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Educating for a Profession

Education in hospital administration has followed a pattern prevalent in many, if not most, other professions. In the early stages there is a period of apprenticeship or learning on the job, then advancement to college-level training, and finally possible licensing.

The physician of three or more generations ago was likely to have learned his skills at the side of an older, practicing physician. He learned to set bones and bleed his patient. He learned to use some of the "heroic" drugs to dose and purge his patients. He had only a few useful drugs, including so-called specifics: quinine for malaria, digitalis for the heart muscle, and ipecac as an emetic. If he were lucky, he might have had some chloroform to use as an anesthetic when he attempted surgery. Lacking chloroform, there was always whiskey.

The learning process for physicians changed somewhat for some of them. These physicians sought better ways of treating patients than the bleeding, purging regimen. Some began to think of treatment in terms of rest, heat treatments, and water cures, or hydrotherapy. But, for all its change, medicine in the nineteenth century was a far cry from medicine in the 1980s.

An alternative mode of medical education in the 1870s was the medical school of the day. For example, Dr. John Harvey Kellogg, the famous medical director of the Battle Creek Sanitarium for over 60 years, received his formal medical education in several places. Kellogg spent 20 weeks at Dr. Russell Trail's Hygieo-Therapeutic College in Florence Heights, New Jersey. Richard W. Schwarz has described the school: "Instruction at the Hygieo-Therapeutic College emphasized the curative powers of the internal and external

use of water, a simple diet, proper exercise, and fresh air."[1] The school placed little reliance on drugs of any kind. Kellogg, however, was not satisified with his medical competence, so he enrolled at the University of Michigan Medical School for two sets of lectures of 24 weeks each. This would earn him an M.D. degree. A short time before the end of the university lecture course, he became disillusioned because of what today we would call a lack of clinical experience. He left the University of Michigan and enrolled at the Bellevue Hospital and Medical College in New York City, where he got experience in taking care of patients, in addition to classroom lectures.

On his graduation from Bellevue after one year, in 1875, Kellogg received his M.D. degree and joined the medical staff of the Western Health Reform Institute in Battle Creek, Michigan, his hometown.[2] A short time later, he became medical director of the institute and convinced its board that Battle Creek Sanitarium was a better name for the institution.

The medical treatment that Kellogg supervised at the Battle Creek Sanitarium was quite different from that prescribed by most other physicians of the time. He used very few drugs, depending instead on diet, hydrotherapy where indicated, exercise, fresh air, rest, and heat treatments. The diet was principally vegetables, fruits, and nuts. He had his patients abstain from alcohol, tobacco, tea, coffee, and meat. He attempted very little surgery because of lack of training and his preference for what he called "biologic living."

Medical education in America was sketchy, at the very best, until after the reforms that followed the publication of the Flexner report in 1910.[3] It was generally believed, among persons who were interested, that to get a really good medical education one had to study in one of the great medical centers of Europe, for example in Vienna, Edinburgh, or Paris. Kellogg also believed that one must go to the fountainhead in order to get the best possible medical education. Consequently, he made several extended visits to Europe over the years in order to observe noted doctors in practice.

Education in nursing developed somewhat differently. In its earliest stages, nursing was done by those most able to care for the sick because of their experience in the work. Later, nurses generally were trained in hospital schools of nursing, where students learned through practice and instruction by senior nurses. This course of instruction gave way to two-year curriculums connected with colleges and offering an associate degree in nursing and to four-year courses offering a bachelor's degree. The baccalaureate training is preferred by educators, but it is not yet clear whether there will be a sufficient number of candidates to produce the number of nurses needed by the field.

Another health profession that has changed in respect to educational standards over

the years has been pharmacy. For example, after the Civil War a person could become a pharmacist by merely opening a drugstore for business. This was the case in Michigan. As late as 1928 in Michigan, a person could take the state pharmacy licensing examination with only a high school diploma and one year's apprenticeship; grandfather clauses granted a license to any applicant who could show 20 years' or more experience working in a drugstore. Today the qualifications needed for taking the Michigan state examination are graduation from a five-year college of pharmacy course and an apprenticeship. Other states have done the same thing.

The same general pattern developed in hospital administration. In the early days, hospital managers, with no special administrative training, often learned by trial and error. Physicians became administrators because they owned their own little hospitals, or they came into the field because management seemed more attractive than medical practice. Nurses became hospital administrators because the institution was small or because there was no other health professional to take on the responsibility. Church-connected hospitals were likely to have a nun or a minister in charge, not so much because of any administrative training, but because of their religious role.

In time, hospitals grew larger and more complex. Finances, personnel, community and government relations, advancing technology, and medical staff privileges and relations became programs that required professional management skills. As with other professions, the trial and error method had to give way first to on-the-job training and then to formal college training in management.

John Mannix is an outstanding result of apprenticeship, or on-the-job training. He himself would respond, modestly, that his teacher and mentor, Frank Chapman of Cleveland, was responsible.

MANNIX:[4]

I was born in Cleveland on June 4, 1902. When I finished high school, I took a position at Mt. Sinai Hospital in Cleveland. Frank E. Chapman was the hospital administrator there at that time. He took me under his wing. He was one of the few business-oriented people serving as a hospital executive, although I was not at all aware of this at the time.

In the 1920s, the larger hospitals of 300 beds or more were generally administered by physicians who, for one reason or another, had given up the practice of medicine. Many of the medium-sized hospitals of 100 to 300 beds were religious hospitals. If they were Catholic hospitals, they were administered by Catholic Sisters. The Protestant hospitals were often administered by ministers. The smaller hospitals of 100 beds or less were, for the most part, administered by nurses. I am generalizing, but it is surprising, in looking back on it later, how true that was.

I worked at Mt. Sinai for a couple months during the summer and then told Mr. Chapman that I was going to go back to school. He said, "I want to talk to you about that."

He was a very persuasive man. He called me into his office and talked to me about a career in hospital administration. As far as I was concerned, hospitals were operated by doctors, Sisters, ministers, and nurses–and he was a very, very rare exception. I felt the future of hospital administration was in the hands of physicians. I felt that anyone other than a physician would not have much success in the long run in hospital administration. This situation, in my opinion, changed only after World War II.

Several forces brought about the shift in responsibility for hospital management to trained, professional hospital administrators: the increase in the number of hospitals in the late 1940s and 1950, the need for physicians, and the experiences of World War II. The W.K. Kellogg Foundation also played a major role in this movement. In particular, it was instrumental in promoting the development of the graduate education programs needed to train hospital managers. Andrew Pattullo,[5] who over his career became synonymous with the foundation's interest in health services management, talked of the foundation's pioneering initiative.

PATTULLO:[6]

In the early 1940s the W.K. Kellogg Foundation was an "operating" foundation. That is, it ran things or had a major part in making things happen. In the post-World War II era, it was committed to changing its character. It became a national and, in fact, an international kind of operation focused on grant-making activities.

Pattuilo became a Kellogg Fellow in 1943 after receiving his master's degree in hospital administration from the University of Chicago. He worked out of the Battle Creek office of the foundation under the direction of Graham Davis, who headed the foundation's hospital program.

PATTULLO:[7]

In 1944 my fellowship year with the foundation ended. I was asked, however, to stay on and help plan for the postwar era. I was named associate director of the division of hospitals. Graham Davis[8] was the director.

I guess you could say that the Kellogg Foundation's romance with health administration education began at about this time. Part of our strategy was to bring together advisory committees.

The first hospital advisory committee was appointed in 1944. Its membership consisted of people such as Jim Hamilton,[9] who was a past president of the American

Hospital Association and had really turned that organization around. John Mannix, a pioneer in the prepayment movement,[10] was another committee member, as was Robin Buerki,[11] a physician and very prominent hospital administrator. Dr. Buerki had been the director of a national study on graduate medical education in the early 1940s. He went on to become the chief executive of Henry Ford Hospital in Detroit. Dr. Harvey Agnew,[12] who was regarded as the patron saint of hospitals in Canada, was on the committee, as was Dr. Basil MacLean,[13] another great hospital administration figure of that time.

Over the subsequent years, our hospital advisory committee changed in composition but continued to contribute a great deal to our program concept and work in the hospital field. Such individuals as George Bugbee,[14] Ed Crosby,[15] Jim Dixon,[16] Ray Brown,[17] Art Bachmeyer,[18] Walter McNerney,[19] Jack Haldeman,[20] George Cartmill,[21] and Mat McNulty[22] were later members. In the mid-1960s we dropped the standing committee format, going to ad hoc groups which focused on a single problem. This latter approach has also served us well.

As to the original group, we brought them together and asked their advice about what the foundation could do in terms of improving hospital services, quality, etc. It was unanimously agreed that education for hospital administration was a project that had tremendous promise and should be our highest priority.

So, we did two things. First, we decided to create a commission on education for hospital administration. The commission wasn't under our direct sponsorship. Rather, we went to the AHA and to the American College of Hospital Administrators and asked them to take the lead. They agreed and became the cosponsors for what was called a "joint commission" because of the two organizations.

The commission was formed, and Robert Bishop, a prominent Cleveland physician-administrator,[23] was selected as chairman. The commission was politically very sound, with good people on it. The study director was Charles E. Prall, who had been the dean of education at Pittsburgh. They embarked on a two-year study to determine what a model curriculum might be like and then some strategies for developing specific programs.

Charlie Prall did a very neat thing. He decided to go out into the field and poll not only administrators themselves, but trustees, department heads, physicians, and so forth as to what they thought the responsibilities and the problems of a hospital, not the administrator, might be. He made that analysis, and then from that the commission tried to derive a curriculum. There were two publications that came out of this: one concerning the problems of hospital administration, and a second focused on curriculum.

By 1945, the Northwestern University Program in Hospital Administration had come

into being; it was the second program to be viable-the University of Chicago Program in Hospital Administration started in 1934, and then Northwestern began in 1943. So in 1945 there were two graduate level degree-granting programs, probably with a combined annual output of 25 to 30 graduates.

Given the limited number of existing training programs, we then, as the second part of our effort, went to a number of universities that we thought might be interested, if we provided initial support, in starting a program in hospital administration. The hospital advisory committee had a great deal to do with the selection of those original universities.

There was a very definite orientation towards schools of public health as a site for these initial programs. In good part this was due to the influence of Dr. Basil MacLean. Dr. MacLean, a past president of the AHA, was the director of Strong Memorial Hospital in Rochester. He had a strong feeling about the need for administrators to have, in addition to management capabilities, an appreciation for community health concerns. He felt that this latter understanding could best be conveyed in schools of public health. That was the bias, and we followed it.

With the exception of Washington University in St. Louis, every program that we helped to initiate at that time was located in a school of public health. There were six, one in Toronto and then, in this country, Yale, Columbia, Johns Hopkins, Minnesota, and Washington University in St. Louis (situated in the medical school). Of those initial programs, all survived except Hopkins, where there was a hiatus for many years and then later a reincarnation.

Our interest in the mid-1940s was also in attracting to hospital administration the many people returning from World War II who had served in the Medical Administrative Corps (MAC). These people were presumed to be a potential pool of students.

My recollection is that ACHA, in cooperation with the army's surgeon general, developed a questionnaire which was distributed to MAC personnel, inquiring as to their interest upon discharge etc., in a civilian hospital administration career. The response was very positive. Consequently, when the new hospital administration programs came into place, beginning in January 1946 (I think Columbia started at that time), there was a pool of students and a ready acceptance. Well, following that (the development of a number of new programs) we have been involved, I guess one could say, with education for health administration ever since, supporting one dimension or one phase or another.

In addition to the formal academic programs at the University of Chicago and Northwestern University, Duke University had a hospital administration training program.

The Duke program was essentially a controlled on-the-job learning experience, culminating in a Certificate of Hospital Administration as opposed to a master's degree. Richard Stull, a graduate of the Duke program, talks about it.

STULL:[24]

My career in hospital administration probably started by a coincidence.

I was hospitalized at the Duke University Medical Center for an extended period. During that time I became acquainted with my nurse. She was a friend of Ross Porter, the assistant superintendent of the hospital. Following my return to school, and through social relations with these individuals, I found out that Porter, along with Harold Mickey, the other assistant superintendent, and Vernon Altwater, superintendent of the hospital, with support from the dean of the School of Medicine, Wilbur C. Davison, were involved in a program for training in hospital administration. I began to explore the program.

After conversation with Mickey, Porter, and Aitwater on what the program offered, I applied. I was accepted in September of 1940.

The Duke program at that time was in the form of what they called a "residency type" or "preceptor type" program, which took the individual into the hospital setting. It started out with a rotation, with your working in every area of the hospital. In addition to working in the various divisions and departments of the hospital, you were allowed to take some courses on campus, but that was purely by your own personal election. Periodically, at least once a week, the superintendent and the assistant superintendents would lecture, or they would bring in people from the outside to talk to the students about things that related to hospital care.

Also as part of the preceptor program, if they had a particular problem area in the hospital, they would give a student an assignment in that area. At the time of my experience, they were having difficulties in two areas of the outpatient department. One was handling and scheduling appointments, the other was in financing. I was given the assignment to try to do something about the outpatient department. I concentrated my efforts on that department for a while. I am happy to say we turned it around by improving the scheduling of the clinic appointments and in establishing arrangements for financial screening. After a period of time the department was in the black.

What I am trying to point out is that in the environment of Duke Medical Center you were given every opportunity to be intimately involved, to play a role in and participate in the operations of the institution. Therefore, you became knowledgeable about the purposes and functions of each department, about their interrelationships, and a great deal about the people relationships in a complex environment of that kind. So, despite the fact there wasn't the

emphasis on the basic management skills which currently is the point of focus in graduate education, you learned a lot about the environment in which you were going to apply the skills. This was an essential thing.

Another person who entered the health field without formal hospital administration education and rose to be a leader of national prominence was Kenneth Williamson. He described his training.

WILLIAMSON:[25]

When I was about 17, I worked Saturdays and after school in the pharmacy of a hospital, the Methodist Hospital of Southern California in Los Angeles. I got really interested in hospitals. I began to think about it as a career at a time when it was not visualized as a career to manage a hospital. People, through a series of circumstances, fell into it. Physicians became administrators, ministers became attached to hospitals and became administrators. Hospitals turned to somebody they thought had a social conscience, you know. Many, many nurses moved from supervisor to superintendent of nursing then into hospital administration.

I thought it would be a smart thing to write to the leaders in the field whose names I had read in the journals at the time. I wrote, as I remember, to five of them: Dr. Benjamin Black, in Alameda County, California, who probably was considered *the* leader in the United States in hospital administration; Harvey Agnew in Canada, a physician; Malcolm MacEachern;[26] and a couple of others I can't remember right now. The letters I got back from each of them indicated they couldn't suggest a formal approach for becoming an administrator. Moreover it seemed that they didn't think there was such a thing.

The only one I got an answer from which had any vision of the future was Malcolm MacEachern's reply. He said there weren't any formal courses yet. He said, "I suggest you take these courses in school." He laid out a course: some hygiene, some physics, some economics, administration, some of the health sciences, and so on. So I set out to try to get a handle on some of these subjects.

Also, it seemed obvious, if I could talk the hospital into allowing me to move around in various capacities, i.e., various jobs in the hospital, that I might learn something. So I did. I went from pharmacy to working in the operating room for a period, then working as an assistant to the purchasing agent, working in medical records for a while, then into administration. I started into school, and I worked nights. I was in charge of admitting. Going to school in the daytime and working at night, I became the night admitting officer and handled accounts receivable. From this experience I learned a lot about hospitals–not

from the textbooks, but from a very practical standpoint. I think anyone would be fortunate to have that opportunity today.

After the W.K. Kellogg Foundation showed its interest in formal, graduate training in hospital administration, some innovative programs were developed.

The Minnesota Program

The Minnesota program was one of those programs. Under the direction of James Hamilton, it established a new model for training hospital managers. Below, Hamilton describes how the program was established and the philosophy it embodied. Two of the graduates of the Minnesota program, Gary Filerman and Edward Connors, also describe it, giving, after some years in the field, a perspective on their education.

HAMILTON:[27]

I was one of the people who served on the W.K. Kellogg Foundation hospital advisory committee.

Graham Davis, assisted by Andy Pattullo, and the hospital advisory committee would meet, I would say, about every three months. On the first hospital advisory committee were Basil MacLean, Bob Buerki, Harvey Agnew, John Mannix, and myself.

Supposedly Graham had chosen us as leaders of the hospital field or various aspects of the hospital field. We didn't always see eye to eye. The other members besides John Mannix and I were medical men.

It was at that committee that we would advise Kellogg where they ought to be putting some of their money. That was the idea of the committee. We had no authority except to advise. Then Kellogg would decide what they wanted to do.

I was responsible on that committee for recommending that graduate schools be established for training hospital administrators. Two of the medical men, I remember, pooh-poohed the idea in no uncertain terms–the idea that you could train an administrator. This seemed to them a strange approach, because they believed very strongly that the only good administrators were medical ones. As a result, and I think it was startling to many, Kellogg came out and decided to establish graduate hospital administration programs.

Nearly all, the early hospital administration graduate programs were started with money put in them by the Kellogg Foundation. The University of Minnesota was one of the schools which approached the foundation and which was given money.

A fellow by the name of Gaylord Anderson and a fellow by the name of Ray Amberg[28] had gone to the Kellogg Foundation, on behalf of the university, to request money to establish a program in hospital administration. The practice of Kellogg was to give a grantee $20,000, provided they also got $20,000 from the university.

They said, "Now we have got to start looking for a director."

Graham Davis said, "How about Hamilton?"

Ray Amberg, who was running the hospital up there, said, "We can't get Hamilton. We can't afford him."

Graham said, "Well, you might try."

Gaylord Anderson, who was the dean of the school of public health, said, "I only know one Hamilton, a guy by the name of Jim Hamilton."

As it happens, Gaylord was a classmate of mine at Dartmouth College. His father had taught there. We didn't know each other very well, but we knew of each other.

While I was still in New Haven, at the New Haven Hospital, I had given some thought to what would be necessary for a strong program in hospital administration. I had done this mostly because I was on the Kellogg advisory committee and I wanted to serve them intelligently. In the process of thinking it through, I became convinced, at least for myself, that, if I was going to run a hospital administration graduate degree program, it would have to be from a position which had some degree of independence. If it didn't have independence, then the program would be forced to follow the lead and meet the requirements of other programs at the university which *did* have the independence to determine their own curriculum and graduation requirements.

For example, at Yale a hospital administration student had to take all the requirements for a master's degree in public health and then add to that some hospital administration courses. I didn't want that. I didn't want hospital administration students to take a graduate degree in some other field and then fill in with hospital administration subjects. I wanted a degree in hospital administration.

I finally got the independence which I thought was needed at Minnesota. So I went there. I said what the requirements were going to be. Although I was located for administrative reasons in the school of public health, I had complete authority. I was able to run it without having requirements to meet for some other kind of degree. I ran it in such a way that the students were taught what they ought to be taught–what I thought they ought to be taught, let's put it that way.

It has been said that I tried to make the program in hospital administration at Minnesota different from other programs. Well, you see, that was the point, the goal. Each of those other programs was put in a school and had to meet the requirements of a degree

in that school. Then they tacked on a little hospital administration. So it would vary in whatever school we were talking about as to how much hospital administration the student really got.

I had come up fundamentally as a teacher, therefore I insisted that we take the field of hospital administration and break it down into subject areas that would teach that field. For example, there are courses in organization and so forth that you take in a business school and which are taught by the business faculty. So if you went to Columbia, for example, for hospital administration, you went into the business school and learned hospital administration by business methods. Then you had to translate it back into hospitals. I didn't. I taught organization and used hospitals all along the way. I taught hospital organization. I taught the fundamental principles of organization, but I taught hospital organization. I applied those principles immediately to hospitals. The fellow who was teaching at Columbia had to keep changing his illustrations because he had mixed classes–some hospital administration students and some business students.

As a result of this, my program was unique. There was no course in the country at that time which was built that way. There have been some since then.

Gary L. Filerman, a former student of Hamilton's and president and chief developer of the Association of University Programs in Health Administration (AUPHA), comments on his experience at Minnesota with unusual insight.

FILERMAN:[29]

There is no question that Hamilton accomplished an immense amount of education with that program. Hamilton was an extraordinary educator.

There was something about the group process in that program which was very intimidating and at the same time motivating. That's exactly what he wanted to accomplish. He was like a staff sergeant. Hamilton was convinced, and I think he was right, that successful administrators first of all had to have style. You had to believe it to do it. To believe it, you had to learn how to act in certain ways–carry yourself in a certain way, to express yourself a certain way. He convinced us that we were decision makers, and there is a style to decisiveness.

The idea was if there was anything that a Minnesota graduate knew how to do, it was to make a decision, live with it, and go on from there.

Now, there's no question that I benefited greatly from the experience. If nothing else, the elitism of the Minnesota program was a great asset, and has continued to be a great asset. For a young profession making its way, it was one of the fundamental building blocks.

It was an effective instrument toward achieving a broader objective.

Edward J. Connors, president of the Sisters of Mercy Health Corporation, Farmington Hills, Michigan, looks back after years of experience in the health field to his days as a student under James A. Hamilton at Minnesota.

CONNORS:[30]

I found the academic experience under Jim Hamilton's leadership to be perhaps not very technically helpful, but enormously helpful in terms of attitude, point of view, concern, understanding, and values. I kind of chuckle occasionally when current persons in academic hospital administration sort of disdain or look down on or criticize or say, "Well, we used to teach a lot about the laundry and so on." Well, that opinion is just nonsense and not accurate.

I don't think such persons knew what Jim Hamilton was like in the classroom. Jim Hamilton was a man of tremendous capacity and ability. He had the day-to-day ability to really challenge students, to stretch them, to make them think. He did it with a lot of tough techniques of teaching. He was a first-class actor. I told him later, after I got to know him a bit better, that he really belonged in the theater. He was a dramatic teacher, but he had a way of making us very, very excited about the career that we had chosen. Realistic, but excited.

Jim Hamilton, I think, made us think very deeply about what is the purpose and role of the hospital. Why does the hospital exist in the first place? 'What is its basic mission? Why is it there? I think that was so important in the formulation of attitudes and opinions that I am everlastingly grateful to him.

The Michigan Program

In the mid-1950s the University of Michigan established a program in hospital administration. The Michigan program not only built on the Minnesota model, but also went a step further, emphasizing research and community service. Walter McNerney, the first director of the Michigan program, describes what he was trying to create.

McNERNEY:[31]

Michigan was my first real opportunity to stand back and develop a hospital administration program totally in my own style. At the University of Pittsburgh (prior to going to Michigan) I had been trying to balance

several jobs at once.[32] Also, the fact that the program at Pittsburgh was tightly contained within the department of public health practice gave it less elbow room. Under those circumstances, I followed more orthodox program lines and simply capitalized on the assets of the school, of the university, and of the medical center to the extent that I could. On the whole, I think the Pittsburgh program was good. It had to start quickly in 1950, but the resources were rich.

So when I went to Michigan I had some experience behind me. Also, being program director was to be my full-time job. I was going to be able to devote the time to it that it needed.

The Michigan program was to be located in the School of Business [Administration] because politically that was how it fit best at that point. The tension between the university hospital and the School of Public Health, and between public health and the Medical School was such that locating the program in the School of Public Health would not have been a smart choice at that point. Since you can compensate for site very easily, why wrestle with it? I said it was fine, let's set it up in the school of business.

I also asked for, and got, an advisory committee comprised of the dean of the school of medicine, the dean of the School of Public Health, the director of the university hospital, and the vice president of the university for academic affairs. That committee met routinely. I reviewed curriculum with them; I reviewed appointments with them; etc. This was a very powerful step, because I was able in good conscience to represent the program as having a firm connection with the Medical School and the School of Public Health, as well as with the business school. It also provided a pipeline to the hospital. It was an important step.

The next thing I did was lay very heavy emphasis on the fact that any program in health administration, then called hospital administration, should operate on three mutually reinforcing planes: education, research, and community service.

The focus on education was apparent. Education alone was not enough. I felt that research was absolutely necessary, because both the teaching programs and the hospital administration field in general needed a firmer factual base, a firmer conceptual underpinning. The field was growing in complexity. If it were to be managed, it needed more facts and more concepts.

Michigan was an innovator in health administration research. All the hospital administration programs tipped their hats to research. They would write papers and so forth. I think our degree of formality of research, for which I took a chiding from a lot of the practitioners who led programs, was special. It was dedicated, it was identified. It stood the scrutiny of the university community as being valid and good research.

The third critical element was community service. I felt that the faculty, particularly

in administration, needed to get its feet wet in community and institutional life. This was necessary both to enhance the teaching and also to raise the questions that should be researched. So we developed an active community service program. Of course, that had the added benefit of getting us into Michigan communities, Upper Peninsula, Lower Peninsula, Detroit area, etc.

When the university would go to Lansing[33] in regard to the budget, one of the things they heard from the legislators was, "I understand you are helping the hospital in Charlevoix," or such and such. Understandably, this would please the administration of the university.

In addition to positioning the program at Michigan to draw widely on a variety of resources in the university, and to develop mutually reinforcing tracks of teaching, research, and community service, I felt at that time that two other things were very important. One was that the orientation of the program should be health administration rather than hospital administration.

I gave a speech on this idea at the University of Chicago and later published a paper on it. I forget what group it was, but I remember that Bugbee and Hamilton and others were there. The point of view I had, and I guess this was about 1958, was that the more challenging academic problems, as opposed to operational problems, involved the total community. One had to understand the environment of health (the problems of industry, of water pollution, of the family, of disease, etc.) before one could develop intelligent goals. Intelligent goals were absolutely indispensable if one were to conceptualize institutions correctly and manage them correctly. Towards that end, I was very careful that the students in the Michigan program got exposed to public health ideas as well as to business school and public administration ideas.

The other thing that I thought was important was that the head of a health administration program should be a full-time director. The early programs in health administration were started by prominent people who in themselves had a lot to offer. Actually there was no one else around, they had to do it. I admired them for it. However, often the program was ancillary to a lot of other interests. Also, due to the fact that the director was not on the grounds all the time, there was a temptation to use a long list of visiting lecturers to pick up the slack. Some of them were good, some of them were dreary. The connections were not always that good among them. That kind of program had a vocationalism about it that reflected the experience of the individual and the fact that there wasn't time to work on the curriculum with the intensity it deserved.

All in all, Michigan was absolutely superb as a site for a program in hospital-health administration. The university was outstanding. It had a wide variety of forces, and they were put at the disposal of the program. The Blue Cross-Blue Shield Plan there was

outstanding and cooperative. There were talented people in management and labor that thought a lot about health. I exchanged classes with Wilbur Cohen[34] and with Bill Haber. Bill Haber was one of the early architects of social legislation; subsequently he became a vice president of the university [actually, "adviser to the executive officers"]. Wilbur Cohen later became secretary of HEW. These were the men who helped me out, taught in my classes, and there was a certain limited amount of reciprocity. That gives you an idea of what there was to offer there.

Edward J. Connors was the first faculty member hired by Walter McNerney for the new University of Michigan program in hospital administration. He talks about this teaching experience.

CONNORS:[35]

I left the Rhode Island Hospital a few months after my administrative residency to join Walt McNerney at the University of Michigan. There was only the two of us at first. The university took us under its wing and helped us enormously.

In those days we were in the business school, plus we were a part of a very excellent university that was committed to quality education. The business school, the Medical School, the university hospital, and the School of Public Health made good their commitment that they would do what it took to develop quality graduate education in hospital administration.

There was quite a debate before Michigan decided to get into the hospital administration field. After the war, when some of the first programs in hospital administration sprung up, Michigan did not develop a program. One of the reasons why they stayed out of it until the mid-1950s, as I understand it, was because there was an understandable rivalry between the School of Public Health, the graduate school of business, and the Medical School as to who should own the turf that health administration represented. There was an impasse for several years. I suppose like most things, given that kind of infighting, university officials decided it wasn't worth a faculty fight as to whether the Medical School, public health school, business school, or university hospital should win.

The decision at Michigan was helped through by the Olsen report.[36] The Olsen report was the result of a study financed by the Kellogg Foundation in the early 1950s as to the content of and the responsibility for graduate education in health administration. One of the conclusions of the report, at least the way the report was interpreted, included the idea that it really didn't make any difference whether a program in hospital administration was in the medical school, business school, or graduate school or whatever. It did make a difference, though, that all the relevant disciplines were brought to bear upon this emerging field.

I think Michigan picked up that cue and developed a multidisciplinary approach.

Residency

One of the hallmarks of the early years of graduate hospital administration education was the requirement that students complete a one-year residency. The residency experience was the second year of the two-year graduate program. Like the Duke University training program, it was a controlled work experience in which the student was exposed, under the supervision of a senior administrator, to the operations of the hospital.

The Minnesota residency is described below, first by James Hamilton and then by Gary Filerman and Edward Connors.

HAMILTON:[37]

I have had very strong feelings about the master's degree program and the residency, or internship, none of which were universally accepted. My thesis was that you could not teach a graduate course like hospital administration and then have the graduates immediately begin to do work of any stature without a practice period. How long should that practice period be? There was a great debate. I said a year.

I began to use the residency system, and I began to impress upon the guys I was using as preceptors of the residents that preceptors were members of the faculty. I had them all voted members of the faculty. The University of Minnesota put them on the faculty as clinical preceptors. This was not any hogwash. It was real. Then, I made the preceptors come back to campus every year for a faculty meeting.

I picked the leading people in the field, from all around the country as preceptors.

We used people like Frank Groner[38] and Boone Powell.[39] We picked them from different parts of the country. Then I would say to them, "You have got to come back to campus and learn how to be a preceptor. Don't talk to me and tell me how you are going to take this student and put him to work. That's just part of his exposure. You have got to be sure he is being taught this and this and this."

So I brought them back to Minnesota, had faculty meetings, and had them put down on paper what a preceptor should be doing. Then it was all mimeographed in different forms for them to use.

I did this to make them honest-to-God members of the faculty. This lasted for about six or seven years, then the older preceptors began to delegate the job to graduates that they had hired from the program.

The residency was a serious business. We didn't do it lightly. I finally dwindled the number of preceptors down to a few. They had to take a resident every year. They didn't choose him, I did.

I said, "You don't ask a teacher of algebra to choose his students. The dean of the school sends the teacher a student, and he has to teach him. You are going to have to do the same thing."

Other hospital administration courses in other schools had been working it in a different manner than this, so I was running into all kinds of comments and criticism. People wanted to know, why didn't I do it like Columbia, which sends its residents to hospitals right close by? Even Kellogg had an idea at one time that they ought to be located in a certain geographic area around each school.

I said, "I think that's a lot of hogwash. What you should do is pick a faculty member and an atmosphere where the student will learn what he needs to learn, what he doesn't know now, or what he needs to know in whatever he is headed for."

I made the residency matching a major process. I would ask the students in November to put down on paper the three places they would like to go. I would then take that information and begin to study that individual. I would not let it be known until April where he was going. In the meantime, I had been studying where to put him.

I would study the appointment and the student very carefully as to the personalities, what the student needed, what the environment was apt to give him–as much as I knew how. Of course, I thought I knew how, without any question. I really did try to match the appointment to the student's wishes wherever possible. If it were going to be different from what he had on his list, I would call him in and discuss that with him. Sometimes I would change my mind after he talked with me–usually against my better judgment.

In other words, I thought I had given enough personal thought to it that I knew more about what a student ought to have than he did. That was an assumption on my part, but it seemed to work pretty well. A lot of students, who at first hated to go where I sent them, told me later how glad they were that I sent them.

FILERMAN:[40]

As one began to look ahead, the critical decision was where to take a residency. I believe that two of my choices were Johns Hopkins and Strong Memorial, so I was definitely interested in a university hospital setting. Hopkins was somewhat selective, in spite of their institutional arrangements with Minnesota, in which Minnesota virtually picked the resident. Hopkins retained a veto, and you had to go there for an interview. If they decided you

didn't have two heads, you were accepted.

My motivating factor in picking Hopkins was the prestige of the name. I didn't know anything about the residency. The director of the hospital, Dr. Russell Nelson, was at that point a major figure in the field, and that added to the stature of going there.

If I had known what kind of a residency it was, I might not have gone there. Maybe I would have anyway, however, because of the prestige of it.

I thought later, as I was in the residency, and I still believe, that the residency experience I had demonstrates some of the fallacies of the residency process. An experience like mine shows some of the traps that the field had fallen into, such as confusing the prestige of the institution with the quality of the residency, or the stature of the administrator with the quality of the preceptorship.

Obviously what I'm saying is that, for many reasons, mine was not a very good residency. Part of the problem was that it was a delegated residency. The hospital's director was not readily accessible to the residents. He had limited knowledge of the program. Beyond that, he wasn't interested and, in fact, didn't really believe in the residency. He really didn't think that it was part of the way by which you learned hospital administration. So he delegated it to an assistant. Russ Nelson believed that the way you learned to run the Johns Hopkins Hospital, and this is a direct quote, was, "You start in the storeroom killing cockroaches and work your way up, or you started on a clinical service as a physician."

Somehow those were not equal. It was not a good residency, because Nelson believed in the separation of the administrative side of the house from the medical side and that the only people who bridged that gap were the medical administrators, the physician administrators. So the residency would by definition be limited to the administrative side of the house. It was also limited in a hierarchical sense, because you were delegated to an assistant administrator. I suppose that I had five hours with Nelson that year and only because I fought for it.

In fact, I had a good residency, but it was in spite of the residency program.

CONNORS:[41]

I went to the Rhode Island Hospital in my administrative residency. I found out that the transition from the classroom to the practical world was difficult and that the real problems were tough. The power struggles, the competing points of view were real.

Mr. Oliver G. Pratt was administrator at that time and was very influential in my life and my development. He prided himself and his organization on the fact that he took young

men from the University of Minnesota–he and Mr. Hamilton were close friends.

I was fortunate enough to be asked to stay on at the Rhode Island Hospital as an administrative assistant.

The Ph.D.

As the hospital management field matured, interest in Ph.D.-level education increased. The pressures for offering a Ph.D. were several, but, as the following comments by Hamilton reflect, the need for such training was not initially accepted by everyone. Hamilton's comments are followed by those of Gary Filerman, who received a Ph.D. from Minnesota.

HAMILTON:[42]

One of the more controversial subjects was the Ph.D. course in hospital administration.

For a long time I was firmly convinced that a Ph.D. in hospital administration meant nothing. I said I was not going to offer a Ph.D. because I don't think a person just because he had a Ph.D. would be a better administrator. Also, I felt that the student who wanted a Ph.D. just for the degree's sake ought not to be an administrator to begin with.

Finally, however, we began to offer a Ph.D. I was being pushed by Kellogg, mostly, to turn out some teachers. The field was beginning to expand. Where do you get the teachers? You try to get the average hospital administrator to go in and teach in a graduate school, and you find out that he hasn't any teaching background. He can't teach, really. Oh, he can convey some information and get across a certain amount of this and that, but he doesn't use or know the fundamentals of teaching.

Kellogg put some money in three places. They put some in the University of Iowa, where Gerry Hartman[43] was trying to turn out a Ph.D. in one year. (I don't think that can be done, by the way. No Ph.D. can be turned out in that time. He discovered later he couldn't. He had to keep them four or five years to train them.) Also, Columbia was trying to teach them in a regular length of time but didn't have enough institutions to work through.

So we started one at Minnesota. Our strategy was that we'll turn out teachers and scholars provided we don't take more than three a year. We'll select them from that point of view. We don't want them to be administrators. We are only training people who were hopefully going to be good teachers. We are only training people who could be scholars and who could do some research in the field–research in administration, not in medicine. So we

began to turn out three at a time. We had, if I remember right, only two classes before I left.

I think they have continued the Ph.D. program at Minnesota, but I don't think they have very many in it.

I thought a Ph.D. was useless if a person was going to be an administrator. It didn't make any sense to me. If he was going to be a scholar or a teacher, that was different. The fellows I trained almost invariably were in demand before I finished training them. So when the time came around for them to write their thesis, I had to let them take a job and write their thesis at the same time. This extended the period a little bit. It was the pressure of need in the field. The five or six I trained all turned out to be good and to do very well.

FILERMAN:[44]

The doctoral program at Minnesota, on balance, I think, knowing what I do today about doctoral programs, was a pretty good one.

From the standpoint of education in terms of what you were exposed to in breadth and depth, it represented a very good education in a very good university. On the other hand, in terms of education from the standpoint of self-definition, making the optimum use of the resources of the university from the perspective of the individual and his growing understanding of his needs and interests, it was quite limited. You didn't have much flexibility. A good part of the judgment as to what was appropriate for you to study and what wasn't resided with Jim Hamilton. So that if I went to Hamilton and said, "I've decided I want to take a three-course sequence in the philosophy of science or in art history," whether or not I was able to do it depended on whether he thought it made sense. That, in turn, depended to a great extent on how it fit with his idea of what you needed.

The doctoral program at Minnesota was really a very difficult experience for everybody concerned. I was in the second cohort; the first cohort was still there. The third cohort was arriving or had arrived, and so the program had thrust upon it a group of pretty bright, motivated people who came with a different set of expectations and experiences than did the master's students. I don't think that Jim Hamilton was prepared for that difference. The question of style wasn't so important to us.

When Hamilton said, "This is the way it is," we said, "Why? or "I don't think so," or, even worse, "Where is your data?"

That led to a great deal of tension, which was not the same kind of tension as we had experienced as master's students. 'When we were master's students we were totally encapsulated in that program–its faculty, its traditions, its whole milieu. As doctoral students we were out across the campus and having experiences with many different faculty members and other doc oral students. So you came back to the program with something to compare

it to. For me, at least, it was not always a pleasant comparison. Hamilton and I were at odds a good part of the time. A number of the students were at odds with him over the same issues.

I believe that Hamilton made a number of really quite remarkable and pivotal contributions, e.g., creating the master's program, setting up the decision-making model and carrying it through so well and convincing a lot of people that they were part of the self-fulfilling prophecy of leadership. He also contributed a great deal by creating the doctoral program and by the vision of what a doctoral program could do for the field. Where he reached his limits was in attempting to put himself academically into the doctoral program. In later life I have learned to appreciate, if not to genuinely admire, a number of individuals in the field who have recognized and dealt with that in themselves.

The following reminiscences by Andrew Pattullo and George Bugbee illustrate the W.K. Kellogg Foundation's continuing interest in health administration education, and particularly in the Association of University Programs in Hospital (later Health) Administration. Pattullo's comments are presented first. Bugbee's observations, which focus on the AUPHA, follow.

PATTULLO:[45]

The foundation's support to the Association of University Programs in Hospital Administration is another example of its continuing involvement with health administration education. I think their first meeting–an informal grouping–was in 1948 during the AHA annual convention.

Later, in the early 1950s, we helped bring AUPHA together with some other interested parties for a conference in Battle Creek to attempt to identify some of the needs at that time in the field, which was very much in its infancy.

In the early 1950s I expect there must have been only a dozen or so programs, and that conference resulted in a number of suggestions which we followed through on: the need for more research orientation in the field and for more faculty being very prominent. At any rate, we did provide support to a few universities in an effort to strengthen what might be described as the field's "intellectual muscle."

Later on, we funded a second study commission, headed by Jim Hamilton as chairman with Herluf Olsen as director. This commission's report came out in the mid-1950s. The report had a very divisive effect in the field, creating quite a schism between programs in schools of public health and other settings. We tried to mend that rift by bringing the differing factions together through several conferences that tried to concentrate on the positive aspects

of the Olsen report. This strategy succeeded, I think, to a reasonable extent.

We were also supporting AUPHA in various ways. At that time, AUPHA had a part-time secretariat that was based at the University of Chicago program. George Bugbee had only recently arrived at the University of Chicago as director of the Center for Health Administration Studies and became interested in AUPHA and its purposes and needs. One evening we had a discussion about AUPHA with Chuck Goulet (who was AUPHA's part-time secretary). I recollect a suggestion was made that the foundation would not be averse to considering support for a reasonable period of time for some kind of full-time secretariat if there was also an agenda toward some objectives. From that conversation they did make such a proposal, and the first secretariat was hired. I think this proved to be a sound investment on our part and a wise decision by AUPHA, allowing it to become a viable organization.

BUGBEE:[46]

As the director of the Program in Hospital Administration at the University of Chicago, I was drawn into the Association of University Programs in Hospital Administration, as it was then called.

Charles Goulet was superintendent of University of Chicago Hospitals and Clinics, and he was secretary and treasurer of AUPHA. One night Chuck and I had dinner with Andy Pattullo. In the course of the dinner Andy talked about AUPHA. We, Chuck and I, were visualizing the program that AUPHA could have, but Andy was indicating that nothing would ever come of it without more full-time leadership and direction.

Chuck had driven us up from the University of Chicago campus to meet Andy. It was about ten miles. On the way back I said, "Chuck, you know what we were being told? For goodness sake, to do something. Stop talking and do something. I think if we submitted a project that made some sense to Andy, the foundation might approve it."

Chuck had a dictating machine at home. He went home and that night dictated a draft application. We put money figures in to provide for five years of funding. We got the grant and looked for an executive secretary.

Well, who could we hire for the executive secretary of AUPHA? It was a hard thing to know. The grant was there, but it wasn't that much money either, you know. We couldn't hire the most expensive fellow in the field. Chuck Goulet was secretary, and he sat in the executive committee, which was small.

Finally Chuck said, "I had a resident at Johns Hopkins Hospital when I was administrator who did his Ph.D. work with Jim Hamilton. He's smart." That was Gary Filerman. We hired him.

Hiring Filerman set the stage for the resurgence of AUPHA, largely through his hard work and talents, and by establishing an accreditation program.

Since the founding of the Program in Hospital Administration at the University of Chicago[47] in the mid-1930s, the field has grown in graduate and undergraduate programs. Today there are over 50 graduate programs in health administration. There are thousands of students each year taking health administration courses at either the graduate or undergraduate level.

One extension of health administration education that should not be overlooked is the excellent program of postgraduate and continuing education developed by the ACHA for practicing administrators and other members of the college. The program has had a great effect on the maturing process whereby an occupation became truly a profession with dignity and status.

Thus education in health administration has evolved from apprenticeship and on-the-job training to graduate and postgraduate education of growing sophistication. No one has more aptly expressed what education in the health field could mean than John S. Millis, an eminent authority in professional education.

MILLIS:[48]

The image I use in trying to explain my thinking is that, in an apprenticeship, the responsibility of a master is to bring the apprentice to his level. The responsibility of the true teacher is to bring the student to his shoulder so he may stand thereon and go beyond. The difference between training and education is the capacity to go beyond.

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. Richard W. Schwarz, John *Harvey Kellogg, M.D.* (Nashville: Southern Publishing Association, 1970), p. 28.

2. The Western Health Reform Institute was opened in Battle Creek, Michigan, by SeventhDay Adventists on September 5, 1866, to treat the sick with water cure rather than drugs. The institute was patterned somewhat after James Caleb Jackson's Our Home on the Hillside, a water cure retreat in Dansville, New York. The establishment of the institute was a "fulfillment of one of the fondest hopes" of Ellen G. White, the Adventist "prophetess of health reform."

3. See chapter 2 for additional comment on the Flexner Report.

4. *John R. Mannix, In the First Person: An Oral History.* See Profiles of Participants, in the center of this book, for biographical information.

5. See Profiles of Participants for biographical information.

6. *Andrew Pattullo, In the First Person: An Oral History.*

7. Ibid.

8. Davis went to the Kellogg Foundation from the Duke Endowment; he was president of the AHA in 1948.

9. See Profiles of Participants for biographical information.

10. *Mannix, Oral History.*

11. Buerki was president of the AHA in 1936.

12. Agnew was president of the AHA in 1939.

13. MacLean was president of the AHA in 1942.

14. See Profiles of Participants for biographical information.

15. Crosby was president of the AHA in 1953 and executive secretary from 1954 to 1972.

16. Dixon is a graduate of the Columbia University course in hospital administration. He was a Kellogg Fellow, a public health officer, a president of Antioch College, and is now a faculty member at the University of North Carolina, Chapel Hill.

17. Brown held various professional positions, among them: director of the University of Chicago Hospitals and Clinics; director of the University of Chicago Program in Hospital Administration; vice president of the University of Chicago; director of the Duke University Program in Hospital Administration; and executive director of a consortium of New England hospitals.

18. Bachmeyer was director of the University of Chicago Hospitals and Clinics and director of the University of Chicago Program in Hospital Administration. He was also director of the Commission on Hospital Care. Bachmeyer was later director of the Commission on Financing of Hospital Care, where he served until his death in 1953.

19. See Profiles of Participants for biographical information.

20. Haldeman was a public health officer who became director of the Hill-Burton program. At the time of his retirement, he was assistant surgeon general of the Public Health Service.

21. Cartmill is the chief executive officer of Harper-Grace Hospitals in Detroit. He was president of the AHA in 1967.

22. McNulty is chancellor of the Georgetown University Medical Center.

23. Bishop was director of the University Hospitals of Cleveland.

24. *Richard Stull, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

25. *Kenneth Williamson, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

26. MacEachern was director of hospital activities of the American College of Surgeons and author of one of the first textbooks in the field.

27. *James A. Hamilton, In the First Person: An Oral History.*

28. Amberg was president of the AHA in 1959.

29. *Gary L. Filerman, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

30. *Edward J. Connors, In the First Person: An Oral History.* See Profiles of Participants for biographical information.

31. *Walter J. McNerney, In the First Person: An Oral History.*

32. McNerney wore three hats at the University of Pittsburgh: assistant to the coordinator of hospitals and clinics and medical centers; administrator of one of the medical center hospitals; and assistant professor in the Program in Hospital Administration.

33. The state capital of Michigan.

34. See Profiles of Participants for biographical information.

35. *Connors, Oral History.*

36. The Olsen report was from one of the three commissions funded by the W.K. Kellogg Foundation to examine hospital and health services education needs. The first commission was set up in the 1940s under the direction of Charles Prall; it produced the Prall report. The second was set up in the 1950s; it was chaired by James A. Hamilton and directed by Herluf Olsen of Dartmouth College. The third, set up in the 1970s, was chaired by James Dixon; Charles Austin was the study director, and Janet Strauss was assistant director. The report was published in three volumes under the general title *Education in Health Administration* by the Health Administration Press in Ann Arbor. It is often referred to as the Dixon report.

37. *Hamilton, Oral History.*

38. Groner was president of the Baptist Memorial Hospital, Memphis.

39. Powell was president of the Baylor University Medical Center, Dallas.

40. *Filerman, Oral History.*

41. *Connors, Oral History.*

42. *Hamilton, Oral History.*

43. See Profiles of Participants for biographical information.

44. *Filerman, Oral History.*

45. *Pattullo, Oral History.*

46. *George Bugbee, In the First Person: An Oral History.*

47. The Program in Hospital Administration at the University of Chicago was founded by Michael Davis in 1934, with start-up money from the Julius Rosenwald Fund.

48. *John S. Millis, In the First Person: An Oral History.* See Profiles of Participants for biographical information.