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The American Hospital Association

In this chapter, we look at the creation and evolution of the American Hospital Association. We focus on its development from almost a small “chowder and marching society” to an organization of institutions committed to helping hospitals realize their potential as community resources.

The organization that became the AHA was created in 1899, when a group of hospital superintendents got together at the Colonial Hotel in Cleveland, Ohio, organized, and called themselves the National Hospital Superintendents’ Association. It was a personal membership group, with affiliation limited to only what today would be called hospital chief executive officers. Eligibility was later enlarged to include assistant superintendents.

At the outset, the organization was essentially a correspondence club that met once a year. The results of the annual meeting were published verbatim as proceedings.

A few years after its founding, the group changed its name to the American Hospital Association. More important, in 1917 it changed from a personal membership society to an organization of institutions. At about the same time, the AHA hired its first paid chief executive and established hospital sections, subgroups of hospitals, within the national association.

Dr. William Walsh was the first paid secretary (chief executive) of the AHA. He served in this capacity on a part-time basis from 1916 to 1918, when he went into active military service and was granted a leave of absence. M. Howell Wright was appointed secretary during Walsh’s absence. In 1919, Dr. A.R. Warner was elected

permanent secretary and served until his death in 1926. Walsh resumed the position of secretary and served until 1928, when he resigned. He was replaced by Dr. Bert W. Caldwell.

Ohio was the first state to be recognized as a section of the AHA. Wisconsin was second, and Michigan was third. Interestingly, a group of Protestant hospitals, the American Protestant Hospital Association, asked to be recognized as a section. The leadership of the AHA rejected its request, feeling that AHA sections should not be based just on religious affiliation.

By the time Caldwell became chief executive, the association had a headquarters building in Chicago (at 18 East Division Street), a small full-time staff, and an annual convention.

Gerhard Hartman was the executive secretary of the American College of Hospital Administrators from 1937 to 1942.¹ During this time, the ACHA had its offices in the AHA building, and Hartman knew and worked with Caldwell.

HARTMAN:²

I would describe Bert Caldwell as a well-dressed, powerfully competent, singularly devoted, operative executive.

Intellectually he was a profound adversary. He didn't cater to Michael Davis,³ because he felt Michael was too much to the left with national health insurance. Even though Bert was a physician of the old school, and I mean the Latin-type old school, he would not buy Morris Fishbein's⁴ diatribes and Fishbein's resistance to prepayment.

I have a story which I think shows Bert at his best. He was a very cavalier gentleman. He had absolute self-control of his person and how he wanted to present his person. There was to be an AHA convention at the Royal York Hotel in Toronto. It also was to be my second ACHA convocation.

Bert said, "Gerry, how about getting on the train with me; we'll go up together. I would like to show you how I put the convention together."

We went up about a week before. He took a suite. I took a room. About ten in the morning the next day we had breakfast in Bert's suite.

He picked up the phone and said to the operator, "I want to see Mr. Sweet, the hotel manager."

The manager came up and said, "Yes, Dr. Caldwell, what can I do for you?"

Bert was in an elegant silk robe, and silk pajamas, and satin slippers.

Bert asked, "What have you to offer this time around?"

Poor Ray Sweet said, "Well, we'll have to come to that."

Bert said, "Fine, come back when you are ready to come to it."

That went on for about three days. Bert kept him on the prod. When

Bert finished (I may be exaggerating, but my recollection is quite vivid), I think he ended up with 24 or 26 complimentary suites for the use of the AHA's officers and board. He also knocked down the price of the banquet, and he got the complete ACHA convocation taken care of, just to be nice to me.

Well, when the convention was over, he called Mr. Sweet again.

Caldwell said, "Were you pleased?"

Sweet said, "The attendance was excellent and we made out very well."

Bert said, "I know you did."

Bert had his faults: he was a bit pompous; he was a bully if he could get away with it. But I also have to say that he was intellectually honest.

During the 1930s the AHA was a modest organization. Caldwell kept it small, with limited new activities. The annual convention was its major function until the mid-1930s, when it also began to publish a journal.

By the mid-1930s, however, people like John Mannix were beginning to press the AHA to change, to restructure its governance so that it would be more representative of the country's hospitals, and to provide more services for its membership.

Restructuring the AMA

MANNIX:⁵

As secretary of the Ohio Hospital Association from 1927 to 1933, I had the opportunity to observe the activities of the AHA on a first-hand basis. I also had the opportunity to make various program activity suggestions. I always felt that my suggestions received a lot of attention. Not much, however, was actually done, though. I was actually told the association did not have the money to finance the implementation of whatever it was that I was suggesting.

I felt that the American Hospital Association should be well supported, that it should have the funds to enable it to carry out the many projects that were needed—projects that could not be performed by a state or a metropolitan area association.

In 1932 the president of the AHA was Paul Fesler, who was the administrator of the University of Minnesota Hospitals. Paul showed some real interest in not only the need for what I called the reorganization of the AHA but also the financing of it.

With this encouragement, I continued to press for some kind of action. Dr. Nathaniel W. Faxon [president of the AHA in 1934], who was administrator of Strong Memorial Hospital in Rochester, New York, and later administrator of Massachusetts General Hospital, became very interested in what I was proposing. I think he was

influenced by my previous conversations with Fesler.

Dr. Faxon agreed to appoint a committee on membership structure to study the American Hospital Association. I was appointed chairman. He inquired who I wanted on the committee, and I proposed three trustees of the AHA and three members representing state hospital associations.

The original group of AHA trustees were Dr. Robin C. Buerki, from Henry Ford Hospital in Detroit; Asa Bacon, who was at Presbyterian Hospital in Chicago and who also was the treasurer of the AHA; and G. Harvey Agnew, who was with the Canadian Hospital Association. The three people representing state associations were James A. Hamilton of New England; Graham Davis, who was with the Carolina-Virginia association and was in charge of hospital activities of the Duke Endowment and later the executive for health activities of the W.K. Kellogg Foundation; and John Hatfield, who was secretary of the Pennsylvania Hospital Association.

It was an excellent committee. Asa Bacon had been president of the AHA, and Agnew, Buerki, Hamilton, Davis, and Hatfield later became presidents of the association.⁶

That committee met from 1934 to 1937. Prior to the AHA's annual meeting in 1935, we developed a report with certain recommendations. The bylaws of the AHA at that time provided that any change in the constitution and bylaws had to be cleared through the constitution and bylaws committee.

In many ways the old leaders of the hospital field were satisfied with the way the AHA was operating and what it was doing. They did not want to change. As a result, our committee's attempts to contact the chairman of the constitution and bylaws committee were not successful. He did not answer our correspondence in advance of the meeting. At the meeting itself, he was completely unavailable. He would not answer our calls at his hotel room, although we knew he was in town. We spent from Monday until Thursday trying to reach him to arrange the required meeting of the constitution and bylaws committee. A meeting never came about, so there was no action. Our committee, however, was reappointed.

In view of later history, it might be just as well that those early recommendations were not acted on, although the final recommendations were not particularly different. The delay provided us with the opportunity to become a little more adept at association politics.

At the 1936 meeting, we had a report, but we insisted that it be a progress report. We argued that we needed another year to acquaint the membership with what we were proposing. We presented the progress report, and some of the then leaders of the AHA insisted on calling for a vote. We stated there was nothing to vote on, that this was just a progress report and we were not making any recommendations. The chairman of the meeting

finally ruled there was nothing to vote on. Actually, they wanted to vote it down. We knew this. Moreover, we knew that they probably had the votes to do it.

The committee continued to meet and to improve its recommendations. There must have been 15 or 20 full-day and two-day meetings over a period of three years.

By 1937 whatever opposition might have initially existed had now vanished. By that time, we had met with a great many of the state associations and we had contacted a lot of key people in the field. So in 1937 the AHA board approved the report and decided that the committee's recommendations should be implemented.

The recommendations included the establishment of a house of delegates of 100 people, with representation from all the states, with the larger states having greater representation. We recommended setting up what we called councils. Prior to this time it was customary for the president of the AHA to appoint committees each year. A president generally would have some special interest and appoint a committee for that purpose. There was no sunset law. Thus, once a committee was appointed, it could continue ad infinitum. This resulted in a lot of overlapping of committee functions and duplicate effort.

We recommended six councils in what we considered six principal areas of association activity and provided that all committees in the future should report to one of the six councils. The councils were to coordinate committee activities. In addition, we recommended a coordinating council which consisted of the chairmen of the six councils.

We also recommended quadrupling the association's dues.

Dr. Caldwell was very concerned about the dues increase. He felt that as a result of the dues increase the association might wind up with only 20 percent of the hospitals remaining as members. Thus, even though the dues would be four times as much, the total income of the AHA would be less. In actuality, the hospitals not only paid the increased dues, but the association had an increase in membership.

For the first time the AHA had the money to do the things that we had been talking about for years. In my opinion, the work of that committee gave the AHA, for the first time, the kind of financing required to do the national job which the hospital field needed.

The restructuring of the AHA was a major accomplishment. As reflected in the comments below by Kenneth Williamson, former director of the AHA's Washington Service Bureau, it provided the basis for a stronger organization. Williamson also notes that later changes may have had an opposite effect.

The committee's plan, however, was not enough. To achieve results, the organizational architecture had to be implemented and pursued with commitment. Comments by James Hague, former editor-in-chief, associate director, and secretary of the AHA, address the problem of moving from a plan to practice. Williamson's comments are presented first, followed by Hague's.

WILLIAMSON:⁷

The AHA structure can be described as consisting of councils, a coordinating council, the board, and the house of delegates. The house is an open forum for debate and discussion of issues. The board's policy recommendations have to be debated and approved in the house.

The AHA leadership was smarter in this regard than the American Medical Association, in that the AHA bylaws provided that the house of delegates could argue about an issue and then turn it back, but it had to come back to the board. The AHA house could not initiate an independent action different than the board's. This has been one of the problems of AMA: they would think on the floor and take actions that would refute the thoughtful recommendations of their committees.

The AHA membership had a voice, a strong voice, and at every meeting you had to think of who the people were in the hospital field who might raise questions and argue. You had to be ready for it, which was good and healthy. It strengthened the association.

Later, to streamline things, the AHA also established regional advisory boards [RABs]. There are nine of them.

The idea underlying the RABs was the desire to provide a means for placing the board's recommendations on the major issues in front of the field. The chairman of each RAB is automatically a member of the board. The regional groups would discuss the issues and argue about them, and then their recommendations would come back to the board.

That brought a lot of input and had many values. It had value for the people in the field, but it also lost something. You can organize to the point where you ruin dissent and you ruin individuality. I think that's what happened to the AHA. The process is now so neat, so slick, and so organized that things get so talked out, that by the time they come to the house of delegates, there is often little interest in the matter.

Caldwell's reaction to the agreed-upon changes in the organization of the AHA was seemingly less than enthusiastic. James Hague comments on this.

HAGUE:⁸

I was told by someone who really should know that Dr. Caldwell was satisfied with the way things were. He didn't want to spend the money made available to him. He was apparently frightened of guys like Mannix and Jim Hamilton.

I am told that what he [Caldwell] would do every year was say, "I think I am going to retire." This kind of comment had the effect of quieting down the efforts to oust him. Then another year would come, a new set of officers would come in, and he would say the same thing.

The officers would say, "Let's not do anything. Bert has been around for a long time. He is a very nice guy. He knows all the right restaurants. Things are going along nicely. We have big crowds at the convention. It's good."

Then a new face came along. It was Jim Hamilton. Hamilton's arrival in the elected leadership positions changed things. Hamilton got great support from guys like Mannix, but it was Hamilton who did what had to be done.

As I understand it, it began with his going to the nominating committee and saying, "Look, I am going to be president of the AHA some day, I'd like to get it behind me, so I want you to nominate me."

I think Harvey Agnew was chairman of the nominating committee. According to Jim Hamilton, Agnew said, "You are going to be president, but it's not your turn yet."

Hamilton said, "I don't care whether it's my turn. I want to be nominated. If you don't nominate me, I will have the votes anyway."

He was nominated, and, of course, he was elected president of the AHA [in 1943]. He made it his business to make the necessary changes. He had to do a fairly dirty job.

There was a lot of pressure on the board not to fire Caldwell. Hamilton said, "At the first meeting of the board at which I preside, he's going to go. Period."

The board was meeting at the Drake Hotel. Hamilton recalls that he was in his room when John Mannix called him from the lobby. Mannix said, "Jim, I am here with Monsignor Griffin.⁹ Come on down, will you please? We would like to talk with you."

Hamilton said, "Look, I just got to bed. It's been a tough day."

John said, "We have lived together for a long time. Come on down."

So Hamilton went down. As he tells it, the conversation was nothing but a straight-out appeal for a delay in dealing with the Caldwell situation. Caldwell apparently aroused a great deal of sympathy among Catholic hospitals and among the Catholic hierarchy.

Hamilton said, "Now look, I have to do it." He said, "I am up to here

with the pressure from the church on this. Now I am going to tell you what I am prepared to do, then I am going to leave. If Caldwell resigns, I will see to it that he is taken care of (a pension or something). If I don't have his resignation by tomorrow morning, he will be fired and that will be the end of it. I have the votes and I am going to do it."

He went out of the room and the next morning he had the resignation. That was the end of that.

Hamilton's own recollections of the events add detail and a first-person perspective.

HAMILTON:¹⁰

Finally I said to Caldwell, "I'm going to become president." (I was only president-elect at that time.) You have to decide whether you are going to be editor of the AHA magazine, *Hospitals*, or the executive secretary (chief executive) of the hospital association."

He wouldn't choose.

So finally I said, "All right, Bert, that's the answer. I am going before the association and have you fired."

"They won't do that," he said. He thought that they wouldn't fire him. He was relying on Monsignor Griffin, who was the power behind the throne.

I said, "Don't count on that, Bert."

I sat down with John Mannix and with Monsignor Griffin, whom I knew and whom John also knew very well.

I said to Monsignor Griffin, "Tomorrow morning I am going into the board meeting and I am going to suggest that you be kicked off the board and somebody take your place. Also, I am going to say that Caldwell must be fired."

We argued about it until I said, "I don't want to argue about it any more. What you have done is wrong. You have made this a religious issue. You have stirred up bishops all around the country, and, the first thing you know, I've got Wilinsky¹¹ of Boston getting in touch with me saying, 'What the hell are you doing with the bishops? The bishops are coming around and telling me that Hamilton's doing terrible things at the hospital association and that he is going to do something horrible.' So that's what has made it religious."

So I said, "The best thing I know to do is get Caldwell out, let's give him a pension or something. We owe him something for all those years of service. Let's get that office going with somebody in charge that can really do it. Then ask the members again to put up more money to do it. We can't run the association on chicken feed. Compare our dues with that

of other associations and it doesn't amount to a row of pins."

The next morning I met with Monsignor Griffin and Dr. Caldwell.

Griffin said to Caldwell, "I guess the jig is up. I can't hold it any longer. Hamilton says he is going to the board and you are going to be kicked out. But Hamilton says if you will resign, he'll fight like hell for a pension for you and a few things like that."

Caldwell resigned and we set him up with a pension.

After Caldwell resigned, we had to look for somebody to replace him as executive secretary. That wasn't easy.

It finally got down to three people: John Mannix, O.G. Pratt,¹² and George Bugbee.¹³

I said to all of them, "George says he would like the job. George is just the kind of guy that will do the job well. He has an understanding of human relations and is able to quietly get things done. The three of us must support him."

They agreed, and we did.

After deliberation, the board chose Bugbee.

Building the Organization

In addition to engineering the change in leadership, Hamilton obtained a fourfold increase in the association's dues. With George Bugbee as chief executive and with adequate revenues, the AHA was now ready to meet the growing needs of the nation's hospitals. James Hague comments on how Bugbee built the organization and set out a clear direction for it to take.

HAGUE:¹⁴

George went to work. Using the additional dues money, he began to hire a good staff. He got good people and he set the association on the right track.

The key staff—C.J. Foley, of the AHA editorial staff; Dr. Hullerman, secretary of the council on professional practice; Maurice Norby; Kenny Williamson; and Bugbee—met in what Bugbee called a "retreat." They came up with a clear statement of what the association should be.

First was representation. You think of representation in more recent years with an emphasis on Washington. Actually there was and is far more to it than just that. Representation meant the AMA, the pathologists, the radiologists, the anesthesiologists, and so forth.

The second had a double name, research and standardization. The AHA was influential in the study of the anesthetic gases.

The third one was education—publications, conventions. George thought of the commercial aspect of conventions as a necessary evil. He wouldn't give the exhibitors the time of day if they interfered with the educational program. He would take their money, but that's it. He ran good conventions, so they came.

Those three—basically three, because research and standardization could be considered one—dominated the AHA's work. The council chairmen were given these three goals, and then George asked them what these councils should be doing and thinking about to further AHA activities toward these goals. They came up with some very exciting things.

Maurice Norby was one of the staff persons who participated in the direction-setting retreat. He came to the association from the Blue Cross Plan Commission, where he had worked directly with Rufus Rorem¹⁵ and the chief executives of the various Blue Cross plans.

NORBY:¹⁶

I liked George. I liked what I saw in him and in the association. It was growing. It was growing without the problems of youthful growth and ego ambition that the Blue Cross Commission had. I thought that maybe the AHA would benefit if it better understood what Blue Cross' problems were. I thought that I could serve both Blue Cross and hospitals best if I was on the hospital platform.

George offered me the secretaryship of the committee on Blue Cross and prepayment plans. From this position, I was an officer of the American Hospital Association. At the same time, I could continue to deal with my peers on the Blue Cross Commission. I thought I could do the commission a better service if I was on the inside of hospital circles than I could if I was back in the commission family. Also, I liked George's method of operation. He was direct, and he was not personally ambitious. He was, however, ambitious for the association.

Shortly after I came to work at the AHA, George called for a "think meeting" with Kenny Williamson, Foley, myself, and Dr. Hullerman. We went to a hotel and locked ourselves in a room. It was what George called a retreat, and its purpose was to decide what the association should be doing.

We decided that the work programs of the association should include education, representation, research, and standardization. All the programs of the association should have some phase of those activities intertwined in their work.

George then brought the proposed work program guidelines to the

board. They agreed with it. So, for example, the council on administrative practice had more education in it. Standardization was emphasized by the council on professional practice. I can remember hospitals were using about 70 kinds of suture needles. They got them standardized down to 20 or a number like that. They got everyone to agree to the standards.

This was the kind of thing that George did. His emphasis was on how to do it, how to improve hospital administration, how to help hospitals and hospital administrators, how to assure better care for all the people.

We also produced manuals. For example, they got out a laundry manual. They had a committee with a couple of administrators and three or four good laundry managers. The secretary of the council on administrative practice was present to assist the committee. They would first agree on what the table of contents should be and then assign people to write chapters. Then they would criticize the chapters and edit them and so on.

They were how-to-do-it manuals. They had quite a number of them, each on a different hospital department. There was no hospital literature at that time, so we gave every hospital a free copy of each manual.

Kenneth Williamson was another of the participants in the Bugbee retreat. Williamson came to the AHA from the California Hospital Association and the Association of Western Hospitals. His comments, while similar to the foregoing, also show another aspect of the direction the association was taking.

WILLIAMSON:¹⁷

Jim Hamilton convinced George Bugbee to leave City Hospital in Cleveland and take the AHA's chief executive position. George, though he came from a hospital and knew hospital operations, didn't know the field. Therefore, he wanted someone who knew the hospital field. I went to Chicago to interview for the job. It sounded interesting. I liked him, and he liked me; so I joined AHA. The staff at that time consisted of 13 people.

When George came to the AHA, there was really not much there. There was no organized hospital field. There were a few spots of organization. Generally, however, the field was unorganized and disconnected. The association had no platform, it had no program, it didn't know where it was going. There was nothing. The association was essentially just a group of people with lots of goodwill.

With George, we used to go and sit together, about three or four of us, and think and talk. Even with the dues increase there were still limited funds. The management task was to spend the funds, spend them in a way that would accomplish the most good.

One of the things that came out of the talking, thinking, and our own

experience was a recognition of a need to organize the field. That meant developing state hospital associations all over the country. That was one of my first jobs. I think there were 36 or 38 state hospital associations I had a hand in organizing. I met with their committees, wrote their bylaws with them, met with the hospital leaders, sold them on doing this and that, and so on. It was a lot of fun, but I was away traveling much of the time. After the state associations came the local or metropolitan hospital councils. We also had a hand in helping some of them get started.

We also developed a series of manuals or textbooks, or perhaps more precisely primers on how to operate every aspect of a hospital. We got the best laundry people together, for example, to learn every phase of how you operate a laundry, and then wrote a text on operating a hospital laundry. We also wrote a textbook, a manual, on hospital housekeeping. That housekeeping manual was interesting, because we got a fellow from the Fleischman Yeast Company to come and talk to us about sterility. He went around and looked in some hospital operating rooms. He said that, if the areas where they made yeast were as dirty as those operating rooms, they would be in trouble.

I also got the chief housekeeper of Marshall Field's, the Chicago department store, to talk with us. If you ever want an interesting experience, go into Marshall Field's when they open in the morning. It is something to behold. The floors shine, and there isn't a fingerprint on any of the glass cases. As I said, it is something to behold. I got this man to go into some hospitals. He said, "If Marshall Field's was as dirty as some of those hospitals, they wouldn't have any customers."

We wrote manuals on all aspects of hospital operations. This was very important, for it affected the economy of the hospital. For instance, the purchasing manual written by purchasing agents who really knew their business led to standardization of supplies for hospitals. We went about the standardization process with a set of objectives that weren't there before. Fortunately, this standardization helped us keep up as medical care changed and evolved. I think it was very fortunate for the public that hospitals were somewhat ready for those changes.

George Bugbee himself describes the organizational context he was moving into and the goals he was trying to achieve.

BUGBEE:¹⁸

Jim Hamilton resigned from Cleveland City Hospital to go to the University Hospital in New Haven. A search committee was set up to find a new superintendent for City Hospital. I ended up with that appointment.

Hamilton, by that time, had become very active in the American Hospital

Association. As a result, he drew me into various activities, including, eventually, appointment as chairman of the association's council on hospital planning—or construction—perhaps hospital planning and construction.

That job, with Jim at the helm as president of AHA [1943], precipitated an evaluation of the staff of the association.

Dr. Bert Caldwell had been the executive secretary of the association for a number of years. He had set up an operation where he did most of the work, with some clerical help. As World War II continued, hospitals needed representation in Washington. Also, they needed many other services. Dr. Caldwell, however, was reluctant to increase his staff or change his style of operations. As you can guess, the situation came to a head, and the board ultimately asked Dr. Caldwell to retire. Then there was a search for an executive to replace him. I was eventually the selection of the board. I took office in May of 1943.

I think it's important to appreciate that Bert Caldwell's conservatism was understandable, even if no longer pertinent. The association just prior to the depression had purchased what had been the Boys' Latin School building at 18 East Division. The association did not have reserve funds, and the purchase required that it take out a substantial mortgage. With the depression, the association's income decreased, and at one point it was thought that it would be impossible to meet the payments on the mortgage. The situation was saved by the sale of bonds to AHA members. Undoubtedly, the danger of losing the building and of the collapse of the association was very much on Bert Caldwell's mind and supported his objection to all the new plans of the so-called Young Turks.

Prior to my being in office, Jim Hamilton, with a committee on association resources, had gone to the board and recommended that the dues of the association be quadrupled. The amount would be rather inconsequential compared to present dues, but the size of the increase was startling in the field. The board recommended it to the house of delegates.

The house of delegates approved the dues increase. In anticipation of their approval, and because there had been a great deal of interest in expanding the role of the association, I was asked to begin planning what the association's program should be. This was pretty short notice, since I hadn't had any association management experience. However, there was a core of people, led by Jim Hamilton, to advise me. Included in this group was John Mannix, who had been instrumental in the reorganization of the association a few years earlier, and O.G. Pratt, who was at that time in Massachusetts administering a hospital, I think in Salem. Bob Buerki and Dr. Robert Bishop¹⁹ were also involved. I won't go into all the locations these men were in, but they were all in key positions. Importantly, they had ideas about what the association should be doing.

The first thing, of course, in support of the dues increase, was money for a Washington office. It would need almost as much money as the total association had been spending up to that time.

It was also decided that the councils of the association, other than the council on government relations, which was in charge of the Washington office, should be staffed and have funds for travel. This may sound inconsequential, but the councils weren't meeting, because there wasn't any money to pay the travel expenses of the council members. Also, there hadn't been money to provide staff support to the various councils. So this was the second item, travel expenses and staff support to the councils, for which the dues increase was used.

The accomplishments of the councils can easily be evaluated by looking at the annual convention transactions published by the association. These were a verbatim transcript of everything said at the annual convention, both the papers delivered and the proceedings of the business meetings. The transactions were discontinued a few years after I was appointed, because both the number of program sessions and the detail of the reports to the house of delegates became so lengthy that they could not all be published in one volume.

Another priority for the new dues money was a public relations program. Jim Hamilton and I arranged an appointment with a vice president of American Bell Telephone to see what his advice would be. Our thinking in seeking them out for advice was based on the fact that the telephone company had done an unusually good job of communicating with the public.

We made the appointment and saw him in New York City. He was very kind and visited with us for a while and asked us how much money we had. I don't recall exactly, but it was around \$150,000. He tried not to laugh, but we got the idea. He said that \$150,000 would buy just about one page in the *Saturday Evening Post*, which was then, probably, as good a medium for reaching the public as any.

We finally ended up hiring a public relations director and working with internal staff to furnish materials to member hospitals. They, in turn, could use these materials for local public relations. I think this met with some success for the hospitals that wanted to do it.

There was also need to employ a staff. I think Kenny Williamson was the first. At the time we hired him, he was secretary of the California Hospital Association and the director of the Association of Western Hospitals. He was experienced. He had worked for Blue Cross also. He was a good addition to the staff.

I also became editor of *Hospitals*. When I took the job as executive secretary, I insisted on not having a separate editor, calling whoever ran the magazine managing editor. The model I wanted to avoid was the Dr. Olin

West and Dr. Morris Fishbein situation at the AMA, where the editor of the American Medical Association journal, Dr. Fishbein, was more powerful than the chief executive, Dr. West. It wasn't a matter of a power play, I just didn't care to have a division of accountability. I also insisted that the director of the Washington Service Bureau, as we called the Washington office, report to me rather than to the council on government relations. If I were going to run the association, I was going to try to do it.

I didn't do as well in staffing the journal. I got a very honest, able fellow named John Storm. John, however, was not a flashy publisher.

Dr. Otho Ball, who was then the owner and editor of *Modern Hospital*, had recommended that I hire someone else. I probably should have followed Ball's advice, but I didn't want him to feel that he had control of the association. You have to remember that at one time the association had been only a desk in the *Modern Hospital* office. Otho Ball was a powerful man, and I wanted to avoid having him think that he was going to continue to play any dominant role. So I got John Storm and then built up the journal's staff.

Up to that time Bert Caldwell had been the editor of *Hospitals*. Really, all he did was publish convention papers. It was hardly, as the library would show, a sparkling journal. I think we did improve it. However, I never thought that we were able to catch up with *Modern Hospital*. That was always a matter of personal frustration with me.

After a few staff members were recruited and on duty, we began to think about the future of the association, whether the budget that was formulated a few months after I got there was a sensible one. I recall we had what was somewhat pretentiously called a retreat, where staff talked over what the functions of the AHA should be.

Of the functions of the association, one was education—running all the way from institutes to the convention and including the journal.

A second function, little understood, I think, by many people, was research moving toward standardization. Its focus was on helping the field develop "best" practice. We spent a great deal of effort bringing in the most knowledgeable people on a given subject, asking them to formulate what might be a manual or a discussion of a procedure, and getting this information out to the field.

The third major function was representation. The obvious level of representation, of course, is with government—all levels of government. However, representation was needed also with the professional associations which affected hospitals. There were many of these, all the way from the American Medical Association to the National Fire Protection Association. If AHA didn't work closely with these groups, they would proceed with their own interests without any attention to what their actions might do to hospitals or hospital care.

Having formulated those three functions, we structured the staff organization to accomplish them and moved ahead to do them.

I stayed at the association until 1954, when I left to become president of the Health Information Foundation. HIF was an organization committed to doing research and public relations, particularly in regard to the advances in medicine that had been useful to people. They also tried to focus on research in areas where research might be helpful in finding the solutions to real problems. HIF's financing came from the pharmaceutical industry, primarily the ethical and proprietary drug companies.

The reasons one voluntarily changes jobs are always complex and perhaps in part just rationalizations. The HIF job was interesting. It also paid a great deal of money. Additionally, it would let me spend more time with my family.

I had another reason, but I think it was part rationalization. When I was hired for the American Hospital Association job, Jim Hamilton told me about one of the engineering associations which had hired an executive for a ten-year term with the promise that they would get him a job at the end of ten years. Their theory was that ten years was about as long as an executive was productive. That might be true.

The other reason for leaving was more pertinent. I never could find a way to run the association easily. It seemed to me that I almost had to be the center of contact between the membership, the councils, the committees, the board, and the house of delegates. I don't mean decide everything, but communication was very important if you weren't going to have a revolt of one sort or another. It got to the point where really every waking hour was occupied, and too much from the standpoint of my family. It would have continued, because it was the only way I could see to do the job properly. I told Ed Crosby²⁰ that when he succeeded me, but he said, "I am not going to work so hard." Of course he did. He did things differently, but he worked equally hard.

A Washington Presence

Under George Bugbee's leadership the AHA came of age, achieving national stature and respect. The strategy that Bugbee employed to accomplish this was twofold. One part focused on membership services: technical support and education. The other concentrated on representation. The following comments by James Hamilton and Kenneth Williamson address representation in Washington, D. C. Hamilton speaks to the needs during the war years. Williamson, who headed the AHA's Washington Service Bureau from 1954 to 1972, follows, taking a longer perspective.

HAMILTON:²¹

When I was at Yale [1938-1946] I was appointed by the secretary of war to be on the National Commission of War. The secretary of war happened to be a Yale graduate.

I also knew the secretary of the treasury. I'd known him for years through Rotary activities. I went to see him and began to talk about the things that were affecting hospitals. About that time, they were shutting down hospitals because of the war effort. There was nobody in Washington telling the government what harm they were doing to the nation's hospitals in the name of war economies.

So I would go to Washington to tell the hospital side of the story. I was going around Washington doing this on my own, feeling that hospitals didn't have anyone in Washington to represent them. Bert Caldwell, who was the executive secretary of the AHA, wasn't focused on Washington.

In those days, the head of each of the major hospital associations (the AHA, the Catholic Hospital Association, etc.) would periodically get together and talk about how the hospital field could or should be represented in Washington. The Catholic Hospital Association fellows would say, "We've got a guy in Washington. We should let him represent the field."

Finally, when I became president of AHA (1943), I said that it was inappropriate to have the Catholic Hospital Association try to represent the whole field. I felt that representation of the entire hospital field should be the job of the AHA. So I established the AHA's wartime service bureau in Washington.

I was asked, "How are we going to finance it?"

I said, "By assessment."

The Catholic hospitals said, "We have a representative in Washington; we won't pay any assessment."

I said, "Fine, we won't represent you."

Well, they came back into the fold. They really had no choice; they were part of the hospital field.

So the AHA started its wartime service bureau in Washington with one guy.

His job was simply to go around and represent hospitals, to bring the hospital point of view to those in government who were making decisions. They (the people in government) were begging for it. The people I found down the line, under secretaries and assistant secretaries, would ask where they could go to get information on hospitals. So we provided it. From that small beginning quite a lot has developed.

WILLIAMSON:²²

You can plot several distinct phases of the hospital field's relationship with government. The first was a time of total voluntary involvement. The

federal government really had very little to do with hospitals. Perhaps the exception to this was during World War II, when there was a more formal relationship through the Emergency Maternal and Infant Care program. The EMIC was a program run by the government to take care of the wives and children of the men who were serving overseas. Government assured these men that their families would get care so they would not have to worry about them while they were away.

Then Hill-Burton came along. It also was voluntary. You didn't have to ask for money if you didn't want to. There were other things that the hospital could choose to do or not to do.

A second phase is represented by direct interaction with government. It started where we began to get exemptions for hospitals from such things as unemployment compensation, the minimum wage law, the National Labor Relations Board, and the Taft-Hartley Act. The AHA worked to get exemptions for the hospital field from the effects of participating under those laws.

Later, hospitals began to lose their exemptions under those laws, and the government began to be a party to the operations of hospitals in a big way. Hospitals came under the kind of rules and regulations that commercial firms were used to. So the ability of hospitals to decide whether or not to relate to government went out the window. They had to relate to government. This had-to-relate phase grew as government programs and government money grew.

At the Washington Service Bureau we got involved with trying to prevent the passage of a lot of bills and propositions that were aimed at controlling the hospital field. Sometimes we were the sole voice, sometimes we were a party with others. Part of our work was in helping to organize the hospital field for political action. This was done through the state hospital association executives. Some of them did it pretty well, some of them very poorly.

In the early years, an annual effort for the AHA was to get adequate funding passed for the Hill-Burton program. The program was no good without money. That took a lot of work and a lot of support. Incidentally, it was interesting how, by and large, the support came from hospitals who hoped to get money from Hill-Burton—some support from those and less support from those who had no interest in it. It was quite a problem.

We also worked on medical education financing. Here, we succeeded in including in the financing program hospitals that weren't owned and operated by universities. If they were recognized medical teaching facilities, even if they were not owned and operated by medical schools, they could get some of the money. In fact, these hospitals got a lot of it.

The AHA really instituted the federal government's role in participating

in the cost of nursing education. This was helpful to the hospitals because they needed nurses and many nursing students didn't have money to pay for tuition. So it was self-interest and public interest at the same time. Organized nursing had less of a role in that than did the AHA. They supported it, but we instigated the legislation and followed it through with their help.

Later, we also instituted our annual meeting in Washington. The notion was that we would have a national meeting in Washington to foster the political side of things, to get people into contact with their elected officials so that they could talk to them about issues. We would have a meeting, then turn the people loose on their congressmen.

A great deal has come from the Washington meeting. A lot of things happened. The hospital people now know the legislators in a way they never did. It has stimulated a lot of contact, not just here in Washington but there has been follow-up. It goes on all the time. I think a lot of definite good comes from it. The hospital field, without a doubt, is now a lot better known.

Representation had another aspect to it, one involving other organizations in the health field. George Bugbee's experience with the AMA, the American College of Surgeons, the American College of Physicians, and what ultimately became the joint Commission on Accreditation of Hospitals provides not only an example of this aspect of representation, but also an interesting story. The episode is told by Maurice Norby and Bugbee himself.

By way of background: the American College of Surgeons had established a standardization program for hospitals in 1916. It established such a program because it needed a means of assuring that it admitted to membership only surgeons of proven ability. Deciding just who these surgeons were was very difficult. To help in this process, the college decided that it needed accurate medical records of surgery performed. Most hospital records were not very good at that time. The American College of Surgeons therefore set up a voluntary hospital accreditation program requiring complete medical records and review of quality of care and plant operation.

The college provided the financial support for the program until the late 1940s, at which time it requested the AHA to assume the operation and financing of the standardization program. Not surprisingly, there were objections to this from the AMA and the American College of Physicians.

NORBY:²³

Dr. MacEachern was the director of the American College of Surgeons [ACS]. He was responsible for the hospital standardization program conducted by the college and was a frequent speaker at hospital association meetings. He also had served on many important committees of the AHA.

So when ACS decided they didn't have the money to continue to support the standardization program, MacEachern suggested that the logical organization to do hospital accreditation was the American Hospital Association.

So, the American College of Surgeons actually approached George Bugbee and asked him to approach the AHA board and determine whether the AHA would like to take on that work and expense. George presented it to the board and recommended acceptance of the transfer of the program to AHA.

Admittedly, there was not a lot of love lost between the American College of Surgeons and the American Medical Association. That, however, wasn't the reason why the ACS came to the AHA. They approached the AHA because it was the logical move.

When the AHA accepted the ACS's invitation to assume the accreditation program, the AMA formally disapproved the transfer. They asked that it be transferred to them, so that it would remain within the medical framework, within medicine's control. There was a little jockeying, then they said, "Let's have a meeting and see how we can do this, maybe jointly."

For that joint meeting, it was decided that the American College of Surgeons should be represented, the American College of Physicians, the AMA, and the AHA—just those four. Each organization was represented by its president and, I think, the president-elect or the past president, one or the other, plus their executive secretaries (chief executives). How I was selected to be recording secretary I do not know, but I was.

At the first meeting, the doctors sat on one side of the table, except the college of surgeons representatives—they sat on the other side of the table with the American Hospital Association group. Both sides seemed to be glaring at each other. I have never been in such an uncomfortable position. Dr. Gundersen from LaCrosse, Wisconsin, who was representing the AMA, was elected chairman.

The objective was to write up a program of accreditation of hospitals. They wrote their objectives, which really would be the preamble to bylaws. They did this at the first meeting and seemed to get along pretty well with it. They knew they would have to have bylaws and would begin drafting them at the next meeting.

Someone said, "Mr. Norby, would you please bring in some 'boilerplate,' some things you think ought to be in the bylaws? We can then go from there."

This I did. I went to the bylaws of various medical groups and selected sections within the objectives which the organizing committee had stated. I brought this material to the committee, and they started working it over at the next meeting. As they worked, they began to feel more comfortable. We had frequent meetings. They would take a section that I brought in and go

through it. I would note their objections and make changes. We would bring that in to the next meeting and then work on a new section. Finally everybody was happy. Then the Canadian Medical Association said they would like to be in the program; so the committee expanded the bylaws to include them.

Then, they needed to find a director, and they were searching around. At one meeting I said, "How about Dr. Crosby²⁴ at Hopkins?" They said that we couldn't possibly get him. I knew a very good friend of his, Dr. Russell Nelson,²⁵ so I said, "I think we may be able to get him." I said, "Dr. Gundersen, if you wait, I'll make some inquiries around, and then I'll let you know. Don't invite Crosby before he is softened up a bit."

So I got Nelson to approach Crosby. To Crosby, it was unthinkable at first. Then Gundersen formally invited him, and, to everyone's surprise and delight, he accepted.

Then we were going to have the formal organizing meeting at the Drake Hotel²⁶ on a Sunday morning. (The doctors almost always met on Sundays; they didn't want to interfere with their practice on weekdays.) I knew the people at the Drake very well, all the kitchen people, the waiters, and all their work force. I arranged the meeting and the breakfast. That Sunday morning, we sat down for breakfast. It was a good breakfast. However, as soon as the meal was over and the plates had been cleared, in walked the waiters carrying trays with stemmed glassware, goblets with bubbles coming up through the amber liquid.

Gundersen, who was still chairman, said, "No, no. Stay away. We are here to do business; we don't want any drinks."

I had told the waiters to bring in the glasses and set one down in front of each person, no matter what the chairman said. So the waiters did as I had requested.

One of the other physicians, a fellow from the Napa Valley in California looked at what was going on and said, "It looks like good California champagne. As long as it is here, let's all stand up and toast to the success of the joint commission."

We all stood up, put our lips to the glass, then, with funny looks on their faces, the committee members began to sit down.

Bugbee said in a loud voice, "Maurice, you are up to your old tricks again, aren't you!"

They saw the bubbles coming up through the amber liquid and thought it was champagne. It was beer.

They then elected officers. It was hard for the chairman to get that meeting adjourned. They were complimenting each other, saying great things. Everyone had to make a speech complimenting the other people. They were so happy and so pleased. I never have seen such a change in a group. The

animosity was completely gone. They were ready to go to work and do a good job. Crosby had accepted. He was there.

BUGBEE:²⁷

The college of surgeons reluctantly decided for economic reasons that they were going to get out of the accreditation program. Then the question was, what's going to happen to it? I knew one thing, if the accreditation program were going to go on, the hospitals had better jump in and be in favor of it and keep it alive. So I proposed to the AHA board that we get in.

The AHA board decided to do it. The AMA got wind of it and showed up in an uproar to tell the AHA that they had no right to be involved. The AMA had pretty good support, particularly from the general practitioners, who had always been seemingly threatened by the accreditation program.

The criticism of the AMA didn't bother me. I thought it added stature to the association. I think I have to admit, however, that we were wrong. The resolution of the argument, and there was plenty of argument, was better than if the AHA had taken it over alone.

The board of trustees of the AHA and the board of trustees of the AMA met together and then appointed a committee, which met repeatedly. The president of AHA at the time [1951] was Dr. Charles Wilinsky of Boston, a wonderful man who had been president of the American Public Health Association and most everything else. He was deaf, but he heard enough so he did better than most who heard everything. He also was unusually adept with the physicians.

The argument, of course, was over how much medicine and how much hospital should be on the commission [Joint Commission on Accreditation of Hospitals]. The AHA by that time, with people like Wilinsky, were not worried about doctors per se. They were worried, however, about the AMA and the attitude of the general practitioner either emasculating the program or killing it. They thought it was a program primarily approved by specialists rather than generalists. So AHA insisted that there be representation from the American College of Surgeons and the balance from the American College of Physicians. It ended up with six AHA commissioners, six AMA commissioners, and three commissioners from each of the colleges. Then somebody said, What about Canada? The Canadian Medical Association was given one, and, since there wasn't a Canadian national hospital association at the time, the AHA was given a seventh commissioner. That was the early texture of the joint commission.

Maturity

Bugbee left the AHA to become president of the Health Information

Foundation. He was succeeded by Dr. Edwin L. Crosby. Crosby went to the AHA from the joint Commission on Accreditation of Hospitals. He died in 1972 at the relatively young age of 64, while still serving as the AHA's chief executive.

The maturing of the AHA under Crosby's leadership is described by James Hague and Maurice Norby, two of the association's senior staff at that time, and Robert M. Cunningham, Jr., the former editor of *Modern Hospital*.

HAGUE:²⁸

Ed Crosby was not a medical scholar. In fact, he never saw himself as a practicing physician at all. He said he wouldn't treat someone's cat.

He brought to the AHA his belief in doing good for as many people as possible. In the field of health, except for the classical public health things like sanitation and immunization, the hospital was the major agency for doing good for people. The hospital had, indeed, supplanted the family physician. It was in the hospital that care was given, and it was in the hospitals that the care givers were trained. Therefore, it was natural for someone who was dedicated to doing good for a lot of people, if they were in the health field, to be working in and for hospitals.

I think he believed that. He had an amazing personality. He knew everyone, and everyone liked him. He was trusted by them, and he could get things done.

He was a Salvation Army child. He married a Salvation Army woman. He quickly went into public health in New York State. The New York State Department of Health had a habit of choosing its brightest people and sending them on to Johns Hopkins for further training in public health. He did his work for his master's and his doctorate in public health at Hopkins, where he came under the strong influence of a man named Lowell Reed.

Reed was an outstanding man, eventually becoming the president of Johns Hopkins. Lowell Reed was not an M.D.-type doctor. He was a Ph.D., a biostatistician. At one time, every chair of biostatistics in the country was held by a graduate of his.

The School of Hygiene and Public Health at Hopkins is right across the street from the hospital. Until recently, the Johns Hopkins Hospital had no formal relationship with the university. The only thing that held them together was one sentence in a letter from Johns Hopkins to both the university and the hospital saying that he wanted them to work together. That's all, and, by God, they did.

Crosby was sent over to the hospital to work in the vital statistics area. Unlike most institutions, Johns Hopkins Hospital placed great reliance on statistical reporting to judge the quality of its care. Its annual reports were full of statistics from the hospital. Not enough attention is paid to that these days.

From this beginning, Crosby moved into the broader field of hospital administration and became Dr. Winford Smith's [the hospital director] chief assistant. Subsequently, he became the hospital director.

Later he took over the joint Commission on Accreditation of Hospitals. Then he came here to the AHA. He built the AHA into what it is today, or just about what it is today, on the foundation that Bugbee had left him.

NORBY:²⁹

Crosby was decisive and would make decisions fast—and I think he got more than his share of correct ones. For example, building the building at 840 North Lake Shore Drive. The board had agreed that they were not going to buy a used facility. He was the one who talked with Northwestern University about getting the land, convincing them that we could rent it. He decided that we should dig the foundation immediately, because prices were only going to go up. The excavation was there for a whole year, sitting full of water. He acted decisively and speedily.

CUNNINGHAM:³⁰

As editor of *Modern Hospital*, I did notice a difference right away when Bugbee moved to the Health Information Foundation and Dr. Crosby came to AHA. They continued to be our competitors, but in a different way. Ed Crosby's basic position was, "You are in the same field as we are, providing information for this professional society, and if we can be of help to you in any way, let us know."

The advertising salesmen continued to cut each other's throats on the street, but we had a different relationship. I expect Crosby may have known what he was doing, because inevitably we were not as critical as we had been in the past.

I had known Ed Crosby when he was at Johns Hopkins. This was even before he was director of Johns Hopkins Hospital, when Winford Smith was the senior director and Ed was his assistant. Then Crosby came to the joint Commission on Accreditation of Hospitals as its first director. He was in Chicago and I knew him better. Then, of course, when he moved to AHA, it was a different kind of relationship.

I think that Ed Crosby's contribution was very significant. George Bugbee took the association from a one-man organization that lived in the shadow of the AMA and made it into a real trade association with useful programs in all of a hospital's major fields of interest and responsibility. I think Crosby moved it into a new and still larger sphere by adding services; getting the AHA building built; and creating a continuing relationship with the medical profession.

Retrospective

John Mannix, who was one of the forces for change in the 1930s and who has watched and helped the AHA grow and develop since then, provides an interesting closing perspective. His observations help to bring into focus the process as well as the progress.

MANNIX:³¹

I think you can say that all the men who have held the position of chief executive of the AHA have done a very good job. It is not easy to keep 6,000 member hospitals happy. In many ways, Caldwell, Bugbee, and Crosby had very similar personalities. All were very good executives, all personable, all well-liked by the field, and all meeting a need of the field which differed with the specific times.

There is no question in my mind that the AHA has gained greatly in national stature. It is an effective national organization today, well-recognized by the medical profession and other organizations in the health field. A large part of this is unquestionably due to these top executives.

Notes

(Transcripts of the oral histories cited here are housed in the library of the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. The Oral History Collection is a joint project of the Hospital Research and Educational Trust and the AHA.)

1. See Profiles of Participants, in the center of this book, for biographical information.
2. *Gerhard Hartman, In the First Person: An Oral History.*
3. Davis was a director of the medical economics division of the Julius Rosenwald Fund and founder of the University of Chicago Program in Hospital Administration.
4. Fishbein was for many years editor of the *Journal of the American Medical Association.*
5. *John R. Mannix, In the First Person: An Oral History.* See Profiles of Participants for biographical information.
6. Robin Buerki was president of the AHA in 1936; Asa S. Bacon in 1923; G. Harvey Agnew in 1939; James A. Hamilton in 1943; Graham L. Davis in 1948; and John H. Hatfield in 1950.
7. *Kenneth Williamson, In the First Person: An Oral History.* See Profiles of Participants for biographical information.
8. *James Hague, In the First Person: An Oral History.* See Profiles of Participants for biographical information.
9. Monsignor Maurice Griffin was a priest in Youngstown, Ohio, in a parish which included St. Elizabeth's Hospital. During World War I, he was pastor of a church and also the Catholic chaplain for St. Elizabeth's. He became interested in the hospital field and was very active in the Ohio Hospital Association. For many years he was a trustee of the Ohio Hospital Association, and at one point he was president of it.

He later became a trustee of the AHA, which he served for more than 25 years. He was also at one time president of the Catholic Hospital Association. He and Caldwell worked very closely together. Besides being professional friends, they were close personal friends. They were about the same age, and both were extremely well-traveled individuals, having been around the world several times.

10. *James A. Hamilton, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

11. Dr. Charles F. Wilinsky was president of the American Hospital Association in 1951.

12. Pratt became administrator of the Rhode Island Hospital in 1946. He was a close personal friend of Hamilton.

13. At this time, Bugbee was superintendent of the Cleveland City Hospital, where he had succeeded Hamilton.

14. *Hague, Oral History.*

15. See Profiles of Participants for biographical information.

16. *Maurice J. Norby, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

17. *Williamson, Oral History.*

18. *George Bugbee, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

19. Bishop was administrator of University Hospitals of Cleveland.

20. Dr. Edwin L. Crosby was executive director of the AHA from 1954 to 1972.

21. *Hamilton, Oral History.*

22. *Williamson, Oral History.*

23. *Norby, Oral History.*

24. Crosby was then executive director of the Johns Hopkins Hospital.

25. Nelson succeeded Crosby as executive director of the Johns Hopkins Hospital.

26. Drake Hotel, Chicago.

27. *Bugbee, Oral History.*

28. *Hague, Oral History.*

29. *Norby, Oral History.*

30. *Robert M. Cunningham, Jr., In the First Person: An Oral History.* See Profiles of Participants for biographical information.

31. *Mannix, Oral History.*