a very complex and varied cultural setting, totally unaware of the concept of culture -- without a systematic, intellectual view of culture. It's unbelievable. But that was, I think, one of the major things I learned at Harvard.

I was introduced to statistics and I was amazed, I was enthralled by statistics. Every morning I would wake up happy. I would say, "Why am I happy today? I do not know. Oh, I have statistics today, so I'm delighted and happy." I ran to school. I wanted to learn more about this statistics thing which is not necessarily how to make means and standard deviations -- I am terrible in the operational part of math, I make endless errors in adding -- but as an intellectual exploration of phenomena. You begin to see things:

things that previously you didn't know how to handle, now you can handle. One of these was the growth charts. But statistics is useful not just in terms of solving a particular problem but in terms of understanding empirical reality. My experience with statistics was, similar to that of reading Kant's Critique of Pure Reason. Here I got another kind of intellectual skill, knowledge, understanding, insight, that was totally new and terribly useful. I kept telling myself, "How did they keep all of this from me? Why didn't they tell me this before? How can anyone be an educated person and live in the world without understanding the fundamentals of statistical thinking?"

This is true not in terms of how to compute a correlation coefficient but the concept of corrèlation, not how to compute a mean but the concept of a mean, the concept of a standard deviation, the concept of sampling variability, of variance, co-variance. How can one understand reality without this powerful tool for organizing reality? So that was the other tremendous intellectual horizon that opened up at the School of Public Health.

I kept medical care organization until the last because I knew nothing about medical care organization.

When in medical school, they spoke about health departments, I couldn't be interested less in health departments and sanitation. (I am probably still not terribly interested in health departments.) As to medical care organization, I didn't know what that was. I did not know anything about Blue Cross/Blue Shield, community agencies, public health nurses, social workers. I had a running battle with the professor of public health nursing because I kept telling her that I didn't understand what a public health nurse did. "I don't think she can do all these things that you say she does. That is the doctor's job. What are you talking to me about? This is ridiculous."

She said, "All right, Donabedian, I am going to assign you to a public health nurse so you can go out and visit with the public health nurse and see what she does."

Actually, I think I asked her for that. I said that I wanted to go visiting with a public health nurse. I didn't believe there was a such a thing. Anyway, I did go out with a public health nurse for a day. We visited families. I watched her work. It was wonderful. It was stupendous. I was so impressed that I began to understand that, yes, there is something called public health nursing.

But actually, to my mind, it could be also a primary physician making a visit. He should be able to do the same things also, although many do not. The impression I am trying to convey is one of total ignorance about everything. Everything was new to me. I knew nothing about medical care organization, and certainly nothing about the American scene, nothing about health insurance, Blue Cross/Blue Shield. Everybody else in the class knew more than I did about everything that was mentioned.

But we had a very good teacher. His name was Franz Goldmann. He had come from Germany. He apparently was one of the pioneers of this field in Germany and in the United States. He had been at Yale before coming to Harvard. He was at Harvard then and he taught us medical care organization. It was interesting. He made it very interesting. And I learned something from him, got interested in the subject. But I can't say that I was more interested in medical care organization than in epidemiology. I can honestly say that I was more interested in cultural anthropology, in epidemiology and in statistics than I was in medical care organization. Even though I admired, very much, Goldmann's intellectual power, his sharp wit, his language. He spoke like me,

with an accent, but I think with a heavier German accent. He had a marvelous command of English. His method of teaching was to invite a lot of outside people to talk which has advantages and disadvantages.

In his case, he tried to make those visits meaningful. Boston is full of really fantastic people in any field, certainly in medical care organization. He invited some people from further away also. One of the bonuses was that I got to meet leaders in medical care organization. I remember, for example, Milton Terris came down and talked to us. He was then, I think, at Buffalo. Cecil Sheps came frequently because he was at the Beth Israel Hospital. He was the director there, and he is a very dynamic, fascinating, absolutely brilliant speaker and teacher. We had Leonard Rosenfeld come in to talk to us. I mention him in particular because I later worked for him. Paul Densen came down and talked to us. I guess if I stopped to think, I could remember a number of other people, all of whom I got to meet there and whom I later got to know better. In a sense, my socialization into the medical care field began through these early contacts with these people. I began to feel that I knew these people. They had lecturered to me; I had met them; I met them later on.

It was the beginning of becoming a part of a family of leaders in health care, a family that, presumably, I have joined since then.

One thing you never heard about at Harvard. (Harvard is, I guess, very oriented to the Eastern establishment.) So one thing I never heard about was Nate Sinai, whose Professorship I now hold; or Solomon J. Axelrod who later became my first department chairman. I didn't hear about Michigan. There was, strangely enough, no contact with it. Harvard was extremely cosmopolitan and very open to the entire world. We had people from England. There were

lots of students from all over the world, students from Norway and Sweden, from France and the Philippines. So I got to know a lot of very interesting students. Some later became well known. But Harvard was not oriented to the Midwest. It was not oriented domestically to anything outside the Eastern United States -- maybe a little bit to California -- but in between California and Boston or New York, not too much. So I didn't know anything about Michigan which was the place I was going to join. I wasn't introduced to it in my work at Harvard.

So that's essentially the way in which I came to know a little bit about Medical Care Organization. Although, I still saw myself basically as a clinician. First of all, I felt that I really hadn't learned at Harvard anything about running the infirmary that I had wanted to learn. I still didn't know how to run the infirmary. I still didn't know about inventory control, personnel management, and the other operational aspects. I learned something that I hadn't come to learn, and that essentially I wasn't looking to learn -- basic policy issues that pertain to the organization and financing of health care, rather than operational issues of providing care in the infirmary.

But I did go to visit Minnesota which had a wonderful program for student health at that time. I spent a week there. I was sent to HIP, the Health Insurance Plan of Greater New York. I spent a week there and I got to know, some of the HIP people -- for example, George Rosen, Henry Makover. I met Jerry (Mildred) Morehead, although I didn't know what she was doing. She was assessing the quality of medical care. She talked to me a little bit about the quality of medical care. Little did I dream that I would later get into medical care and that Jerry Morehead was going to be, in a sense, one of my

teachers, one of the people on whose work I would base a great deal of my own thinking, and that she would become a great friend.

Again, that is part of getting to know people and getting to be so that you are part of this circle of medical care people.

WEEKS:

What made you decide not to go back?

DONABEDIAN:

I always felt that the Middle East was going to be in turmoil. We loved and still love Lebanon and Beirut, particularly. I feel more attached to Beirut than attached to Ramallah where I grew up because essentially Beirut was the place where my intellectual horizons were expanded and Lebanon is beautiful and the Lebanese people are just marvelous people. I always wanted to go back, but I was afraid to. I felt there would be no peace there.

My parents had already gone through one genocide and we had lost our property in Jerusalem because of the war. My father had a house; we lost that. We had land; we lost that. My office that I was just beginning to furnish -- I never saw a single patient in my office. I told you that I wanted to be a part-time physician, part time in the hospital -- I rented an office and started furnishing it and never saw a patient there. It was destroyed. I decided that I had had enough. My parents went through this in a terrible way; I went through it in a small way -- I don't want my children to go through another one of these crazy things. It's enough.

So I really was predisposed to staying in the United States. I was torn. I wanted to go back. I loved Beirut. But I thought I wanted to stay in the United States, become a citizen and maybe go back as a citizen and if the situation go to be bad then the Americans were always known to bring in their

carriers and cruisers and take away the Americans to safety. I wanted to be one of those people who if anything went wrong in the Middle East, Uncle Sam would bring his ships, home, safe.

So we decided to stay on. I was looking for some reason to stay on. I guess there was a pretext. The president of the university had a heart attack and died. There was a change of administration. I wrote back saying, "Now that I have studied public health, I would like to come back and teach in the school of public health."

I got a very lukewarm reply..."Well, we'll see, we'll judge your qualifications," you know,....And I was doing brilliantly at Harvard. I was at the top of my class. I graduated magna cum laude. I had forgotten, really, what a good student I had been. When I was at the university, I had tremendous prestige as a tremendously good student.....

What I was commenting on is that, in a sense, when you are working you don't get feedback that says you are really a very exceptional kind of person, the way you do in school if you are a good student. School is geared to rewarding you very quickly in grades and other things for being a good scholar.

So when I went back to Harvard and I did so well, I remembered myself. I said, "You know, Donabedian, you are really an exceptional scholar, you're a good student, you're really remarkable in terms of these intellectual skills."

I became a little bit, I guess, big-headed and I kind of had an inflated view of myself and I decided if I go to Beirut, I'm going to go like a conquering hero and go to the school of public health and be one of their stars. They weren't seeing me that way there. They were seeing someone who was very junior who would come back and, maybe, somebody who has no training in public health really. We'll see how good he is. If he is good, we'll give

him something to do.

I got upset, and decided, "Okay, if that's the way you want to treat me, I'm not coming back." But I don't think this was the fundamental reason. I think the fundamental reason was the instability of the Middle East. As I saw it was a future which was not very challenging; frought with danger for my family. I decided I would stay in the United States where it was safer for my family and there was more to do for me in terms of pursuing this new interest that I was developing at that time.

I really saw myself as going back to clinical medicine. I never thought that I would become a medical care organization man. All of this training was part of going back and doing a better job in the infirmary and now I was beginning to think, "Now I can teach public health. I can really teach some of these things, get involved in the public health aspects. Now I am getting a new career interest here."

But I think the anchor was still clinical work and running the infirmary with greater success. So for the reason that I mentioned, we decided that we would look for a job here.

Leonard Rosenfeld, whom I mentioned earlier, was then running a research project in evaluating community services. I think he was in the first year of a three or four year project. He was looking for people. He had spoken to my professor, my advisor, Professor Goldmann about somebody. I had spoken to Goldmann about my interest in staying in the United States if something reasonable would come up. And, in fact, I think I was secretly hoping that the Harvard School of Public Health would say, of course, we want you and we want to keep you. Somebody like you should stay at Harvard. I still think that somebody like me should have stayed at Harvard. I think they missed out

on something.

They said they had nothing to offer. Sure, I could stay at Harvard, but don't expect payment. They had hangers-on. Harvard was full of endless hangers-on who stayed on for the prestige; did other work and gave services free to Harvard. And, in fact, I was later appointed something, I don't know what, some minor post -- research associate, lecturer, visiting lecturer. None of it was associated with any amount of money, but I enjoyed doing it.

So Rosenfeld was looking for somebody and my name was mentioned. He also interviewed somebody else named Kaprio. Kaprio was from Finland. He was a very highly experienced person in health care and he was working for his doctorate. He got his doctorate and Leonard chose Kaprio as his first choice, obviously. He had all of the qualifications and I had very few.

But I told him, "Look, Leonard, if Kaprio doesn't want the job for some reason, let me know. Strangely enough, Kaprio got a better job somewhere, either in Finland, or with WHO. He is now with WHO in a very senior position. I don't know where he is.

After accepting and everything being arranged, he told Leonard, "Sorry I can't take the job." Leonard was terribly upset and he settled for second best. He called me and I said I would come in.

I think later he discovered that he had not settled for second best. I don't mean to cast any aspersions on Kaprio but I think Rosenfeld was very happy that I had joined his team. I learned a lot about research from him. He was the person, in essence, who really introduced me to research methods. We had a brilliant statistician from Harvard who later became a professor of biostatistics at the Harvard School of Public Health. I don't know why I can't remember his name, oh, Professor Reed. I worked with Rosenfeld very

closely and I got to know something about empirical research and got to write research reports and later wrote one paper and still later, another paper....collaborating with him. So my introduction to becoming a researcher and a scholar and a writer in medical care essentially I owe to Leonard Rosenfeld.

I worked with Rosenfeld until the project was completed. It was a project in the assessment of health care. It had a very heavy quality component. Leonard was interested in finding out, developing methods for assessing, the effectiveness and the quality of health care services in a metropolitan community like Boston. One of the studies was a study of the quality of prenatal care or of the content of prenatal care described so we could draw quality inferences. I was heavily involved in that.

Another study was of its actual clinical quality of care in several Boston hospitals -- Beth Israel, Massachusetts General, I think Cambridge City Hospital and I believe another hospital -- anyway, several hospitals. Two teaching hospitals, a community hospital and so on. Rosenfeld did a study of the quality of clinical work based on a review of records. He developed schedules, developed criteria with a group of clinicians and did a study of quality. I was not directly involved in the quality study but I was there when it was done and I sat in on some of the meetings. I think he did a beautiful job of quality assessment -- developing methods that I think are still valid today. So that was an introduction to the quality aspect. The perinatal care and the maternal care part, the prenatal care study, had strong quality implications but not in such clinical detail. I was involved in that, and in some other studies of the effectiveness of care in metropolitan Boston. Rosenfeld's project had a heavy evalutive orientation, with a

considerable quality assessment content. So, in a sense, you begin to see some interest, I think, and some exposure to quality issues.

Leonard was a very good friend of Cecil Sheps and his wife Mindel Sheps. Mindel Sheps was a biostatistician. Shep, at that time I think, about the time when I was there, wrote a very basic paper on quality assessment which had a very deep effect on my thinking -- probably then as well as later through many, many subsequent readings. There again, I think we see the quality aspect.

So through Leonard, I also got to know Cecil Sheps and Mindel Sheps a little bit. But probably they got to know more about me through Leonard than I got to know about them. I also met a number of other people who were on the board of directors or consultants to this study and again broadened my circle of acquaintances at least. Probably it worked more in the sense that they got to know about me as a young man entering health care organization rather than my knowing them. Then later, as I became more senior, I began to associate with them on a more equal footing -- previously it was more on the basis that they were more senior and I was more a protege type rather than a peer.

As I said, Leonard had a very great influence in terms of introducing me to this research.

But when the research ended, Leonard had to fend for himself and he had to find something to do. I believe he came to -- although I am not absolutely certain -- he came directly from there to Michigan to join the United Automobile Workers Union to develop their Community Health Plan. I think that was what it was called. Essentially, it was a prepaid group practice based in Metropolitan Hospital, which still exists, although I'm not sure whether the auspices are the same.

WEEKS:

I think Blue Cross entered into that some way.

DONABEDIAN:

Anyway, Rosenfeld developed that prepaid group practice plan. As for me, I looked for a job and was interviewed, interestingly enough by Paul Lembcke who was one of our great leaders in quality assessment.

WEEKS:

Was he at Rochester then?

DONABEDIAN:

I don't know where he was. I met him at APHA because Leonard was trying to help me find a job. He was looking for a job himself, and at the same time he knew that I was looking so he introduced me to Paul. I remember Paul very clearly as a rather small, rather thin, pale man. (At that time I think he was beginning to be rather ill.) And nothing happened. He was not interested in my working with him. He didn't have room for me.

I interviewed with Vergil Slee much more intensively. Virgil Slee decided that I didn't know enough about American hospitals -- otherwise I would be at CPHA now. What narrow escapes I've had! Later I got to know him better as a friend and I have the highest regard for Vergil.

However, what worked out then was a job at New York Medical College under Jonas Muller. I think Jonas was probably the most brilliant person I have ever met, intellectually speaking. He said "yes" and I joined his department and taught social medicine which was essentially epidemiology. Muller saw himself as mainly a medical care organization type so he did most of the MCO teaching. I didn't teach MCO. He asked me to teach epidemiology which I loved teaching. I even taught a little biostatistics or helped the

biostatistician. He had a biostatistician to teach biostatistics.

I was in the social medicine or community medicine department for three years.

Meanwhile, as I said, Leonard was in Michigan working in Detroit developing this plan. And of course he knew Axelrod and he knew Nate Sinai. He was working with Mott -- Fred Mott. Fred Mott was his boss. I was getting restless at New York Medical College. The Medical College is not related to any university. It is one of these independent medical colleges. It used to be, I think, a homeopathic college like Michigan used to be. It had now become an independent medical college, not associated with any university. I don't think it was a first rate medical school. It did not have many of the hallmarks of an academic institution. It was more like a trade school, I think, at that time, although it has continued to improve. My salary was very low and I was getting restless. I could see myself continuing to work all my life in social medicine. It was wonderful, just what I wanted. I was teaching epidemiology and biostatistics -- just what I wanted. But I couldn't see myself staying at New York Medical College and being able to educate my children on the salary that they were paying me. The prospects for promotion and salary increases were rather dim. So I started looking around.

I considered working in HIP (Health Insurance Plan of Greater New York) as a clinician. Fortunately, it didn't work out. Then I wrote to Leonard to help me. Leonard spoke to Sy Axelrod, who was his friend. He told him there was a young man here, he thought would do very well in medical care organization. Sy Axelrod had just taken over the Michigan program from Nate Sinai. We were not then a department. It was the Bureau of Public Health Economics. So I joined. He called me and came to see me. I had never heard

of Michigan; never knew there was a program like that. But I was desperate, I had to go somewhere. Sy came and interviewed me and then invited me over to Michigan to be interviewed.

I came to Michigan to be interviewed and then we came back a second time, with Dorothy. Apparently I did well enough so that they said, "Okay, come back with your wife." So I came back with my wife. I remember it was a beautiful spring day or summer day, I don't remember which. The campus was in full glory; the sun was shining. The students were everywhere and I said, "This is it. That's it. This is what I want. Michigan is what I want." We agreed with Sy and I joined the University of Michigan and was asked to teach MCO. I had never taught MCO before. When he told me, next week you teach a course in MCO, I thought I was going to faint. Epidemiology, maybe, I could teach. MCO, I could not. So I had to work very, very, very hard that first year. I learned more medical care organization teaching that first elementary course than I have ever done in my life. That's how I started working at Michigan.

WEEKS:

I would just like to make a comment here.

I jotted down some of the things that you have done in medicine, general medicine, pediatrics, dermatology, venereology; they all go together, don't they?

DONABEDIAN:

Used to.

WEEKS:

Physical medicine and rehabilitation, we didn't talk about that.

DONABEDIAN:

Very little.

WEEKS:

I would assume that since you did that nursing home study, you have some understanding of geriatrics.

DONABEDIAN:

No, no.

WEEKS:

And preventive medicine? And medical care research, administration, and then, of course, your writing. So, maybe surgery is something you haven't yet....

Then you came to Michigan to be a Professor of Public Health Economics?

DONABEDIAN:

Yes, I really began to specialize when I came to Michigan. Up until then I wasn't sure what I wanted to do. Except, when I was young -- after I went to medical school -- I decided that I was going to be a clinician, a family physician with some interest in pediatrics and dermatology. I did a large number of things. I didn't specialize, I hadn't focused my efforts on anything; I didn't achieve anything notable in any field. I was just interested in too many things. I was willing to do whatever presented itself. I didn't have a specific plan that I was following.

But when I came to Michigan, by virtue of joining a department which had a particular mission -- even after I came to Michigan, I was often tempted to teach epidemiology -- but Sy Axelrod made it impossible. He made very sure that I had no chance to ever have anything to do with epidemiology. In a sense, I had to work in the area of the mission of the department. And that's when I focused my energies on one area. I don't think I focused on any one

specific topic in that area but on a general area which was medical care organization, as we call it in our department. I did all my work in that one area. I think whatever progress I have made I owe to the fact that I finally decided to settle down and stop fooling around with a large number of topics and stick to one general area like that.

WEEKS:

You mentioned that Nate Sinai left about the time you came there. He is a person we can't interview now. I have heard so much about him from various persons. I wonder if you could tell me what you know about him and his thinking and his work.

DONABEDIAN:

I know very little, unfortunately, about Nate. Since I am the Nathan Sinai Professor of Public Health, I would like very much to spend some time reading about Nate and maybe write a little paper on Nate. Maybe sometime that could be a special paper for Inquiry. Or if somebody establishes a lectureship in Nate's name then I could take time out to read a paper or talk about Nate and his contribution.

I came to Michigan because Nate Sinai had received some kind of leave of absence to study the state employees' health insurance or state employees' health care plan in California. Nate, you see, was a Californian. He was always interested in California. He had always wanted to go back. He eventually did return to California and I think part of his breaking away from Michigan, retiring and going to California, as a prelude to actual retirement, was this study of state employees' health plans in California.

When Nate took that on, there was a vacancy in the department and money available to hire somebody else. That's why Sy was looking and he settled on

me. My initial appointment was only for the duration of the time when Nate was on leave of absence, which was I think two years. I came on a very limited contract. The general idea was that I would probably do more research than teaching. But I was more interested in teaching and scholarship than research. So Sinai was not here physically when I came. He was doing this work in California. But he would come in every now and then and stop by my cubicle -- I didn't have a room then, we had a big room in the department that was divided into cubicles and I had one of the cubicles -- he would come in and say, "Oh, so this is the man who is replacing me."

And I would say, "Nate, hardly; how could I or anybody replace you? I am just here trying to do the best I can while you are away."

I had not known about him before I came to Michigan, as I told you. I got to know him here. He was always cordial and witty and warm and urbane. A very striking person. I learned about him from Sy and from other colleagues who had worked with him. He happened to be a very good friend of the Atwoods. Atwood was Dean of the School of Engineering and his daughter, Julia Atwood, worked in our department. Her cubicle was next to mine and we were good friends. He would come to talk to her. He was a very, very close family friend. She would tell me things about him sometimes. In a sense, it was a friendship through a friend -- a mutual friend. I heard him speak once or twice. He was an exceedingly good speaker, spellbinding, a raconteur, rather formal and careful in the way he spoke but always with wit and charm.

I did read some of his work on health insurance and was particularly impressed by his work for the EMIC, Emergency Maternity and Infant Care, I think. I believe during the second world war there were problems in providing care for the families of servicemen, especially maternity care. Nate Sinai

made a study of the program that was developed to take care of these people.

For many years, my opinion was that that book, that monograph published by the department, which was then the Bureau of Public Health Economics, was in a sense the best single exposition of medical care organization and administration anywhere. I used it extensively. I learned a lot from it and used it extensively in my teaching as a text book until I wrote my own. I found Nate's writing in health insurance that I read and the EMIC monograph very insightful and in many ways unique, possibly examples of the best, most advanced thinking in health care organization available in the country at that time. And still, probably.

I would like to have a chance to go back and read more and in a sense arrive at a more balanced appreciation of his work. I think one would find out that he would stand very, very high in the ranks of people who have made very important contributions to our understanding of medical care organization as an intellectual discipline.

WEEKS:

He did the so-called Windsor Study, didn't he? That was a study of some kind of HMO operation in Windsor.

DONABEDIAN:

He was involved, I think, as a consultant to Windsor and the medical society there. It is possible that many features of the plan were proposed by him, I really don't know. As I said, Sy Axelrod, I think, worked with him very closely and also Ben Darsky.

The book that was written about Windsor grew, I believe, out of the doctoral dissertation of Ben Darsky. Ben Darsky was then a member of the faculty but he joined it before he got his Ph.D. Then, while he was a member

of the faculty, he did this study and it was the basis for his Ph.D. dissertation. Then he wrote the book which is a more simplified, less theoretical, version of the Windsor experience. I think the major author of that is Benjamin Darsky. I don't know to what extent Sinai and Axelrod, who are coauthors of the book, also participated. I think the original design of the Windsor plan probably was heavily influenced by Nate. But I don't know to what extent the study itself was his.

That book is also a very remarkable book. It is one of the earliest systematic studies of two forms of organization,: the Windsor prepaid plan and fee-for-service. I guess now we would call the Windsor plan medical foundation type plan, like some kind of independent practice association, that form of HMO. The plan provided care under prepayment to a large number of people in Windsor, not everybody, but to a large number of people in Windsor. The book studies the effect of this arrangement on use of service, on cost and so on.

I think from that point of view it is a pioneering piece of work. Still of great interest to me. I have used it, certainly, in my own writing.

WEEKS:

Didn't he do some kind of consulting work for the Michigan Medical Society?

DONABEDIAN:

I don't know about that.

He was not well regarded by the physicians because they thought he was a proponent of so-called socialized medicine. He made enemies and he was viewed with great suspicion by the medical establishment.

WEEKS:

Yes, from what I have learned he was considered very far to the left and

dangerous.

DONABEDIAN:

Not in retrospect. But I think at that time maybe you are right.

WEEKS:

Your days in Michigan have sort of sublimated into two major interests. One, the medical care organization and the other, quality assessment. I am using that term widely. Would you like to talk about this?

DONABEDIAN:

I would.

I regard myself basically as a teacher and a scholar rather than as a researcher. I have done a little bit of field research, empirical research, actually collecting data and analyzing them. Mostly that was done in Boston under, or in collaboration with, Rosenfeld. But after I came here, my major interest has been teaching and scholarship. In essence the scholarship can be seen as the avenue for teaching. I wanted to teach, but I didn't know what to teach. I didn't know how to teach. There wasn't enough to teach, not just descriptively -- to say this is what we have in the United States -- but analytically, to say why it is this way. To understand it in a more analytic, more generalizable, deeper fashion.

So my reading and thinking was really a tool to more effective, better understanding and from that would follow better teaching.

Then it happened that this stuff that in a sense can be seen as preparing lecture notes was publishable. When it began to be published, I became a writer. I became a scholar in terms of preparing for publication as a by-product. But I think that more recently that has become essentially the major thrust of my interest.

By observing student reaction, I can tell whether my material works or doesn't work. Sometimes this is through student comments. But just by talking about something. I begin to feel if it doesn't sound just right and I can go back and work some more.

So fortunately for me, teaching and scholarship haven't been two separate things, but one has been a tool for the other. Mainly the scholarship feeds into the teaching but sometimes the teaching feeds into the scholarship. The areas of scholarship are set to some extent by the areas in which there is no material to teach well.

I see myself mainly as a generalist in medical care even though I have been recognized, I think, mostly for my work on quality -- my more distinctive contribution. I think I see myself as a generalist. In fact, I have done more work, I have published more in pages, in non-quality than in quality. My largest book, Aspects of Medical Care Administration, has nothing about quality in it. It is about medical care organization with special emphasis on values, objectives and assessing requirements for health care.

Then another major book, Benefits in Medical Care Programs, has to do with health insurance benefits. Again quality is related to that, but it is not mainly about quality. It is only recently that I have been concentrating on a series of books on quality. And I did that not because I wanted to, particularly, but because I felt that this was a subject where it was easiest for me to get money. I don't want to sound mercenary or overly pragmatic. This is a subject that interests me a great deal. But there are other subjects that I would have wanted to work on, mainly because I knew less about the other subjects. And I think other people know less about these other subjects. Had I been given my preference and told here's money, what would you like to spend

it on? I would have chosen to go somewhere else, I think. I would probably have studied physicians and clients in organizations, a topic that is very poorly understood. But I realized that if I applied to the government or to a private agency for support for that kind of a study I was less likely to get money than if I said, "I want to assess the literature on the quality of medical care or write a definitive series of texts or a definitive monograph, on the state of the art of quality assessment."

I was right. Maybe I would have gotten money for the other project also...but I am not sure. That is why I am seen as having published mainly in the quality area but that is not necessarily the way I see myself.

WEEKS:

But you are fulfilling a need. I am sure that we can correlate the willingness of the government to support the study or a survey of what has been written for a subject which is in great need at that time. For instance, we probably have done a very bad job on assessing quality of care. We haven't found a yardstick but we know there is a need for assessing the quality of care.

DONABEDIAN:

I agree, it is very important. But we know even less about some other things.

I am attracted by the unexplored. I am not really an explorer but I am impelled by my ignorance. When I don't understand something, I have a great need to understand it. I know less about some of these other things like clients in organizations than I know about quality, so I would like to go there. I think I would make a better contribution, probably, there, since the subject of quality, I felt, was reasonably well understood and there are lots

of people working in quality -- there has been no lack of people working in quality, at least in the recent past.

But the story of the quality assessment, if I can go back to it...When I was at the Harvard School of Public Health, I wrote a paper on quality assessment for Franz Goldmann, so I must have had some interest in that. Then I got involved through Leonard Rosenfeld in his evaluative study, which as I said before had a large quality component, although I did not make any contributions to his study of clinical quality. So there was an interest in that.

When I came to Michigan, Leonard was involved with the Health Services Research Study Section which was then chaired by Kerr White. Kerr White initiated a remarkable project in which various authorities on specific subjects relevant to medical care organization were commissioned and paid -- I don't know how much we were paid, one thousand dollars, fifteen hundred or something in that range -- to write papers on subjects that Kerr White and his committee had decided deserved attention. And then these papers came out in a series of monographs and then were published in the Milbank Memorial Fund Quarterly and later put together in a book. I think they are a remarkable contribution, as a whole, to our literature. (I think the most remarkable piece of literature or work on medical care organization in this country or in any other country at any time is the works published under the auspices of the Committee on the Costs of Medical Care. A monumental piece.)

WEEKS:

Yes, twenty-eight volumes.

DONABEDIAN:

It is unbelievable.

Then if you say after that, "What other studies are there?" There are a

few major studies. I think the Michigan study of health economics is one -- now we come from a big star (the CCMC) to second level contributions -- the Michigan study would be one of them. There are some others. This Milbank collection of monographs, I think, would also rate at that level, below the work of the Committee on the Costs of Medical Care.

You will be interested to know that there are three monographs in that Milbank collection by Michigan people. More monographs by Michigan than by any other university, I believe, in that collection of twenty or more. One by Irwin Rosenstock on health behavior; one by Paul Feldstein, I believe on demand; and one by me on quality.

I was asked to do the quality study although at that time I was not considered on authority on anything, not on quality or anything else. I was basically a beginner. I think Leonard Rosenfeld wanted to do the thing on quality himself and he just didn't have the time. So he said, "Okay, I have a friend who worked with me. I know he will do a good job."

And he gave my name. So I owe that to Leonard. When they asked me to do it...yes, why not? That was the first time, in preparing that paper, that I sat down and reviewed the literature on quality assessment very assiduously. At that time it was rather small. I think I probably read eighty percent of the stuff on quality assessment that was available in six months. I prepared notes and then sat in the library -- I remember still how tired I was -- and snipped my notes into pieces, put them into piles and that way organized the material into subsets. Each subset was a pile of clippings on yellow legal pads. I had a kind of outline in my mind, and put it together as a paper. It was terrible. I felt this just couldn't possibly be good. I was so tired. I was so stale as I wrote it. I was just pushing myself.

When these monographs were completed, they were handed in. There was a big meeting of everybody involved. I met Kerr White and I said, "Kerr, my paper is terrible, isn't it."

I felt it couldn't have been good. I was just too tired. He said, "My friend, this is going to be a classic."

I was genuinely surprised. I wasn't just pretending. It has proven to be a very important contribution. As I read that paper years after that, I always find that I really have very little new to say. Everything is there in embryonic form. Every idea that I have developed later, almost every idea, I can see in that initial paper in embryonic form as an interest, as an indication. I think it is remarkable how some of these things happen.

Afterwards, the next step in the quality assessment ladder was the monograph for the American Public Health Association, A Guide to Medical Care Administration, Volume II: Medical Care Appraisal--Quality and Utilization. Rosenfeld was very instrumental in bringing that to me. Again, he wanted to do it but he didn't have time, though I think he would have done a very nice job.

There was a conference. Leonard Rosenfeld, I think, was involved in the conference. Cecil Sheps was heavily involved in that conference. A conference that involved a number of people that had done work in quality, to meet, I think, in New York. A transcript was made of the proceedings of that conference. I think Beverly Payne was there and people from New Jersey who were working on something like utilization review, which set the pattern for PSROs, were there. The Sheps, of course, were there. Riedel was involved. Densen was involved. Jerry Morehead was involved. So a large number of people who had done work in quality were involved in that conference.

This entire transcript of everything, the papers that had been presented and the transcript of every word that had been said, was dumped on my table by Leonard Rosenfeld. And he said, "Here, edit this."

Now I looked at that and I decided, yes, I could edit that but it really wasn't complete. There was a larger framework within which it could fit. And that framework arose mainly from my own earlier paper on quality and my own thinking since that. So I took that material and I believe I used every single bit of it. I put the content of that material on cards, paying very careful attention to who said what. And all of it is recorded in the monograph so that the contributions of the participants are not lost; I did not appropriate any of their ideas. I did provide the overall framework and I added material from the literature, additional to what was there. That, in essence, became my second major piece on quality, the first volume on quality. My reputation really rests on these two and one or two other papers. One that appeared in Medical Care and which won a prize, by the way, from the American College of Hospital Administrators.

WEEKS:

Dean Conley?

DONABEDIAN:

It got the Dean Conley award. That year, also by the way, there were two Michigan people. Paul Feldstein's paper on hospital economics, I think, won an award and I won the Dean Conley Award. So you had two Michigan people there that year.

So I got to be known. At that time there was little systematic work on quality. Nobody had really taken the time to put the ideas together, to organize the pieces. I did the organization and it appeared to be

successful. I got a reputation for quality. I did not intend to go into this area. In a sense, I got into it by happenstance.

WEEKS:

When I came to Michigan, Bev Payne was working on something.

DONABEDIAN:

He was included in this conference.

WEEKS:

He was doing some kind of a guide book, wasn't he?

DONABEDIAN:

You see, Bev's involvement in quality came about, I think, as follows: He should speak for himself. But I think what happened was that he was a consultant to McNerney on this very major study of hospital economics that I was mentioning. Riedel and Fitzpatrick were in charge of a piece of that study which had to do with the appropriateness of hospital use. They were interested in the efficiency of hospital use, or the appropriateness of the hospital for the purposes for which it was designed, and the effectiveness of that use, seen, I think, in terms of whether the skills in the hospital and the equipment in the hospital were sufficient to provide the level of care that the patients needed. Whether these were or less than was sufficient. Also whether people were admitted to the hospital when they needed to be; were not admitted when they did not need to be in the hospital. These were the things they were interested in.

In order to do their study, they needed criteria for hospital admission and criteria for length-of-stay and criteria judging whether the services in the hospital were congruent to the clinical needs of the patient. Payne's job, in consultation with panels of experts, was to provide the criteria for

these three things, admission, stay, and what services the patient requires so that one can judge the patients' needs against what the hospital has to offer.

The study succeeded in looking at need for admission and need for stay but did not go that next step into matching the hospital's resources with the services required.

Payne took that last step, but not in terms of the concordance between hospital resources and required services, but in terms of concordance between what was done and what was needed to be done. He gave it a clinical focus, because Payne really is not interested in medical care organization, per se. He is interested in the clinician's performance. I would say that he is not even interested, primarily, in judging clinician performance. He is interested in improving clinician performance. He wants to find whether the physician does well or not so that he can then introduce educational activities and improve physicians' skills. His major interest is in doing something about improving performance. So that's the direction which Payne took and it fell to him, in a sense, to develop this approach. The approach he used was the same, to develop these criteria and he has remained faithful to that approach ever since and has done enormous work in Michigan, Hawaii, and elsewhere. He continues, by the way, to this moment to work along the same line.

WEEKS:

Walt McNerney felt that he left for the job at Blue Cross before Payne was through with his work and had written his -- I don't know what to call the book -- guidebook or whatever. McNerney felt that if they had been able to hold their organization together longer -- they had run out of money -- that they might have gotten more publicity for this and that this might have

brought in a PSRO-like arrangement years before it came. But, of course, this is just a conjecture, it can't be proved or disproved.

DONABEDIAN:

Well, Payne's work, I think, had a tremendous influence on the PSRO, the design of the PSRO. Because the PSROs, at least initially and to some extent later, emphasized the use of explicit criteria such as those that Payne had developed.

The explicit criteria approach was not really invented by this group. No one knows who invents things like this but Lembcke had earlier worked very hard developing explicit criteria, though of a different kind, not precisely this kind. I think the Michigan group, under McNerney's leadership and the participation by Payne, Fitzpatrick and Riedel, rediscovered the approach and developed a new format for these criteria. Then Payne continued working by himself, first at St. Joseph Hospital. Then this guide which you refer to, I think, was the work he did with the Michigan State Medical Society. It involved a large number of groups of physicians, each group taking responsibility for one or more diagnoses and developing explicit criteria. Then the explicit criteria were put together in a manual and that was it.

The manual is essentially, mainly, a collection of explicit criteria. I think the Michigan State Medical Society initially approved then disowned the manual -- then it was published by the Postgraduate Medicine Department of the University of Michigan.

Later Payne was invited to Nassau County to do a study of hospital stay similar to the Michigan Study. Then he was invited to go to Hawaii and do the Hawaii study. That was the first full-blown test of his method. And after that it became very widely known and it became established as one of the key

approaches. Actually the dominant approach in quality assessment is now, I think, this approach.

WEEKS:

Looking at it from an operative sense rather than the conceptual sense, do you believe that our quality assessment mechanisms are working, such as PSRO or utilization review or joint commission, or whatever? We've got several approaches here....

DONABEDIAN:

It is hard to say, it is really hard to say because all of these things were introduced without experimental design, so to speak. Nobody said okay we are going to introduce the requirements of the Joint Commission on Accreditation of Hospitals in five states and not have them in another five; or have PSROs here and not there and then see what the resulting differences are going to be. Each one of these was added on to something already there, meanwhile the world is changing and medical education is changing, so you can never tell what would have happened without them.

WEEKS:

In other words, if someone said, "What is a PSRO?" You would probably say, "What locus?"

DONABEDIAN:

Yes, we would say, "What is it doing?"

If you introduce a PSRO where there is no quality control at all and where there is no utilization review of any kind, the PSRO is going to be much more effective than if it is an add-on to something already existing, in which case you could say "This is really not much better than what we had before." But what we had before had some features of PSROs in it. So that is one of the

problems. If you want to really know what happens with social change, you have to do it experimentally, but social change is difficult to introduce experimentally.

I think PSROs have had an effect. It has not been very large. I think, more importantly, PSROs and quality assessment mechanisms can work. They can work brilliantly, and there are examples of their working brilliantly, if we want them to work. I really don't know what I mean by "if we want them to work." It's obvious that in some settings under certain kinds of leadership, mechanisms of this kind, whether they are PSROs or quality control or utilization control of another kind, have had very profound effects. It's also obvious that in other situations, we've had accreditation, we've had PSRO, we've had other quality control mechanisms and they have not worked. In other words, the physicians have not changed their behavior, the system has not changed its behavior.

One of the major research issues in quality assessment is to explore and understand why this thing works in some places and not in other places, or under some situations and not others. What are the factors? We can guess. We can say if you have a strong leader, or if there are few beds when it will work; if there are a lot of hospital beds then it will not work. We can guess that quality control can work if the physicians want to. One doesn't know what we mean by physicians wanting to. Why should they want to in some cases and not want to in other cases? Questions of this kind. That is one of the major research issues in quality assessment. How to make them effective. What factors influence effectiveness? Why is monitoring effective sometimes and not effective at other times when what you are doing seems to be the same thing?

WEEKS:

Some suggestions have been made that we should use the joint commission approach -- have an outside team come in and work in a hospital rather than local peer review. Of course, I suppose that operationally it would be almost impossible to work that sort of thing. I sometimes wonder how well the Joint Commission works. How well these teams -- don't they get tired of traveling and spending three days here and three days there -- what kind of quality in examiners can you expect to hire under bad social conditions of being away from the family?

DONABEDIAN:

I don't think we have shown convincingly that accredited hospitals perform better than a non-accredited hospital when the only variable is accreditation. There are some studies that show that accreditation has some small effect in some situations, but it is a very difficult thing to come to grips with because there are no unaccredited hospitals in certain categories of hospitals. I mean, you don't have university affiliated hospitals that are not accredited. So you can't test the effect of accreditation there. Accreditation effects can be tested only on certain community hospitals, test for differences, and on certain proprietary hospitals -- and when one does, one finds, in the very few studies that I can think of, that accreditation has either no effect or a small effect, depending on the circumstances.

My approach would be very similar to the one that the PSRO tried to implement, namely, a multitiered, multifaceted approach where there is on-going internal review supported by an external monitoring mechanism.

WEEKS:

Such as computer, you mean?

DONABEDIAN:

For example, the PSRO will delegate its activities to a hospital, never-the-less the hospital has to report to the PSRO and the PSRO has the right to check. So that's a combination of internal and external review, you see. I am kind of sympathetic to physicians and other professionals being given the primary responsibility to monitor themselves. That is a professional function. I can't see professionals working like technicians under outside supervision. I don't think you get good work that way; you don't get good people that way. So professionals ought to have a great deal of autonomy and a lot of opportunity to develop methods to monitor their own work. I also believe that they can't do it by themselves and we have the social responsibility of making sure that they do it and that they do it properly. So there ought to be accountability to an external body as well. So I believe in a combination of internal and external control.

But I think even more important than monitoring is getting the system to be different, organizing it differently so that you change the incentives. Of course, we need more and better education so physicians are able to give quality care. I think we may need a redefinition of quality and what we mean by it to go beyond technical quality and include aspects of the interpersonal relationship between the patient and the physician, access. These are aspects of quality too.

WEEKS:

Haven't we been losing some of that?

DONABEDIAN:

We have been losing some of that so we ought to put that back. We need perhaps to reorganize care. I think that the HMOs would be one example of a

situation where the physician has less incentive to provide excessive care, perhaps; less incentive to hospitalize and so on. Although, there might also be incentives not to give the care that is needed.

We can change the incentives by reorganizing medical care. And then the monitoring and quality control and quality assessment mechanisms are on top of that. There are ways of obtaining information as to whether we are doing well or not. In other words, primary reliance for quality should not be on the monitoring system. Primary reliance is on good education, good working conditions, proper kinds of incentives. I think it's these things that are the cornerstone. Monitoring is an indispensible adjunct, I think, rather than a primary cornerstone.

WEEKS:

What would you say about the patient's responsibility toward receiving good care? Can we educate him to live better, I mean more healthfully? Are his expectations too great sometimes? Does he expect too much?

If we had a national health service tomorrow with free care for everyone with every condition, how could we optimize a patient's healthful state in such a way that he would not be going to the doctor's office too often -- whatever that is -- that he would be taking care of himself, not smoking, not drinking, overeating, that sort of thing? As a society, what should we expect of the patient or what can we educate him to do, or can't we?

DONABEDIAN:

I think, maybe, if we have a national health plan in which physicians have no stake in illness and have a larger stake in health...

We have, I think, an example in Blue Cross/Blue Shield recently. More and more we find Blue Cross involved in propoganda or advertising or health

education which says take care of yourself and so on. Why is that? Partly it is because of a sense of social responsibility but partly because as the premiums go up, as illness becomes prevalent, then medical care costs go up, premiums go up. They have a stake in keeping people healthy.

So one could argue, theoretically, that having a health oriented system with emphasis on health and less emphasis on illness would be a good thing. Having said that, I really have no empirical evidence to support it. I don't know enough about medical care in other countries to know whether, let's say in Britain which has a national health service, there is more attention to health and less attention to illness. I suspect the answer is negative. Theoretically, you could argue that a health system ought to put more emphasis on health and less on illness, but in practice, probably, that is not really true.

I am a great believer in education and I think physicians have to be educated differently and understand health more broadly than they do now. In medical school we learn about illness. I really don't know that there is any medical school -- I don't know that there is any textbook of medicine -- that begins with a chapter on health. What is health? There may be such a book but I haven't seen one. You see more of this orientation in pediatrics and obstetrics...You have normal obstetrics and normal pediatrics, I mean a normal child, a normal pregnant woman. In medicine, you have illness mainly. I think students have to be educated differently, medical students and nurses and so on. And also people in general ought to be educated differently in the importance of healthful living. Obviously I agree with you in what I inferred from what you said, that it is extremely important for a patient to participate actively in his own care.

I think quality consists not in the physician's saying what the patient ought to do but in the physician and the patient jointly deciding what is the best course of action for any particular patient in any particular situation. Yes, patients ought to participate more actively.

One thing that I notice is that the way in which people define health is really broader, more inclusive, more holistic than the way in which health professionals define health. We can learn a lot from people about what health is. We physicians know about illness and the absence of illness. But we really don't have an understanding of positive health. The layman seems to see health whole, to see health as having many more aspects, to see health as healthful living; much more so than the individual physician and almost, in a sense, they are going to lead us through their jogging and dieting and their emphasis on healthful living. They are going to change the views of physicians. I would like to see it the other way around. I would like to see all the health professionals, not just physicians, telling people what healthful living is. I think that now, to some extent, it is the other way around, although there is some evidence of a change in medical attitudes and education as well.

WEEKS:

You mentioned holistic. I don't know whether you were referring to the holistic medicine practiced in the Chicago area now but I did a little reading in that and it seemed to me that they had a good approach in that they were thinking of things besides physical ailments. They were thinking about social problems, they were thinking about family problems. In other words, a patient could come in and unload himself or herself of all the worries, all the troubles, all the stresses, all the strain and be treated, psychologically, as

well as physically by a physician. It seemed to me that sometimes we don't realize what is causing our physical ailments as much as we should and possibly this is a way. I am sure that a patient could converse with a nurse and a physician and maybe even a social worker in one office visit, so to speak, and benefit greatly from it.

DONABEDIAN:

I use the physician only as a type of health professional. Certainly care is given by many more people than just a physician. I think you are right in that all aspects of one's function, social, physical and psychological function, ought to be taken into account.

But even before we get there, even if the illness is primarily physical, let's say diabetes or cancer of the breast or cancer of the lung, the decision as to what to do and the measure of success has to be more than the traditional measures of success. We have to think of the ability of the patient to function in a way that is concordant with that patient's objectives in life and role in life, situation in life. I think that the quality of life, in a broad sense, becomes the objective of health care rather than a very narrow thing like, "Okay, I want your blood pressure to come down."

It is much more than that. The other day somebody was telling me, he's a professor of surgery at a medical school, and he was telling me about his wife. She had asthma and she went to a doctor, a specialist. The specialist said, "Okay, what you have to do is stop working, this work is very tense, very difficult, creating psychological problems; take it easy, redecorate your house, take a vacation and your asthma will get better, and you will be happier."

She came back and told her husband that she wanted a different doctor.

She wanted a doctor who would help her do what she wanted to do, with less disability than she was experiencing. She did not want a doctor to remove her asthma and take half her life away with it. So she went to another doctor and he said, "That's crazy. You obviously want to work. Do you want to work?"

"Yes, I want to work. My life is my work and my work is my life to a large extent. Can you help me to do my work with less asthma rather than curing my asthma no matter what the price in terms of my inability to do what I want to do?"

I think those are two very different objectives and I think one is quality care and the other is not. I think the doctor who says "I can cure her asthma but she will have to become a totally different kind of person" may not be providing quality care, unless the person wants that. The treatment has to be adapted to each person's objectives. This orientation, I think, is not taught in medical school, but it is beginning to appear more and more in quality assessment as a major criterion of quality assessment.

The objective in quality care is to achieve the patient's objectives defined in the broadest sense possible.

WEEKS:

You were speaking a few minutes ago about your study in Boston, the nursing home study. I assume to study the potential for these patients in the nursing homes, is that right?

DONABEDIAN:

I wasn't involved in a nursing home study in Boston; it was mainly a hospital study. There was a nursing home study in New York. My involvement in that was not very deep. I think this had to do with the potential for rehabilitation in nursing homes for certain groups of patients. I think the

results were negative. It was found that people who got rehabilitation services didn't do any better than people who did not. It was totally negative.

WEEKS:

The reason I ask is because I am in the older citizen's group now. It seems to me that in looking at my contemporaries that so many of them are doing nothing and are worrying about their arthritis or asthma or whatever. I think we are going to have to do something about inciting the interest of these people in something in life that will take their attention away from their own disabilities because we both know that as you grow older you are going to have pains here and there and that sort of thing. But if you could show some interest in life, possibly that is good medicine, too. But how are we going to do that? We have all these millions of older people now.

DONABEDIAN:

I think we have seen nursing homes largely as places where you put people away. I think it is a disgrace for our society to have that as essentially the only solution or the major solution or a major part of the solution for old people. We still put mentally ill people in hospitals, put them away; put criminal offenders in prisons, put them away; put old people in nursing homes, put them away, out of sight. All of these are cop-outs in a sense. We have to find some alternative, I agree with you, for keeping older people useful and closer to the mainstream of life. Unless they don't want to. I think some old people really would like to withdraw and do very little and sit in a corner. I would respect the right of a person who wants that to have that, but not unless an alternative has been offered and rejected. That alternative we have not been able to agree on and to provide.

For example, this business now of taking away from social security, or of slowing the growth of Social Security, really shows a very short-sighted and narrow view of the needs of old age. We should be thinking of enriching Social Security rather than weakening it so that people can look forward to a secure old age when they can do things. Much of the inability of old people to do the things they want is just that they don't have money.

WEEKS:

But a great many of them have money.

DONABEDIAN:

Yes, many do. But if you have money you can go to a good nursing home and you have social activities and you have opportunities to go to the movies and you can write letters and you can have a small garden and you get a nice room; you can have visitors and you can go to town and you can have theater. If you have good money, you can have a good retirement.

WEEKS:

But now many of these people don't. For instance, I have a relative who is 94 1/2, is alert. She has to get around with a walker or a wheelchair but she is content to stay in her room and not try to converse. She goes out to a religious service on Sunday -- they have a minister come in in the afternoon. She doesn't go to anything else, she doesn't go to any of their movies or any of the other entertainments that they have for the people.

We were there on Sunday and she had been out that morning, one of her great-nephews came and took her for a ride around the city where she lived all her life. She was so excited because of all the things she had seen that day. Then we came unexpectedly. She had a religious service in the afternoon. So her day was very exciting. Wouldn't it be wonderful if she

could do something every day so that she would be entertained or she would be stimulated in some way so that she would wake up in the morning and say this is another nice day out, and have a good day.

But so many people are worried about whether to take their pink pill or the yellow pill. I don't know what is going to happen. I am very much afraid when I look at the figures -- I may quote these figures incorrectly but I think I'm about right -- the first year of Medicare cost us about 4.5 billion and now it's costing us a billion a week. We are going to have an increase in the percentage of population of older people on Medicare. Is this the only answer we have is to spend all this money and not do something for these people?

I like your idea that Social Security should give some attention to other things that they can do for people. I assume that you meant stimulating...

DONABEDIAN:

Well, I was thinking that Social Security should not be cut in terms of the cash benefits.

What has happened is that the federal government has gone into Medicare care for the aged and has subsidized medical care, with a narrow definition of medical care, defining it in the traditional sense, which means pills and shots and nurses and doctors. We have lost the balance. We probably do too much of this and too little of other things. If you want to get somebody to come into the nursing home and take the old person out shopping and bring that person back, there is no government program which pays for that. Medicare will not pay money for that kind of service. What will it pay for? It would pay for the doctor coming to see the patient. So you get the doctor or you get a pill. I think we have ever-medicalized nursing home care because

medical care is an okay service for government to pay for and these other services are not recognized as important. So we ought to redress the balance so we get less attention to medical care, as traditionally defined, and more attention to other aspects of care, whether provided professionally or by helping volunteers or by family members.

I could be wrong about this but I can get a tax break if I put heat insulation in my house. I am told that I can even get a tax break if I put glass around this porch and make it into a solarium and hot house or something. I can scarcely believe that but I was telling Dorothy that maybe we can just get somebody to put glass here and we could say that this is a solarium and get the government to pay part of the expenses. But what tax break would I get if I built a room for my grandmother? I don't know. I guess she could be a dependent. That is about all I could get as a tax deduction.

I think the care of the aged is a very difficult topic. I certainly am not qualified to deal with it. But it requires a whole range of social programs, I think. Why are we spending so much on medicine? I agree with you, it is because we have accepted the social responsibility for medical care, without accepting it as much, maybe, for some of the other things that are needed, and we ought to redress that balance. We ought to pay less attention to medicine and more attention to things that are more effective than medicine like friendship and recreational activity and healthful living.

WEEKS:

We certainly haven't done as well as we should, I think.

Your first major book was Aspects...., wasn't it? How did you happen to write that?

DONABEDIAN:

When I came here I began teaching a very elementary course in medical care organization to the nurses, essentially. I mention them because they wanted to take medical care but they didn't want to specialize in medical care organization and they couldn't take the course with everybody else. So there was an additional course for them and I was given this additional thing to teach. Then I taught the medical care course for the students who were in medical care organization. That was well done, I think, before I came, by Axelrod; and after I came, Axelrod and I taught it together very often. It is still being taught. The basic medical care course is a great success no matter who teaches it, within limits.

But the problem had always been in developing a second level medical care course. We just didn't know what a second level medical care course should be like. What we did was teach more medical care, of a descriptive nature during the second level coursework. My task was to develop a more advanced second level course.

As I told you, for a long time I depended heavily on Nate Sinai's EMIC monograph for teaching some aspects of that. I started working on developing some framework for teaching something. First I had to teach myself and then teach what I had taught myself. I developed over time a series of lecture notes -- it was a very, very hard job -- and the course I don't think was ever successful and I think it is still not fully satisfactory.

When my sabbatical year came around, I thought "How nice. I will take my sabbatical; I will take these lecture notes and I will develop them and write, in a sense, a textbook for this course, so that we can teach this course properly. And that is how I started working on Aspects."

Aspects of Medical Care Organization, after working for a year or more, covered only the first two or three or four segments of the course. The rest was not written because I just was bogged down and the subject began to grow and grow and grow and I didn't know how to stop or where to stop. So in essence it is one quarter or one fifth of the course.

Later I took time out to write some other chapters to deal with other segments. Then I wrote the book on Benefits. That was again during another sabbatical year with support from outside sources. But that, again, is a small piece of the whole course.

Then the piece on quality that I did, and the work that I have done in quality since then, can be seen as still another piece of this course. The final piece of the course. That is not yet finished and I am not sure it will ever be finished.

So one can say that all these books are really attempts to develop teaching materials. First to develop a framework and understanding, a certain degree of depth in my own thinking, in preparation for teaching. And I use this material in teaching, but of course in a condensed form. Obviously, the material in the books cannot all be taught. There is just too much of it. The students can supplement the lectures by reading the texts.

WEEKS:

This is also the way your chartbook came into existence?

DONABEDIAN:

The chartbook began as a series of class materials. I began developing something like this when I was at New York Medical College, when I taught either medical care or epidemiology. I had a series of dittoed charts and tables which we passed to the students. I think this approach I borrowed from

Professor Goldmann and also the professor of epidemiology at Harvard, John Gordon. They used to hand out these things which we then would use as class visual aids or memoranda or materials to have in front of us for the lecture.

So I developed a collection of a dozen or twenty charts to illustrate the teaching of the basic course in medical care, just as someone would use slides. Instead of using slides, I had the charts reproduced on ditto. Axelrod saw this and he was very taken with it. He said "I think you should develop this." So I did develop it further. And I must say that he saw the value of it better than I did. I was thinking in terms simply of my own use for my students. And he said "No, this is great, I think we can publish this."

So he and I published the first Medical Care Chartbook which was rather small. Then it was so successful -- it has been the most successful publication certainly that I have done and the most successful that the department has ever published. Then there were successive editions. The purpose always was, primarily, to use these materials as teaching aids.

But people in the outside world who saw the Chartbook saw it as their own source of data and information as well as a teaching aid. They started asking us for more material, not to fill a teaching need but to fill a reference source book kind of need. So we have compromised. We have added some information that we don't really use in our teaching but which we think other people expect to find in the chartbook. But still, the primary purpose, the primary design, as we designed the different editions and arranged the material, is that these should illustrate our teaching. The charts are arranged in a very special way and that special way is really in concordance with out lecture outline. So you start the lecture with chart 1, chart 2, chart 3, etc.

There is a story line in the chartbook which people who know medical care can see immediately. People who don't know medical care have trouble with it. Also the story line is somewhat disturbed by this additional material which we have included in deference to what others want. People who buy the book want more stuff of a reference kind. So if they want to know how much money is spent by the government on medical care, they want to see it in the Chartbook of this kind. If you remove some of that extraneous material there is a very clear story line. We who have designed the Chartbook know what that story line is and if we were to annotate each chart, the reader would immediately know that this was really like a textbook. It has a story, it has a plot. It is not just a collection of charts.

That is what I am trying to show in my chartbook on quality assessment that I am working on. Volume three on quality is going to be in chartbook form. If it succeeds, then we hope to do the entire chartbook that way.

WEEKS:

This is with annotations?

DONABEDIAN:

I was working on the quality chartbook when you came. This is my enterprise for this summer. It begins with an introduction. Then on one side we have a chart and on the other side there will be a printed page of description. Then another chart and another page of description. So the story line becomes clear. One chart depends on another so there is a thread, there is a classification. It is like a textbook except -- if you wish, it is like a comic book -- it has the story and the pictures. It is graphic and it has, of course, data and it has sources of information. It has a design and it is keyed, to the extent possible, to other publications, mine and other

people's. So that if somebody wants to read more, that person can go and read some more somewhere else.

There will be an index which will have to be very, very complete. And maybe various other addenda which will say, if you want to know about such-and-such, you can look through the following charts in this order and get a clear picture it. Let's say you are interested in the relationship between specialty status and quality, you go to the listing for specialty studies and quality in the index. You read the whole chartbook like a textbook.

We'll see whether it works. It should work, there is no reason why it shouldn't.

WEEKS:

I think that is an ingenious idea.

DONABEDIAN:

It is a development of the chartbook experience and I think it will work. Apparently it is sufficiently attractive that I was able to get some financial support for it...a modest amount of financial support.

WEEKS:

You told me quite a great deal about Nate Sinai and Leonard Rosenfeld. Is he still alive?

DONABEDIAN:

Yes, Leonard most recently was at North Carolina. He was a professor of medical care organization at Chapel Hill. Where Sheps is. And he is, I think, formally retired, almost completely. He may still be doing a little bit of teaching but I think he is beginning retirement now.

WEEKS:

I should interview him, shouldn't I?

DONABEDIAN:

He has a lot to say...he knows all these people and he also knows of the work in Saskatchewan by a group of people who later all became very, very prominent including Milton Roemer, Cecil Sheps and his wife, they are Canadian, and Rosenfeld and perhaps some others. There is a kind of little connection there between Saskatchewan and the medical care movement in the United States.

WEEKS:

Gary Hartman was up there too, wasn't he?

DONABEDIAN:

Could be.

WEEKS:

I think he went up there as a consultant.

DONABEDIAN:

Yes, Saskatchewan was the first Canadian province to introduce universal insurance including office care, physician care. So they were pioneers, first in hospital insurance in Canada, then in universal health insurance for everybody. People from the United States played a tremendous role in those developments. It is worth documenting, I think. I think Roemer and Sheps and Rosenfeld -- I really don't know whether Fred Mott is alive or not.

WEEKS:

His name crops up. He was with the Department of Agriculture during Roosevelt days, I think. I don't know how he got into the health picture.

DONABEDIAN:

I think the Department of Agriculture had a health program for migrant workers or agricultural families or something. Didn't Axelrod have something

to do with that? That was another hotbed of "medical careniks", that program.

WEEKS:

I interviewed Nelson Cruikshank. He was telling me about his early days and working in the WPA or some such organization and they, some way, came under the Department of Agriculture to take care of these migrant farm workers in the West. They developed mobile medical offices and dental offices which were finally taken over by the Army when the war broke out. But he spoke of Fred Mott and I have heard of Fred Mott several times but I've never met him.

I do agree with you, I think the Saskatchewan episode would be worth recording.

DONABEDIAN:

Milt Roemer and Fred Mott wrote a book on rural health.

WEEKS:

I was not familiar with that.

DONABEDIAN:

That is one of the connections. Then Fred Mott was retained by the UAW in Detroit to develop this health plan, a prepaid group practice and he asked Leonard to join him in planning for that. When it was finished, Leonard stayed on as Executive Director of the plan for a while until he left.

WEEKS:

What is Mott's background? Is he an M.D.?

DONABEDIAN:

I think Mott is an M.D., but I don't know much about his background.

WEEKS:

You mentioned Paul Densen. He's from Harvard, isn't he? What can you tell me about him?

DONABEDIAN:

I don't know Paul well. I think Paul used to be at Duke University, if I'm not wrong. Or Vanderbilt. I believe he is a biostatistician. He is a Doctor of Science. I know him a little bit, I told you that he lectured at Harvard occasionally. At that time I believe he was in charge of research at the Health Insurance Plan of Greater New York. The HIP was a major early experiment in prepaid group practice. I think it was initially encouraged and sponsored by Mayor Fiorello LaGuardia who was looking for some way of providing health care for city workers.

HIP can be credited with starting the program but more importantly for carrying a large number of studies of what such a program can do and how it differs from more traditional forms of organizing care. Paul Densen was in charge of the research division and he was responsible for the design and the execution of many of these early studies which threw tremendous light on this subject. I really don't think that the recent work that has been done by others has added a heck of a lot that is new to these early findings. Some of the early research studies at HIP were very well designed.

Densen's associate at HIP was Sam Shapiro who later became, of course, in his own right a major figure in health services research. He now directs the health services research center at Johns Hopkins. So I got to know Sam a little bit when I went to HIP. I met him and met Densen. I have not been close with either of them but I consider them to be friends and I meet them occasionally and we talk about old times.

Densen's major contribution was as one of the early pioneers in health services research. He is a person who, together with Sam Shapiro, introduced methodological rigor and more rigorous research design and analysis into our

studies of that kind.

Later Sam Shapiro continued to do work which was more of an epidemiological nature in addition to health services research, or organizational reseach. That whole body of research at HIP was, again, a very, very major contribution to our understanding of our field. To mention again Dr. Mildred Morehead. She was in that department, I believe, but involved mainly in a different branch, a different activity...the quality assessment activity. That was another major contribution of HIP...a series of quality assessment studies. It began with Makover, then Dailey and Morehead. Afterwards Morehead left HIP and went to Columbia and she and Ray Trussel, who was her husband then, did the work, with others, on quality assessment at Columbia. There were several pieces of work, and also work comparing various kinds of group practices, group practice and solo practice. After that Morehead continued with her quality assessment studies at Brandeis, where she is now. She did a quality study for the OEO. She evaluated the OEO clinics, later worked with PSROs and is still involved in quality assessment.

Her work is another stream in quality assessment. There is the Michigan stream which began with McNerney and his group, Fitzpatrick, Riedel, and Payne, and continued with Payne and his associates. That is one big stream in quality assessment. The other stream, which is not as large, I think, but is still a significant stream, uses a somewhat different approach to quality assessment. It is the stream that began in HIP with Makover and Dailey, picked up and developed by Morehead at HIP, Columbia, Brandeis.

WEEKS:

She would probably be a good person to interview, too, wouldn't she?

DONABEDIAN:

Yes, certainly on the subject of quality assessment.

I would say still another major school of quality assessment would be centered in North Carolina but it does not have any particular approach associated with it. It is a mixture of approaches. The previous two streams are methodologically different. But the North Carolina school, though it has produced a number of significant studies, has used various methodologies, but that is another center of important quality assessment studies.

I guess if we want to look at a fourth center, it would be the association of the Rand Corporation with the University of California, Los Angeles. Another school is led by Williamson at Johns Hopkins. In fact the work at Rand, in a sense, could be considered a development that goes back to Johns Hopkins, that concentrates more on the outcomes of care, on the measurement of outcomes. Then Williamson's students, especially [Robert] Book, went to Rand and essentially took some of those ideas with them and that is another kind of meandering important stream in quality assessment.

WEEKS:

Does Newhouse enter into that?

DONABEDIAN:

No, I think Newhouse would be more in the area of economics. He would not be in the area of quality, although they are now working together.

You were talking about quality and how important it is. I think there has been less and less emphasis on quality in recent years, the last two, three, four years, and more emphasis on cost control. In some ways quality studies are in kind of an eclipse, though I am currently working on quality. Usually I feel that I work in a field a year or two or five ahead of developments. Now, I think, I am working on quality in a kind of rear-guard, action because

interest in quality is diminishing.

But quality is very important because whatever problem you deal with, there comes a point where somebody asks, "Well what about quality." Let me illustrate.

Let's say you want cost control, all right. Here is a method which organizes medical care in such a way as to reduce costs. The immediate response is "Ah!....but what does it do to quality?"

So that almost any problem of reorganization of financing in health care that you want to deal with has to assume that quality is constance, or has to assume that quality is not hurt, or has to make a statement about quality. The HMO initiative -- what does it do to quality? Procompetition proposals in Congress -- what do they do to quality? Prospective reimbursement -- does it reduce cost? Aha, but what does it do to quality? Does it reduce cost at the expense of quality? So I think there is no question you can ask, really, of this general kind, a fundamental question of medical care, the answer to which does not require some statement about quality because, after all, quality is the essence of what we are aiming for. For that reason I feel that there is really no time when quality is not going be fundamentally important; all the work that is devoted to it is necessary and justified.

WEEKS:

I think somewhere you have said or used a measurement or used a qualification that the quality of an institution is somewhat limited by its resources. So that you judge the quality of performance within resources? Would that be a fair statement?

DONABEDIAN:

You can. You may have to.

WEEKS:

What I am leading up to is how has quality of care entered into regionalization with the University Hospital at the top and the medium sized hospital and smaller hospital all referring patients up the ladder as need be. Is that an element of quality? Is it felt that this referral policy brings better quality or at least it brings some services, I understand, that would not be available, but could it also be correlated with the quality of care?

DONABEDIAN:

I think this was one of the major questions that the McNerney report, as I said, was trying deal with. Mainly, whether the resources of the hospital are concordant with things it tries to do. Is a hospital that does not have an electrocardiogram, let's say, trying to treat a coronary accident which requires one? You can't do one without the other, you see. They were interested in that, but they never really went much further than developing the criteria and they couldn't implement that part of their study.

I think intuitively and theoretically, if you wish, there are very important relationships -- one feels that there are very important relationships. For example, you said a while ago that the quality of care in a hospital or an institution has to be judged in relation to its resources. There really is no reason why a hospital which is small and has limited resources cannot do first class work, technically speaking, as long as it limits itself to that which it is equipped to do. There is no reason why a generalist cannot do superb work as long as he or she limit themselves to what they are trained to do when they have something beyond them, they refer that something to somebody else.

Now we know that most studies of generalists and specialists have shown that specialists do better, as long as the specialists remain within their area of specialty. When they go outside their area of specialty, they do very badly. They may do worse than the generalist. So there is no reason why a small hospital should not do as well as a large hospital, if they refer. So I think regionalization has something to do with that.

We know that nurse practitioners do as well as doctors and may do even better than physicians, but that is only because they accept their limitations and they refer to the doctor or somebody who knows better when they exceed their limits.

So I would say that in a regionalized system, one would expect that each institution is good at what it does and refers patients to the higher level institution. That higher level institution will see more of the cases which are rare and therefore will have more experience doing the difficult operations, more experience dealing with the rare conditions, more opportunity to develop expertise and skill and be good at it. Why should a hospital that gets only one open-heart surgery case a month, do open heart surgery? It should go to a place where they do twenty a month or thirty a month. Right? So everything points in the direction of quality along those lines, specialization and referral by physicians, health professionals and hospitals.

Now, if you ask me, "Are there really empirical studies that would support this picture?" my answer would be that we have pieces of evidence. For example, recently Luft did a study which showed that hospitals which did more of certain kinds of surgery had better results, mortality was less. But for other kinds of operations, this was not the case. For an appendectomy, it may not matter where you go. But that is an exaggeration, it does matter some.

But for open-heart surgery, it does.

So, yes, regionalization must be related to quality but I have not seen a study that tests a regional system as a whole. I have seen studies that test little pieces of this paradigm that we presented.

WEEKS:

Don Riedel and McNerney tried to do it with that regionalization book they wrote. But they were reporting a failure rather than a success story. One of the causes for the failure was that the smaller hospitals felt that they were on the losing side of the battle because they were always referring people up the ladder, but never getting any back. So referral has to work both ways.

Your example of the hospital that does a great number of operations does them better than one that does them only occasionally reminds me of a talk I heard a few years ago from an emergency team from the old Detroit Receiving Hospital. Three or four young surgeons were telling about their amazing success in removing bullets from the heart. They had so many of them coming in from street fights and gun battles in Detroit that they became experts in removing lead from the heart. Where the average hospital wouldn't see a case like that once in five years probably. That was an extreme of what you were speaking of.

I guess I am at the end of my questions. Do you have something that you would like to add? You should add a summary here or a postscript.

DONABEDIAN:

The only thing that I can add is that working in the area of health care organization has been, for me, very exciting and satisfying. A very satisfying experience. I particularly have enjoyed the opportunity to teach for a term and to do scholarship and writing for two terms and that is the

ideal way I would like to continue -- the ideal life for me. I do enjoy the teaching and the teaching is important because it raises questions and it also provides some answers. The scholarship is important because it provides material for teaching and it is exciting in itself.

I said earlier that my urge to work in scholarship is basically to satisfy a need that I have to understand and to clarify -- I just enjoy learning and understanding. And then I like the aesthetic, the intellectual challenge as well as the challenge to create something aesthetically satisfying both in terms of the intellectual structure and in terms of its design and presentation in words. The language aspect, the literary aspect appeals to me a great deal and I think will appeal to me more and more as time goes on. So I think it is a marvelous life.

The only complaint I have is that it is increasingly difficult to get financial support for scholarship. That is partly because support for research in general is declining and partly because, I think, when you compare scholarship with original empirical research, scholarship always comes out second as something which is okay, is needed, but is really on the reworking of old material. I think the creative element of scholarship is not well appreciated and understood. Now scholarship can be just reviews of the literature or it can be a more creative reformulation of the literature. Then you discover new things that even the people who did the original studies did not know were there. I have many examples of finding things in the work of others that neither they nor I dreamed about until I developed a key, a conceptual key that opened that stuff for me, as well as for somebody else. So I think it's a very, very important thing. Especially in our field which is lacking in scholarship. We don't really have a good standard textbook in

health care organization as yet. So the conceptual work, the organizing work, the scholarly work is quite important. If we don't do it, we are destined to keep repeating and repeating, making the same errors, discovering the wheel again, again and again. Sometimes there are examples of a new effort at research and development which finds a wheel that is inferior to the one that we already have. There are new studies which are worse than old studies already in the literature. Somebody has already found a better way and we spend enormous amounts of money designing a square wheel when we already had a round one. If we don't support scholarship, we will be continually doing the same thing.

I guess this is somewhat self-serving in the sense that I would like my work to continue, but since I am coming more or less to the end of my work, it is more a plea for this kind of support to be available to other scholars. Now it has to be selected people. Not everybody can do this work. I think it is a very rare kind of interest and gift to be able to devote one's life, in a sense, remining the works of others in order to create something new out of them. Most people would not want to do it. I love to do it. I think it is very useful and I hope that it will continue to be done.

WEEKS:

In line with this, I thought of another question.

My friend and colleague, Howard Berman, as you know probably, is a Group Vice-President of the American Hospital Association. He has now been given, among other duties, the overall supervision of the library. This is in his division.

DONABEDIAN:

He should commission some new works. I would work for him.

WEEKS:

He is now interested in this. He says we have the library. It's supposed to be a fine library. How can we make it better? How can we make it more available to the schools? What kinds of service can we provide for the schools?

Of course, in Ann Arbor we have an exceptionally good library. But there must be many schools among these fifty or one hundred schools teaching in the health field that don't have complete or rather complete libraries, who don't have services, who don't have special collections, who don't have the things that the AHA library has. I wonder how we can find out other than asking questions, how we can find out how AHA library can become more useful.

DONABEDIAN:

You know more about this than I do, Lew, because this has been part of your life's work. But I have been very lucky in being at Michigan because we have this marvelous Reference Collection. I wouldn't have been able to learn as much about medical care as quickly as I did if we didn't have the reference collection. It is very well classified. And you can really go in there and look for something that you want and find it. We have an excellent reference librarian, Jack Tobias, and he is helped by Lillian Fagin...fine people. They can find things for you. You can say, I want something like this and they can work together and get it.

So I would say that the availability of this kind of service would be one way in which it could help. This business of having the books available for circulation, xeroxing rare documents, that's obvious. But the availability of a bibliographic service which finds things, prepares reading lists, prepares annotated things. Perhaps we ought to go one step beyond the things which a

library usually does, commissioning good review pieces or even small monographs on selected topics. But one needs to select writers very carefully because the hit rate is very low, and very often you pay somebody to do a good job and he doesn't do a good job, or he doesn't do it at all. That commissioning of reviews can be a very nice thing. I am saying so because I hope they give me one of the commissions to do a review on a subject that I choose.

I have one more quality book that I would like to write and that is on methodology and the methods of measurement. When that is done, I want to put that subject of quality assessment to sleep and if I am still alive, move somewhere else. The next thing that I would really like to do would be about clients in organizations, their feelings, the factors in their satisfaction. We need some way of beginning to understand the fate and the career of the client in an organized health care system. How to think about it, what are the important elements?

WEEKS:

What their expectations are?

DONABEDIAN:

We don't know yet. That, of course, would be there. But how to organize that intellectual terrain. I am really entering a terrain and I don't have a map. What kind of map would I prepare for that? Obviously client satisfaction would be there, client expectations would be there.

WEEKS:

Would this mean direct interviews?

DONABEDIAN:

I work always from available literature. I don't do any research. Just

thinking and imagining and using material that others have, produced work that others have done.

WEEKS:

I have often wondered how good these patient satisfaction questionnaires are. This is something that AHA might be able to do for you, they might be able to furnish you either results from questionnaires presented to patients on their departure from the hospital. We tried some of this on our study at McPherson Hospital in Howell, the Progressive Patient Care study. We discovered that in the OB ward, if a woman went home with a healthy baby, everything was fine. We discovered in the other parts of the hospital that there were more concerns with whether the coffee was good or not or whether their food was warm when it got to them -- this kind of thing. I think, in research of this kind it might be good to ask some hospitals to attempt certain kinds of questionnaires and use this as a basis for considering what the state of the client was. I think that a questionnaire would need quite a lot of thought. I don't think most of them have been constructed with a great deal of thought from those I've seen, including ours that we used in Howell. There must be some way of asking four or five questions of a patient on his dismissal from the hospital that would give you some idea of whether he was satisfied with his care -- and how much you could depend on his opinion.

Thank you for granting this interview.

Interview in Ann Arbor, MI

June 13, 1982

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