HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Billy G. McCall

BILLY G. McCALL

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPTIAL ADMINISTRATION ORAL HISTORY COLLECTION
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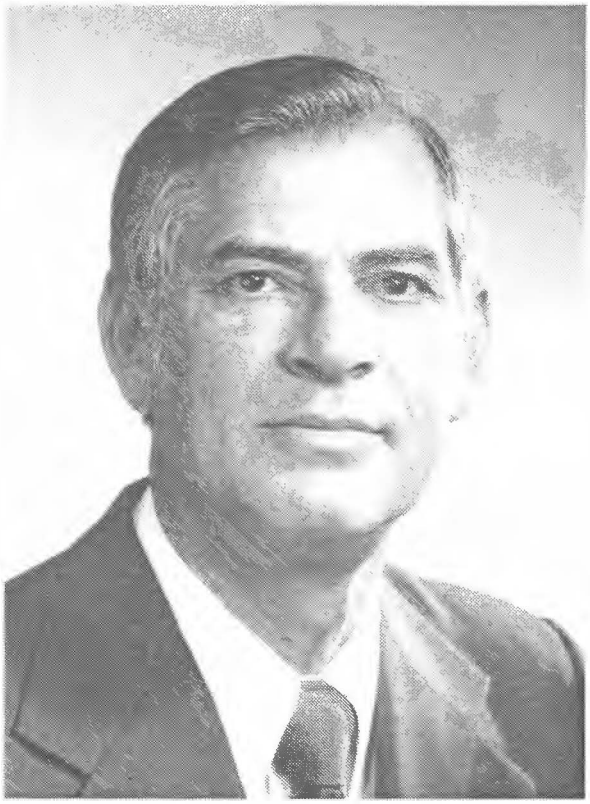

Billy G. McCall

CHRONOLOGY

1928	born in Ellerbe, NC, son of Arthur and Letha Belle Anderson McCall
1950	Clemson University, B.S. (with high honor)
1953	Charlotte (NC) Memorial Hospital, Certificate in Hospital Administration
1953-1954	Anderson (SC) Memorial Hospital, Assistant Administrator
	The Duke Endowment, Hospital and Child Care Section
1954-1962	Field Representative
1962-1966	Director, Management Service
1966-1970	Assistant Executive Director
1970-1977	Associate Executive Director
1977-1980	Executive Director
	The Duke Endowment
1966-1980	Assistant Secretary
1980-1986	Deputy Executive Director, Secretary
1987-	Deputy Executive Director

MEMBERSHIPS AND AFFILIATIONS

American Hospital Association, Honorary Membership

Bioethics Resource Group, Treasurer

Charlotte-Mecklenburg Senior Centers, Past President

Commission on Professional and Hospital Activities,
Chairman 1977-1978

Davidson College, Member Board of Visitors

Kate B. Reynolds Health Care Trust, Member Advisory Board

Lineberger Cancer Research Center, University of North Carolina,
Chapel Hill, Past Member, Board of Visitors

North Carolina Hospital Association, Member

North Carolina Institute of Medicine, Member

North Carolina Medical Care Commission, Member Executive
Committee, Vice Chairman

Presbyterian Home for the Aged at Charlotte, NC, Past President

Queens College (Charlotte, NC), Member Advisory Board

South Carolina Hospital Association, Member

Southern Piedmont Health Systems Agency, Past Chairman

United Way of Mecklenburg and Union Counties, Past member of the
Board of Directors

AWARDS AND HONORS

American College of Healthcare Executives

Honorary Fellowship 1988

North Carolina Hospital Association

Meritorious Service Award 1987

Phi Kappa Phi

National Honor Society

South Carolina Hospital Association

Merit Award 1980

Who's Who Among Students in American Colleges and Universities

Listing, 1950

Who's Who in America

Listing, 1984

WEEKS:

Mr. McCall, in my notes I have you as having been born in Ellerbe, North Carolina in 1928.

McCALL:

That's correct.

WEEKS:

And that you graduated from Clemson University with high honors. What was your major?

McCALL:

I have a Bachelor of Science degree with a major in economics and sociology and a minor in biological science.

WEEKS:

Then you were really preparing yourself for the job you have now without probably realizing that you might be there.

McCALL:

That's correct. I was preparing myself for hospital administration. I started to Clemson shortly after I graduated from high school in 1945. I was enrolled in a program which was sponsored by the army for high school students. It was the army specialized training reserve program. The proposition was that one would join the Army Reserve at the age of seventeen and would be sent to college until the end of the term in which he became eighteen at which time he would go on active duty. At that time, for the duration of World War II, plus six months. The war in Europe had ended at that time, but the war with Japan was still going on. I reported to Clemson in July of 1945. Of course the war with Japan ended in August of 1945. I remained at Clemson until the end of the year. When I returned to Clemson

following my Christmas vacation, I learned that the army was beginning to close and consolidate programs and that they were closing the program at Clemson and I was transferred to VPI. I went to school at VPI for one quarter and then became eighteen and went on active duty.

My army assignment was with a hospital on Guam. It was there that I became interested in hospital administration. So when I returned following my army service -- first of all, I liked it at Clemson and determined to go back there to finish my education. I corresponded with the people at Duke University to ask them what my academic preparation should be for hospital administration. What they outlined was essentially a degree in business. Clemson didn't offer a degree in business, so I sort of structured my own curriculum within the College of Arts and Sciences, with a major in economics to give me the business courses that I needed; in sociology to give me some of the people skills which I felt I needed; and with a minor in biological science I was exposed to at least scientific procedure which I felt I would encounter in hospital work. So, that's the background.

WEEKS:

Just in passing -- I always have a nice memory of Clemson. We once went out of our way to see John C. Calhoun's house.

McCALL:

Yes, on the Clemson campus.

WEEKS:

I will always remember that with great interest.

You are speaking of preparing yourself for hospital administration. In the Carolinas there was the certificate in hospital administration available through hospitals, is that not right?

McCALL:

That's correct. Duke University was probably the first institution in the country to establish a formal training program for hospital administrators. It goes back to the mid-1930s. It was an initiative of Dr. W.C. Davison who was the first dean of the Duke Medical School. He saw the need for specialized training for hospital administrators and he established a program at Duke which was essentially a two year preceptorship in which the student would rotate through all the major departments of the hospital. In the process of that rotation he would learn how a hospital runs and would become somewhat trained to run a hospital. This preceded the graduate degree programs.

There were some other hospitals then that followed, other community hospitals, one of which was in Charlotte. The Charlotte Memorial Hospital. That program was established by Zack Thomas, who was himself a Duke graduate. He patterned his program at Charlotte Memorial after the Duke program. It was a two-year preceptorship in which the trainee rotated through all the departments, worked as a staff member of that department for an assigned period of time. Then as he became familiar with that department's operation he rotated to another department and repeated the process.

So when I graduated from college I applied for a spot in the program at Charlotte Memorial. I received a certificate from Charlotte Memorial. I was in that program for eight months when the Korean conflict occurred and I was ordered back to active duty. I had to withdraw from the program for a year. At the completion of my second tour of military service, I went back to Charlotte Memorial and finished.

WEEKS:

Were there others there going through the course at the same time?

McCALL:

Yes, there were. The Charlotte Memorial program took two students per year. One would come in at about the beginning of the year and the second in mid-year. It being a two-year program, as a rule there were four trainees at any given time.

WEEKS:

Did they have a preceptor who was responsible for the whole program? How did they organize it?

McCALL:

Zack Thomas fulfilled that role himself. He designed the program. He determined the amount of time that would be required in each activity. For example, a student's first assignment normally was in the admitting office. This was a three month assignment. The student came in and sat behind the typewriter and admitted patients, took a regular shift as a regular staff admitting officer. Toward the end of that three month period the student was expected to function almost in a department head capacity, of course under the supervision of the chief admitting officer, so as to gain the management experience. From that point there was a five months assignment in the hospital business office which included cashiering, insurance estimating and billing of accounts receivable, dealing with third-party payors, credit and collections. That was followed by a tour in general accounting and payroll with all of the personnel payroll records, general accounting, financial statement preparation, that kind of activity. The next assignment was in the purchasing department where we spent time with the purchasing agent, worked in

the storeroom as a storeroom clerk to become familiar with the materials that the hospital stored. From that point on the progression through the departments was rather rapid, a month here or six weeks there, rotating through the nursing office, the nursing school, medical social services, outpatient clinics, the dietary department, housekeeping, plant maintenance. So that at the end of that two year period we would have been exposed to every facet of the hospital's operation.

Zack Thomas designed the program. He made some changes from what he had experienced in the Duke program in that the Charlotte Memorial rotation really included more hospital departments. A large portion of the Duke experience was in purchasing and stores. He felt that that was perhaps too long a period and the student needed exposure to other aspects of running a hospital.

Interestingly enough, a part of that training experience, both in the Duke program and in others, was a period of time in which the student was assigned to the Duke Endowment. The Duke Endowment worked out assignments with beneficiary hospitals which hopefully assisted the student in his career preparation, but also it was rendering a service to those hospitals. A hospital administrator, for example, who was going on a month's vacation frequently would contact the Duke Endowment and say, "Could you send a student to sit in my chair while I'm gone?" That was an excellent educational experience for that student.

In my own case, I was sent to a small hospital in Roanoke Rapids, North Carolina. The administrator of the hospital there had suffered a heart attack and was incapacitated for a period of time. My student assignment was to sit in his chair while he recuperated. It was a tremendous learning experience for me. I learned very quickly how far it was from one side of that desk to

the other. The Endowment was involved with that process for the Duke program and other certificate type programs. There were other hospitals besides Charlotte Memorial who had that activity. Rex Hospital in Raleigh; Presbyterian Hospital in Charlotte; I believe James Walker Memorial Hospital in Wilmington produced a few graduates; and the Duke Endowment itself produced some hospital administrators in the early years. It was their practice to bring aboard a trainee who would function as a field representative of the Endowment working with beneficiary hospitals, primarily with small hospitals. They would work with the hospital bookkeepers and medical records librarians principally, and in the process of doing that work they learned a great deal about running a hospital. Typically, a trainee would come in and spend two or three years and then would move out into the hospital. People like J.P. Richardson who was a long time administrator of Presbyterian Hospital in Charlotte came through the Duke Endowment training program, as did Doug Kincaid, who for many years was with the James A. Hamilton consulting group. He received his training from the Duke Endowment.

WEEKS:

How large a hospital was Charlotte Memorial at the time you were there?

McCALL:

Charlotte Memorial was about 250 or 300 beds.

WEEKS:

A good sized general hospital then.

McCALL:

Yes. It maintained a teaching program. It had a medical education program.

WEEKS:

Another question that comes to mind is: Was there any financial support for these hospital administration programs?

McCALL:

Yes, there was. The Endowment's support was largely through arranging for these students to have practical experience which I have just described. But in addition we have been involved in a financial way in some of the programs. Going back to some of the very earliest years and continuing to the present time we are still a very substantial supporter of the Duke University program which is now a master's program. Our records indicate that over the years we have contributed about $1,400,000 to all of these programs.

WEEKS:

This is very interesting. I just happened to learn by chance that Dick Stull had been a graduate of Duke.

McCALL:

Duke University -- the certificate program.

WEEKS:

When I interviewed him before he died he just happened to mention it. I had no idea that this had existed, but this goes as far back as the University of Chicago program does. That was about 1934, and that was the first that really survived. I think Northwestern had one maybe before that. I was amazed to learn from Dick Stull about this certificate program at Duke. I am glad we are able to put this information into the oral history collection because I haven't run across it anywhere else. I don't think it has been mentioned.

McCALL:

I don't remember when that program actually started but I know it had to be in the early 1930s. Mr. Ross Porter, whom you might have encountered, was a long-time figure in hospital affairs in this country.

WEEKS:

He was at Duke, wasn't he?

McCALL:

Yes, at Duke. Another man named Vernon Altvater. I think he came from Oklahoma or Colorado. Ross Porter and Vernon Altvater were the two original trainees in the Duke program.

WEEKS:

I would have to look it up to verify the way it actually went, but I remember Dick Stull telling me that he had a football injury and he was in the hospital and was wondering what to do with himself. He couldn't go out for athletics with a bad knee, and apparently Ross Porter was the friend of a nurse that was taking care of Stull and that's the way they started talking about it. He finally ended up taking the certificate course.

McCALL:

Incidentally, Dick Stull's son, Dick Stull, Jr., was a product of the Charlotte Memorial program.

WEEKS:

Is that right? I didn't know that. I met him casually shortly after his father died. I had no idea. I will have to look carefully at the college directory to see how many I can find that have a significant...

McCALL:

John Rankin was another. You may remember him. He was at Milwaukee for

many years. He was a graduate of the Duke program. And a recent chairman of the American Hospital Association, Jack Skarupa, was a graduate of the Duke certificate program as was Kirk Oglesby, who is the immediate past chairman of the ACHE. He was a product of the Duke certificate program.

WEEKS:

Skarupa is in Greenville?

McCALL:

Greenville, South Carolina. Oglesby is in Anderson, South Carolina.

WEEKS:

It is really interesting what you come across in these conversations, because things are brought to light that I haven't known -- maybe I'm just an ignorant person, but I've been around long enough so I thought I knew most of the things that had happened. I find that I haven't.

I've run across something, too, either in Andy Pattullo's history or somewhere, that the Kellogg Foundation, back in these early days in the '30s, sent people to North Carolina hospitals to take this certificate course because there was no course at Michigan and Chicago was limited to about twelve persons. I hadn't read that anywhere else.

McCALL:

I think what that probably refers to is that from time to time the Duke Endowment would sponsor seminars, or short courses, a week-long seminar to which would be invited practicing hospital administrators. In those days, particularly in the small hospitals, the people who ran those institutions had no formal training in hospital administration. This was an attempt on the part of the Endowment to provide some management training for active hospital administrators.

It generally consisted of intensive bookkeeping type courses, some help with medical records, classification of hospitalization by diagnosis, which was a very important part of our work, which I can describe in more detail if you would like to hear about that.

WEEKS:

What I was going through was trying to cover the period up until you went with the Endowment and then, when we get into the Endowment, if you care to we can discuss the different sections and the duties and responsibilities you have had in various positions, the policies and attitudes and positions that the Endowment takes, and that sort of thing.

After you completed your certificate in hospital administration in Charlotte Memorial you went to Anderson Memorial Hospital?

McCALL:

To Anderson Memorial Hospital as an assistant administrator. I was in this job about fourteen months when I was invited to join the staff of the Duke Endowment which I accepted. I have been there ever since.

WEEKS:

I was going to ask you; when you were at Anderson in South Carolina, that was before Jim Neely came to South Carolina?

McCALL:

That's correct.

WEEKS:

How did you happen to change jobs and go to the Endowment?

McCALL:

I guess it was through my experience as a student on this field assignment which I mentioned that I became known to the Duke Endowment. They

were in the process of discontinuing this trainee program which I mentioned earlier in this interview. So that trainee position was being replaced with a full time permanent employee. I was selected to be that person.

I joined the staff of the Endowment as a field representative and served in that position for eight years. I then became director of management services and then assistant director of the hospital division, then associate director and then finally director of the hospital and child care divisions.

WEEKS:

I would like to go into some detail on those jobs. Could you tell me something about the Duke Endowment and how it came to be? Maybe about the Duke family?

McCALL:

James Buchanan Duke.

WEEKS:

Maybe you could give me some history. I have not run into this anywhere in hospital literature.

McCALL:

The Duke Endowment was established by a trust indenture which was signed by James Buchanan Duke on December 11, 1924. Mr. Duke first made his fortune in tobacco. His father returned from the Civil War almost penniless, but he had stored in the family tobacco warehouse small amounts of tobacco which he and his sons, by hand, processed and packaged in small cloth bags and began to market that product.

WEEKS:

Is this the Duke's Mixture?

McCALL:

That was one of them. I think the first product was named Bull Durham. The business expanded and it ultimately became the American Tobacco Company. The American Tobacco Company, over time, became a virtual monopoly of the tobacco industry. It was broken up as a monopoly in the early 1900's. Mr. Duke then turned his attention to the development of hydroelectric power. He had had some experience with the power industry through a venture in Canada, but he was persuaded by some of his associates to look at the potential for the development of hydroelectric power in the Piedmont Carolinas, centering on the Catawba River which runs through the Piedmont Carolinas. He wanted to develop hydroelectric power as an inexpensive source of energy to promote the development of the textile industry in the Carolinas. This was the bulk of the assets which were turned over to the trust, or placed in the trust at the time it was signed. In many respects, the Duke Endowment was simply an institutionalization of the philanthropic pattern which had been established by the Duke family through the years.

The Duke family, for example, was highly influential in moving Trinity College from Randolph County, North Carolina to the Durham campus. So the pattern of assisting in educational matters was therefore established. All along they had been involved in child care interests through the Duke family's assistance to -- they called them orphanages in those days -- but to child care institutions, primarily through Oxford Orphanage. It was through that institution that the pattern of assisting in child care or of being concerned with matters of child care was established.

The Duke family had been instrumental in the construction of Lincoln Hospital in Durham. So its interest in health affairs and hospital affairs

was established. Mr. Duke had a great appreciation for the Methodist Church. He had a great admiration for the circuit riding Methodist ministers who served small rural congregations throughout the Carolinas, and gave the Methodist Church a great deal of credit for shaping his own character. So these were the fields in which the family had already established an interest.

In establishing the Duke Endowment and in contributing as its major assets large holdings in Duke Power Company, it was his intention for the power company and the endowment to work hand-in-hand. His view was that as the power company ministered to the economic well-being of the region, then the fruits of that activity, through the Endowment, would minister to the social well-being of the Carolinas. He provided in the trust indenture that the Endowment would be active in four fields: in education, through assistance to Duke University, to Davidson College, to Furman University and to Johnson C. Smith University -- those four institutions. Of course the major single beneficiary in the Endowment is Duke University. He provided in the trust indenture for the establishment of a university which would bear the name Duke University as a tribute to his father, Washington Duke. He provided that if Trinity College would change its name to Duke University it could become the nucleus of this new university which would be established. Trinity College, of course, did that and today the undergraduate college of arts and sciences at Duke University is known as Trinity College.

The uniqueness of the Endowment among the large foundations is its limitations to these four fields and its limitations to the geographic areas of North and South Carolina, but this was a very deliberate act on his part and he says in the trust indenture, "I might have extended this aid to other sections (meaning outside the Carolinas), or to other charitable objects

(other than these four fields) but my opinion is that in so doing would be productive of less good by reason of attempting too much." So it was very deliberate to limit it to these four fields and to the Carolinas in order to be able to make a difference to this area and in these fields rather than trying to be all things to all people and really not being able to make an impact.

WEEKS:

I am thinking of Kellogg and their relationship to the Kellogg company -- the Kellogg Foundation to the Kellogg Company. Is there a relationship between the Endowment and the Duke Power Company, the American Tobacco Company now, as far as ownership is concerned?

McCALL:

Not in connection with the tobacco company, but in the case of the power company we still own a large interest in Duke Power Company -- thirteen million one hundred thousand shares of Duke Power which produces about 75% of our income. Our relationship with the power company is not as close today as it once was. Under the tax reform act of 1969, foundations are prohibited from owning controlling interest in a corporation and that has been defined as, I believe the figure is twenty percent of the stock of any corporation. So, since that time the Endowment has reduced its percentage of ownership in the power company, not by disposing of Duke Power securities but simply by refraining from the purchase of any additional interest in the company. So that through the years as Duke Power Company has expanded and issued new stock, our holdings in the company are well within the requirements of the law. It is now something like thirteen percent of the ownership of the company.

WEEKS:

I know Kellogg faced that same problem, and it had a chain of foundations but I think they eventually sold much of their stock back to the company to comply with the law.

Would this be a good time, before we start talking about your activities in the Endowment, to say a few words about Graham Davis for the record?

McCALL:

What I know about him.

WEEKS:

Could we repeat some of this? Was he an accountant or was he an attorney?

McCALL:

Graham Davis, you realize, came considerably before my time.

WEEKS:

Yes, I know.

McCALL:

Although I have met Graham Davis and I knew him in his later years, I never worked with him. My understanding is that Graham's expertise was in the field of accounting.

WEEKS:

I think he worked with Rufus Rorem, didn't he, and some of the other people in the early days of AHA to come up with a chart of accounts or some formal way to approach hospital finance.

McCALL:

Yes, that is true. I think this is a good point for me to talk about the Endowment's role in really developing uniform accounting for hospitals. Then

perhaps we can talk about Graham Davis' role in that. Our contribution to uniform accounting and reporting for hospitals really is rooted in the trust indenture by which the Endowment was established, because the trust says that the trustees may exclude from participation, that is in the Endowment's gifts, any hospital that is so maintained and operated as not to deserve inclusion under the Trust, or so financed as not to need it. In those days, in 1925, there were no standards by which the trustees could make this judgment. We didn't have things like the Joint Commission on Accreditation. So, the Endowment's involvement in uniform accounting grows out of that provision in the trust.

The first director of the hospital division of the Duke Endowment was a man by the name of Dr. Watson S. Rankin who came to the Endowment from a position as the state health officer in North Carolina. From that background in public health, Dr. Rankin was accustomed to dealing with statistics, in dealing with averages which defined a certain standard of performance. So it was his idea to develop a statistical system and draw comparisons between hospitals as a means of assisting the trustees in making this judgment of proper or improper operation. In order to accomplish that, a very detailed annual report was designed which was essentially a complete financial and statistical reporting on the activities that had occurred in the hospital in the previous year. That is what we commonly refer to as our annual application for assistance.

I should tell you that this annual assistance to hospitals is based upon the amount of indigent care which the hospital renders. Under the terms of the trust, that assistance cannot exceed $1 per day for each day that a bed is occupied by patients unable to pay. In 1924, when the Endowment was

established, hospital costs were approximately three to four dollars per day. So that $1 per day was a significant portion of the cost of providing indigent care in community hospitals. Today it is not as significant, but in relative terms it is still a substantial amount of money and amounts to over a million dollars a year which we distribute to hospitals, based upon their indigent care. In terms of underwriting the cost of indigent care it is much less significant today than it was then.

This annual application for assistance which is essentially this annual report, became the basis for assisting the trustees in making this determination. It followed then that if you were to have uniform reporting, you needed to have uniform recordkeeping to produce this report. So, the Duke Endowment developed a uniform system of accounting for hospitals in North and South Carolina. Following the receipt of those applications reports, each year the hospitals were grouped by size and certain comparisons were drawn then as to costs per patient day, broken down by departments as to administration, dietary, housekeeping, plant maintenance, medical records, nursing, pharmacy, things of that sort. They also reported the number of personnel in each of these activities so that any hospital could compare its operation with similar sized institutions throughout the Carolinas. That, to my knowledge, was one of the first efforts anywhere in the country to develop uniform accounting and recordkeeping and reporting for hospitals. The experience in the Carolinas became, then, the basis for some of the later work which was done by the American Hospital Association in developing uniform accounting. It was through that Association that Graham Davis then began to make his contribution to the health field on a national scale. Graham became president of the American Hospital Association in 1948, I believe.

WEEKS:

He was the only non-administrator to ever hold that position too, wasn't he?

McCALL:

I'm not sure about that.

WEEKS:

I think I've read that somewhere. It was quite unusual. He was very prominent in Duke Endowment and then the W.K. Kellogg Foundation, both foundations really benefited from his presence.

McCALL:

That is correct.

WEEKS:

To your knowledge, was he a native of North Carolina?

McCALL:

Yes, he was born in Woodville in northeastern North Carolina.

WEEKS:

I just wondered. The story I heard was that he started working in the New York office and came down to Charlotte from there. I got the impression it was sort of a coming home, that he was from North Carolina.

McCALL:

He was enrolled at New York University just prior to joining our organization in Charlotte in 1925. During World War I he was an officer in the army in France and met his wife in France.

WEEKS:

Is that right? I hadn't heard that before.

Shall we go back to talking about your activities as you took a job with

the Endowment? You originally were in the hospital and child care division?

McCALL:

Yes.

WEEKS:

What were your duties as a field representative as I have you down for your first assignment?

McCALL:

My duties as field representative were really to travel the states of North and South Carolina, working primarily with small hospitals with their recordkeeping personnel in maintaining their financial records, in working with medical records personnel in classifying patients as to service, all of which built in to this uniform accounting and reporting system which I described earlier.

WEEKS:

In the report that you get, your annual report, did you have collective statistics for all of the hospitals in North and South Carolina or just those that you had some connection with?

McCALL:

All of those with which we had connections. I might say at this point that the beneficiaries named in the trust in the health field are not-for-profit hospitals. Because most of the hospitals in the Carolinas were not-for-profit, it was almost the entire universe but not entirely. There were still a few hospitals that were investor-owned or proprietary in nature which were not eligible for assistance from the Duke Endowment.

WEEKS:

How about government hospitals?

McCALL:

Government hospitals were classified as eligible beneficiaries. Those hospitals "not operated for private gain" were the words of the trust.

WEEKS:

That would mean back in those days maybe a hospital owned by a doctor. The proprietaries were not as numerous then as they are now, I don't suppose.

McCALL:

Well, in those days -- I'm not sure the statistics would bear this out -- but I suspect that a great deal of the health care, the hospitalization provided in the Carolinas, was provided in hospitals that were owned by physicians. They were proprietary in nature and not eligible for participation in the Endowment's program. In order to deal with this matter in those early years, several hospitals that were owned by physicians were leased to not-for-profit boards for operation. We did not participate in capital gifts to those institutions, but because the operation of the hospitals was vested in a non-profit community board, they became eligible for this operational assistance, the indigent care program. So, even though some of those hospitals were privately owned, they did participate in those programs. The Endowment was also instrumental in converting some of these facilities from proprietary ownership to community ownership. As time went by and as it became more difficult for individual owners to maintain those facilities and to keep them current in hospital and medical practice, communities began to see the need to develop their own community hospital. The Endowment had a standing offer to those communities that if they wanted to build a new hospital that it would participate in assisting them to build. But recognizing that the medical staff would be key to the success of the

operation of that new community enterprise, we realized that the private hospitals couldn't exist side by side with the community enterprise and see that community enterprise be successful. It really meant that the older privately-owned hospital should close when the new hospital opened. In order to facilitate that transition the Endowment had a standing offer that where this occurred it would contribute half of the appraised value of that proprietary hospital to assist the community board in purchasing it. This made it easy for the physician owners to contribute the other half and therefore enable them to salvage something of their investment and make it easier for them to get out of the hospital business when the new community enterprise started. We did that in a number of communities throughout the Carolinas. Until recent years, virtually all of the hospitals in the Carolinas were not-for-profit in operation.

WEEKS:

In a case like that where they were supporting a new hospital, did the Endowment have any participation in the planning or in setting up some kind of standards as to the kind of services that they were going to provide? I suppose the Endowment worked with a community committee or something to plan the new hospital and the services they were going to provide.

McCALL:

Going back to this repository of data, because the Endowment did possess a great deal of data on hospital operations. The staff through the years has been consulted by administrators, by boards of trustees, even by hospital consultants and others engaged in planning and operating facilities. Up until very recent times we participated in a significant way in the planning of facilities because anyone interested in building a hospital, or expanding a

hospital, would come to our office seeking data on which to project the probable results of building a hospital and operating it. We have a section in the hospital division today on planning and design of facilities. The person who staffs that activity is not an architect; he is a hospital administrator by background, a graduate of the Medical College of Virginia. He had had experience prior to coming to us with the Hill-Burton program on a regional level. It is a standard provision in our capital building appropriations that the plans must be submitted for review by our hospital division. That's not to say that we are so much smarter than anybody else that we know the best approaches to design, but when you are associated with 180 hospitals, you are bound to learn what works and what doesn't work.

One of the things which this section provides is going back and talking with people after a facility is placed in operation to learn what is good about the design and what is not so good. I guess architects and consultants don't bother to do that sort of thing because they go from one job to the next. But that is one service that we can render. Our staff can go back after a hospital has operated for a year or two and sit down and talk with a nurse at a nursing station and say, "What is there about the way this work station is laid out that makes your job easy or makes it difficult?" That puts us in the position of being a clearinghouse of information. We are in a position, through our grant making for capital purposes and through our review of these plans, to pass the good and the bad along to the next one.

WEEKS:

How about community involvement? Of course the board of trustees of the hospital represents the community, but do you have any other contact with the community as far as this followup to see if they are satisfied with the

service that the hospital is providing?

McCALL:

No. That is essentially it. One of the main philosophies of the Endowment is that our interest is secondary to that of the local community. It is their primary responsibility. Just as a matter of principle, in our grant-making we do not go out and promote our own agenda. We don't dangle money in front of people and say, "If you will do so-and-so here is so much money to help you do it." We feel that the responsibility belongs with the local community to make their decisions and have them come to us and say, "This is what we want to do. Will you help us do it?" That is our basic philosophy in all of our grant-making.

WEEKS:

What if you come to a situation where your knowledge is too limited for you to make a decision? Do you have any research or study capacities that you would call in to examine the situation? Maybe not on a formal consulting basis but on a fact-finding basis, let us say.

McCALL:

Our approach to that kind of situation is to assist the community in getting that kind of information. They wouldn't be consultants to us. We have done some of this, where we would suggest to a community that they obtain the services of a consultant and we would assist them in the cost of that consultation. Quite recently, for example, we had two small rural hospitals, each of which was struggling for survival and we suggested to them that the two hospitals go together and employ a consultant to come in and look at their individual situations and make recommendations to both communities as to the proper role which each should fulfill in rendering health services to that

area. The consultant's recommendation was that there be a merger of the two institutions, and those boards are now in the process of considering those recommendations. That sort of thing is not easy to do when each community has pride in its own hospital, and when a role for one is defined which is different from that to which they are accustomed, it becomes a very difficult decision for them to make. Yet, the provision of this outside consultation is a very logical and useful way, I think, to approach questions of that nature.

WEEKS:

Particularly for the Endowment. You don't become involved.

McCALL:

We are not in the position of making the decision or even making the recommendation, but we can assist them in obtaining the help which will enable them to make the decision for themselves which often is the best decision.

WEEKS:

I think I am beginning to get a good picture now of how the Endowment works.

May we go then to your next step as director of management services?

McCALL:

Yes. In the early 1960s the Endowment was approached by a hospital for some help in obtaining the services of management consultants to take a look at their operation and make recommendations to them as to how they may improve. Up to that time, management consultants had not been used to any great extent by hospitals. As a matter of fact, their reputations were not all that good, and there was a suspicion on the part of hospital administrators of management consultants. Frequently when consultants were used the administrator lost his job. Perhaps the fact that the hospital board

felt the necessity of calling in an outside consultant was symptomatic of problems that existed.

In any event, we felt that there was a useful role for management consultants to perform for hospitals. We used this one hospital that came to us for help to demonstrate that indeed management consultants could be helpful to hospitals and that it didn't always follow that the administrator would be fired when you brought in a management consultant. So we engaged the firm of -- Ernst & Ernst at that time, now Ernst & Whinney -- to help us develop a program to assist hospitals with many of their problems. We chose ten hospitals which ranged in size and in characteristics. That is, there were a couple of larger teaching hospitals involved, there were medium-sized hospitals and there were small hospitals. We took this management program into those hospitals to undertake some studies. I had the good fortune of being the staff person from the Endowment to work with the consultants from Ernst & Ernst in doing these management studies.

Those studies concentrated primarily on financial controls -- in two areas. One was on financial controls in terms of getting control of their accounts receivable, getting control of their inventories and the way supplies and particularly chargeable items were accounted for in the hospital. The second aspect of that had to do with the way personnel were used. Ernst & Ernst used a work sampling technique to document how personnel were used throughout the hospital. From that, recommendations were made with respect to staffing and scheduling and matters of that sort.

The Endowment paid the entire cost of this consultation in each hospital. It was a successful program. I think that in our area we did establish the principle that management consultants could be useful. We began to see more

and more of that happening. As a hospital encountered a particular problem they were less reluctant to bring in an outsider to help them solve that problem. Because of my experience with that program, we established an activity within our own staff which we called management services, and I became its first director.

WEEKS:

Did you work with individual hospitals then? How did you purvey your services?

McCALL:

Entirely by request. This activity was almost a continuation of what we had done all along. Beginning with the time that hospitals began to recognize that because we possessed data which would enable them to compare themselves with someone else, our staff was consulted on a wide variety of management type problems, from the way the board of trustees was organized and elected or appointed to the way it functioned in relation to its chief executive officer and to the community, its relationship to the medical staff, that kind of thing. As we developed our own skills in all aspects of hospital operations then we became a resource which hospitals turned to for help. Frequently when a hospital had a change or was facing a change in administrator, the board, the search committee, would come and consult with our staff about what we saw as their need, what strengths should they look for in the person that they would ultimately employ as an administrator. We became sort of a clearinghouse for hospital personnel. Because of the relationship which existed between our organization and the hospitals in the two states, we came to know every administrator very well. We were involved in their training from the time they were a student until they got their first job. Typically,

a young administrator would come into a thirty bed hospital and after a period of two, three, five years he was ready to take the next step to a fifty bed hospital and to a hundred bed hospital and to a larger one. We played a role in assisting communities in finding the right person and assisting individuals who were moving along in their own careers. We never attempt to place people in jobs, but we were a clearinghouse of information. As a board of trustees sought our help in finding a new administrator, we would help them think through what they were looking for and then we would provide them with a list of people whom we thought met the criteria which they established. From that point on the board was responsible for conducting its interviews and making its own selection. We played no role in that, in moving people around.

Likewise, an administrator who felt that he was ready to take the next step in his career would frequently come to us and say, "I want my name on your list, and if the appropriate opportunity comes along I would like to be considered for it." So, it worked both ways. We simply played the role of intermediary in bringing together those who were seeking an administrator and those who were ready to make a change.

WEEKS:

You were speaking about your experience as director of management services in 1962 until 1966. Then you became assistant executive director of the hospital section in 1966. Would you care to take it up there?

McCALL:

As assistant executive director of the hospital section I became more closely involved with the grant-making process. The actual processing of grant requests from hospitals for buildings, equipment, program support. That was the essential change, moving from a consultative role to one closely

associated with grant making opportunities.

WEEKS:

It was a promotion in line when you became associate executive director?

McCALL:

That was more of the same except that as associate director I became more involved in the administrative aspects of running the office. I continued my grant-making activities, but then began to assume administrative responsibility for the management of that division, assisting the executive director and acting for him in his absence.

WEEKS:

Then you became the executive director yourself in 1977?

McCALL:

That is correct. Of course then I became the chief administrative officer for the hospital and child care divisions which was the activity housed in our Charlotte office at the time.

WEEKS:

Shortly after that is when the New York office was closed -- 1979, I think you said.

McCALL:

That is correct.

WEEKS:

In conversation you mentioned the name of a former director of the hospital division. Is there anything you would like to say about former directors that might be of historical significance?

McCALL:

One of the great privileges of my career has been to work very closely

with Marshall Pickens through the years. I, of course, knew Dr. Rankin and was privileged to talk with him on occasion, but he had retired at the time I came on the staff of the Duke Endowment, so for most of my career with the Duke Endowment I have had a close association with Marshall Pickens.

WEEKS:

He was currently the director when you joined?

McCALL:

He was the director of the hospital and child care divisions when I joined the staff in 1954. To the people in the Carolinas, Mr. Pickens was the Duke Endowment. He was a staff member of the Endowment almost from the beginning. He came with the Endowment in 1928 and has been associated with the Endowment continuously to the present time. Mr. Pickens became director of the hospital and child care divisions in 1950 and retired in 1969. However, he was a trustee of the Duke Endowment, as well as being director of the hospital and child care sections, ultimately became chairman of the trustees. He is now chairman emeritus. He remains a trustee at this time. He still comes to the office several times a week and we still have the benefit of his counsel. It has meant a great deal not only to all of the beneficiaries of the Endowment through the years, but it has meant a great deal to the staff personally because he is such a fine, extraordinary gentleman.

WEEKS:

He must be getting quite along in years now.

McCALL:

Eighty-four.

WEEKS:

It doesn't seem so old by my perspective anymore. It's good that he has remained active and feels a part of it. That's very important.

McCALL:

It's a great benefit to us to have his wealth of experience and first-hand knowledge of the history of the Endowment.

WEEKS:

Nearly forty years of experience. That's wonderful.

McCALL:

In reality it is sixty years, from 1928. He has been a part of the Endowment family for about sixty years.

WEEKS:

That's right.

McCALL:

Marshall Pickens was followed by Jim Felts who was on the staff of the Endowment. He became assistant to the director shortly after I arrived in 1954, and then progressed through the same ladder which I described to become director of the hospital and child care divisions which was the Carolinas operation.

WEEKS:

It seems to me that this has progressed effectively because you have been able to raise people through the ranks to take over the executive position. Many foundations go outside and get a new man to come in. I have often wondered if it doesn't sometimes change the philosophy or the goals by bringing in outsiders who haven't had the experience with the foundation in the past. As an example, I was just reading the other day about the Ford

Foundation and how one of the Bundys came in as director and spent a great deal of the capital on projects that were supposed to be futuristic but turned out to be quite expensive and non-productive. It would seem to me that this probably was against all of the original ideas of what the foundation should do. This is one of the remarkable things I see about the Duke foundation.

McCALL:

I think that can work both ways. Of course, outside leadership almost inevitably results in changes in direction or changes in emphasis. In the case of the Duke Endowment, that is less likely to happen even with outside leadership because of the careful prescription in the trust as to the kinds of things the Endowment does. Naming the four educational beneficiaries, hospitals in the health care field, child care institutions in child care, and the rural Methodist church in North Carolina in the field of religion. So, the things that the Endowment does are very carefully prescribed by the trust.

WEEKS:

While you are speaking of the four goals, would you care to elaborate a little more on the child care?

McCALL:

When the trust was established a major social problem at the time was taking care of orphan and half-orphan children. A half-orphan being one who had lost one parent. So this was a provision in the trust. The child care provision was to assist institutions which had been established for the purpose of taking care of orphaned and half-orphaned children. All of the money specified for this activity was available for that purpose. We developed an accounting system, an application in the child care field, just as we did for hospitals. We did several kinds of comparisons as a means of

elevating their standards, their performance. But, at the end of the year the number of orphan and half-orphan days in all of these institutions were divided into the amount of money available for that purpose and simply distributed to the institutions on the basis of that institution's orphan and half-orphan days times this common factor.

As time has gone by, a great deal of changes have occurred in the child care field. The orphan and half-orphan are no longer the major social problem, but there are other problems which have emerged as a result of changes in our society. I think the Social Security Act, for example, which made it possible for a surviving parent to take care of a child, or for family members to take care of children who had lost both of their parents. So we see now the orphan or the half-orphan being a much smaller percentage of the population of these child care institutions. We have attempted to alter our program to meet some of these specialized needs. For example, some of these institutions have completely changed their program to try to serve the mentally disturbed child, the emotionally disturbed child who might be the product of a broken home or some other traumatic event in the child's life. We see those institutions, now, changing their programs to respond to emerging needs in the child care field. We call these institutions child care institutions, simply modernized the term, but we are still talking basically of those institutions which provide twenty-four hour care to children. The same institutions that Mr. Duke called orphanages in the trust, and we have simply changed the name in an effort to be in step with the times, but we are still talking basically about the same institutions.

WEEKS:

I have a couple of questions. One, I talked with Sister Irene Kraus not

long ago about her early life and about the activities of the Daughters of Charity. We were talking about an orphanage that we both knew about in Detroit and how the Sisters were looking at this and thinking they need more space, they need more room to take care of more children, so they apparently got permission from the Church to go ahead and plan for this, and then went to the United Fund or United Way or one of these concerns to get capital help. They were turned down. The United Fund, I think they are called in Michigan, explained that they had no criticism of the Daughters of Charity and the work they had done in the orphanage before, but lifestyle was changing and that unmarried mothers were raising their children with the help of federal funds, so there was no longer a need to put these babies or children in orphanages to the same extent there used to be because the government was supporting the families of mother and child. I don't know whether you have run into that yet or not?

McCALL:

Yes, that is another contributing factor. We also see more effort made now to place children in foster care, to keep them in a family setting as opposed to an institutional setting. More effort is made at adoptive placements. We assist two programs, one in Greensboro, North Carolina and one in Columbia, South Carolina, who have developed significant programs to place hard-to-place children. These are older children who might not normally be candidates for adoption. Placing children in sibling groups -- it is easier to place one child for adoption, but when you are trying to place two or three siblings for adoption it becomes harder. For handicapped children, children with physical or mental handicaps, racially mixed children, and those categories of children who are more difficult to place, we have two agencies

who expend a great deal of effort. We have provided financial assistance to those agencies in carrying on those programs.

WEEKS:

One thing that occurred to me when we were talking about Sister Irene, I wondered what happens under your program in the church related hospitals, not-for-profit. Are they considered along with the non-church?

McCALL:

Yes.

WEEKS:

The cutting point is profit or not-for-profit?

McCALL:

That is correct. In order to be eligible for our assistance they must have some type of tax exempt classification under the Internal Revenue Code, either 501(C)(3) or one of the governmental classifications, a city owned hospital or a county owned hospital, or a hospital authority, all of which would have a tax exempt classification. In the words of the trust it is hospitals not operated for private gain. We interpret "private gain" to mean those with proprietary ownership, invester-owned.

WEEKS:

Is that much of an item in the Carolinas, the proprietary hospital, Hospital Corporation of Americar and Humana and the rest of them?

McCALL:

It is a factor in the Carolinas. A number of communities did turn in that direction to address their hospital needs. Frequently it arose in connection with communities which had aging plants and needed to replace the hospital. The governing authorities didn't see their way clear to finance it with bonds

or county tax funds. They were reluctant to borrow the money needed to do that kind of thing, so they turned to the investor-owned chains to provide the facilities in their community. That has occurred in several communities in the Carolinas.

WEEKS:

I wondered how the policy is developed in the Duke Endowment, how ideas are introduced, who makes the decision, and this sort of thing.

McCALL:

Generally speaking, ideas are developed out of a recognition of a need. That could come from a beneficiary, a hospital or a child care institution, that sees a particular need to be addressed. It might come from some initiative of the state hospital association which would see a need to be addressed. They would present the idea to us, generally to staff. Staff then would do a background study or workup to present the idea to the trustees. The first point of contact would be with a committee of the board of trustees. There is a committee to deal with issues in each beneficiary area, hospitals, child care, rural Methodist church and education. The ideas or proposals are brought from the staff to these committees. The committees thoroughly examine the issue and either support the recommendations of staff or they ask staff to go back and get more information which they feel they need in making a decision. They come to some conclusion with a recommendation to the full board of trustees. When the board approves the recommendation of one of its committees, it then becomes policy.

WEEKS:

Does a staff member have any authority to turn down a proposal before it reaches the board?

McCALL:

Yes, they do. If it is clear to the staff member that a particular proposal or request is not consistent with policy. For example, we get a number of requests from organizations that are clearly not eligible beneficiaries. So the staff simply says, "Sorry, your proposal is not possible for us to support under the terms of the trust." That is an example of a staff member turning down a request without it ever going to the board.

WEEKS:

This is something that is very definitely spelled out so there is no question about their need to refuse it.

McCALL:

That is correct. On a proposal that comes from a beneficiary, the staff might turn down a request if it is part of a program that has already been discontinued. As an example, we have supported over a period of years the hospital's participation in the HAS and PAS programs. I can go into that in a little bit more detail later. That program support was discontinued in 1987, after twenty years. If a hospital now came and asked for support for their continued participation, the staff would say no, because by our recommendation and trustee approval the support for that activity was discontinued. The staff wouldn't ordinarily turn down a legitimate request from a beneficiary in the absence of that kind of direction, because the trustees do set policy. It is our responsibility to carry out that policy. It would be only if we saw a particular proposal as something that was counter to policy that was established. The staff would not take it upon itself to turn it down.

WEEKS:

But you could recommend that it needed more looking after?

McCALL:

Yes. We would do that. As a matter of fact, in many of the projects that come to our board, the staff has been working with the proposer for months or maybe even years before it gets to the approval or the appropriation stage. It is not at all unusual for a hospital to come to us and say, "We are beginning work on a proposal to build a new magnetic resonance imaging facility." They might ask for our suggestions as to places that have a good facility, good functional facility, or architects who have experience in designing these kind of facilities. Then we might refer them to a hospital that has done this, refer them to the architect who was used, whatever help they need. We would begin by working in that preliminary kind of way and we ask them to communicate with us as soon as their project is defined to the point that it can be described, let us know what it is that they intend to do, what their timetable is, the approximate cost. Then as early as possible we take it to our board committee and say, "Here is a project that is developing, we expect it to come to us within the next nine months or within the next two months, or we will bring it back to you next month." Sometimes these projects go, as I say, maybe even over a period of a year or two, but we work along and develop the project to the point that they are about ready to begin and they need their money. At that point then we bring it back to our board committee for their approval, modification, and then on to the board of trustees. We try not to take the project to them until the need for money is imminent, because in our process when an appropriation is made that money is encumbered for that project. We would hate to encumber money a year ahead of its need and having it encumbered so that it is not available to another project which might be ready to start. So, the staff manages that aspect of the thing so

that they don't come to the trustees too quickly. We try to time their presentation to coincide with the actual need for money.

WEEKS:

That seems like a good way to do it.

Has the Endowment any subsidiaries, any corporations such as insurance companies? You don't do anything from an operational level at all?

McCALL:

No.

WEEKS:

Everything is grant money. So you are not bothered about this unrelated business tax?

McCALL:

No, sir.

WEEKS:

The Endowment funds are most heavily invested in the power company?

McCALL:

About seventy-five percent of our assets. The trust indenture requires the trustees to hold that asset except in response to the most unusual and extraordinary circumstances. That security can be disposed of only by unanimous vote of the trustees.

WEEKS:

That probably hasn't occurred very often.

McCALL:

It has not happened at all.

WEEKS:

It looks like this endowment was pretty well planned.

McCALL:

Indeed it was.

WEEKS:

When you look ahead two or three generations and find it still going on, operating well, it is remarkable. Do you see any changes in the Endowment in the future?

McCALL:

Only changes in emphasis.

WEEKS:

Things that may arise that you can't visualize now probably.

McCALL:

If something extraordinary occurred, the trustees could go to the courts and have the basic instrument changed. But as long as the needs are as great in these fields, there is no need to do that. If some event like the nationalization of the health care industry should occur, for example, that would be an event that would be significant to the Endowment. It would not be impossible for the Endowment to deal with it, because the trust provides that the trustees have the authority to withhold funds from one purpose of the trust and dedicate it to other purposes. So if by this event, that is if the health care industry were nationalized so that there was no longer a need for us to be active in that field, then the funds which are available for that purpose under the trust could be dedicated or redirected by trustee action to the remaining three purposes of the trust, or for any like charitable purpose. Even an event of that sort would not paralyze the Endowment, because it is flexible enough that the trustees could deal with that kind of situation.

WEEKS:

This makes me think of the changes that have come about since HMOs. What has been the experience in the Carolinas with HMOs?

McCALL:

Most of them are struggling as they are nationally. I do not have detailed information about that. Any comment that I would make is simply a reflection of my own reading of descriptions of problems. From what I read most of them are having a hard time.

WEEKS:

Including Maxicare, the big one. They are, I guess, on the verge of bankruptcy or trying to prevent it.

McCALL:

One in Charlotte recently ceased to operate. There was one in the Spartanburg area of South Carolina that ceased to operate. We do not have detailed information about those. My response to that is simply conditioned on what I have read in the press.

WEEKS:

Most of us have to depend on that, or watch for the annual report or something of that sort.

How about the effect in the Carolinas of DRGs? Has this affected the financial condition of hospitals?

McCALL:

Yes, particularly the small hospitals. They are really struggling to survive. The DRG gives the hospital so little margin, particularly in the small hospitals and particularly in the rural areas. The Medicare and Medicaid population is about sixty-five percent of a hospital's business in some

places. If the hospitals sustain a loss or even barely break even on those patients, it leaves them very few remaining patients from which to generate enough margin to perpetuate themselves. It is becoming a very serious situation in the Carolinas. We have attempted to respond to that by developing a program which we call our program for small and rural hospitals. It is something that we are going through with the participation of both the North and South Carolina hospital associations.

The major thrust of that program has been to assist these hospitals in engaging in strategic planning. In order to survive, many of them are going to have to redefine their missions and see themselves no longer as acute care institutions but to examine other opportunities which they have to diversify their services as a means of survival. This means getting into the home care business for some. It means developing adult day care programs, certainly developing and emphasizing outpatient services as opposed to acute inpatient, converting some of their facilities to long-term care and that kind of thing. We have assisted these hospitals to engage in that kind of strategic planning which has resulted in some redefinition of missions and changes in programs in order to survive. We have been into that initiative since 1986, and to the present time we have had 39 hospitals in the Carolinas to be engaged in this kind of strategic planning. We define a small hospital, incidentally, as one with 100 beds or fewer. That has been done by 39 hospitals and we have invested over $500,000 since 1986 to assist these small hospitals to engage in this kind of planning and redirection of their efforts. Yes, the impact of DRGs on the hospital, particularly small ones, is severe.

WEEKS:

It seems hospitals are caught between two forces here, the DRGs and the

HMOs demanding lower rates. The hospital has a lower occupancy and a lower income per bed.

McCALL:

That also applies -- not only to HMOs and to the government sponsored cases -- so many of the major employers now are getting into this kind of thing with their own group insurance contracts. They are attempting to negotiate favored rates with the hospitals in the area in which they do business. Of course the threat is always there, 'You either meet our demands or we are going to direct our patients to your competing facility.' So things of that sort are beginning to evolve.

WEEKS:

I am sure you are right in saying that hospitals have to diversify their services in order to survive.

McCALL:

There are people who sincerely believe that a lot of these small "inefficient" hospitals should close. But with our transportations systems being what they are today, our road systems, many of the regional medical centers have developed helicopter service for transporting the critically ill and injured, so there are well meaning people who believe that a number of these small community-oriented hospitals have outlived their usefulness.

WEEKS:

As we mentioned before, it is going to be difficult to sell that idea to all of the communities because there is a lot of community pride in having their own hospital.

McCALL:

There is that. A few years ago I would have said that we simply wouldn't

see community hospitals closing for that very reason. Yet it has happened. I have seen it happen in the Carolinas. We have had several community hospitals close. I always felt that when things really came to the point that a decision was made to close the hospital or have some fund-raising effort in the community or tax support, that that kind of support would be forthcoming rather than see the hospital close. Yet I have seen some communities in which that did not happen and the hospital did close. But I think it is because people do see that they can have access to quality health centers because of improved road systems and other means of transportation which, at least in time, bring them closer to health services than they were at the time the hospital was originally established.

WEEKS:

I think another factor entering here too is the expense for the diagnostic technology that all hospitals want now. I'm sure that in many cases it has been over done. There has been too much technology purchased, the technology team enters into this. The expense is so great there. I'm sure this is one thing to look at. On the other hand, people today want to benefit from the latest technology. They want to have a CAT scan or they want to have whatever imaging of one kind or another.

McCALL:

The issue of quality enters in also. The fact is that if a facility has the equipment and the personnel to do open-heart surgery, by-pass surgery, whatever, the results are better in those facilities that do these things almost routinely than the one that only does it occasionally. So I think the issue of quality is involved here.

WEEKS:

I think so too. The other thing that I am amazed at is the number of transplants that are being done. You read of 14,000 or 15,000 kidney transplants in a year, thousands of heart transplants. I am just amazed. This can only be done in a place that is set up to do sophisticated surgery. It can't be done in a little fifty bed hospital. We have found no way to have referral back and forth, a two-way street. So the little hospital is losing on that end of it too, because people are going into the tertiary hospital for sophisticated care but they are not sent for convalescence back to the small one. Of course, maybe they can't because of DRGs too. We have so many complicating factors here.

McCALL:

That is also an issue of patient preference. A patient who has had a major procedure done wants to stay as close to the fellow who did it until he feels he is safe to make it on his own, rather than the day following surgery to be referred back to a small hospital with his own family physician. I think that there are many cases in which referral back home to the small facility can be done safely and it makes a lot of sense. It not only would help the small hospital for that to occur, but it would also enable the large hospital to concentrate on those things which it does best and not always be trying to expand because it would utilize the bed in the small hospital for that post operative period rather than having to provide that bed on its own campus.

WEEKS:

This idea of where to put the patient has been going on for quite a while. In fact, the way I started at the university was to work on a study of

progressive patient care which back in the early 1960s was a bright idea. Well, it goes back to the referral idea, the transfer of a patient. The doctor doesn't like to release his hold on the patient. He likes to call the shot, which he should of course.

Your support to the hospitals started out at $1 a day. Now you decide on a certain sum of money for all the hospitals and then average it out according to the number of charity patients?

McCALL:

It is still $1 a day. The trust says, "in an amount not to exceed $1 for each day that a bed is occupied free of charge by a patient unable to pay." That money is still distributed on the basis of $1 per day of indigent care. That is a general distribution which is made to all eligible beneficiaries once a year. In addition to that, hospitals come to us throughout the year with requests for special purposes. It could be for capital for building, for renovating, expanding, new equipment, that sort of thing. Or it could be to help support program initiatives.

WEEKS:

One question I wanted to ask you came out of a talk I had with Haynes Rice. He was telling me about...

McCALL:

He had his beginnings in North Carolina.

WEEKS:

Yes. I talked with Dr. Montague Cobb. He is at Howard University. He taught anatomy there for years and years. I think he is probably retired now. He was active in the NAACP. We were talking about segregation and desegregation in the health field. He said everybody was concerned about

getting desegregation but he said he sometimes looks back and thinks it wasn't all a blessing because we no longer have encouraged Negro hospitals. They had a place in the picture. We haven't really encouraged Negro medical schools. There are really only two major ones, Howard and Meharry. Morehouse has a two year program, I guess, and there is one on the west coast -- is it Drew? But he said, "To us who look at it historically there is a little sadness there, these passing." Are there any strictly Negro hospitals in the Carolinas now?

McCALL:

There is only one that is virtually in that category. It is in Greensboro. There is nothing that identifies it as an all black hospital, but in practice that is virtually true. Now, for all the reasons that we have been talking about that hospital has had a hard time surviving. They recently underwent a change of ownership in which private investors, some of which were black physicians, acquired ownership of the hospital and leased it back to a non-profit group to operate. That was simply a means of raising some capital. They are in the process of converting some of their unused acute care space for other uses like long-term care and adolescent substance abuse and that type of program. As they move more into this sphere of activity, my guess is that it will be less and less identified as a black institution.

WEEKS:

It is just a sentimental thing on the part of Dr. Cobb. I just wondered how it worked out.

Haynes Rice told me about the struggle that they had when he was working in all black hospitals back in his early days. Getting the black community behind it. The total picture was nice.

McCALL:

I think the primary justification for the existence of these facilities, at least during my career, has been that it provided a place for the black physician to practice. Many of whom, for whatever reason, could not meet the professional qualifications for staff membership in the "white" hospitals. So the black hospital was a means of providing a place for the black physician to hospitalize his patients. That was the primary reason for their existence. Other than the traditional patterns of segregation.

WEEKS:

South Carolina is really almost the starting point of multi-hospital systems, wasn't it?

McCALL:

That's correct. Bob Toomey and the Greenville Hospital System were among the first.

WEEKS:

You have some more multi-hospital systems now in the Carolinas?

McCALL:

Oh, yes indeed. The Charlotte-Mecklenberg Hospital Authority is another example of the multi-hospital system in the Carolinas. The large central facility is the Charlotte Memorial Hospital and Medical Center.

WEEKS:

Is that the one that Ben Latimer is connected with?

McCALL:

No. He is associated with Sun Health. We are talking about the Charlotte-Mecklenberg Hospital Authority. When it was established, the Charlotte Memorial Hospital was the only facility. As time went by it began

to develop or acquire other facilities like the Charlotte Rehabilitation Hospital, which adjoins the campus of the Charlotte Memorial Hospital. But it began as a separate entity. It ultimately came under the umbrella of the Charlotte-Mecklenberg Hospital Authority.

Another institution was the old Good Samaritan Hospital which was the black hospital in Charlotte. It came under the Authority umbrella and it now functions as a rest home type facility serving all races. It has long since ceased to exist as a black hospital. A chronic disease hospital which started out as a TB sanatorium in Huntersville, still in Mecklenberg County, a number of years ago came under the Authority umbrella as a chronic disease hospital. Then they developed a skilled nursing facility in connection with it. They now operate the mental health facility in Mecklenberg. They recently built a small 130 bed hospital out in the area of the University of North Carolina at Charlotte, a rapidly developing area. That facility becomes a feeder facility for the main hospital. It is developing as a diversified hospital system in its own right.

WEEKS:

You are speaking of the rehabilitative medicine and drug abuse and psychiatric hospitals. I have been interested to observe that some of the proprietaries are going into this type of care because they can make money doing this sort of thing. Maybe the answer is for these specialized hospitals to be connected on a campus, some call them clusters, where they can have all the services available to all the hospitals. They can have their own common imaging center, they can have many things in common that they couldn't afford separately. Maybe that is something in the future that is coming.

You talked about seminars that you had back in the early days. Was the

Duke Forum an outgrowth of that type of thing? Is the Duke Forum something that is ongoing?

McCALL:

The Duke Forum is something that was established by Ray Brown at the time he was director of the program in health administration at Duke. Ray, of course, was interested in education and continuing education for practicing administrators throughout his career. He saw this as something which Duke University should do. It was during his administration at Duke as the chairman of the department or director of the program in health care administration that that forum was established.

WEEKS:

Maybe I am wrong on this but it seems to me that I remember Bob Toomey said that he and you were on the first forum or helped organize the first forum and the topic was multi-hospitals.

McCALL:

I attended, and certainly we played a role, but I don't remember exactly what my role or my involvement was except that I was present. It could be that I did play a part in helping to plan or choose the topic along with Toomey and with Ray Brown. The Endowment has supported that effort practically from the beginning, yet not from the beginning. We supported it with special grants to underwrite the costs of speakers, their expenses -- the expenses of the program. There is usually a meal or two in connection with it and the Endowment underwrote the cost of that program in the beginning. As time went by it became more and more expensive as it cost more to get speakers in, to serve them meals and this kind of thing. Working with Duke we developed a sort of two-stage support. We felt that the conference itself

ought to be self-supporting through registration fees. Duke then established a registration fee to participate. At that point the Endowment said that we would make an annual gift to support the publication of the proceedings so that publication could be made available for general distribution. We still do that to this day. We make an annual gift, now $10,000, which is intended to underwrite the cost of that publication. Whether our gift underwrites the entire cost, I am not sure. We obtain enough copies of the publication to send to every one of our beneficiary hospitals. We see that the administrator and the chairman of the board get copies of the proceedings of those events.

WEEKS:

That's good.

Can we talk about nursing? There are so many things I seem to talk about in nursing such as educational levels for registered nurses, the role of the nurse, the nurse versus the doctor, the nurse shortage, the nurse and other vocations which accounts for the shortage possibly. Could we start by talking about nursing education in the Carolinas?

McCALL:

Yes. This is a problem. I guess nursing education is related to the nurse supply. This issue surfaces from time to time. The last time that a shortage existed, I know that Kate B. Reynolds Health Care Trust in Winston-Salem on whose advisory board I sit became concerned with the nursing shortage and actually made money available through the hospital foundation of the North Carolina Hospital Association to assemble a group of people who were knowledgeable about nursing education issues and to address this constantly recurring nursing shortage and to make some recommendations which might lead to some long-term solutions. One of the first things they did was to look at

the way nurses were educated. At the present time, in North Carolina, we have the two year associate degree in a community college system. There are still a very few of the three-year diploma programs. Then, of course, there are the baccalaureate programs. Graduates of those three programs are eligible to sit for the state board. For those who pass it they are recognized as registered nurses, regardless of the educational track they followed.

This task force worked for a period of a year or so examining what are the skills that we expect the beginning nurse to possess? -- regardless of the level of education the nurse receives, either one of these three tracks. They would need to develop some kind of scheme to enable that nurse who had obtained an associate degree and aspired to a baccalaureate degree to move from that level into a baccalaureate program without having to start over. The career ladder. They did a good job, I think, in defining some of these things that had troubled nursing education for a long time. About the time they finished their work the nursing shortage really ceased to exist. The thing that really improved the nursing supply was the economic recession that we had at that time, the troubled textile industry in which a lot of spouses lost their jobs and the wife who was a nurse could go back to work very easily during that period of time. Well, when the economy picked up and the husband went back to work, the wife dropped out of nursing. But at the time this task force finished its work the nursing shortage was sort of all over because of this economic slump. People sort of forgot about it. Now its being visited upon us again.

I know of the insistence on the part of the professional nurse organizations like the American Nurses Association and others, the insistence of a minimum of baccalaureate preparation for a nurse. I can't disagree with

that, because in today's environment with increasing technology, with increasing complexity of the nurse's responsibility, it is not at all unreasonable to insist on the baccalaureate preparation as the minimum requirement for the profession. Those who achieve that status, however, don't have the same motivation or desire to become involved in a lot of the bedside routines. That, to me, is the dilemma as you upgrade the educational requirements for the nurse then they become less and less interested in the bedside aspects of nursing. Then there has to be some category of person who does that. I don't know what the answer is going to be.

WEEKS:

Do you have licensed practical nurses?

McCALL:

Yes.

WEEKS:

Do you have training for aides to the point where they could do a lot of the bedside procedures?

McCALL:

We do. We do have those classifications, nurse assistants and licensed practical nurses. Each is carefully defined.

WEEKS:

I have found too in talking with people from different hospitals that they find when they hire nurses, unless they come from a local school or local connection, that they may have to have quite a lot of in-service training in order for them to do the procedures that that hospital allows a nurse to do. Another hospital may not allow that same nurse the same privileges, or the same procedures.

McCALL:

That's true in our area too. We find that there needs to be some kind of additional training beyond the baccalaureate to make that transition from the classroom to the bedside. Now I know that there is clinical experience that goes along with the educational process, but by and large, at least in our area, they get that through affiliations between the nursing school and the hospital. By and large the instructor comes with the students to the hospital. They are really under the control and supervision of that instructor and the practicing nurse on the floor. I have talked to hospital administrators who, if they had their choice from the standpoint of floor duty nursing, would rather have a diploma graduate than a BSN, because the diploma graduate has learned more of those clinical skills, practice skills, and is better prepared to go to work on the floor immediately doing bedside nursing than the baccalaureate graduate. Here again, the Reynolds Trust made a grant -- as a matter of fact, we participated in that program along with the Reynolds Trust -- made grants to Pitt Memorial Hospital which is the hospital affiliate of East Carolina Medical School to develop some materials, largely computer assisted instruction to assist young BSN graduates to make that transition from the classroom to the bedside. They did it simply as a matter of retention of new graduates. Some of those new graduates became so frustrated through their inability to assume the duties that they thought they had gone to school to learn. They needed this extra preparation. The computer assisted instruction was to enable the student to work along at her own pace and her own time, the times most convenient to her. It really has been a good program.

WEEKS:

Sort of a continuing education. Is there any requirement in the Carolinas for nurses to have continuing education credits, so many a year or so many every two years? I don't know whether you require it of your physicians, but probably you do your pharmacists.

McCALL:

I think that is the case, but I am not sure. I know that many educational programs are advertised as meeting the criteria for continuing education needs.

WEEKS:

It would seem to me that with all of this advance in technology and the advance in everything to do with health care that continuing education would become a must for many of these professionals.

McCALL:

I agree.

WEEKS:

I still have a pharmacy license in Michigan. I haven't practiced in over twenty years, but I keep my license up and I take continuing education courses. They are becoming so complicated, some of these new synthetic drugs, that I find difficulty because I don't have the actual practice with them. I find a great deal of difficulty in trying to keep up. It would seem to me that every professional is facing the same thing. There doesn't seem to be any movement as far as nurses being required to, to my knowledge.

McCALL:

I do not know that to be a fact either.

WEEKS:

Sometimes when you think of the health situation today, the terrific increase in prices and costs, and the regulations and the DRGs and the HMOs and all of these financial things -- we haven't gotten into unions yet, but we will talk about them later -- it is very discouraging just to think of it. You wonder how we will ever get out of this mess. At least I do.

What about the role of the nurse? We talked about the nurse being prepared for bedside service. What about the master's degree nurse or the doctoral nurse who is a clinical nurse or a practitioner? What about the attitude of the physician toward the nurse? Is this changing at all?

McCALL:

It is hard really to speak to that in very definite terms. I think as a rule physicians are beginning to work better with other professionals as a team. I think generally speaking that physicians do view the nurse as a member of their team. Just as they learned to turn to social workers for certain things, or they view the pharmacist more as a member of the team -- they consult pharmacists regularly now particularly as to the new drugs and the contra-indications in their interaction with other drugs and that sort of thing. So physicians, I think, are having to rely more on other professionals. He is still the captain of the ship, and I think always should be. But I think nurses benefit from that ability to work as a team.

WEEKS:

Maybe this has been a big benefit that has come in with all of this sophisticated surgery and all of these different procedures that take many people to do it. I hadn't thought of it in that term.

McCALL:

I don't think that is universally true. There is still the physician who views the nurse as a handmaiden and when that happens then nurses resent it and I think rightfully so. I don't think that the average nurse views herself as the equal of a physician, but she wants the physician to recognize her professionalism just as she recognizes his.

WEEKS:

I think you have stated it very well.

McCALL:

I am saying "she," but I realize that there are more and more men in the nursing profession.

WEEKS:

That may be a source of more nurses in the future, if we can get some men to go into that. Since the pay scale has been going up in recent years it may become more attractive to men to get into it.

Did you happen to see 20/20 which had the section on nurses in the emergency room? It was on this past week. It was a highly dramatized thing and you would look at it and say "my goodness." It showed all of the cases that were coming into the emergency room. Everything imaginable came at once, which I suppose happens sometimes. Nurses were everywhere. Nurses were running everything. I was thinking, 'where is the physician.' When they started doing triage I thought, 'should the nurse be doing this?' Maybe she is trained to do it, I don't know. As I said, this was a highly dramatized show made basically for the general public.

McCALL:

I did not see this segment, but I suppose the nurse is trained as a family nurse practitioner and probably had the capability to do triage.

WEEKS:

Some of the insurance companies are hiring nurses to work in congested areas where they have a lot of people that they are protecting who can be close to the community and can offer some kind of advice or help without the patient having to go to the doctor.

McCALL:

Yes, get the shots and something like that.

WEEKS:

Maybe the nurse's role is going to change. I hope it does because we need good nurses and they need to be respected certainly.

I have been reading some disturbing figures recently about the financial condition of Blue Cross and Blue Shield Plans. It seems to me that I read that last year there was about a billion dollars reduction in their reserves. There is still a lot of money in the reserves, but if it is going down that is probably a condition that should be looked at. Your Blue Cross Plans always seem to be pretty healthy, but there are some that are in bad shape. There are a couple in New York State -- I think the Albany Plan.

McCALL:

I don't know. I would only know that through reading and I have not read that.

WEEKS:

I wondered if you had been alerted to any problems in the Carolinas.

McCALL:

I am not aware of any acute problems. I have understood that the South Carolina Blue Cross Plan which does sponsor an HMO lost a lot of money on that effort last year. My understanding is that their loss was something that they predicted, so it didn't come as a surprise to them. But the fact that they were willing to sustain losses of that sort to get an HMO going as a means of serving more and more of the population in a larger variety of ways makes it tougher for the other HMOs, particularly the small independent ones, to survive.

WEEKS:

The start up costs must be tremendous.

McCALL:

The Duke Endowment did play a role in the beginning of the Blue Cross Plan, going back to 1935. We made an initial gift of $15,000 and an additional $10,000 a little later for a total of $25,000 to Hospital Saving Association which was the first Blue Cross Plan in North Carolina. As a matter of fact, I have heard some discussion that it might have been the first in the nation. I know that the Texas plan claims to be the first Blue Cross Plan in the nation. The Hospital Saving Association of Chapel Hill I think would be a close second.

WEEKS:

The people who I have read who have tried to trace the history know, of course, Blue Cross didn't come in as Blue Cross until a few years later, but the Texas plan was one of the early ones. There were even earlier programs before that that were either small or unnoticed. It is very difficult to put your finger on who was number one. I don't think Texas was number one if you

included everybody.

McCALL:

The Endowment also made a $4,000 gift in 1939 to the Greenville, South Carolina Hospital Care Association. In 1947 this organization merged into the South Carolina Hospital Service Plan, which was the Blue Cross Plan of South Carolina, and the Duke Endowment contributed another $10,000 to this new organization. Then there was the Hospital Care Association which was a Durham Blue Cross Plan. We contributed some $6,000 in 1957 to assist in the enrollment of rural residents. Ultimately the Hospital Care Association in Durham and the Hospital Saving Association in Chapel Hill merged to form North Carolina Blue Cross/Blue Shield which Alex McMahon served as the first president.

WEEKS:

It looks like you have been in this from the beginning then, the Endowment.

Would this be a good time to talk about malpractice? Is that a problem in the Carolinas?

McCALL:

Yes. Of course the physician community in North Carolina reacts to the crisis as they do elsewhere in the country. I suspect it has become most acute in the obstetrics area which has caused a large number of physicians, particularly family physicians who did obstetrics in small communities, to abandon the practice because they simply cannot afford the cost of malpractice insurance. Particularly when they do so few deliveries. The cost of the malpractice insurance for the few deliveries they do, simply they cannot justify. They can't pass it on to their patients in any kind of equitable,

reasonable way, so there are communities in North and South Carolina who do not now have the services of physicians to deliver babies.

WEEKS:

Are the midwives going to step into this?

McCALL:

There has been some discussion of that for nurse midwives. There are some nurse midwives in use.

WEEKS:

How do they get insured?

McCALL:

I suspect that a lot of the litigation that is going on in this area results simply from a parent who is disappointed with a bad result and wants to recover from somebody and they see the physician as one with deep pockets. I would suspect that they would not see the nurse midwife, at least not at the moment, as having the same deep pockets. So, it is not really worth their effort.

WEEKS:

Certainly she isn't insured with an insurance company that has deep pockets so there isn't the inducement to go to court.

McCALL:

That is my assessment of it, right or wrong.

WEEKS:

I would agree with you. It is a case of conjecture, I am sure, but I would think that.

The next big problem that we can't escape is AIDS. The big cities of Detroit and Chicago and Los Angeles and San Francisco and New York have the

largest portion of that problem, but it must be tipping over into smaller cities and rural areas.

McCALL:

I don't think that the problem is as severe in our area certainly as it is in other areas like New York and Los Angeles. But, I am told that one would be surprised at how much there is already. Last December the Endowment sponsored a conference on AIDS which was not an attempt on our part to deal with the subject the way other groups have. Because of our concern for hospitals, we confined our discussion to the impact of AIDS on hospitals. We didn't get into prevention and public education and protocols for treatment and that sort of thing. We tried to confine our consideration of the matter to its impact on hospitals. We dealt with such things as, of course, the financial consideration. Who is going to pay for the treatment? Some of the legal issues that arise with the physician who is infected with AIDS. What do you permit him to do? How can you restrict his practice? What about the physician or the employee who refuses to serve an AIDS patient? What do you do about that? This was the kind of thing we dealt with in our conference, trying to point out to hospitals what sorts of things they are facing and to give them some guidance and help them understand where they can go for help. Of course both the state hospital associations and the American Hospital Association have put out a lot of material to assist hospitals in that. Perhaps we did some duplication, but we thought that because of the uniqueness of our relationship with our hospitals this might be a service that we could render to them. The program was well attended.

Interesting thing in connection with that conference. We combined two of our interests, because as our hospital staff began to talk about the plans for

that program, our child care director said, "You know, that is a subject that interests the institutions that I am working with, the child care institutions." So we brought them into this conference. We had a separate breakout session at one point in our program for the child care institutions to go and have their own program. But for a good part of the program they were along side the hospital people hearing the speakers and panel discussions and things of that sort. That was interesting to me. It had not occurred to me until that point that this is an issue that is becoming of interest to people in the child care field.

WEEKS:

Yes, I suppose children can inherit it from the mother at birth or in some congenital way.

McCALL:

Drug abuse enters into this thing. The matter of drug abuse is taken up by children. This would be of concern to those institutions. As they become sexually active earlier and earlier. That is a problem as well.

WEEKS:

There doesn't seem to be any way to control it.

I was wondering if you have a role as representing your hospitals in the Carolinas, such as: Do you ever represent your hospitals before Congress?

McCALL:

We are specifically prohibited from doing that. In terms of the lobbying restrictions on foundations. We are not permitted to lobby.

WEEKS:

I didn't realize that you couldn't if you were called.

McCALL:

If we were called, that's a different matter. If Congress would call upon us we could appear, but if we feel that hospitals are not being treated fairly by the DRG or something else, we could not go and lobby the Congress on behalf of the hospitals.

WEEKS:

So the only way you could get your word in is if you were asked to speak.

McCALL:

We have not been asked to do that sort of thing. The hospital associations themselves are quite capable of doing that.

WEEKS:

Strangely enough this brings up another problem. One of the things that AHA is supposed to do is represent the hospitals. This goes back -- it was verbalized back in George Bugbee's days back about 1943 or 1944. But today we have so many -- the voluntary hospitals, the federation of hospitals, the Catholic hospitals, the Protestant hospitals, the multi-hospital systems, even the American College, all are in some way or another stepping forward to represent all of the hospitals. To complicate the matter, AHA is faced with trying to be all things to all people. There are so many splinter groups that don't agree that it must be a terrific job trying to represent all of the hospitals. Then the question comes; If there are all of these different associations -- and I didn't begin to name the state and metro area associations, but literally there are hundreds of them -- if you were recommending to the hospitals in your state about joining... Do they ever stop to think how much it costs them to belong to AHA and the state associations and all of these different things? It is getting to the point

where some of the people I have talked to have said that their group has decided that they should belong to the AHA and to their state association and the other groups they will have to pass by because of the terrific cost of membership. Do you think that is a growing attitude?

McCALL:

I don't know how widespread it is. I know that it is a factor. It gets to be a problem. We faced it in our own organization because, as a means of supporting a class of institutions which are major beneficiaries of the Endowment, we belong to organizations of this sort. We belong to the American Hospital Association, the North Carolina Association, the South Carolina Association. Then there are our own organizations like the National Council of Foundations, the Southeastern Council of Foundations, the independent sector. This becomes a sizable budget item after a while. So we face the same thing in our own operation. I think that the American Hospital Association and the state hospital associations, at least in our area, do a very good job of representing the interests of hospitals as diverse as they are. I know that both the AHA and the state hospital associations have to walk a tightrope to avoid conflicts or taking positions which are supportive of one segment of their membership but might be to the detriment of another. One issue that comes to mind immediately is in the Medicare reimbursement thing, to do with the DRGs. It was the matter of return on equity factor which was allowed to the investor-owned but not to the not-for-profits. Supposedly that was to sort of even the playing field between the two groups. The investor-owned pays taxes which the non-profits don't do. But that put the hospital associations in a very difficult position with respect to that issue. Do they want to lobby on behalf of their investor-owned members to

obtain that or would they side with the not-for-profits who said they are getting a break that we are not. It puts them in a tough spot.

As to their membership in other organizations like the Voluntary Hospitals of America, the Sun Health Organization, those are organizations that produce some additional benefits for them in terms of shared purchasing or all sorts of shared programs and things of that sort. So they are getting another benefit from their membership in those organizations. But the membership type organizations like AHA and the state hospital associations, I don't see how they can keep going much beyond those two things in terms of what they belong to except for those which do provide a benefit for belonging such as breaks in their purchasing.

WEEKS:

You almost have to belong to a buying group in order to exist today, because there are so many competing buying groups where they get special rates. It would seem to me if you were just an individual hospital buying at the top price you would find it very expensive.

McCALL:

A couple of weeks ago I attended the Southeastern Hospital Conference in Atlanta. It is essentially a trade show. They have significant blocks of time reserved for visiting the exhibits. They don't have competing programs. The exhibitors really support the thing. Out of courtesy to them the governing body has said that they won't have any programs to compete with the chance to go to the exhibits. The point I want to make was that I was struck by the changes that have taken place in the exhibits in these trade shows. A few years ago, much earlier in my career, when you went to these things you could see a whole operating room set up with the table and the lights and all

of that business there. I saw almost none of that at the Southeastern Hospital Conference. They had the whirlpool tub that would lift up and stand the patient upright, things like that. But the equipment displays were very limited. Quite a few of them, certainly the majority of the displays, exhibits, were related to the service business-like information systems, automated laboratories, personnel recruiters and things of that sort were the kinds of booths you saw on the exhibit floor and not a whole lot of equipment. I guess the reason for that is because there are these large group purchasers who go to manufacturers and make those deals on behalf of the administrators. So there is less and less need for the administrator to walk around the exhibit to see what is new and what he ought to be buying for his hospital. It is being done in another way.

WEEKS:

It is amazing how these changes are coming about.

I would like to ask you about care for the aged. I noticed that you were on the Presbyterian Home for the Aged, on the board of that.

McCALL:

I was. That grew out of a church obligation rather than because of my work. I am sure that my work had something to do with my being chosen or asked by the church to take on that responsibility. I was president of the Presbyterian Home in Charlotte during its formative stages, first selecting the board and organizing it, buying the land to build it, working with the architect to design and the builder to build it, place it in operation. I was the president of that home for seven and a half years during the formation and start up period.

WEEKS:

What kind of services does this home provide?

McCALL:

It is what we would call today, I guess, a total care or a life care arrangement. It is essentially residential facility. It provides for the congregate living of the elderly. There are a variety of facilities available to do that. The main building contains individual rooms, two-room apartments with one room being a bedroom and the other a living room with kitchen arrangement. There are individual cottages on the site. There are duplexes on the site. Inside the main building, of course, are the necessary supporting facilities like dietary services, meals for the main dining room, recreational type things, crafts. There are two levels of health care. One being a skilled nursing facility which takes care of peoples' needs to the very end. They have some beds which are staffed as intermediate care facilities.

WEEKS:

Ambulatory people?

McCALL:

Yes. Well, they have some ambulatory people whose nursing needs are not as intense as in the skilled facility. Then at one time -- I'm not sure this is still true, because I have been off that board for a while -- there was a section of the living facility in close proximity to the nursing facility for those people who, say during the day, might be able to be up and about but who are insecure at night or who need help with medication and that sort of thing. They moved them from an independent living, one room apartment situation to that in order to be close to the nurses' station for supervision. All of the

rooms, including the cottages and the duplexes, are tied in by intercom so that if a resident gets in trouble in the middle of the night, they can summon help regardless of where they are in this complex of facilties. I expect they have between 300 and 350 people housed. It started off as 105 residential beds and 20 nursing beds.

WEEKS:

Is there medical care available too, or do you have to have your own doctor?

McCALL:

That can be done both ways. They do have a medical director. He has two levels of responsibility. One is an administrative responsibility to the home in terms of its health care policies, supervision of the nursing staff, the quality of care in the institution. Then that physician would be available for any unassigned patients. Many of them come from the Charlotte community and they have had their own Charlotte doctor who has looked after them for years. That Charlotte physician follows them right into the home and continues to be their physician. For those who don't have that kind of an arrangement, then as a practical matter the medical director, which I believe is a contractual arrangement with a medical group, provides care for them. Even some of those who have their longtime physician simply, as a matter of convenience, will switch over to the home doctor, because he is out there anyway seeing other patients. It is not easy to get a physician, even though it is for a longtime patient, to come from his office out to this facility.

WEEKS:

How is this financed?

McCALL:

The home, as far as I know -- did not when I was president -- did not take Medicare assignments. Persons receiving skilled nursing care, at whatever level, paid the same rate as a resident of the home. Obviously the rates had to be sufficient to enable the home to build up a reserve for the provision of this level of care when needed. The home has been in existence for about twenty years, and it got to be a burden on the home as more and more of the residents moved to skilled nursing. In its young days the skilled nursing was not a major factor in its operation. As time has gone on and as the population has aged, more and more of them have migrated to that nursing level. So whether or not they can continue to sustain that on the basis of the same rate I am not sure. I have an idea that maybe there is a cost plus, a residential rate with a plus factor when one goes to the skilled facility.

WEEKS:

Some places charge maybe $75 a day extra if you go into to the area where nursing is necessary.

McCALL:

There is a new such facility being constructed in Davidson. It really is an outgrowth of an interest of some faculty and staff people at Davidson College. A lot of those people belong to the Davidson College Presbyterian Church. The initiative grew out of the church. They are establishing a retirement community in Davidson. I am not on that board, but I have been serving on a health committee which was charged with the responsibility of overseeing the design of the health facility, establishing its policies for operating the health facility or recommending to the executive committee. I have kept in touch with that through that connection. At a meeting last week

we talked about rates. They will have a differential rate in their skilled facility, over and above the residential rate.

WEEKS:

I am interested in looking into this life care. I have some material that Howard Berman sent me from Rochester Blue Cross which is selling a new kind of insurance. I don't know how common it is. I am at an age now where naturally I look at retirement homes and wonder what is going to happen to me in ten years. Many, many people are not going to be able to afford this kind of thing because some of these would run $1700 or $1800 a month plus the second person may have to pay $1000 a month. Most retired people either don't have that money or they are afraid to use what money they have because they might run out of money. From your experience on this retirement home, do you see any improvements that have come about other than selling insurance at an early age? Or beginning Social Security tax at an early age?

McCALL:

Are you asking me if I see any improvement in the ability of older people to avail themselves of this kind of facility?

WEEKS:

That or can we provide the facilities that they can avail themselves of?

McCALL:

I think we can have facilities for much less than we are doing in some of these. I know at Sharon Towers, the home in Charlotte, we have the same arrangement. The figure was not nearly as high as you named but it depended upon what you were getting. If you were going into a one-room apartment, I think the initial founder's fee was $12,500. For two rooms it was twice that. If you had a couple who were going in and wanted a two-room arrangment with a

living room and a bedroom and a small kitchen, it was roughly $12,500 a room. We had one or two three-room units with a living room, sort of a den arrangement, and a bedroom. Beyond that we went into the cottages. If somebody built a cottage they, the original owners, were responsible for paying for all of the construction. The design had to meet the approval of the home. It reserved the right to approve the design, the size, the layout, the safety features and all of that, but the initial owner paid for it and the facility belonged to the home. When the original owner no longer occupied it, then the home simply sold it to the next one. That was a way of generating the capital to pay off the loans that we obtained to build.

WEEKS:

How about the monthly fees for living there?

McCALL:

The monthly fees were designed to roughly cover costs.

WEEKS:

They had food service and recreation and so forth.

McCALL:

Right. Now, I said I think we can build these facilities for less than we are doing. The reaction that a lot of our initial residents had at Sharon Towers was, 'Boy, this is a plush place.' I've been told that there is similar reaction to the Pines that Davidson has established. They have people look at it and say it is far beyond anything they think is necessary. What you really need for elderly people is something that's safe, that's reasonably attractive, but you can do that for a lot less money than this. Of course the tendency is when you hire an architect to design something he wants to make it as attractive and as pleasant and all those things as he possibly can. You

sort of get caught up in this thing and the next thing you know it takes a $90,000 entrance fee.

WEEKS:

Some of these places are very lush.

McCALL:

I think we can do more of developing modest cost facilities for the elderly.

WEEKS:

So people can afford them.

Do you have any opinion on the mandated insurance plans, all the way from Kennedy and Dukakis?

McCALL:

There is no question in my mind that if I had my preference I would like to see as much of this health care system stay in the private domain as possible so people can do things voluntarily because it's right. Employers do things for their employees because it's right. I realize that that might be idealistic. I think that any kind of mandated coverage, like the Kennedy plan or like the Massachusetts plan, of course is immediately opposed by particularly the small employers and for good reason. A lot of those businesses are operating on a hand-to-mouth existence. When government imposes one more thing they either price their service or commodity out of business or they simply say that is one more cost which I cannot absorb and I have no choice but to go out of business. Either that or they lay people off instead of employing as many people as they can. They say that is something that I can't afford so I will have to lay off one employee here or two employees to make ends meet. In which case then you worsen the unemployment,

that's part of the problem. I see these kinds of things associated with it. As much as I hate to admit it, I sometimes think there is really no answer to this whole business of affordable and unrestricted access to health care but some kind of a national scheme.

WEEKS:

It seems that way. Another point that enters in here to complicate things is that we expect too much. If we have insurance coverage we use it whether we need to or not. I grew up when you didn't go to the doctor unless you had a pain. We have friends that just use doctors' services ten times as much as I think they need.

McCALL:

I agree. I observe that too. Frankly, I don't want to waste my time sitting around in his office waiting to be seen. I don't understand the mentality of the people who are always looking for an excuse to go to the doctor. That is not the way I was brought up, and it's hard for me to understand that and yet I know it happens. The more I look at this thing the more I reluctantly come to the conclusion that I don't know how you can ever really level out this playing field without some kind of a national scheme. And I hate to think of that.

WEEKS:

I hate to think of it too. I have seen it work in England, and I don't think it is quite as bad as the publicity it gets. Of course Americans probably wouldn't go along with the English system.

McCALL:

I have been over there too and have observed it. My observation on the basis of the three weeks I spent there is that I think they do a better job of

primary care than we do. Each physician has his panel of patients for whom he accepts responsibility for their primary care. Then they are referred to the hospital for what they call specialist's care. I don't think they do as good a job of that as we do. Even with the British system health care is rationed through the queues, the waiting lines that they have for elective surgery, and through the things which they've defined that after a certain age, as a matter of policy, a person is not a candidate for kidney dialysis or a hip replacement, or a variety of other things. In spite of the fact that they have a universal health plan, it has its rationing schemes just as we do ours. We do it strictly on the basis of economics, whether you can pay for it or whether you can't.

WEEKS:

Ours is a little more subtle maybe.

I think I will jump ahead and ask you about a few of the things that I find you are affiliated with and maybe you can answer shortly. I am not familiar with the North Carolina Medical Care Commission.

McCALL:

The North Carolina Medical Care Commission is a state agency that was established in the early days of the Hill-Burton program to oversee hospital construction, allocate the funds under the Hill-Burton program. Over time it has become the agency that is responsible for licensure of all the hospitals, the nursing homes, the ambulance service, the helicopters. It has become the licensing agency for health facilities.

WEEKS:

Certificate of need?

McCALL:

Well, the certificate of need is in the big department in state government, the Department of Human Resources. The Medical Care Commission is a state commission which operates under that umbrella. The state health plan, the certificate of need, all of that operates under this big umbrella called the Department of Human Resources. The Medical Care Commission has specific responsibilities for licensure, promulgation of regulations pertaining to the safety and meeting licensure standards. We have a tax-exempt bond program in North Carolina whereby hospitals or health facilities can apply for tax-exempt financing. Those bonds are issued in the name of the state with the full faith and credit of the state behind, but in reality the hospitals or the health facilities pay back these tax-exempt bonds through their own operation. The Medical Care Commission oversees that program. We have a pool fund for lending low interest money or tax-exempt monies to hospital for minor things like equipment purchases where you don't want to go to the expense of a bond issue and so forth. But the state issues bonds for a pool of money and then hospitals can draw from that pool for relatively minor things without going through the financial feasibility study and all of the stuff that goes into a bond issue. That is what the Medical Care Commission does. It is by gubernatorial appointment.

WEEKS:

Did you serve on the Perloff committee?

McCALL:

No.

WEEKS:

Another concern I have come across, and I don't know whether it has

occurred in the Carolinas or not, is the hospital research and development institute. Are you familiar with that?

McCALL:

No.

WEEKS:

What it was: a group of administrators got together with a group of medical equipment and drug companies and said we will try out your instruments or your medications or something and report to you on a fee basis, or it may have been financed by these companies paying a certain amount of money into it and then as a benefit they received this service of product examination.

McCALL:

No. I am not familiar with that at all.

WEEKS:

I didn't think it was terrifically ethical, because I think the administrators were benefiting from it themselves.

The Bioethics Research Group.

McCALL:

Each year, we at the Duke Endowment attempt to -- we have sort of drawn the two state hospital associations into this as co-sponsors with us -- we attempt to address a single issue which we think is important to the health field in our area. That was started in 1984. The issue we chose to address that year was ethics, bioethics. With the increasing complexity of health care and with our almost unlimited ability to keep people alive through artificial means we felt that the time had come to begin to try to develop some sensitivity at the community level to the issues involved in that kind of thing. Who makes decisions about whether to withhold treatment, whether to

stop treatment, or whether you go full bore when the situation is hopeless, promote living wills and that sort of thing? What we tried to do was to stimulate local thought on that issue. I think it is too important to be left entirely to the medical profession or to the legal profession, the courts, to make all of these decisions for us. I think people ought to think about it and from their own values, from the community values, begin to formulate some positions that have an influence on the medical and legal systems in that regard.

So, in 1984 we sponsored this conference on bioethics. We had Fred Friendly, former president of CBS News to come down. You know he did the series on the Constitution on public television. I don't know whether you saw it, but it is the same program format that we put together for this ethics panel. It was through the use of case presentations that we began to develop some of these ethical themes. We invited to that conference people like boards of trustees from our hospitals in the Carolinas, educators, people of that sort, legislative people, city councilmen, county commissioners, people who we thought ought to be sensitive to these issues. Then we announced a program by which individual communities could develop programs in their own community in their own way. Some of them took the form of town meetings, some panel discussions, some video productions and things of that nature. But in the last four years, we have sponsored those programs in thirty communities over the Carolinas and we have devoted $500,000 to the support of those things.

In addition, we have done a one-hour documentary ourselves which has just been completed. It hasn't been shown yet. We hope to get that on nationwide television. It dramatizes, through people's own stories, the issues. The

bioethics group was a group in Charlotte which was formed as an outgrowth of this program. The county medical society took the major initiative in forming this group, but it consists of physicians; nurses, many of whom are involved in the critical care, intensive care, neonatal care; clergy, both hospital chaplains and parish ministers; we've got a couple of lawyers. The media is represented, both the print and video, top executives in a local television station and the Charlotte Observer, our major newspaper. That is the mix of the group. We meet once a month and discuss, usually around a case presentation. We tried to promote in the community a standard approach to DNR, do not resuscitate orders, so that if a doctor in our community writes a DNR order on the chart the same response will take place in any hospital in the community. We've been trying to get that through. We've done some educational programming. Last year we brought in Dr. Ed Pellegrino from Georgetown University. We used him in a variety of ways -- grand rounds at Charlotte Memorial Hospital, consultation with the hospital ethics committees, a community-type forum presentation. Those are the kinds of things that the bioethics group does.

WEEKS:

I think it is really a necessary step to be taking now. So many of these questions are bothering people.

The North Carolina Institute of Medicine?

McCALL:

The North Carolina Institute of Medicine was formed by an act of the legislature about three or four years ago. Its purpose is to do, on the state level, things similar to what the National Institute of Medicine does on a national level. The state's motivation in creating this was to establish a

body which could advise the legislature or committees of the legislature, state government, in an unbiased way on matters affecting health. An example of something they've gotten behind is the whole matter of financing indigent care in North Carolina. That's a long story, and I won't get into it since we don't have time, but there are about five or six foundations in North Carolina that sponsored a study of indigent care in North Carolina to investigate the magnitude of the problem in terms of how many people are involved who are now underserved; a look at the uninsured population in North Carolina, how big is the population, what it would take to get them included; what are some of the techniques that could be used to serve these people, either through state appropriated funds or some other technique. The foundations sponsored that kind of a study. A legislative commission was appointed to really dig into it and to develop the necessary legislative remedies for the state to deal with this. The Institute of Medicine acted also as a resource to that legislative body. It is addressing now the problem of infant mortality, which is a serious problem in our state. It is looking into interventions for the elderly, what may be done to avoid unnecessary institutionalization of the elderly. That is the kind of organization it is. It is largely funded by state grants, but we are attempting to develop a more independent means of support because there is a feeling that if you get all of your money from the state government, it is difficult to be independent in advising state government. So we try to develop as much independence as we can by seeking more diversity in funding.

WEEKS:

Gordon Gray was president of the University of North Carolina about the time you came?

McCALL:

I guess that's right.

WEEKS:

It isn't an important fact. It's just that about this time he was chairman, I think, of the commission on financing hospital care, the one that Graham Davis headed.

McCALL:

I guess I was a student at Charlotte Memorial while that was being done. I remember as a follow up to that there was a similar program in South Carolina which Charlie Frenzel headed up. He used to be the head of Duke Hospital and was head of the program in health administration at Duke at one time. He is now retired. He was at Philadelphia at a Catholic hospital for a while. His last job was in Florence, South Carolina. He built a new hospital and started it.

WEEKS:

Is there anything you would like to say about Alex McMahon that you haven't already said?

McCALL:

I don't know of anything. Of course, we felt that Alex was the right man for the job at the time at the AHA. We felt very proud that a person with his North Carolina connections was chosen to head the American Hospital Association at a very critical time.

WEEKS:

It is a strange thing, but I understand that McNerney felt that if he were appointed to AHA he would recommend Alex to succeed him at BCA.

McCALL:

Is that right?

WEEKS:

It turned just the opposite.

McCALL:

I never knew that.

WEEKS:

Anything more you would like to say about Dick Stull?

McCALL:

No, I never had very close contact with Dick Stull. In the earlier years of my career Dick was out in California. So I did not get to know Dick except for having met him. I met him at AHA meetings. I got to know him better, I guess, as the chief executive of the ACHE, although I am not affiliated with the ACHE.

WEEKS:

I just took it for granted that you were.

McCALL:

No. Earlier in my career when I might have pursued that kind of thing people who did the kind of work I do were not eligible. It was a hospital administrators' society. I don't know when the change came about, when they changed it to make people like myself eligible...

WEEKS:

But you had been an administrator.

McCALL:

Only for a short time. It was really odd that in my role -- I have explained the consultative type thing that we did -- I was acting as a

consultant to hospital administrators and yet was not eligible to belong to their society.

WEEKS:

Is there anything more you would like to say about Bob Toomey? We mentioned him.

McCALL:

I have a great respect for Bob Toomey. I think he has been one of the real forward thinkers of our time in terms of developing the systems approach to health care in his community. I admire him as a teacher. Probably the thing that Bob enjoys more than anything else is teaching. Even his approach to management was almost as a teacher. Any time that I have had contact with him it was while he was either teaching his staff or teaching me or my associates. I think that is the role he enjoys.

WEEKS:

He is still teaching, isn't he?

McCALL:

He does some work as a adjunct professor at Duke.

WEEKS:

I enjoyed talking with him. I hadn't met him previous to talking with him. Another resident of North Carolina whom I have not met is Cecil Sheps.

McCALL:

I know of Dr. Sheps, and I am sure I have met him on occasion but I have not had close enough contact with him to really speak of.

WEEKS:

He is so research oriented that he probably wouldn't get into the operating side very much.

A man I enjoyed meeting two years ago who is now retired is Dr. Mayes -- the School of Public Health at North Carolina. Do you know Frank Groner?

McCALL:

Frank Groner from Tennessee? I have met him. I can't say that I know him. I have certainly met him and knew him as a matter of his reputation for being one of the leaders of health care in the early years of my career.

WEEKS:

I hope to talk to Frank in the next couple of months.

A couple of things I skipped over before that maybe we could talk about. Do you want to talk about the Lineberger Cancer Center?

McCALL:

The Lineberger Cancer Research Center is a facility on the campus of the University of North Carolina at Chapel Hill. I became involved in that operation as a member of the board of visitors, by invitation of a fellow member that the cancer center might be something in which I might have an interest. I did participate for two or three years. I have a great deal of respect for what they are doing but really the function of the advisory board or the board of visitors was to raise money. This is not a task in which I am extremely comfortable. I am entirely comfortable on the other side of the fence, but I am not very good at fund-raising. While I admire and respect a great deal what they are doing I felt like it was not the kind of thing that I wanted to continue to do.

WEEKS:

I don't think we should leave without talking about the CPHA and Vergil Slee and the value or not of the data bank they have.

McCALL:

Yes, I have that on my list too. I've explained to you already our early involvement in statistical accumulation. About the time of the advent of Medicare, about 1966, our hospitals seemed to feel the need for more timely comparative data than we were providing to them on this annual basis which grew out of their annual application process, which I have described early in this interview. They asked us to consider a more frequent reporting arrangement. At that point we had to make a decision about developing a massive computer system to pull together information from 180 hospitals and digest it and furnish it back to them on a monthly or even quarterly basis. We had to make a decision what to do about it. Frankly, we were reluctant to get that involved in that kind of operation. Typically, our style is to assist others to develop capability rather than pulling it unto ourselves and developing the capabilities internally.

We decided to support existing systems as being preferable to developing our own in-house capability. We turned at that time to HAS, Hospital Administrative Services of the AHA program, to provide timely administrative and financial data. We turned to PAS to provide clinical and quality data. The proposition we made our hospitals was that we would provide them full reimbursement for their first three years of participation for any and all hospitals who chose to participate. Then we would reduce that level of support at 10% per year until we were sharing the cost equally. So from 1967 to 1987, we ran that program in that way and in that period of time, twenty years, we spent a total of $1,650,000 to support our hospitals' participation in HAS and $4,625,000 to support their participation in PAS. That assistance was terminated last year after twenty years. Frankly, both programs had

become so diverse and so almost menu driven. When we first started, there was one HAS type report and there was only one PAS type report. Then they both began to diversify their programs so that there were a lot of add-ons. There was really no way that we could be equitable in the way we administered this program when each one was sort of menu driven and the hospitals could pick from the menu whatever they wanted.

Too, our style is not to support something in perpetuity, but to help it get started, let it demonstrate its value, and if it is worth anything they will pick it up themselves rather than our continuing to support it. After twenty years we felt it was time to terminate that support.

WEEKS:

I have often wondered, on the PAS particularly, how much the hospital administrators use their reports.

McCALL:

I'm not sure that the administrators used it a great deal. I think it was an excellent tool for the medical staff to use. I would describe it as a statistical approach to measuring the quality of care. I describe it as purely a statistical approach. It is an indicator. It doesn't define quality. But it points to some things which do indicate quality. I think that when properly used by the medical staff it was an extremely valuable piece of work. I think the administrator who failed to try to motivate his medical staff to use the data missed a good bet. I thought there was valuable data there. Sometimes the medical staff just needed motivation, needed an offer of assistance, to be properly educated in its use, its significance. But it is an interesting thing, once physicians really got on to what was there, they became enthusiastic supporters of it. The physicians who served

on the CPHA board at the time I was on it were all enthusiastic about its value.

WEEKS:

That has always seemed to me to be the weakness of most data collection systems. They don't have a mechanism for applying their research where it should be applied.

McCALL:

I think the approach to medical audit which was made possible by PAS really was -- if the physicians could have been made aware of how much time it would save them. I see no reason really to waste your time on doing detailed medical audits where the indications say there is nothing wrong. If you establish a certain protocol and it shows up statistically that a patient with diabetes, for example, didn't get a fasting blood sugar, if that was a part of protocol, then that abstract would pick that up. It was a technique of looking at the exceptions and asking why. If that patient didn't get that test he was supposed to get then why not. So you concentrate on things like that instead of the things that went the way they were supposed to go.

WEEKS:

Are there any things on your list that we didn't talk about?

McCALL:

A few.

There is a list of things in which the Endowment has been involved during my career which I consider to be significant events. This is how I have compiled my list, most of which we have already talked about.

One of the things which we did was to assist both of our state hospital associations to develop a full-time staff. When I first came with the

Endowment the association activities were carried on purely by volunteers. There was no full-time staff, no headquarters. The offices simply rotated from year to year and there was nothing really to pull the activities of the associations together. In 1956 the officers of the North Carolina Hospital Association came and asked us to assist them in establishing a full-time executive office, consisting of an executive and a secretary in the beginning, to rent a little space for a headquarters and to begin a full-time association operation.

The South Carolina association followed one year later in 1957. So we did the same kind of thing with them.

Typically our grant pattern was to pay most of the cost of the new program the first year, a lesser amount the second year and a smaller amount the third year. This approach gave them the opportunity to adjust their dues structure gradually to assume the cost of that operation without doing it all at one time.

We've assisted as these two organizations have developed their own capability through the years. We have invested $4,700,000 in those two associations to assit them in developing their own programs, building their own headquarters buildings and things of that sort. They both are very effective organizations today.

We could have done a lot that the hospital asssociations began to do in terms of the educational programs and things of that nature -- we could have done that in-house by simply adding to our staff and doing those things. But, I mention once again, our style is to assist someone else in doing that instead of taking it upon ourselves. This is a significant contribution to the health scene in the two states.

Another thing which I think is significant is our encouragement of the development of graduate medical education programs in community teaching hospitals as a means of improving the distribution of well trained physicians. We have been told, and I have read in a number of cases, that the place of residency has a greater influence on the practice site than the medical school that the student attended. They tend to establish relationships during the residency period which become lasting. A medical student from Pennsylvania who goes to UNC and does his residency at Charlotte Memorial is more likely to practice in Charlotte than to go back to Chapel Hill or even to Pennsylvania.

So we saw this, the development of good graduate medical education programs in key community hospitals around the Carolinas, as a means of encouraging a better distribution of well-trained physicians. Between 1962 and 1978 we assisted thirteen hospitals in the Carolinas to do that. We committed $3,730,000 in the process. The typical pattern was to assist the hospital to employ a full-time director of medical education, to get it off the ground. Prior to that time it was just like the hospital association, the person who headed the teaching program was a volunteer activity which was passed around to members of the medical staff on some kind of rotating basis. We were convinced that the most effective way to strenghthen that activity in the hospital was to employ a full-time director and make him or her responsible for educational activities. Typically, after the director of medical education was firmly established, the next step was 'we need help in employing full-time heads of our major clinical departments like internal medicine, surgery, OB/GYN, pediatrics. So we helped them with the employment of full-time clinical directors and in that way strengthened the graduate medical education programs.

Now at Charlotte Memorial, for example, they have an affilitation with the University of North Carolina School of Medicine, and they have junior and senior medical students who come down and take part of their educational experience. I think that was a significant thing that we did.

A corollary to this: we supported summer internships for junior and senior medical students to work under the tutelage of community physicians. This was a program that Dr. Davison wanted to do while he was dean at Duke. He said, "You leave these students around an academic medical center all of the time, and the faculty and department chairmen will talk them into staying around the medical center to do research and teach. What we want to do is train physicians to go out and take care of people." He said that one way of overcoming this influence of the academic medical center was to let these students get out in the community and see what community practice is like by following around a family doctor during the summer of his junior and senior medical school years. So we did that. I don't know how many individuals were involved, -- we were involved in that program about six years, from 1961 to 1967 -- there were 39 hospitals that participated in that.

I mentioned earlier today that in 1975 we joined the Kate B. Reynolds Health Care Trust and the Z. Smith Reynolds Foundation, both North Carolina foundations, in supporting a program on access to health care. This was an attempt to improve access in small rural communities. Many times they only had maybe two or three physicians in the community. Particularly after hours it was very difficult for these people to get medical care. Typically, these few physicians took their turns rotating on after hours calls which made it very difficult for them to maintain a private practice and to do that every third night or whatever. We felt that one way to improve access to health

care in these communities was to assist the small rural hospital in obtaining full-time, or at least after hours coverage of their emergency room by a paid physician. So we established this program jointly. Another aspect of the program on access to health care was to develop various approaches to assist the elderly in maintaining their independence. This involves developing case management systems for early discharge from the hospital or plugging in to other community agencies which make it possible for them to get services after they leave the hospital. Combine the elderly projects and these emergency room physicians program from 1975 to the present, some 67 hospitals were involved and we have committed $1,800,000. The Z. Smith Reynolds Foundation gave a like amount and the Kate B. Reynolds Health Care Trust, approximately twice that amount. They had a problem with accumulation of income. They went through a court case to change the terms of their trust eleven years ago. While that issue was working its way through the courts they did not distribute any money, so after the court decision was reached they really needed to accelerate their distribution. So, by agreement the Kate B. Reynolds Trust picked up half of the cost and the Z. Smith Reynolds Foundation and the Duke Endowment each picked up a fourth of it.

That is one of the joys of the kind of work I do, too, our ability to work with other foundations in funding things together. I mentioned earlier today some things that we have done jointly with the Kellogg Foundation. We have a particularly good relationship with the Reynolds Foundations.

The only other thing that I would mention is our involvement in the development of the Sun Health organization. It started out as CHHS, Carolinas Hospital and Health Services. I was in on the birth of that organization. I came to a meeting of a group of hospitals in South Carolina. This was in

about 1967 or 1968. They wanted to explore the shared use of an industrial engineer. That was in the very early stages of hospitals' recognition that industrial engineering might be something that they could benefit from using. We talked about what it would take to support a program of that sort. It was obvious to me -- of course they were interested in getting Duke Endowment support to help get the program started. And we were willing to support it. It became obvious to me that unless some more interest could be generated that there were not really enough hospitals to make it a viable program.

I suggested to them that instead of trying to start a program that would be underfinanced and weak from the beginning that we ought to explore the possibility of the interest of a similar group of hospitals in North Carolina to see if between the two states we could put together enough hospitals that could really support a good program. I happened to know that there were some hospitals in North Carolina that were interested in doing just that. So, as a result of that, we did convene a meeting of those interested in two states and we had a large enough critical mass to put together a program. Then Ben Latimer was hired as the first employee of CHHS to provide industrial engineering services on a shared basis. That is all it was intended to do.

Pretty soon the demand for service was much greater than Ben could satisfy, so he had to begin hiring some staff.

One of the first things they ran into was the plight of the small rural hospital who had difficulty in getting their sensitive medical equipment serviced and properly calibrated. Things like incubators and isolettes and x-ray machines and things of that sort they had to rely principally on the manufacturer for service. So one of the early services they added was what they called biomedical technicians, specially trained by the community college

system to service equipment. That was their second program which they called CHESS, Carolinas Hospital Equipment Support Service.

From that point they got into shared purchasing and then other programs, credit collection operations. A little further down the line they became involved in contract management, which is an area in which we sort of pushed them. We saw the need. We saw what was happening in the investor-owned chains. We said this might be a viable alternative to the not-for-profits, if an organization of this sort could contract manage these small hospitals. We encouraged them to get into that field, and before long they started managing hospitals. From that point they became involved in an affiliation with the Sun Alliance, which is an organization of large teaching hospitals. Because of the Sun Alliance and the major opportunities which they saw in doing things together, out of that affiliation has grown the Sun Health. Sun Health recently converted to a for-profit corporation and are no longer eligible for our help. But from '69 to about a year ago we committed over $2,000,000 to the development of CHHS which ultimately became Sun Health. That is a significant achievement, I think.

WEEKS:

I think this interviewww has been very productive. I really appreciate your coming to Ann Arbor and sitting for this interview. I really believe it will be a contribution.

Interview with Billy G. McCall

Ann Arbor, Michigan

April 27, 1988

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