HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

C. Wesley Eisele

C. WESLEY EISELE

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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CHRONOLOGY

1906	Born New Albany, IN, April 6
1928	North Central College, A.B.
1931	Northwestern University School of Medicine, M.S.
1933	Northwestern University School of Medicine, M.D.
1932-1933	Presbyterian Hospital, Chicago, Internship
1933-1934	Charity Hospital, New Orleans, Resident in pathology
1934-1951	University of Chicago School of Medicine, Faculty
1941-1948	Department of Medicine, Secretary
1941-1951	General Medical Clinic, Chief
1945-1951	Associate Professor of Medicine
1951-1974	University of Colorado School of Medicine, Faculty
1951-1953	Continuing Medical Education, Associate Director
1951-1967	Associate Professor of Medicine
1953-1955	Continuing Medical Education, Director
1955-1974	Continuing Medical Education, Associate Dean
1967-1974	Professor of Medicine
1974-1981	Professor of Preventive Medicine and Comprehensive Health Care
1981-	Emeritus Professor of Medicine;
	Faculty Practice Committee, Chairman;
	Intern-Residence Committee;
	Professional Practice Committee
1974-1983	Estes Park Institute, Program Director
1983-	Estes Park Institute, President and CEO

MEMBERSHIPS and AFFILIATIONS

American Board of Internal Medicine, Certification, 1941

American College of Physicians, Fellow, 1964; Committee for Hospital Standards, Member; Medical Auditor in Internal Medicine, 1956-1957

American College of Surgeons, Medical Audit Committee (representing the American College of Physicians)

American Hospital Association, Committee on Physicians, Founding Member, 1972-1976

American Medical Association, Council on Medical Education and Hospitals, Residencies; Review Committee on Internal Medicine

Chicago Lying In Hospital, Consultant

Colorado General Hospital, Attending Staff, Member; Board of Trustees, Member

Colorado State Medical Society, House of Delegates, Member

Commission on Professional and Hospital Activities, Trustee representing ACP, 1956-1972; President, 1960-1961

Fitzsimmons Army Hospital, Denver, Education Committee, Member

Gates Rubber Co. Clinic, Denver, Consultant in Internal Medicine

Kwajalein Medical Facilities, Consultant in Internal Medicine

Lowry Air Force Base, Consultant in Internal Medicine

National Institutes of Health, Advisory Committee on Epidemiology and Biometry, Member

National Jewish Hospital, Denver, Consultant in Internal Medicine

Presbyterian Medical Services of the Southwest, Founding Member and Chairman of the Board, 1967-1975; Resident Physician; Advisory Board, Member

St. Joseph Hospital, Denver, Consultant in Internal Medicine

Southwestern Michigan Hospital Council, Medical Auditor, 1949-1953

Swedish Medical Center & Porter Memorial Hospital, Combined Medical Staff, Institutional Review Committee, Member

U.S. Department of HEW, Advisory Committee on Hospital Effectiveness, 1968

U.S. Public Health Service, Consultant to the Surgeon General

Veterans Administration Hospitals (Denver, Grand Junction, CO; Albuquerque, NM) Consultant in Internal Medicine

AWARDS and HONORS

Alpha Omega Alpha

American Academy of General Practice

Certificate of Meterious Service, 1961

American College of Hospital Administrators

Honorary Fellow, 1966

American Hospital Association

Honorary Membership, 1972

University of Chicago Alumni Association

Distinguished Service Award, 1959

Colorado Medical Society

Certificate of Service (Master of Postgraduate Medical Education) 1970

Sigma Xi

WEEKS:

I'd like to ask you a question: I noticed in your curriculum vitae that you attended North Central College. Is that in Naperville, Illinois?

EISELE:

Yes.

WEEKS:

The reason I ask you that is because it used to be a church college years ago.

EISELE:

It still is. When I graduated it was Evangelical United Brethren...now it's United Methodist. All from the mergings of the churches.

WEEKS:

My wife grew up in that church in Detroit. So I had to ask that question.

I'd like to have you talk about your professional life. The first event I have here is that you attended Northwestern University Medical School. I wonder how you happened to decide on medicine.

EISELE:

It was late in my college career. It was about Thanksgiving time of my senior year in college. My brother was then a senior at Northwestern University Medical School and my two closest friends were going to medical school. I had a major in chemistry and a minor in physics and a minor in math and I was going to be a research chemist. I thought: I don't want to stick around a laboratory all of my life. So I switched, that late in my college career. It wasn't easy. I did not have a single hour of biology. So I dropped some courses in advanced math and started with the freshman course in

biology. The professor had a student assistant named Blanche Kennell that helped me get caught up.

Blanche and I graduated from college at the same time. Teaching jobs were scarce, so she went into nurse's training at Presbyterian Hospital in Chicago. I went on to Northwestern. By the time I graduated, she was a graduate registered nurse, working as night supervisor in obstetrics at Presbyterian.

I interned at Presbyterian Hospital in Chicago--I believe I was the only Northwestern man among a host of Rush men. I had a sixteen month internship--eight months of medicine and eight months of surgery. I was paid $10 a month plus room and board and uniforms. There were no married interns then; the hospital would not accept them. When I completed the sixteen months, Asa Bacon, then Superintendent of the hospital, handed me my certificate. Then Blanche and I were married and headed for New Orleans where I had a residency in pathology at Charity Hospital. (There I got $50 a month.)

In the meantime, George Dick, for whom I had interned, went down to the south side as head of medicine at the University of Chicago clinics. After I was in New Orleans for about six months, he invited me to join his group, which I did. I stayed at the University of Chicago for seventeen years, from 1934 to 1951.

I was interested in infectious disease research. I teamed up with Norman McCullough, a medical student who had a Ph.D. in bacteriology from Michigan State. He had worked with Huddleson, who was the veterinary medicine expert on "Bangs" disease (Brucellosis). When McCullough was a junior, I got a grant from Swift and Company to study that "weird disease" that was decimating their workers. Norm and I teamed up, and we had a pretty lively research program

going and we came up with some interesting findings.

At that time I had a very satisfactory practice in general internal medicine; I had a good teaching program and an active research program. I was pretty happy.

Arthur Bachmeyer was our Dean at that time. One afternoon in 1949 Dr. Bachmeyer called and asked me to come to his office. He introduced me to a man from the Kellogg Foundation, Graham Davis, who was looking for someone to look into the quality of practice in about a dozen southern Michigan hospitals to which the Foundation was giving some support.

I wasn't interested, because I was busy and enjoyed what I was doing.

He said, "At least, do me the favor and come up and spend the weekend with us and let us show you some of these places."

That was my undoing. I think it was in May. Andy Pattullo, who was then a young assistant to Graham Davis, drove me around to these beautiful places in Michigan. One of the places he showed me was Hillsdale. There was a lake there.

So I agreed to spend a month of my vacation in Hillsdale. I rented a cottage out on the lake and with my wife and two young children, Mary and John, stayed there while I spent my days in the hospital.

No one could tell me how to evaluate medical care. Kellogg sent me on a trip to talk to people in the East, Rochester, N.Y., where Paul Lembcke was doing some things. Then I went to the Commonwealth Fund in New York and talked to Lester Evans, who said, "If you find out how to measure the quality of care, we'd sure like to hear from you."

So I went to Hillsdale and drew up a list of questions to ask, and then pulled a bunch of records. This was in 1950. I'd go through all of the

records of a category, like appendectomy, or hysterectomy, or peptic ulcer, or heart attacks, to find what I thought were deficiencies in diagnosis or treatment. I came up with a group of patient records in which I found serious deficiencies. But it was largely subjective, my judgment.

I found that they were doing an awful lot of tonsil and adenoid operations. I felt that there were too many being done. But there were no data for comparison. So I examined the records of all the children of these operating doctors and found that every one of their kids had tonsillectomies when they came of age--four or five years old, usually. So they believed in it, not because of income, but because they felt that medically it was a good thing to do.

A great number of appendectomies had a diagnosis of "active, chronic appendicitis," whatever that is. I was of the school that believed there was no such thing as chronic appendicitis. So if I read the microscopic report and did not find some active inflammatory disease, I called that a normal appendix. I found a lot of those.

There were other categories. They were doing many sub-total hysterectomies. One physician, particularly, would go in and just take off the top of the uterus and leave the cervix, which had no function, but had the potential of someday becoming cancerous.

They did many uterine suspension operations for backaches and minor complaints of one kind or another. They would tighten the ligaments and sew the uterus up, so that would be more upright and not retroverted. But there was no evidence that the position of that uterus had anything to the do with symptoms. Of course, the woman would spend a couple of weeks in bed--the first vacation she had had in recent years, with the result that she came out

of the hospital feeling good; so it was regarded as a useful operation.

Those are some of the things I found.

WEEKS:

As I understand it, the Kellogg Foundation had an advisory committee on which George Bugbee and others sat which was trying to set up priorities on how and for what purposes they would spend some of their money.

EISELE:

Perhaps so. I didn't know about that. And I didn't know Bugbee until many years later. I had no contact with him in Chicago that I can remember.

WEEKS:

I suppose someone at the Foundation called him because he was at the American Hospital Association and he, in turn, as he tells the story, called Bachmeyer and Bachmeyer then talked to you.

EISELE:

No. I didn't get that story at all. As far as I knew, it all came from the man on the staff at Kellogg who came to Bachmeyer. And Bachmeyer called me on that afternoon and introduced us. Whether Bugbee was in the background of that, I have no knowledge.

WEEKS:

After all of these years it probably doesn't make much difference.

EISELE:

No. Except that I did not know Bachmeyer until he came down from Minnesota to take over what Ray Brown was doing in the program of hospital and health administration.

It was during these years that Bachmeyer started what I understand to be the first graduate program in hospital administration.

WEEKS:

I think Michael Davis of the Rosenwald Fund supported the program in its early years. I think he was the head of the program until Bachmeyer came.

EISELE:

I understand that they didn't have a program until Bachmeyer took the first group of a dozen people into graduate school in the School of Business.

WEEKS:

It may have been actually that. I know that they got a little money from Rosenwald.

EISELE:

It could well be.

WEEKS:

I was interested in reading here--you have answered the question, but I would like to emphasize it a little bit--I was reading your publications and I notice that you had several on brucellosis. Then I realized that, one, this is Chicago...maybe the incidence of it there is higher because of the packing companies and then you said Swift. But also, another thing that struck me...this is about the time that the sulfa drugs and the antibiotics were coming in. I know that later that became a treatment for undulant fever. I was wondering what your experiences were on that.

EISELE:

Let's back up then. Norman McCullough and I published the first successful treatment of undulant fever in J.A.M.A. 1949, the use of three antibiotic agents simultaneously. One was a sulfonamide, a sulfa; one was aureomycin, the forerunner of the tetracycline family of drugs; and the third, streptomycin.

We had a long-standing case, a janitor in Chicago who had bought a little farm west of town. The first year there he went broke because all of his cattle aborted and he came down with this long febrile illness. He had had 60 consecutive positive blood cultures for brucella. So we would try one drug after another, but his cultures remained positive; another and another with the same results. Finally, we combined the three, and for the first time he had negative blood cultures and proceeded to get well. That was our first publication on the three-drug synergism.

Brucella is a strange organism in that it resembles a virus in being intracellular. Most other bacterial diseases do not get inside cells. For a cure, you had to give antibiotics for a long time--a month at least, until the cell breaks down and the drugs get to the organisms. Before this combined treatment, drugs would suppress but not eradicate the infection. That was one of the many things we did.

WEEKS:

It seems to me that you were very research minded at that time--clinical research anyway, so I guess it was natural that you would move to research on record evaluation. What was the term? Medical evaluation--was that the term they used?

EISELE:

Yes. I think you could call it that. Clinical evaluation.

WEEKS:

But they didn't use medical audit until later.

EISELE:

No. I think maybe I invented that term. I'm not susre. I apologize for using the term "audit," for it was so far removed from the CPA audit.

WEEKS:

I've been wondering about the connection. We've got the Professional Activity Study, "PAS," right here in Ann Arbor and the Medical Audit Program "MAP". We've got programs like the American College of Surgeons Hospital Standardization...were they going on then? They must have been, because they gave it up about 1950, didn't they?

EISELE:

The American College of Surgeons program started in 1918, I believe. They were more concerned with the physical characteristics of the hospital: Did it have good sanitary conditions, and fire safety, and things like that. PAS and MAP came later.

Getting back to the Hillsdale story...after a month poking around there, I met one afternoon with the governing board of the hospital. The chairman was a dentist. I gave them a very brief resume of what I had been finding. Then I met that evening with the medical staff. There were, I think, twelve physicians on the staff. There was one surgeon and one internist, his name was Art Strom. He was the key person. He was, I think, a board-certified internist. The others were general practitioners, all of whom did surgery.

I met with that medical staff that evening until long after midnight just giving case after case in a very abbreviated and anonymous report of what I found, and said, "What do you think of this practice?" They said, "This is terrible!" Before they left that evening they formed their own committee called the Medical Standards Committee, with the understanding that every physician on the staff would work on that committee for three months every year. This was excellent continuing education. Later, I wrote a paper, "Medical Audit is Continuing Education."

Then I took off, leaving my written report. The next summer I went to Allegan and did the same sort of thing with very similar findings. But I didn't get much response from their staff when I gave them my report.

The following summer I went to Albion and did it again. I was pretty discouraged that nothing was happening. Then Hillsdale called and asked me if I would come back and repeat my study, which was then three years after the first one.

I decided to do that, and I found a spectacular difference in the level of practice and in the morale of the whole institution. The staff liked themselves and they were proud of what they were doing. The administrator said, "Do you know what you are doing? We have lost so much income because they have cut down on so much of the surgery that we are going to go broke. Except we can get around that: we can raise room charges."

But he was smiling. They were losing income because the volume of surgery had been decimated.

So again I examined the records, and I was fascinated. I mentioned Arthur Strom--he was the key man; he was the change agent in that hospital.

WEEKS:

How did the Board of Trustees react? How did they feel?

EISELE:

They were happy.

WEEKS:

Did they feel that they could enter into this in any way?

EISELE:

I don't remember that they had any specific interaction.

WEEKS:

I'm getting back to the responsibility of the trustees.

EISELE:

I don't think they felt much responsibility. At that time the boards of trustees were largely honorary positions. They were there primarily to raise money. They didn't feel any particular responsibility for the quality of care. This was, I think, characteristic of the era.

WEEKS:

Were the other administrators like this one you were telling me about?

EISELE:

No. The one at Allegan was a nurse who sort of tolerated me. At Albion I found a strange thing: I couldn't get any information from many of their records because there wasn't a jot by a physician on many of the records, only nurses notes. After thirty days whether there were physicians' notes or not, the record was simply filed. So I had problems getting data there.

I think John MacRitchie, Administrator of the Hillsdale Hospital, was the man who got Kellogg involved in supporting this. I was told that it resulted from an incident at Hillsdale where a three- or four-year old child bled to death...at night after a tonsillectomy. The nurse called the physician three or four times, but he didn't respond. There was a suspicion that he was at home drunk. No one else was called so the child expired. This so preyed upon MacRitchie that he went to Kellogg and needled them into getting involved. They gave the hospital a small grant out of which I was paid and reimbursed for my expenses.

After this second inspection of the records at Hillsdale, I went to Battle Creek to talk to Andy Pattullo. I said, "Look, why don't you give up

this idea of trying to find outside medical audit people to come in?" (And I think I used that term.) "Give that up, and do something to help the hospital medical staff to do it themselves. Hillsdale has shown that it can be done, and done very effectively." Dr. Vergil Slee was visiting the Kellogg Foundation that same day, and Andy said, "There's somebody here that I think you ought to meet." It was a most serendipitous meeting.

Vergil was then at Hastings, Michigan, a hospital administrator and county public health officer. He was doing a study in the Southwestern Hospital Council, fifteen hospitals, gathering data on about one hundred items of health care, each lumped together, and finding very little difference among the hospitals. He believed that if he could gather data on a case-by-case basis, he might discover differences. That was where the whole concept of this PAS thing started--right there.

WEEKS:

Was that when they financed PAS?

EISELE:

Yes, except that Kellogg wouldn't give money to one as an individual. For PAS, they gave it to the Southwestern Michigan Hospital Council, and, initially, for medical audit research, they gave it to the American College of Surgeons.

SLEE:

You were talking about the American College of Surgeons and its standardization program. You will recall that they had introduced the death reviews early. Then in the '40s they put in tissue committees, and somehow the Kellogg people questioned whether that tissue committee idea could be broadened to include internal medicine, obstetrics, and so on. I don't know

what really happened--whether Graham Davis went over to talk to General Paul Hawley, who was then The Director of the College of Surgeons, or whatever. But that was in parallel with their support of Eisele and of PAS.

EISELE:

Anyway, it all came together: they gave the money for a pilot study of these fifteen hospitals, which Vergil directed and upon which I consulted.

We started placing case data on punch cards in Fay Hemphill's office at the School of Public Health in Ann Arbor. He was a professor of public health statistics. He had a graduate student, Robert Hoffmann, who was given a small stipend for helping handle this data.

SLEE:

Hemphill did the national Salk vaccine evaluation for Tommy Francis. That was one of his big operations.

EISELE:

I remember that Vergil and I visited all of these hospitals and read chart after chart. One of the problems we worked on was primary appendectomy. We reviewed about 2,000 cases. We would read the tissue report and find whether or not the appendix was acutely inflamed. Either they had it or they didn't, even though most of them had the pathology diagnosis of "active chronic appendicitis."

There was one pathologist who was a circuit rider, examining tissues for almost all these hospitals. "Active chronic appendicitis" was his favorite diagnosis. In that way he could avoid offending anyone by saying, "this is a normal appendix."

We found great variations, among hospitals and individual surgeons. I recall one surgeon who did twenty-six consecutive appendectomies without

hitting the diagnosis right a single time. They were all normal.

WEEKS:

Where does Paul Lembcke enter into this?

EISELE:

He was having the same sort of trouble that Vergil was because he, too, was lumping data together. We didn't have any more contact with Paul Lembcke for quite a number of years, until he had left Rochester and moved out to UCLA.

SLEE:

Paul compared statistics among hospitals. Actually, until 1953, the Southwestern Michigan Hospital Council program was almost a copy of Lembcke in that each hospital compiled its own gross data which was then compared. Our change was to look at each case. It was in 1953 that we proposed to Kellogg that we turn around 180 degrees.

WEEKS:

So Lembcke's data were total hospital rather than the individual.

SLEE:

As far as I know, he never got to cases at Rochester. Later, out West, he did look at individual hysterectomy cases, but never as a system of operating data. It was a study of hysterectomies.

EISELE:

And he never looked at the cases himself: He had a nurse assistant who would abstract the charts.

WEEKS:

People like Kerr White or John Mannix talk about data on a whole population basis, for a region, or state, or so on. Did you get into that--

looking at a region? You might have with Southwestern Michigan. Did you look at that as a region?

EISELE:

No. We didn't try to define a population base. Hillsdale was the only hospital in a county from which many people travelled to Ann Arbor for serious illnesses, serious surgery, for example. So we couldn't define population bases then.

SLEE:

No. Population bases are a different question. Both hospital practice and population-based studies are good questions and have to be answered. The problem is that all participation in PAS and what Wes and I worked with was voluntary.

To get a total population, you must either have the power to force yourself upon others, or wait until you have enough volunteer hospitals to cover its defined population. We never could do either until about 1970 when an epidemiologist working for CPHA, Sam Kaplan, worked on it for two or three years.

He identified a number of census geographic areas in the United States in which PAS had data on all of the hospitals. We publicized the fact that we had the data and did a little bit with it, but there was always difficulty financing that kind of research because we were primarily supported by the services that we sold to hospitals.

WEEKS:

We've been talking about two kinds of data. We have been talking about patient data and we've been talking about the medical audit kind of data. I suppose they do overlap and go together. You started out with the PAS. When

did you start the medical audit?

SLEE:

The American College of Surgeons assigned Robert Myers to their medical audit project. This was a grant project from Kellogg, in which the College of Surgeons agreed to try to generalize from the tissue committee thinking to all of medicine. I think you were an advisor to that project, Wes.

Myers knew that we had to have baseline data on the hospital. For instance, when Wes studied appendectomies, he needed to know about the rest of the surgery in that hospital: What was the extent of it, and the content of it; what percent of the surgery was appendectomies, and so on. So Myers and I got to working on that.

Because Wes and others had defined the pertinent factors defining good care, we discovered that we could tabulate those data in such a way that we could examine quality better than had ever been possible before, and do it for the whole hospital.

The Medical Audit Program (MAP) was simply a further tabulation. The data for PAS and MAP were exactly the same, the same information taken out of medical record. For PAS we did rather pedestrian things: We indexed the medical records so that the hospitals could meet the accreditation requirements. We tallied up the deaths and the lengths of stay; data that fitted the form in MacEachern's book.

In fact that's what we used: We went to the Physicians' Record Company in Chicago for the blank forms which the hospital was to tabulate so that we could put the information necessary to fill in the forms into individual patient punch cards for tabulation.

We tabulated the same data much more creatively in the Medical Audit

Program beginning along about 1958.

In 1959, the College of Surgeons gave the whole program over to the Commission on Professional and Hospital Activities (CPHA) of which the American College of Surgeons was one of the national sponsors. The other sponsors were the American College of Physicians, the American Hospital Association, and the Southwestern Michigan Hospital Council. This transfer of the medical audit research occurred primarily because, in medicine, anything that is sponsored only by surgeons automatically produces enemies among the other specialties.

EISELE:

Very early, when we were doing the pilot study in those fifteen hospitals we found that it was relatively easy to evaluate--audit, whatever you want to call it--surgical practices, and very difficult to do the same for other medical practice. I think this is because, in surgery, only five or six common operations covered ninety percent of the surgery in most hospitals.

SLEE:

So you could easily collect many cases for any procedure, and patterns of practice would show up.

EISELE:

But in the practice of the rest of medicine, scattered over scores of often ill-defined syndromes, it was very difficult to make comparisons. Probably the diseases that ought to be evaluated most are the ones which are most poorly defined.

In 1955, Vergil and Hoffmann and I prepared a paper for the American College of Physicians' annual meeting entitled, "Can the Practice of Internal Medicine Be Evaluated?" We had data from these fifteen hospitals on such

things as blood sugar determinations...half-a-dozen criteria. Our answer was, of course, "yes". We presented the data from these fifteen hospitals, published in the Annals of Internal Medicine in 1956.

In 1981 when Estes Park Institute had a seminar over in London to study the British health care system, Professor Neil McIntyre was one of our speakers and I introduced myself.

He said, "Oh, Dr. Eisele, I'm so happy to meet you--I've been reading your wonderful research."

I didn't know what he was talking about until, in his talk, he referred to that 1956 paper a half a dozen times. It appears that is just about where the British are right now, because they are very primitive in evaluating quality.

WEEKS:

Don't they have something called HIPA or HIPE...Hospital In-patient Evaluation?

EISELE:

Yes, but I'm talking about clinical evaluation. Medical audit kinds of things.

The Scandinavian countries at the EPI seminars there in 1983 frankly admitted to us that they have no programs for evaluating the quality of care.

SLEE:

Britain's HIPE is a copy of PAS, but it doesn't get anywhere because they don't do three things: 1) There is no standardization among the districts--each of the health districts collects data differently so one can't make any comparison; 2) the data are superficial; and 3) there is no feedback.

WEEKS:

Now we come to the question of what do you do with all these data. You had fifteen hospitals.

EISELE:

One thing...we fed it back to the hospital administrators, then we would discuss it with the medical staffs. We experienced great resistance among some physicians to being involved in this: "I'm not my brother's keeper", and, "Do you mean that they are going to look at my practice?" "That's my own business."

General practitioners were especially suspicious because they thought this was an attempt by surgeons to cut them out of doing surgery. Perhaps it should have been, but it wasn't: I found at Hillsdale, Allegan and Albion that all of the general practitioners on the staff did surgery. Many of them learned how to perform three or four operations, technically, so their diagnoses were often forced into the mold of what they could perform in the operating room. That's why they did so much of it, but much of it was done poorly.

That wasn't unique to Michigan. When I went to Colorado I started to audit some rural hospitals in the mountains, again with Kellogg support. Accompanied by a member of the clinical surgical staff at the University, we would spend a couple of weeks reviewing the records and teaching. We found horrible things going on.

WEEKS:

As I understand it, Kellogg was trying to find a way for the administrator and the board to work better with the medical staff. Did you have the feeling that the administrator and the board got into the act at all.

EISELE:

No, I didn't at that time. To me, that was a hidden agenda. My concept was that I was to work with the medical staff and see if we could evaluate what they were doing and get them to do better work--to find out what they were doing, feed it back to them, and get them to do something about it. It worked in one of three Michigan hospitals, but I came away feeling I had wasted both my time and theirs in the other two.

WEEKS:

But at least you had one success.

EISELE:

That was the one thing that changed my life.

SLEE:

You see, the success was due to Art Strom. It was this person.

EISELE:

And Strom's partner, a surgeon.

SLEE:

The surgeon was certainly helpful, but not a pusher.

EISELE:

I recall that occasionally he was doing some obsolete surgery. I said to him: "Look, you know better than to do uterine suspensions for backaches."

He said, "Sure. But if I don't do it, and I say, 'You don't need it,' they'll go to one of these clowns who will do a poor job of it. So I might as well do it and be sure that it's done right."

That was his way of excusing it, but he shaped up after that too.

SLEE:

But Art Strom, that one person in the medical staff, was just the key and

there was no such person on the scene at either Allegan or Albion. And that's the difference. It is such a clear lesson. People tend to think that the data will do it themselves.

EISELE:

You have to have some kind of a change agent.

WEEKS:

I guess what you are saying here is that you can't generalize and depend on a medical staff to police itself unless you've got the right person in there to lead it.

EISELE:

Exactly.

WEEKS:

So how should these audits be? How should the PSROs or its successor, how should they operate? Should that operate with outside people coming in like you came in?

EISELE:

I think the key change has to be internal. You can have external stimulation, as we now have with the Joint Commission requirements. Every hospital now has to have a quality assurance or quality management program in place. But, unhappily, so many of them are just paper plans. They are complying with the letter but not the spirit of the law; they are just doing the minimal thing possible. Often, they turn the management over to some inexperienced, untrained young woman who has no clout.

We are making progress, but progress is slow.

WEEKS:

So even if you have the data, you've got to have the means of putting it

into operation--using it?

EISELE:

First you have to get people to look at it. I think this has been one of the problems with the whole PAS program.

SLEE:

It is no different from the fact that I've got a five foot shelf of books over there but only when I have enough reason to read them do they do anything but sit there. You can't expect everybody to want to read the encyclopedia or the Sears Roebuck catalog. But when you have a purpose, then you've got to have an encyclopedia or a catalog.

The Joint Commission's requirement of quality assurance is one type of pressure; PSRO is another type of pressure; PROs are another. There is fear of malpractice. All of these pressures push people to ask: "How do I look?"

In Hillsdale, you had Art Strom with a conscience, high standards, and a certain flair for running that medical staff.

EISELE:

He had great leadership ability.

SLEE:

He was never trained to do that. He just was.

WEEKS:

He was a strong enough personality that they accepted it.

SLEE:

He ran the place.

EISELE:

Yes, and they loved him--and they loved what happened, after the fact. They were so damn proud of themselves.

SLEE:

He was a skilled person, but more or less intuitively. Some people can get things done and some can't: He can.

EISELE:

Right in the middle of all of these early beginnings, I left Chicago and moved to Colorado in April, 1951. I had these two kids growing up and I lived about a block from the hospital and the university. I was looking for a chance to get out of Chicago. This opening in Colorado came along, so we moved there the first of April in 1951, a month after I was recovering from a severe case of mumps acquired from my daughter.

WEEKS:

Was Ward Darley out there then?

EISELE:

Darley is the one that took me out of Chicago. I worked with Charley Smyth, who was a Michigander. A rheumatologist. I went out as his assistant in a program of continuing education. He soon dropped out of that program and I had the whole thing in my lap.

Vergil kept nudging me to put on a post-graduate course on this medical audit thing. Finally, I think it was in 1960, we offered a conference on the internal medical audit--"internal", to distinguish it from having an outsider come in and look at it--and how it can be done by the medical staff itself. There was a surprising flood of registrations from across the country.

Then I dropped the ball because about a month later my wife Blanche died of acute leukemia after a ten-day illness. I was pretty depressed for a couple of years, so nothing much happened for a while. I remarried three years later--a widow with five children, a pediatrician. We were married

three weeks after our first date, which took place at one of my post-graduate pediatric courses in Estes Park. We had a wonderful life. She died four years ago of a breast cancer. So I have lost two wives much too young with cancer.

So after 1960 I wasn't very productive. Finally, Vergil kept nudging and we got a small grant from the Public Health Service--John McGibbony--three thousand dollars or something like that--to put on the first conference, what we called the Chiefs of Staff Conference, in 1964 at the Medical School in Denver.

We had a overflow registration there at the university. The next year we moved the conference up to Estes Park and we called it the Hospital Medical Staff Conference--we broadened it. We did one there every year in September or October. We tried to limit the registration to 400, maybe 500, and we turned that many people away. In 1971 there were 724 registrants. It just exploded.

Then some people said, "Our hospital couldn't get in, so would you come and do a conference for us in our area?" This is how our regional conferences began.

The first one was at Sun Valley, Idaho, in 1971, for the three northwest hospital associations. The Sun Valley conferences kept going every year until this year when we moved it to Seattle because it was getting harder and harder to bring large groups into Sun Valley by plane. The schedules are terrible.

The one on Cape Cod was started the same year and went on for three years and then it folded. The New Englanders didn't participate very well. I think the last year there were more people from California than from all six of the New England states combined. So we then moved the Conference, first to the

Poconos for two years, then to Asheville, then to Florida.

WEEKS:

What has been the general subject matter?

EISELE:

The conferences have evolved with the times. As new issues evolve, we try to keep ahead of the new issues--the emerging issues. Right now they are exploding so fast we are really scrambling to keep abreast of all the new developments.

SLEE:

There have been basic themes though.

EISELE:

One basic theme has been to improve the relationships among the medical staff, administration and board.

SLEE:

For one thing, there has always been a legal base for the participants.

EISELE:

Oh, yes. And we have always emphasized quality assurance and quality measurements, quality management. It is sort of a hidden agenda sometimes.

SLEE:

Back to the origin: I must admit that some of my learning came from watching Tony Rourke (Anthony J.J. Rourke, MD) who was hired by the Sisters of the Holy Cross, who run seven or eight hospitals spread from Silver Springs, Maryland to California. In the late '50s or early '60s, they regularly convened their pathologists, their chiefs of staff, and their chiefs of services, and asked Tony to put on programs for them. I participated two or three times. It struck me that what he had to tell them was that they had

work to do. And they said, "Oh, my, we have duties for the hospital?"

I kept relaying this sort of stuff to Wes.

EISELE:

We had Tony participate in our early conferences.

WEEKS:

You went out there in 1951. Before '51, you had been doing this work in Southwestern Michigan. In fact, there is a funny story that Pattullo tells about a speech he made in St. Louis back in about the middle '50s--at the AHA convention. He talked about your work and called you "Dr. X". The newspapers picked it up as sort of a sensation, an expose of the hospitals. Andy said that probably if he had just called you by name there would have been no reaction at all. Then, he used fictitious names for the hospitals so they wouldn't be affected, but apparently he identified them as being located in Southwestern Michigan.

EISELE:

Yes, I came under a lot of suspicion as an underground spy, out there to get something on somebody so we could sue them.

WEEKS:

After the Michigan audits, did you do others?

EISELE:

A few. I had a hard time dealing with some of the resulting hostility and couldn't see this as a career.

In 1959, I undertook a medical audit in a large Oklahoma hospital. There were 20,000 discharges for the year I audited. I took a portable microfilm camera and reader along. My wife, Blanche, and my 18-year-old daughter, Mary, microfilmed the entire charts of my sample of 2,000 patients. For the next

six months, I spent evenings and week ends at home, reading those records. Vergil put my data on his computer.

I found nearly 100 cases of grossly deficient care, mostly surgical, some of it bordering on malpractice. There was a group of young board-certified surgeons doing excellent work. Then there were a half dozen or so older surgeons who had the carriage trade, and they controlled the staff. The chief of surgery was one of the worst.

I gave my report to the board and they voted to give the medical staff six months to clean up their act. The medical staff gave my report a cool to cold reception. The upshot was that the board restricted privileges for five surgeons and withdrew all privileges for one.

The six surgeons then left the staff and opened their own hospital. I understand they were going to name it after me, calling it "Wesley Hospital." But the Methodist bishop would not permit it, so it was called "Doctor's Hospital."

I was harassed in every way they could think of. They called the American College of Surgeons: "What right does this internist have to criticize our surgery?" Spike Myers took the call. He told them: "Eisele is the most respected medical auditor in the country." They even tried to get the American Academy of General Practice to withdraw accreditation of my General Practice Review Courses at the University. One surgeon threatened to sue me for defamation. I reminded him that I had the complete records of his cases on microfilm, and I knew an attorney that would pay me well for that film. That was the last I heard about being sued. I really guarded that film--I should have put it in my bank box.

WEEKS:

Were there others?

EISELE:

Not many after that.

I did one for the Colorado Medical Society on a small hospital in the mountains. A woman trustee of the hospital complained to the Medical Society that the doctors were doing too many pelvic examinations. I found that they were not doing enough. I still remember the look on her face when I gave the board my report.

In 1963, I had an unusual invitation. I was asked to evaluate the medical care on Kwajalein, a tiny atoll in the Marshall Islands on the other side of the International Date Line. Kwajalein was the site of the Nike-Zeus missile range where they shot the missiles to hit the ICBM missiles launched from Vandenburg Air Base in California. I flew all night from Honolulu in an ancient prop plane to get there.

Two thousand people were living on that tiny island, scientists and engineers and their families. There was a complete school system. The people were accustomed to high level medical care and some were concerned about it on Kwajalein. There was a small hospital, a clinic of four general practitioners, and an overnight plane three times a week to Honolulu hospitals. An emergency flight could also be arranged.

I found the medical care reasonably satisfactory, except the physicians were far removed from main stream medicine. I proposed that I recruit specialists from my medical school faculty to visit the island for two-week visits, to consult and teach. This proposal was accepted, and I sent them a pediatrician and a dermatologist. Then the program was ended by a change in

the firm that had the management contract.

WEEKS:

We talked about the connection with the American College of Surgeons--how that was affected and probably in turn would affect the Joint Commission, the work that you did fed into what, later, became the Joint Commission. I was wondering about such things as the Commission on Hospital Care that was operating back in the middle '40s with the idea of trying to find out about hospitals so that there could be post-war planning. At that time I was surprised to learn in the middle '40s, there was no such thing as an AHA Guide Issue. There was no list of all hospitals that showed what services they provided, or how they were financed or governed. This came out of this Commission on Hospital Care. I was wondering if they approached either of you or the Southwestern Michigan for data?

EISELE:

I've never heard from them.

SLEE:

No. I never was approached, either.

WEEKS:

They apparently did a study on regionalization for Kellogg back at that time as a supplementary study. But you had no input into that?

EISELE:

Not at all.

WEEKS:

How about the Public Health Service? Were they in contact with you because Tom Parran was trying to get ready for what became Hill-Burton later on?

SLEE:

Well, the Hill-Burton was ahead of this. Because when I ran that hospital in Hastings we got Hill-Burton money and that was in 1949. That was ahead of this.

WEEKS:

But Wes started this work in southwestern Michigan...

EISELE:

The first year that I reviewed was for the year '49 at Hillsdale. So I did this in 1950.

WEEKS:

Well, that's later. What year was it you two met?

SLEE:

Probably '53? We already had the punch cards running.

WEEKS:

Originally you started the conferences as continuing education for physicians. When did you bring the trustees and administrators in?

EISELE:

That's an interesting sequence. The early ones were called the "Hospital Medical Staff Conference," for physicians who had leadership roles in community hospitals. Administrators or trustees could not come on their own, only when they accompanied their physicians. No hospital could send a chairman of the board or administrator without a physician. We wouldn't accept their registration.

SLEE:

Otherwise, we would have 2,000 nuns.

EISELE:

Incidentally, the Catholic hospitals were our earliest, best supporters. They really came en mass. In those days we had Father John Flanagan, executive of the Catholic Hospital Association, give the overview at the end of the conference. He was tremendous.

WEEKS:

There was quite a rivalry back in the '40s between the American Hospital Association and the Catholic Hospital Association, especially when Father Schwitalla headed the latter. He was quite a forceful character, wasn't he?

EISELE:

Absolutely.

WEEKS:

I think that at one time the Catholic Hospital Association was really stronger than the AHA.

EISELE:

He was also the Dean of the St. Louis University Medical School. When he retired, the search committee came up to Chicago...Dr. Kinsella, an internist, was one of the three members of that committee...and invited me to apply.

I said, "I think you've got the wrong man. I happen to be a deacon in the Hyde Park Baptist Church down the street here."

He said that wouldn't make any difference at all. I did go down to St. Louis and spent three or four days looking at the situation. I decided then and there that life was too short. I didn't have the patience to be any dean. So that dried up fast.

WEEKS:

Later on did Estes Park go on to trustee seminars?

EISELE:

We did offer conferences specifically for trustees.

SLEE:

We had trustees coming anyway.

EISELE:

They were coming, but they were always there more or less by sufferance. They were there to find out about the medical staff problems.

Then in 1977 we got a grant of $250,000 from the Kellogg Foundation and began what we called the Hospital Trustee Forum. Later we were wise enough to merge this with the Hospital Medical Staff Conference. The two are now given together, called "The Hospital Medical Staff and Trustee Conference." Most of the time is in plenary sessions, and then trustees meet separately for some individual sessions.

We have Leland Kaiser do the trustees' forum on Tuesday morning, on principles of hospital trusteeship. The next morning Hugh Greeley talks about the trustees' responsibility for the quality of medical care and how their role can best be fulfilled.

WEEKS:

Have you had any feelings about physicians being on the board of trustees?

EISELE:

Oh, I think it is now almost mandatory. But my feeling has taken a 180 degree turn. I once thought it was not proper; it was a conflict of interest. But now I recognize that it works well if the physician is there for the right reason, not as a partisan representative of the medical staff, but as a representative of the community interest in the hospital and medical care.

But if he is there as a partisan to promote the interests of the medical staff, he is there for the wrong reason.

WEEKS:

Over at McPherson in Howell, Michigan, they have sort of a compromise. The chief of staff is an ex-officio member of the board of trustees because he knows everything that is going on. That works out pretty well, depending on his personality.

EISELE:

Exactly. But many hospitals do put the chief of staff or the immediate past chief of staff on the board. Others just appoint a doctor from the medical staff on the basis of the best representative of the community...regardless of his stature in the medical staff.

WEEKS:

Have you any feelings about how boards of trustees should be formed? Whether the board should be self-perpetuating, or whether there isn't some better means of appointment, or whether they should be democratically elected by the community? Assume that the corporate set-up is such that you can be a member of the corporation if you pay $5.00 a year.

SLEE:

You're talking about the board.

EISELE:

Generally Boards of Trustees are self-perpetuating, and as long as they recognize their real purpose and get the right kind of expertise and representation of the community, it works pretty well. The ones who are elected from dioceses, or appointed may have little knowledge of health care. They are just good people.

WEEKS:

Maybe good talkers or something.

EISELE:

Or a housewife who has been active in the community gets it because she is a nice person even though she has absolutely no background or interest in health care. But sometimes they turn out to be the best ones anyway. They are bright and they become the leaders.

WEEKS:

They realize their shortcomings, so they study.

EISELE:

They are the ones who come to our conferences and catch fire. They say, "Well, I think our whole board should come to this."--and sometimes they do.

At Seattle in June, one of the hospitals in that local area sent twenty-two people. The Director of Medical Affairs said, "I told them it was the best conference in the whole country. As long as it is in our backyard, we had better take advantage of it--it doesn't cost us any travel expenses."

Another one sent 19, and one sent 22.

WEEKS:

Wonderful.

EISELE:

St. Mary's Hospital in San Francisco is sending twelve or fifteen down to Monterey.

SLEE:

But it is different from New England where nobody...

EISELE:

Nobody would come, or at best one person would come.

SLEE:

From their local area. And here we had a complete surprise in Seattle.

EISELE:

One of the key things, I think, is that so many hospitals send groups every year until they have as many as a hundred people who have attended these conferences to hear essentially the same message. We like to think that changes take place after a critical mass of knowledgeable people has been established.

WEEKS:

They may believe that it is better to get the message from the horse's mouth than it is to have it relayed second-hand.

EISELE:

Yes, that helps some. We have had administrators tell us, "I wouldn't want my job if I couldn't send them to your conference. I can tell them the same stuff, but they won't believe me. They've got to hear it from you experts."

Conferences may function as retreats. Some groups have evening meetings during the conference and invite our speakers. Sometimes they pay an honorarium. One group that does this is The Forbes Health System out of Pittsburgh. They will bring fifteen people, usually to Florida. They have their own meetings every afternoon after our schedule is over and invite one of our faculty to meet with them.

WEEKS:

Then too, as at any convention meeting, trustees have a chance to meet other trustees and learn of their problems.

EISELE:

...From across the country. Their counterparts from other hospitals.

WEEKS:

I think this is probably more important for the trustees than for administrators or physicians because they are professionals anyway.

EISELE:

They have their own clubs. The administrators go to the American College of Hospital Administrators, or the American Hospital Association: those are their clubs.

WEEKS:

This is a good point. Every week it seems that I get something in the mail--and I know you do too--about another institute or seminar on all kinds of subjects, at all kinds of rates. They are charging up to $700 or $800 sometimes.

Let me also say that AHA and ACHA, as we all know, are making a lot of educational efforts--holding seminars and institutes. Do you compete with each other?

EISELE:

We had the area all to ourselves at first. It's a real competitive area now. This turf that we had always staked out as our own is being invaded by high-powered competitors--especially the medical staff section of the American Medical Association that now holds conferences and seminars on the hospital medical staff. Their viewpoint is a little different than ours. It's more...

SLEE:

...adversary.

EISELE:

I still marvel at how EPI continues to prosper the way it is; we fill our conferences and have waiting lists.

SLEE:

In the beginning, I think the university and medical school setting was absolutely critical, because doctors, particularly, trust a medical school more than their own AMA. They know that the AMA has a vested interest.

EISELE:

Twenty years ago they trusted medical schools a lot more than they do now.

SLEE:

Further, they figure that if the hospital association puts it on, it will be biased.

EISELE:

We are independent of the burdens of national organizations.

SLEE:

I guess the closest the EPI institutes have ever come to anything like that--it really isn't close--is that occasionally they have somebody from the Joint Commission to answer questions.

EISELE:

We used to do that. It was not a very popular part of our agenda lately.

SLEE:

So no part of our program carries a message from another organization.

EISELE:

We have had some Feds with us occasionally--often they've been inept. Not entirely.

SLEE:

It depends. For instance, in late '65, when Medicare was passed, we scooped the world with...

EISELE:

At our Estes Park conference, we had someone come from Washington to explain this new legislation that had been enacted but not yet implemented.

SLEE:

Tom Tierney.

EISELE:

We had Tom every year for awhile but...

SLEE:

I think Tom was the first person we ever got, in the fall of 1965. You pulled it off because he went from Colorado to the Social Security Administration.

EISELE:

He was such a glib Irishman with such good Irish stories that he made them like it. Maybe it was an evening of that same conference--we had a woman come out to explain the techniques and implications of the new legislation. But the audience was very, very hostile.

WEEKS:

I guess it was 1966 before AHA had Wilbur Cohen, wasn't it? Medicaid had already gone into effect a month or so before he spoke to them. I remember hearing him in Chicago and I think it was '66--when the Act was already implemented.

SLEE:

Is he in your series?

WEEKS:

Yes. He doesn't say too much. He is still a political figure. I think he is a good man. I think he wants to do the right thing. But he isn't a financial man--let's say it that way.

I was wondering too about your competitors--Aspen Publishing Company--they are running a lot of conferences, too, now aren't they?

EISELE:

They certainly are. They are one of our competitors and this is kind of awkward because they are named after another Colorado mountain village; people get us confused.

SLEE:

They do a lot of one shot, one topic things.

EISELE:

Yes.

WEEKS:

But yours is generally covering the general situation. What do you do for faculty--I call them faculty--what do you do for speakers?

EISELE:

I think this is one of our great strengths. We have a very great faculty of speakers who have the expertise and the knowledge and the ability to communicate, often with very pleasing bits of humor. This is a rare combination. There are many experts who know everything about a subject, but they can't communicate. I don't know why. It is not simple. Another strong plus is that our core faculty attend a planning session each year and interact with each other.

One of our regular speakers is Lee Kaiser. He's been with us for many

years. He is a Colorado boy. He is extremely bright, knows the subject inside and out, and he has an excellent way of communicating. His only fault is that sometimes he tries to put so much into his hour; he talks so fast and sometimes he may be a little difficult to keep up with.

Another one is William Fifer from Minneapolis. He is a very humorous speaker, a wonderful mimic. He imitates people's reactions. He reads constantly; he travels constantly; he is right on top of issues, and he gives very practical suggestions.

Some speakers may be used only once because their presentation doesn't catch on. Incidentally, we get excellent feedback. We have evaluation forms to grade each speaker. Then we also get a global or overall rating. I feed this back--good, bad or indifferent--to the speakers. Sometimes a form will give specific comments about a presentation which is then fed back to the concerned speaker. Some of them are devastated, but then they correct their deficiencies. A couple of them in the past had problems using too much profanity. When they see that evaluation, they get the message. One speaker said "hell" and "damn" too much. It may impress some of the men, but especially the women trustees say "profanity is not necessary."

SLEE:

I must tell you that once a nun complained that the big guru chairman was not formal enough.

EISELE:

I didn't wear a tie and jacket.

WEEKS:

How is this organized? You started out as a university activity?

EISELE:

Yes. I was Associate Dean for continuing postgraduate education. Our primary role was to give clinical postgraduate courses, continuing education. With Toma Wilson, who was with me at the university and is now with me at the Estes Park Institute, we probably did four or five hundred clinical conferences over the years. We also had some firsts there.

I think this year the University is offering the twenty-eighth annual Family Practice Review which was the first of its kind. We set this program up to run for six days, and the lectures each day were given by a different clinical department. We'd have internal medicine on Monday; Tuesday would be obstetrics, Wednesday pediatrics, and so on. A department could get in and give it a one day punch and get out without disrupting their ongoing program. Then, there got to be some competition among departments as to who could do the best job and get the best feedback.

Then instead of doing it once year, we did offer it three and four times a year.

We also had an annual conference on internal medicine which is now in its twenty-second year. And we had an annual conference on pediatrics, and so on.

SLEE:

From an observer's point of view, it seemed to me that Wes developed the reputation of the University of Colorado in continuing education to the degree that doctors didn't worry much about the quality, it was going to be good. And they would come. Once they saw a brochure from the University of Colorado, that did most of it. They didn't read much farther. It didn't matter what all that fine print was.

I think you should pump him on the tricks that he employed to achieve

that kind of a reputation for the continuing medical education.

EISELE:

I don't know what the tricks are, Vergil.

SLEE:

Let me tell you about one of them: One time he had a muffin tin on the table in the registration area. He had set out free samples of pills in these little cups. One cup had pills for diarrhea. One was full of aspirin. Another had seconal for sleeping. then he had one labeled "placebo".

EISELE:

That was M & Ms. They went fast. You know, the Hospital Medical Staff Conference was in October. We would get boxes of apples. we would just set them around everywhere--maybe fifty boxes of apples. People would help themselves. Mary Koehne, then assistant in the office, thought up that trick. In Colorado one year the crop failed, so we got Washington apples. We'd have another tub with miniature Hershey bars in it.

In Seattle, we found a hotel that had their logo on little packages of Lifesavers. We are now trying to order those by the thousands with <u>our</u> logo on them.

SLEE:

One gimmick was to have a desk full of tickets to everything...Red Rocks, the rodeo...

EISELE:

We held the General Practice Review on the same week that they had the big rodeo in Denver: the National Western Stock Show. Farmers would come from Nebraska and Kansas with their cattle. Our registrants would go to the rodeo and stock show at night, and we supplied tickets to the arena.

SLEE:

You didn't give the tickets away: You kept money revolving through.

EISELE:

We made it easy for them to get those tickets which were often in short supply.

Then there was a Playboy Club in town; I would go down and get a hundred guest keys. They would really scramble for those. Then I'd go back and get another hundred. I'd say "These are the ground rules; it's cash on the barrelhead: no checks, no credit cards. You pay cash for your dinner. You can look, but don't touch unless you want to get a judo chop." They could go home and brag, "I was at the Playboy Club."

SLEE:

These are the things you don't find in the written histories, Lew. In 1960, we went up to Centennial at Central City.

EISELE:

Yes. We chartered buses to take them up there and to the operas. We also chartered buses to bring them in to the medical school from the downtown hotels every morning and take them back in the evening. We always had the meetings right at the medical school. I think there was a lot of merit in having the meeting in the medical school instead of a downtown hotel.

WEEKS:

These so-called tricks loosened them up and made them feel at home.

SLEE:

The first year, at the internal medical audit, I think it was, he had about twice the registrations he expected which meant twice as many people as could be served in the cafeteria. By noon he had a movie for the people in

the auditorium who had to wait to be served.

EISELE:

Then we started bringing in box lunches for them. They could sit in the auditorium and watch the movie -- usually it would be a clinical movie and eat their sandwiches.

Some of the movies were not clinical, but subjects like skiing in the Rockies. Another thing, we would have a whole pile of morning papers ready when the first bus load arrived. Then the buses would go back and get another load. So those who got there a half hour early were given a daily paper to read. That sort of thing.

WEEKS:

You started this before continuing education credits were necessary, didn't you?

EISELE:

That's right. This was so that anyone could get refreshed on the latest developments.

WEEKS:

I assume that at some point you separated from the university and became a separate corporation.

EISELE:

That was when I had reached retirement age, in 1974.

One of the things that I also did when I was at the university: I got to be familiar with the general practitioners around the state, so that when they wanted to refer a patient they would call me and I would put them into the right hands. Inadvertently I became sort of a PR man to the practicing physicians for the university. I became famous for wearing loud shirts. Many

of the doctors from cities wondered about correct apparel and showed up in three-piece suits and ties. I would say it is perfectly all right for you to wear a conservative sport shirt (like me). They didn't have anything like a conservative shirt. I began to get a collection of wild shirts, most of them given to me. Then, when I went to these resort areas, I'd take some with me. I'd wear two different shirts every day, one in the morning and one in the afternoon.

Then in 1974, I retired from the medical school and started this new job the next day.

In the spring of 1974, a group of physicians, administrators, and trustees based at Swedish Medical Center in Englewood, Colorado and at Porter Memorial Hospital in Denver, organized a nonprofit corporation, whose primary purpose was to perpetuate the regional Hospital Medical Staff Conferences. They named it the Estes Park Institute. Immediately, it was simply referred to as "EPI". The establishment of EPI on 1 July 1974 coincided with my retirement from the University of Colorado and I accepted the position of Program Director for EPI on the same date.

For the following three years, the University of Colorado attempted to hold the Hospital Medical Staff Conferences at Estes Park in the fall, without my help which had been offered, but the Conferences dwindled rapidly and were losing so much money that they were abandoned. EPI then told the University of Colorado--that EPI would put on a conference in Estes Park in September, 1977 and we offered to do it jointly. EPI did all the work, all the promotion and had the University as a co-sponsor. They had an advisor as their representative to the program, but it was a purely nominal thing. We gave the university a royalty for everyone who attended. This arrangement continued

for three years.

At present, we do one in Estes Park every year in September and five more at different places around the country throughout the year. They are all national conferences. Everyone of them is attended by people from twenty-five or thirty states: they are truly national in scope.

WEEKS:

You have had some international meetings too, haven't you?

EISELE:

We had the first one two years ago in London, an invitational conference to study the British health care system. We took our regular faculty and their spouses as students. Then we invited about a dozen or so other people who had attended EPI to go along. We had a good cross-section of hospital administrators, trustees and medical staff to interact with the British faculty.

The second one was this past May in the Scandinavian countries. Richard Bates, an internist in Lansing, Michigan, and long time EPI faculty member, was the director and he prepared the format. I'm looking forward to his report because we had a great local faculty, and we had good interaction. We visited hospitals, clinics, nursing homes, and talked to men on the street, and got their reactions to the system. I think it is going to be a meaningful report. We'll see that you get it.

WEEKS:

I'd like to. There has been great interest for several years in foreign systems, with the idea that maybe someday we'll have a national system.

EISELE:

How does it bear on our health care delivery? What are their problems?

In Scandinavia, I made a problem list of about ten things that I saw as problems in their systems. It was a very interesting parallel to problems in our own system.

They have physician glut and a dentist glut in Norway and Sweden, but yet a mal-distribution, too many physicians and dentists in Stockholm, Oslo and Bergen, not enough up north.

The systems cost too much. They are taking an ever bigger bite out of the gross national product. People object to the fifty percent income tax that they have to pay to support this.

WEEKS:

Yes. I think we forget that the Scandinavian countries may have a high income but they really have a high income tax too. It's amazing. Not only high income tax, but they have a tax on everything, transfer of property...any old thing. It is very, very high.

EISELE:

I think in Stockholm, wasn't there an add-on tax of twenty-four or twenty-five percent on the hotel bill?

SLEE:

The game changes: It becomes "How do you beat the tax?"

WEEKS:

I know a couple in Denmark who inherited a little money--not much--but the man has stopped working at fifty because it is so useless. His take home pay isn't very great, so he would much rather live on the little income from the modest amount of money he inherited than work. Not because he doesn't like to work, but because he doesn't like to pay all of those taxes.

EISELE:

Yes. We found a lot of early retirement. Their pensions are pretty good, but their pension fund is also facing bankruptcy, like some fear for our Medicare and Social Security.

WEEKS:

Did you come to any conclusions about the high suicide rate we hear about, or this early retirement how does it affect health? Did you come to any conclusions about that?

EISELE:

Well, I don't think any specific ones.

SLEE:

We brought up the suicide rate and they were offended. They said it isn't so.

EISELE:

They are very proud of their very low infant mortality rate and their general longevity rate. I think I brought up the question that, because they have abortion on demand, perhaps a lot of their high-risk pregnancy women choose abortion. They denied it, but I think that can account for some of their very favorable perinatal survival rate.

One of the things about their favorable rate is that they do have early access to prenatal care which is generally given by a midwife. Then, another midwife in the hospital delivers the baby. And our very intelligent, highly-educated tour guide was asked:

"Who delivered your three babies?"

She said, "Our midwife."

WEEKS:

This is in Sweden?

EISELE:

This was in Norway. But the Queen in Sweden had three children delivered by a midwife.

Unless there is some specific complication, the obstetrician is a consultant.

WEEKS:

Are you going to continue these foreign meetings?

EISELE:

This is still questionable. We had preliminary plans to have one in 1984 in Germany and Austria. Toma Wilson and I spent two weeks over there last August traveling with a group of radiologists in a symposium called "Roentgen Revisited". It was conducted by Travel Planners who do all of our offshore work. We made tentative arrangements to do one there the last week of May in Munich and the first week of June in Vienna.

In the interim, between those two conferences, we would go by chartered bus first to Oberammergau for the 350th anniversary production of the Passion Play. My wife Jessica and I were there in 1970 and saw the Passion Play and it was a tremendous experience. We thought this would be a good interim event. And from there we would go and spend two nights in Salzburg and then on to Vienna for five nights.

We had to make our hotel reservations and we had made our arrangements in Oberammergeau. Then at a board meeting, the plan was postponed.

So it's in limbo right now. Of course, getting the Oberammergeau thing is '84; or not at all. Unless we wait until 1990.

WEEKS:

Yes, it would be nice if you could do it.

EISELE:

So I don't think we'll do anything in 1984. We would have to have it arranged already.

WEEKS:

You are now operating as a non-profit corporation?

EISELE:

Yes. Originally, the board was heavily weighted with trustees from Swedish Hospital and from Porter Memorial Hospital. Porter has dropped off the board, and the Swedish Medical Center members have dropped off substantially. Some on our board are our faculty people. I think the active board is now down to eight. John Horty is the vice-chairman of the board. Richard Malone is the chairman of the board. He is President of the Baptist Medical Center in Jacksonville, Florida.

There is one clergyman on the board, which is sort of unusual. That's Charles Petet. He had been the Assistant Dean at the University of Colorado Dental School, trying to bring some humanity to dentistry. He was the director or head of the admissions committee. After that, he was involved with a group of oncologists. Dr. Richard YaDeau, Dr. Vergil Slee, Dr. Richard Bates, and Dr. William Robinson are physician faculty and board members.

WEEKS:

How much does the board enter into the planning?

EISELE:

We have about four board meetings a year in conjunction with our conferences.

WEEKS:

Who does this planning? Do you do it or does the Board? You must have to plan a year ahead.

EISELE:

We are always open to suggestions and comments but I have the responsibility as program director.

WEEKS:

You have the contacts with the faculty, so that if you want some new person...

EISELE:

I just go get him.

WEEKS:

Where the board itself wouldn't have that acquaintanceship.

Would you like to talk more about your professional life and the things you have done?

EISELE:

I hardly know where to start.

George and Gladys Dick had a tremendous influence on my early professional development. I was George Dick's intern at Presbyterian Hospital, Chicago.

WEEKS:

Was he the inventor of the Dick test?

EISELE:

Yes, the Dick test. He taught all his fellows about hemolytic streptococcus. He was an old time physician, a family practitioner in Michigan. He had done appendectomies on kitchen tables. He had been a

pathologist for fourteen years before he became an internist. He had been head of pathology at St. Joseph's Hospital in Chicago.

I asked him one day, "What do you think I should do next year to go into the practice of internal medicine."

He said, "The first thing you should do is get some pathology. Everyone needs some pathology. Then that afternoon the head of the Department of Pathology at Charity Hospital in New Orleans and Louisiana State University came in as a patient. While I was taking his history I got myself signed up for a residency.

The next morning on rounds, I said, "Dr. Dick, I took your advice about pathology. I got myself a residency last night."

After I went to New Orleans, Dr. Dick moved to the University of Chicago as Chairman of Medicine. Very soon he called me to join him. He was a generalist, in a sense. I always was too: I always had a hard time settling down to a narrow specialty. I became head of the general medicine service at the University of Chicago Clinics. We had fourteen specialty divisions in that Department of Internal Medicine and they all lorded it over the generalist. I had worked for four years in several subspecialties: two years in gastroenterology, in the chest pavilion for a year, and then allergy for a year. I ended up with this general medicine clinic, and I was also a general medicine consultant to the Lying-In Hospital across the street.

Then I got involved in brucellosis research. I enjoyed myself very much. I was taking care of patients. I had a great array of patients with ill-defined diagnoses. I was sort of a doctors' doctor. I took care of a lot of faculty members' wives and sisters and families.

A psychiatrist came to me one day and said, "Wes, you are a specialist in

vague complaints, I want you to see my wife."

Dean Lowell Coggeshall brought his sister in for me to take care of. I had a lot of that kind of thing.

WEEKS:

Was this the famous Dr. Coggeshall of the Coggeshall report? I would like to know more about him.

EISELE:

Coggeshall was one of my best friends in Chicago. When I first arrived, he and I worked together as fellows on the gastrointestinal service under Dr. Walter Palmer. Cogg was then a fifth year fellow. Cogg had a research background in parasitology and malaria, so he spent the next ten years at the Rockefeller Institute and the Navy. He returned to Chicago as Professor of Medicine and rapidly progressed to Chairman of the Department, then Dean of the Division of Biological Sciences, then the Vice President of the university and member of the Board of Trustees. Cogg seemed to like everyone. He served on many national boards and commissions.

WEEKS:

Wasn't he a fairly open-minded man?

EISELE:

Very much so.

WEEKS:

It seems to me that he was not the AMA type, if I may say that. He was not hide-bound. He could see the other fellow's point of view.

EISELE:

He was a great administrator.

SLEE:

Didn't he do something during World War II in our area? Did he head a commission?

EISELE:

He did some research in elephantiasis and malaria, of course. He was on all kinds of commissions.

WEEKS:

He was the type of man who was willing to listen to prepaid hospital insurance as a concept, where a lot of the AMA would turn it down cold.

EISELE:

He was not an AMA man.

WEEKS:

That's the impression I have of him. I am glad to know someone who knew him. I now recall that Dr. Coggeshall headed a committee that made suggestions to the Association of American Medical Colleges (AAMC) that resulted in the AAMC opening their door to specialty societies and teaching hospitals, thus being of great help in graduate medical education.

You were going to tell me something about Ward Darley also.

EISELE:

Before I went to the University of Colorado in 1951, Ward had been an internist in private practice in Denver. He was born in Colorado. He then moved over to the medical school and was the head of the Department of Medicine, and then was the dean. He had become vice president by the time I arrived. He was a very influential man in developing curricula in medicine. He started the first general practice residency program in a medical school in the United States in 1947. That's where I went four years later. We had

residents in all the specialties under our administrative wing. They were all registered in the graduate school, some of them earning a master's degree. They all had graduate school credits. We saw general practice as a legitimate specialty. I think Darley deserves a lot of credit for that.

WEEKS:

Was this in the early days of continuing education in medicine?

EISELE:

Yes, indeed.

WEEKS:

This really was an innovation back then?

EISELE:

It was pretty advanced in Colorado.

Then Darley got talked into going to Boulder as University Chancellor, which he later said was the biggest mistake in his life because his time was taken up with administrative duties. When he gave that up he went to Evanston as the first full-time director of AAMC.

WEEKS:

Was he there until he died then?

EISELE:

No, he retired. He and Pauline moved out to a retirement village in California where he died. Pauline is now in a retirement home in Boulder.

SLEE:

We had him on some of the Estes Park programs.

EISELE:

Yes. He was a great supporter of what we were trying to do.

WEEKS:

Did you have much to do with Arthur Bachmeyer?

EISELE:

He was the Dean of the Medical School at Chicago. He was highly respected. I told you about his getting me involved in Michigan and this whole area of quality of care. He was a very effective administrator.

WEEKS:

He was a hard worker, wasn't he?

EISELE:

Very much so. He had three prongs of activity: One was hospital administration. He started the University of Chicago graduate program. He was President of the AHA (As they called that position in 1926). He also served as Chairman or President of the AAMC. So he held some top leadership posts.

WEEKS:

He must have been a good administrator also. I have a reference to his serving as the Director of the Commission on Hospital Care. That was a study of hospitals back in the years previous to Hill-Burton, so that would be in the middle 1940s. He also was the head of another one called the "Commission on the Financing of Hospital Care". I think he was busy on that when he died at Washington Airport. He dropped dead in the airport, I think.

EISELE:

I had forgotten the circumstances of his death.

WEEKS:

We haven't talked about the future yet. Young fellows like you and I have to look to the future.

EISELE:

I am not so much interested in predicting the future as what can we do to shape it ourselves. How can we shape the future? Individually, as an organization, as a nation, as a society. We should all get involved in shaping the future.

WEEKS:

In your institutes do you attempt to mold the future by bending the minds of others.

EISELE:

Perhaps. We attempt to predict the future and also mold it. This is where Leland Kaiser comes in.

WEEKS:

He is a futurist, isn't he?

EISELE:

Yes, he is a futurist. He delivers some great lectures. Some of them are just fantastic.

WEEKS:

I remember very vividly the one he delivered in Memphis in the mid-seventies at the Kellogg-sponsored meeting about the responsibilities of hospital trustees.

I remember his rapid fire delivery about the fourteen points, bang, bang, bang.

EISELE:

I also was at that trustee conference in Memphis. One afternoon there Kaiser and I sat down with Bob DeVries from Kellogg and outlined a plan we had at EPI for trustee education. In addition to conferences, we planned some

reviews and educational programs in selected hospitals with the hospital picking up half of the expenses. We needed a grant. DeVries said, "Don't send us a formal application. We get 300 a week and can't read them all. Just send me a 5 or 6 page letter about what you just told me, along with a one page budget and I will get back to you if I need more." I did this the following week. About a month later, DeVries' secretary called and asked about the hospital's support for the site visit, then said they were taking it to the Board the next day, "To whom should we send the money?" That was how EPI got into trustee education.

We have Spence Meighan, a Scottish physician now from Portland, Oregon. He's a dramatist. He produces "Alice Does It Again", a presentation he has given all over the country. It's based on "Alice in Wonderland": Alice goes to the hospital with her physician friend and looks around. She says, "Who's in charge here?" The drama goes on from there.

He has another skit called "The Promised Land", about an internist, a leader in a community hospital, who got elected president of the state medical society. He takes his job very seriously. He falls asleep and dreams that he gets in a time machine and is transported twenty years into the future and visits the hospital. He finds tremendous and disturbing changes. The medical staff isn't in charge anymore. It's frightening. This is futurism saying we had better get busy and protect our interests now, because we are going to lose control of everything down the line. That's what the medical staff is going to do: They are going to lose control. There will be a new definition of the medical staff. They won't call it that anymore. It will be the "organized staff."

WEEKS:

Will this include...?

EISELE:

This will include nurse practitioners, podiatrists, psychologists, naturopaths, chiropractors, anybody can get in. If you have a department of psychiatry with four psychiatrists and twenty psychologists, all members of the department, next year a psychologist could be chairman of the department.

The Joint Commission is changing all the requirements about who will be on the staff by putting the responsibility for the decision back on the hospital.

WEEKS:

Is there a movement among chiropractors to try to get appointed to the staffs of general hospitals?

EISELE:

You bet there is. They don't care much about privileges at this time. They want membership, so that they can advertise it. They want to be able to say, "I am a member of the staff of such and such." They want to be able to use the x-ray department, the laboratory department. They want to use that as self-promotion of their practices. They don't want hospital admitting privileges at present, but they will eventually.

WEEKS:

You mean they don't want to be able to admit a patient?

EISELE:

They probably would, but they are not fighting for that now. First they just want to be members.

WEEKS:

They just want to be on par with...

EISELE:

We went through this same sort of thing with osteopaths. In the old days, we wouldn't have dreamed of having osteopaths on the hospital medical staff. I could tell you a story about the hell some M.D.s gave me for admitting D.O.s to our General Practice Reviews in 1950s.

WEEKS:

Didn't World War II change that?

EISELE:

They got accepted with a commission in the Army.

WEEKS:

Can they have a commission in the Army now?

EISELE:

Oh yes.

Another thing is that their education and level of practice has changed dramatically. It used to be purely manipulation. Now they have the same general type of education as medical doctors.

WEEKS:

As one of my osteopath friends would say in defense of his profession, "Why should there be any distinction between the osteopaths and the M.D.s? We study out of the same books." He was not considering the other factors that go into the interpretation of the books.

Chiropodists can get in too, can't they?

EISELE:

At our meeting in Williamsburg last April it was like they were in the

promised land. There was a group of physicians from Franklin Hospital in Philadelphia that included a podiatrist who was the head of the Department of Podiatry at Franklin. John Horty in his speech at the Institute gave podiatrists a hard time. This podiatrist in the audience demanded five minutes time for rebuttal. I gave it to him.

The next morning I told the Chair that this man was a podiatrist who wanted to give the other side of the argument. He was not flamboyant. He had it all written out: What their education is, what their privileges are, and how they fit into the whole medical picture. I am sure he didn't make many converts, but I am his friend for life.

WEEKS:

You took the heat off, and gave him recognition.

EISELE:

We don't try to duck controversial things. We have got to face them.

WEEKS:

The changes in the organization of the staff may have lasting effects in the future?

EISELE:

I think in the future we are going to have a much broader medical staff. This is a very sensitive issue. Physicians feel they have given too much of their practice away to other ancillary professions: Some nurse practitioners are setting up independent practices, siphoning off some of the physicians' patients. Psychologists, and others of like practice. I think we have to be sure the physician maintains overall control of the medical care of the patient. If a podiatrist brings in a patient, can he do the medical examination or overall medical evaluation? No, he can't. Neither can a

dentist. Dentists have had privileges for a long time, usually in connection with a physician.

WEEKS:

Isn't it usually for dental surgery?

EISELE:

That's right. If there is a medical problem, they don't try to get into it. This is a very important development.

WEEKS:

I see two things here I'd like your opinion on. One is that we have been talking about the organization of the staff. There are a lot of paraprofessionals coming up. Paraprofessionals of one kind or another. I detect, at least in my own mind, that there is a movement for organization. First, they have a national organization. that is the way they start. Then they begin to ask for privileges or professional recognition.

EISELE:

Getting licensed.

WEEKS:

Yes, getting licensed. They like that. Am I seeing a movement there?

SLEE:

About ten years ago a fellow from the Kellogg Foundation identified something like 200 labeled "allied health professions". That's a very serious problem that they are trying to squelch in Scandinavia because every one of these "allies" increases costs. Each one tends to specialize. Once you had a person who could do three different things, now you have to have three different people. There is a conscious effort over there, remember, Wes, to keep the allieds from becoming any more numerous or specialized.

WEEKS:

I think one profession that has been hurt a lot is nursing. The nurse doesn't really know what her role is.

EISELE:

Very confused.

WEEKS:

Especially now that we are getting more and more nurses with bachelor's and master's degrees. They are professionals in their minds and they should be in everyone else's mind. I have gotten in a little on the union movement in hospitals. I find that nurses are starting to organize more than they used to, not always for money, but for better hours, and for better patient care. They want to take charge of patients. You see words like "diagnosis" coming into their speech to describe judgments they make about patients. Now they have tempered it a little bit and call it nursing care diagnosis. Some of them feel the doctor could say, "Nurse, here is a case of so and so, we need to watch such and such". From there on, the nurse takes over because she knows how to take care of that kind of patient. She would like to do that. Do you find that true?

EISELE:

There is a bumper sticker: "Nursing power: more say and more pay."

WEEKS:

I talked with a union leader, Leon Davis. I don't know if you have ever heard of him or not. He organized hospitals in New York City, and for fifty years he was head of the union there. He built a pharmacists' union of four or five thousand members into a union of sixty or seventy thousand hospital workers.

He said, "We have learned one thing: We used to think we would organize the service workers: the dietary, the housekeeping, maintenance workers. At first we didn't try to organize the clerical workers, the technicians or the nurses. We found that we could have a strike and call out all the service workers, but the professionals and the paraprofessionals could possibly carry on, at least on a limited scale. So now when we organize we need to get the nurses in and the clerical workers in so that when we strike--if we need one--we can close up the place if necessary."

This is a movement that I don't think everyone realizes is happening. There are more and more nurses organizing: there will be even more in the future.

EISELE:

There are more and more workers unionizing so that you can't fire anyone for doing bad work. Neither can you reward them for good work.

WEEKS:

Talking about Scandinavia -- and you have seen the British system, too--what does the future hold for compensating the physicians? Are we going to see less and less fee-for-service? Are more physicians going to work on a salary?

EISELE:

I think there will be more and more salaried physicians.

WEEKS:

In your medical audit work have you had a chance to look at proprietary hospitals versus community hospitals? Some people say that proprietary hospitals don't provide all the services, particularly those services that are unprofitable.

EISELE:

I can't document it, but that is the general impression--the general feeling.

WEEKS:

This brings up another question. We hear a great deal about multihospital systems and chain operations being great and wonderful because the home office has "experts" that can bring expertise that a small hospital couldn't afford. Is that likely?

EISELE:

That's probably true, to some extent.

WEEKS:

I guess I am a little bit skeptical. Because a man has a degree in hospital administration or hospital finance, does that necessarily mean he is an expert?

EISELE:

I think that a small community hospital can lose control. A small rural hospital that loses complete control has lost something very valuable in the community. If you can get them to change so that they maintain their own basic control it can be very valuable.

WEEKS:

Aren't you saying, possibly, that they are a community institution and they should be close to the community, and responsive to the community? That this they might not be if outsiders were calling the shots?

EISELE:

Being controlled by outsiders who may be only interested in whether a profit is shown or not.

WEEKS:

We have not only multihospital systems, but also management systems. Henry Ford Hospital, I understand, manages several hospitals. Management firms offer management contracts and take over. The community tells the management firm to take the hospital and run it because they know how to do it best.

EISELE:

In Naperville, my home town, there is Edwards Hospital, once a sanitarium. The sanitarium was closed because of the change in tuberculosis therapy, so it became a general hospital. It has 150 beds or something like that. The hospital was going broke, going down the drain, so they got a management company to come in. The first thing they did was fire the administrator and put in their own man. Under the contract they could do pretty much as they pleased. This situation caused trouble among factions in the community. Some of the people didn't think they were doing the proper thing with the hospital so that it caused constant turmoil. People were losing confidence. According to the articles in the local newspaper, about twenty percent of the patients in town are going to Edwards Hospital, but the rest are going to hospitals in nearby communities. People are losing their allegiance to the community because they have lost confidence in this hospital.

WEEKS:

Carrying this thing a little further, do you find that if they want to build a new wing or have need for other capital projects community hospitals turn to their communities for financial support?

EISELE:

They may have to go outside the community: Where else are they going to get it?

WEEKS:

The next point is then: Aren't they losing some of that close feeling by letting a management company in there? Won't they feel that this is not their hospital anymore?

EISELE:

Right. I think that is one of the big problems. They are losing a valuable community asset.

WEEKS:

I had an interesting experience when I first started at the University of Michigan. John Griffith and I were doing a study of progressive patient care at McPherson Community Health Center at Howell, Michigan. They built a new section and opened one of the first small-hospital intensive care units. There were also self care, home care, long-term care--the whole works. There were hospital-based nurses for the home care. We explained what the various units were in the local paper each week. After that if you went down the street, or out socially, you would hear people talking, "Do you know that in our hospital we have this and this and this" (naming the various units).

They were proud of it. When the hospital put on a funds drive, they had no trouble getting money because the hospital was theirs. They would bring visitors to the hospital. There were days for special tours of the hospital. Aren't the hospitals going to lose some of that spirit if they turn the institution over to a management company?

EISELE:

"Our hospital is now a part of the Hospital Corporation of America."

WEEKS:

Do you think there is a possibility that doctors may work more willingly for a salary?

EISELE:

I think the doctor glut is real and will get more real in the next five or ten years. There already is a pipeline filled with developing physicians. They are going to be competing for jobs. Very few young men and women coming out of medical school are going into private practice on their own. They may join a group and be a flunky for them for a long time, or find some position in a hospital. Emergency physician is a popular specialty right now.

SLEE:

I don't think there ever has been trouble hiring doctors if you paid enough. Remember in England we were told by Gordon McLachlan, "When we started socialized medicine under Aneurin Bevin, we filled their mouths with gold." That was Aneurin Bevin's answer to the medical profession in Great Britain: "Fill their mouths with gold."

WEEKS:

Didn't they offer a little sop to the specialists to get them to agree to the arrangements first? So the general practitioners would have to follow?

SLEE:

I don't know that part of it.

WEEKS:

Didn't the National Health Service give some honors to specialists after they had served a certain number of years? You would know better than I.

Didn't they give them an extra title and a little more money? I guess they are more conscious of honors there than we are here. I believe they had two or three gradations of consultants. You couldn't become a consultant unless there was an opening, could you?

SLEE:

They have qualified people standing in training positions, so-called "registrars", for years.

EISELE:

In Sweden they have trouble getting doctors to locate in the north. They offer them an opportunity to practice up there for a few years and then come down and enter specialty training.

WEEKS:

They assign physicians to locations in England, too, don't they?

EISELE:

In essence they do assign doctors because there may be only a few places open.

WEEKS:

Then they can't stay in London if London's quota is filled, can they?

EISELE:

Some London practitioners are allowed to hire assistants.

WEEKS:

He's allowed to do that?

EISELE:

Yes.

WEEKS:

It has been several years since I have been in England, so I have lost

track of developments in the National Health Service.

I talked with Dr. George Crile, Jr. of the Cleveland Clinic about fee-for-service surgery which he opposed in a magazine article. Cleveland Clinic's surgeons all worked on salary. They didn't have to operate to make money, so they didn't do a lot of unnecessary surgery. He had another term for it, but he meant the same thing. I asked him about peer review. He said they kept looking over each others' shoulders all the time anyway. He said they didn't need any formal peer review.

In connection with fee for service vs. salaries for physicians you mentioned Bob Buerki at Henry Ford Hospital in Detroit.

SLEE:

I understand that he controlled every person's salary directly and privately negotiated with every doctor he hired. He would transfer money to an accounting firm every month; the firm would write checks for the doctors. Nobody knew what others were getting. If anyone blabbed, it was suicidal. When he needed a neurosurgeon, he would go and pay whatever he needed to get one. It was a secret between the neurosurgeon and the accounting firm. I heard that he tried never to leave the accounting records in the hospital.

WEEKS:

If I see him again I'll have to ask him. I talked with him once about it, but he seemed hesitant to talk about the salaried physicians and Ford Hospital. I believe he has a very beautiful pension, and he probably didn't want to disturb that.

SLEE:

He also had cars.

WEEKS:

I have been told that he had a new Lincoln every year.

SLEE:

Twice a year.

WEEKS:

I drove with him once in his Lincoln. That was an experience in itself. I think he was treated pretty well by Henry Ford Hospital.

SLEE:

He was a character. He had a staff meeting every morning at six or seven o'clock. Ted Howell was there for years. I have heard him say he had to be up every morning bright and early, all spit and polish in Buerki's office at seven every morning. Buerki had his key people like that.

WEEKS:

He ran what they call a tight ship, I guess.

He was one of the inner group, the old boy network with people like Jim Hamilton, O.G. Pratt, George Bugbee--a few of them like that. There may have been a dozen or so who could get on the phone with each other and get things done. I dare say that, in your case, maybe Graham Davis called George Bugbee first to talk with Bachmeyer before he went to see...

EISELE:

Could be. I don't know.

WEEKS:

This is the way they worked, by telephone. They knew each other. They knew they could depend on each to be perfectly frank and honest with each other.

When I interviewed Jim Hamilton he would say, for instance about Dick

Stull and the Hill-Burton job in California. Jim said, "I got him the job." Another time he said, "When I brought George Bugbee from Ann Arbor down to Cleveland." He was moving these people all around. Maybe he did. The old boys knew everybody of importance in the field.

SLEE:

To digress what was Bugbee's relation to Lunt and Fontanne?

WEEKS:

Lunt was Bugbee's wife's half brother.

Lynn Fontanne was an English actress. She and Alfred Lunt were married and were an outstanding couple in the theater.

Did you see the newspaper yesterday which reported her death? George's name was mentioned. The newspaper said that Lynn Fontanne died yesterday at Genesee Depot, Wisconsin--where George lives, you know. When she died at age 95, George Bugbee, her brother-in-law, was at the bedside.

Did you see the story in the paper yesterday on the growth in numbers of physicians. Didn't it predict that there would be 700 thousand physicians in the United States by 1990?

EISELE:

There will be a trend to cut back enrollments in medical schools.

WEEKS:

The University of Michigan has already cut back, hasn't it?

EISELE:

I think so.

WEEKS:

The effect will take a few years to show.

EISELE:

Probably ten years. The first cut, I think, will come in opportunities for foreign trained physicians.

WEEKS:

There are a lot of Americans who get foreign schooling and come back.

EISELE:

A lot of Americans are attending Caribbean and Mexican medical schools. They probably are getting second-rate training. All of them expect some day to be able to come back to the States and practice, and get jobs.

WEEKS:

We haven't talked about health insurance. Do you cover that subject in your institutes?

EISELE:

Not to a great degree.

SLEE:

We do pay a great deal of attention right now to the competition for Federal payments.

WEEKS:

Federal payments?

SLEE:

The voucher systems. That's causing quite a lot of attention.

WEEKS:

You have seen national health systems in Britain and Scandinavia. Do you think that the general American population would accept anything like they have in Britain?

EISELE:

I don't think so. They are a smaller and more homogeneous population.

WEEKS:

The present British system is not too different from what they had before World War II, is it? They have a general practitioner who screens everything, don't they? If need be, he sends a patient to the hospital for a consultant to take over.

EISELE:

I think that is one of their plusses. A patient cannot go directly to the hospital or to a surgeon. Even a private patient--and there is a lot of private practice--goes through his private physician, a general practitioner. This is sort of a gatekeeper system, as they call it. They have very effective gatekeepers, I think.

WEEKS:

Out of 1,000 cases that came in to a gatekeeper, you probably wouldn't find many in critical condition, would you?

EISELE:

Very few of them would be.

WEEKS:

A gatekeeper could take care of most of them but if there was something questionable or beyond his expertise, he could send the patient on to someone he thought might be of help.

EISELE:

Then they can go to the consultant or specialist. Surgeons are trained to operate; they love to operate.

WEEKS:

Isn't it true that you are likely to see treatment in terms of your training? If you are an internist, you are likely to do what you were trained to do as an internist before you think of surgery. If you are a surgeon, likewise you think of surgery.

EISELE:

I hate to think of it that way, but there probably are economic reasons for many of the things we do.

WEEKS:

You may not want to answer this question; you may not know the answer. Have you ever thought of why people enter medicine?

Do they do it because they want to be a healer or do they do it because it is a dignified and highly paid profession?

EISELE:

There are many reasons why people do things. Many are highly motivated; some are very mercenary.

WEEKS:

Very difficult to generalize?

EISELE:

I was chairman of the intern selection committee and also on the admissions committee at the University of Colorado. One applicant said that he wanted to get into medical school because he wanted to be a healer to make the sick well again. I asked him what practice he would be interested in. He said, "I think I would like ophthalmology"--A highly remunerative field.

WEEKS:

I used to interview some of the candidates for graduate study in hospital

administration. You could tell those people who had had experience in interviewing. If they had been around a little bit, the first thing they would say was, "I have always wanted to do things for people--I want to help--I feel that in the hospital field I could be of help to sick people." I knew someone had coached them.

EISELE:

Now the key words are: "I want to be a family physician out in the country."

WEEKS:

Or in the ghetto.

EISELE:

They get coached.

WEEKS:

I don't suppose you want to make any predictions about whether we will have a national health service or national health insurance.

EISELE:

I don't think we will. I think the window on that has long been closed. The economic situation now is such that we can't do it, even if we wanted to. I don't think even Ted Kennedy is talking about it anymore. But I recall a professor of sociology I had as a patient at Chicago about 1940, saying emphatically, "You mark my words, we will have national health insurance, and soon."

WEEKS:

I have been trying to get Ig Falk to write a paper on Kennedy and his favoring national health insurance, where they would put a pot of money in each region. The providers would have to submit their charges to the pot.

When the money in the pot was gone, the providers would have to serve without pay, or find some other way of getting revenue. I don't think the physicians would go for that. We never have been very successful in having them follow a schedule of fees, have we?

EISELE:

They would resist that very much. I am a rather poor predictor of what might happen in the next ten years. There probably will be great changes.

WEEKS:

Yes, many changes. "This too shall pass."

SLEE:

There is a book by Buckminster Fuller titled, _It Came to Pass, Not to Stay._

WEEKS:

That's one sure thing: there is going to be change.

Dr. Eisele, you served many times as a consultant to an Air Force Base or a hospital. Do these have any special significance you would like to comment on? I was wondering what did you do as a consultant? Were you a consultant in internal medicine?

EISELE:

Once a week I consulted with the staff on clinical diagnostic and therapeutic problem cases.

SLEE:

You were on an HEW commission.

EISELE:

I was on Secretary John Gardner's commission on hospital effectiveness which met in Washington every month for two or three years. The commission

was made up of about 50% physicians and 50% administrators and other nonphysicians. At the end we wrote a 32-page report, the shortest one in history. We listed about a dozen "do-ables"--things that could be done. One of them was on medical insurance and the evils of paying the first dollar. Hospital insurance should be like automobile collision insurance with deductibles, coinsurance. This has come to pass.

SLEE:

You were also on that AHA Committee on Physicians.

EISELE:

Yes. I was one of the founders.

WEEKS:

What was AHA trying to do, develop communications with physicians? Did the AMA enter into this?

EISELE:

No, not directly. The AHA had this committee on medical staff problems. They developed a little monthly journal called, Hospital Medical Staff.

SLEE:

I think you should tell about that honorary AHA membership.

EISELE:

It was an honorary life membership.

SLEE:

I think we have an anecdote here: You came all dressed up.

EISELE:

I was going to be up on the platform at the banquet at the Palmer House in Chicago. It was in August, so I went out and rented a white dinner jacket. I had a black one at home.

When I got to the hotel, I found that Julie Eisenhower was going to be a guest, on very short notice. Photographers don't like people in white, so one of the aides went up and got a black tuxedo jacket but it was too short and too tight. Having Julie there disrupted the whole seating arrangement. What was to have been a very quiet affair changed. The secret service demanded that they have an agent seated at every front table. If you wanted to go out to the john, they would give you a pass to get back in: a grandstand ticket for the Kentucky Derby. Security was very tight.

SLEE:

Was that the time that Walter McNerney screwed everything up?

EISELE:

He just went up to the platform and asked Julie to dance. They stopped the music right there: There was no more dancing or music until dinner was over, the head table group had retired, and the Secret Service checked things out.

We had had a pre-dinner meeting with Julie.

SLEE:

That was the same year Andy Pattullo got an award, wasn't it?

EISELE:

Yes.

SLEE:

I guess I have never seen anyone more angry than Jean Pattullo. The security cut Jean from the pre-dinner reception. Here is Andy's wife in one of his moments of glory, expecting to be with him. She never did get in to that reception. She was just livid, and quite rightly. I sat at a table with Dan Schechter who had been on his feet for 48 hours trying to meet the Secret

Services Mickey Mouse requirements. For example, en route from Washington they had radioed, "We are bringing a directive that we want you to have printed and at everyone's place." When they landed, Dan had to be ready to take this to a printer.

EISELE:

You see, all these arrangements were for Julie to bring greetings from President Nixon. All the arrangements had been set, but then at the last minute the President wanted to send greetings by his daughter. It disrupted things.

SLEE:

Dan couldn't smile much that day: He was pretty angry.

WEEKS:

These things happen. Somebody like Dan who had to worry about procedures probably was glad when things were over. I can understand Jean Pattullo.

You also received awards from the American Academy of General Practice.

EISELE:

I was the general practitioner's friend back in those days. I had this General Practice Review course every year, and I also had the general practice residency program. They looked on me as their great friend, and I was. I still am. They gave me a certificate for service.

WEEKS:

I have a note that it was called "A Certificate for Meritorious Service."

EISELE:

I went down to their meeting in Miami to receive it.

SLEE:

He also is an honorary fellow of the American College of Hospital

Administrators.

WEEKS:

I have a note that you received that in 1966.

EISELE:

They invited me to their convocation in Chicago and gave me the certificate, and recognition at the banquet and all those things. They probably award honorary fellowships to two or three people a year.

Boone Powell was president, or chairman of ACHA that year.

WEEKS:

Both you and Vergil have been given honorary fellowships in the American College of Hospital Administrators, haven't you? Was it the same year?

SLEE:

Mine came three years later.

WEEKS:

Dr. Eisele, I note that you were also given the Distinguished Service Award by the University of Chicago Alumni Association.

EISELE:

Yes. I wasn't an alumnus, just a faculty member. They gave that to me at an annual alumni banquet.

WEEKS:

The Colorado Medical Society gave you a Certificate of Service. They gave you a master's degree, didn't they?

EISELE:

No, a designation of "master" because of the post graduate programs I directed. No degree.

WEEKS:

Nice though.

EISELE:

Yes, that was a nice recognition in what was a pretty hot town-and-gown situation most of the time.

WEEKS:

Your principal interests now are the Institute?

EISELE:

That's about all I have now. I don't practice medicine; I don't see patients anymore.

WEEKS:

You travel a lot?

EISELE:

Nine or ten months out of the year,

WEEKS:

You should take some time out and enjoy your new home.

EISELE:

That won't be hard to do. Then, I want to visit my seven kids who are widely scattered--every year--have reunions, get them all together. Actually, living alone isn't my cup of tea. When I'm there alone, I get bored. I get a little depressed. Not too much. My friendships are in my work. We have very active sessions eight to ten times a year. That's where my friends are.

WEEKS:

You would miss that if you didn't have it.

EISELE:

I don't belong to any fraternal orders. I don't play golf. I don't

belong to any service club. I am not much of a joiner.

WEEKS:

You have so many interesting things to do it would be a waste of time to do some of those things you mentioned.

EISELE:

I read a lot. I try to keep up on professional things. I regret that I have lost out in much clinical reading. I do get monthly and annual professional publications on which I try to keep current. I also read "who done its".

WEEKS:

That's good recreation.

Dr. Eisele, you were saying there was another committee you were on.

EISELE:

An NIH committee, a committee on biometry and epidemiology. Although I am not in either of those professions, I was in it quite a few years and did many site visits. They were trying to develop biometry for epidemiologists and made grants to schools to develop these kinds of professions.

The executive of the committee was a man named George Kennedy. This was in the 60s. He often called my office to arrange for me to go somewhere on a site visit. I remember once when I was showing an important visitor around the medical school, we walked into my office and my secretary, Mary Koehne, said, "Mr. Kennedy just called from Washington and wants you to call him right back."

I asked, "Was it Jack or Bob?"

She answered, "He didn't say," with a perfectly straight face.

I said, "Let him wait, then." My visitor dropped his teeth.

I went on many site visits with George. I was with him at the University of New Mexico sitting in the chancellor's office when a secretary announced that the President has been shot in Dallas. That site visit ended abruptly.

WEEKS:

You raised an interesting point in my mind. How many events are there in your life that some one could say to you, "Do you remember when...?" I think most of us remember when John Kennedy was shot. I don't remember where I was when Robert Kennedy was shot. You probably remember where you were on Pearl Harbor Day.

EISELE:

Yes. That was on a Sunday. I'd just come out of church.

WEEKS:

Do you remember where you were when Franklin Roosevelt died?

SLEE:

No. I was in the Army then, but I remember where I was when Martin Luther King was shot.

WEEKS:

I remember the day, but I don't remember the first specific report.

SLEE:

I remember two days. I was at a meeting of the American College of Physicians in Boston. That night Beth and I went to the convocation which starts at five o'clock in the afternoon. After the meeting we walked down to the Statler Hotel where we were staying. By the time we got there the shooting of Martin Luther King was on the television news. We got up the next morning and drove home. The second remembrance is that Otis Neumann who was number two at Mass General and I were talking a year or two later. Being a

Bostonian, he said that at the news of King's death, he had called his wife and told her to get in the car with their kids and head out of town, because he was so sure there would be an uprising in Boston. So we have often thought how free of fear we were.

EISELE:

Martin Luther King preached at our church shortly before he was assassinated. Talk about an overflow crowd!

Vergil, do you remember the American College of Physicians meeting in Philadelphia when a group of us were having dinner? Art Strom was with us. I pulled a key that I had bought at a gift shop out of my pocket. It was a replica of the key to Independence Hall. I said, "I have got a key to Independence Hall."

Art said, "Let's go and see if it works."

Five of us jammed into a taxicab and went to Independence Hall, went up to the front door. Art inserted the key. It turned, but it didn't quite open it: I think it was about an eighth of an inch too long. So we went around to the back and walked in the door. We said to the guard, "Did you lose the key to the front door?"

He took the key and looked at it. Then looked at his own key and saw that they were almost exactly alike. He went out and tried it, but it didn't work for him either.

I was on some committees of the American College of Physicians. I would go down to Philadelphia every year in November for committee meetings. ACP sponsored the PAS program so you, Vergil, would go to them, too. I was on an ad hoc committee to try to develop standards that the Joint Commission could use to evaluate internal medicine. To that end, for two summers, I visited

about a dozen hospitals in Indiana where I studied records, and tried to develop criteria. It was hard to come up with specific criteria in internal medicine. We came up with some, but I don't think the Joint Commission ever used them.

SLEE:

They weren't ready for them.

At one of these sessions in Philadelphia, Wes and I shared a room. The telephone rang one evening. It was one of Wes' gangster patients calling him.

EISELE:

His brewery kept me supplied in Chicago. After I went to Denver, he continued to call me with problems. His grandson had received some of the Cutter Laboratories' polio vaccine from the lot that had caused some active infections.

He said, "What should I do? What should I do?"

I told him I had a Public Health Specialist in the room and put Slee on the phone. He asked, "Has he had gamma globulin?"

The answer was "Yes."

Slee said, "He is all right."

SLEE:

That scared me, too, because if the kid did go bad, I figured I was in it also, and they would knock Wes and me both off.

WEEKS:

Chicago was a great city. You were there, Wes, after the Capone era, weren't you?

EISELE:

I was in medical school then and they had the big St. Valentine's Day

Massacre on the North Side, not far from where I was living.

WEEKS:

Chicago really had a bad reputation for a few years.

We used to see gangsters in Detroit because the bootleggers used to smuggle whiskey across the river from Canada into the so-called "down-river towns." We had gangsters: The Purple Gang, and the Sugar House Gang. They used to fight among themselves. I think they warred among themselves rather than on innocent people unless those people got caught in the crossfire. I lived there and was not conscious of anything going on unless I read about it in the newspaper or heard it on the radio.

EISELE:

This patient was trying to be a legitimate business man. He owned the brewery and had other business interests. He owned a hotel up on the Chicago near-North Side and lived in a penthouse up on top of it. One time he had a convulsion and they brought him into the hospital. He had never had one before. I studied him for causes: You always have to consider brain tumors in a case like that. He was about 60 years old. I finally told him we had gone as far as we could go without doing studies where we put air into the brain ventricles and then take x-rays.

He said, "That is brain surgery, isn't it?"

I said, "Yes, in a sense."

He said, "If I have any brain surgery, I want my friend, Dr. Adson, head of neurosurgery at the Mayo Clinic, to do it. I'll go up there next week, and you come along as my consultant."

I said, "I can arrange that."

The next day before I sent him home he said, "I have a better idea. I'll

have Dr. Adson come down here. Then you can meet him at my apartment. I thought he had a fat chance of getting Dr. Adson to come down to see him.

The next week he called me and said, "Dr. Adson is going to be at my apartment for dinner next Thursday. Come and join us, please, and bring my x-rays."

The head of neurosurgery at the University was Ted Rasmussen, who had his training with Adson at the Mayo Clinic.

Rasmussen said, "Wes, if you want to have some fun, take along a reflex hammer and a few instruments, and ask Dr. Adson to examine the patient. He won't do it. He hasn't examined a patient in 20 years. He just cuts where the neurologist tells him to."

Sure enough, after I had given Dr. Adson the case history and the x-rays, I pulled out my bag and said, "I am sure you will want to examine the patient, Dr. Adson."

"No, no, Dr. Eisele, I don't need to. I'll accept your examination. You have examined him and he is all right. I know he doesn't have a brain tumor because he doesn't have headaches."

That was the consultation.

WEEKS:

I wonder what fee he got for the visit.

EISELE:

What would bring him down to Chicago?

SLEE:

What didn't happen to him because he made the visit? A negative fee?

EISELE:

The patient just needed reassurance: "You are all right; you are in good

hands; you have a good physician; you don't have a brain tumor." He didn't need an air study. He didn't have anymore trouble until he died of acute lead poisoning, shot coming out of a restaurant.

He was my patient, and so were his wife and daughter. After he was shot, I dropped a note of condolence to his widow and sent it to the hotel. A month or so later, I was in Chicago and had some time, so I thought I would go and give her my condolences. I went in the hotel and asked for her. They acted like they had never heard of her. She had just completely disappeared. End of story.

SLEE:

You never heard any more?

EISELE:

No. I think I sent her a note and it was returned marked "Unknown."

WEEKS:

She got out of town fast.

EISELE:

She got out of town fast. She originally was from Texas; I imagine she's moved back to Texas.

WEEKS:

Oh, yes.

EISELE:

It was an old grudge that was settled.

Another experience: In my internship, Herman Kretchmer was a urologist. One of his patients was Heber J. Grant of Salt Lake City, the President and Chief Apostle of the Mormon Church. I took care of him for weeks. He had a miserable time. He was a wonderful man and we became quite good friends.

WEEKS:

He was elderly, wasn't he?

EISELE:

Up in his seventies.

Last January in Hawaii at our conference the administrator of the LDS Hospital in Salt Lake City introduced me to one of his trustees. It was Senator Willis Bennett. Bennett, of course, was the author of the famous amendment that led to PSRO. During the conversation I said, "I once knew Senator Smoot from your state. The way I got to know him was that I had Heber J. Grant as a patient in the hospital and Senator Smoot frequently came to visit him."

Senator Bennett said, "It just so happens that Heber J. Grant was my wife's father."

I almost put my foot in my mouth because I was just about to say that I knew his wife's mother too. Then I recalled that Grant had four wives. They made him chief apostle and president when he returned from Japan. I thought it interesting that the Senator was the son-in-law.

WEEKS:

Have you had many Mormons attend your institutes?

EISELE:

Quite a few from Utah hospitals.

WEEKS:

Is their hospital organization much different from others?

EISELE:

I don't think so. They have a large chain but I don't know anything about the organization.

WEEKS:

I see we are getting near the time to close. I really appreciate your making a special trip for this oral history.

EISELE:

I am honored to be asked. This is part of my vacation to visit my friends, the Slees.

Interview with Dr. Eisele at the home of Dr. and Mrs. Vergil Slee, Ann Arbor, Michigan, August 1, 1983. Vergil Slee, MD, was present and participated in the interview.

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