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LOCAL HISTORY

ORAL HISTORY
MR. ANTHONY J. PERRY
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This is Betty Turnell with the oral history series sponsored by the Decatur Public Library. Our guest today is Mr. Anthony J. Perry. We are recording at Mr. Perry's Office in Millikin Court. He served the Decatur Memorial Hospital since his arrival at Decatur in 1951.

Q. Mr. Perry, what jobs did you hold at the hospital?

A. Originally I came as a student. I was an administrative resident from 1951 until 1952, which is the period of time I had to serve to qualify for a Master's Degree in Hospital Administration from Northwestern University. Upon completion of my degree requirements, I was appointed Assistant Administrator in 1952 and then later became the Associate Administrator in 1958, and in 1961 I succeeded Leon C. Pullen, Jr, who was then the Administrator. I served as Administrator from 1961 until 1969, when my title was changed to "Executive Vice-President" and to "President" and "Chief Executive Officer" in 1974. I retired from the hospital in 1986 after 35 years of service. As you may know, the hospital was called the "Decatur and Macon County Hospital." Its name was changed to "Decatur Memorial Hospital" later.

Q. Those are impressive jobs! I have just been re-reading the history of Decatur Memorial Hospital in the book The Vigil Never Ceases - Two Miles North. In this book, your work with the hospital is given very high praise. You are described as "one of the most vital forces since the adventurous days of Dr. Will Barnes." We want to hear more about your career, of course, but first let's hear about your early life - where you were born and where you grew up and so forth. Will you tell us something about that?

A. I'll be happy to. I was the youngest of a family of five, born on a New England truck farm of immigrant parents. I was the only member of the family privileged to go to college. I went on to obtain a bachelor's degree in education. From there I went into the military. I went to New York University for a year, studying meteorology. I was a weather officer, a weather forecaster in World War II for almost three years. I was discharged from the military in Europe and went to work for TWA International, which was just starting its overseas route. I worked for TWA International for about fourteen months in Lisbon, Portugal, where I had been previously based with the military. Interesting enough, Portugal was a neutral country, so for the last year that I was in the military I was in civilian clothes and I was a government official in Lisbon, Portugal.

I then decided I had lived in Europe long enough, and I came back to the United States. Being still single, I decided I was getting to the age when I should be considering a family. I went to work for Peruvian International Airways in New York City at LaGuardia Airport.

I had the privilege of running the first scheduled passenger-carrying flight out of J. F. K. Airport in New York, which was then called

"Idlewild." Our airline was the first airline to be moved over to J. F. K.

I met my wife at J. F. K. She was working for KLM, the Royal Dutch Airline.

From there, I worked for a brief time for Pan-American Airlines in New York and then decided that I would go back to school.

I then enrolled in Northwestern University and had to take some prerequisites. I finished my master's degree in hospital administration at Northwestern University in 1952.

Q. What caused you to choose hospital administration as your career? After your experience with aviation?

A. I was very fascinated with aviation. I loved aviation, and I flew myself, but my future was uncertain. I had been employed overseas, and I didn't know how long I was going to have to work overseas with TWA. When I came back to the United States, it was pretty much with the idea that I would look for another career. The airline industry was in some disarray at that time. It was growing rapidly, but in a very disorganized manner.

A man who was very, very influential in my life kept re-appearing at critical points in my life. I first ran into him when I was in high school. He was the superintendent of schools. His name was Norman Bailey. My sister was his secretary for twelve years. He encouraged me and other young country boys to go on and get an education and go to college. I did, and when I came out of college, I was successful in getting a commission in the military. When I came back to New York, he was running a hospital in New York City. He had gotten out of school administration into hospital administration and was teaching at Columbia University School of Hospital Administration. About the time I made my decision, he decided to come back to Chicago, where he had been originally on the faculty of Northwestern University. So I quit my job in New York, got married, moved to Chicago, and enrolled in Northwestern and spent my academic year on the campus at Northwestern. When I was ready for my residency, which I had to serve to qualify for my degree, I had to find an acceptable preceptor.

It so happened that I had worked at Michael Reese Hospital when I was going to Northwestern. Leon Pullen, who was the administrator here at the time, had worked at Michael Reese in Chicago while he was going to Northwestern because it was an evening program.

So Norm Bailey said that Leon Pullen was looking for someone to help him in Decatur. As a result of the mutual friendship, I came to Decatur to spend my one year with Leon Pullen. At the end of the year the hospital decided they would offer me an administrative position here in Decatur and Macon County Hospital.

So that is how I ended up in Decatur. It's interesting that Leon Pullen and his wife Nancy became very close friends of ours. He was from Portland, Maine. We were both New Englanders'. We got along very well.

Q. Very good! It's amazing how all the parts of your life seem to fit together like parts of a puzzle. All these people seemed to get together and help you decide your future.

A. I can't say that I ever had a master plan. I always felt that if I did a good job at whatever I was doing that something good would happen. And it seemed to work out that way.

Q. So in a way, Decatur is the benefactor of your experience even if you didn't choose it, exactly, but you did finally find yourself in Decatur. What was the situation when you arrived here?

A. It was what I referred to as a golden opportunity. The hospital, of course, had been through the depression, World War II, and was into the Korean War situation. Almost anything you did was a help. It needed many, many things including good organization. It needed to develop employees. It had not had any professional management for some time. Mr. Pullen came only a year before I did and was the first professionally trained hospital administrator that the hospital had had - not that they didn't have some good people running the hospital before. Back in the late 20's and 30's, it had excellent administration under the supervision of a physician. But as a result of the wars and the depression, it was badly in need of many, many things. Of course, after World War II, health care just exploded in technology and as a result of what was learned in World War II.

Q. So you were the right person in the right place at the right time.

You told us of the great help and influence of Mr. Pullen. There probably were others who influenced you at Decatur Memorial Hospital.

A. Yes, there were many others, too many to mention, but among them were the Chairmen of the Board of Directors. I believe that during my experience here in Decatur, I worked under thirteen different Chairmen of the Board. They were all top executives and I feel they did a lot to further my executive skills.

I also had the pleasure of working with several outstanding physicians and developed a very close understanding of medicine as it is practiced in a community like ours. We also had a great group of employees, who were very helpful and very loyal. You can't be a leader unless you have a following.

Q. You've mentioned some of the great explosive events following World War II. Among them was the advent of Medicare. That certainly must have had an influence on the hospital.

A. Yes, it had a profound influence on the hospital. Not only did we have Medicare, but we had accelerating inflation. We had accelerating cost of care and increased cost of the new technology.

So there were profound changes in the way a hospital was paid for the care of the elderly, as an example. Prior to Medicare, we relied upon the resources of retired people to pay their own hospital bills.

After Medicare, even though it may not have paid as much as the health care industry felt that it should, it was certainly more than what was being paid in the earlier years when we had to rely on the resources of elderly people. The community and the hospital, however, are very well endowed and that was very, very helpful in providing care.

Also there has been a very profound change in the way that patients are treated. I can remember when we had two 10-bed wards that were full of patients who were really there until they died. Of course, in today's world those people are not in the hospital. They are in nursing homes and other health care facilities.

Q. There were certain physical needs for building and maintenance that you had to take care of too, weren't there?

A. Yes, the hospital was what I refer to as a "tuberculosis sanitarium configuration." It was spread out and that was fine when it was originally designed - before air-conditioning, no toilet facilities in most of the patients rooms. The traffic patterns in the institution were difficult for visitors and difficult for new personnel. We had to cope with all of those things. I can remember when we put in our first window air conditioning unit. We put colored lines on the floor to direct people to go from one location to another.

Then, of course, we had to begin to vertically integrate the institution and start to go up with it. Vertical transportation in elevators is much more efficient than horizontal transportation on wheeled vehicles.

So we had to cope with all those changes plus the fact that we had to institute a lot of programs.

We had no pension program for our employees. We had employees who had worked there for 35 years who weren't even covered by social security.

The social changes were coming along, and we had to be able to retire those people with dignity. So we joined the social security program. We put in a pension program. We started a training program to develop new employees in the new technology. We had to train maintenance people to maintain the new air conditioning system and all the electronics that were coming down the road.

Q. And there was a great advance in the treatment of certain diseases such as the use of radiation and other ways of treating diseases?

A. That's true, but surprisingly enough, back in the early days of the hospital, the hospital was very, very advanced.

Dr. Barnes, as you may have read, was a real progressive thinking man. We actually had radiation therapy here before the depression. Dr. Barnes was insistent that we be right up to date. He had a huge radiation therapy machine. It was back where eventually the offices ended up in the old main building. He had one of the first laminographs west of the Appalachian Mountains. It was one of the first hospitals in the country licensed to use insulin.

So there was a big spurt of technology before the depression. Then everything sort of collapsed during the depression, and it started again after World War II when we started using some of the new technology and the new radiographic equipment and therapy equipment.

It wasn't until 1968 that we put in the present day type of radiation therapy equipment to treat cancer.

Q. Now Decatur Memorial is one of the outstanding units in the treatment of cancer, isn't it?

A. Yes. We have a cancer care center. We have added not only the X-ray or radiation therapy treatment but also linear accelators. We have also added chemotherapy, which is the treatment of cancer medically with drugs.

Q. You mentioned something about the organization of the staff and so on, but I read about the graduate directors' council. What was that?

A. This was an interesting development. When I came here, and when Mr. Pullen was here, we found the Board of Directors was composed of people who had been on the board for many, many years. Many were getting along in years, and they really didn't want to serve on the board any longer, but there was no mechanism for rotating board members at that time.

Staley's idea, that is, A. E. Staley, Jr., was that there should be some way of rotating people off of the board and yet not lose their talent and their support. Many of these board members had been loyal supporters, not only organizationally, but financially.

Mr. Staley suggested that we create a Graduate Directors' Council. If anyone had served on the board nine years, he would be eligible to be appointed to the graduate directors' council, which served as an advisory board and still serves today as an advisory group to the board of directors and the management of the hospital.

Q. And it works?

A. It works very, very well. Unfortunately, many of the graduate directors who were here when I came and during my early years have passed on, but a new corps of graduate directors is being produced because now the maximum term on the board of directors is nine years.

Q. And you can make use of all that experience that has been built up?

A. Yes. They have been invaluable. We had people who were on the board like A. E. Staley, Jr., John Wagner, Ira Abbott, Mr. Scheiter from the Staley Company, Bill Barnes, Mr. Van Law, and many of those people who were shakers and movers, so to speak, and who made things happen. They were men who could make things happen. They were men who could make a decision while sitting at a table. They didn't have to go back and consult with anyone to do it.

Q. Good. There were outside factors that brought pressure on the hospital, too. We read about it in the papers everyday - malpractice suits, insurance costs, etc. Did that cause you any problem?

A. As you know, wherever there is a pot of gold, there is an attempt for people to get some of it. Prior to the middle '50's, hospitals had what was called "charitable immunity." A hospital could not be sued for malpractice because it was a charitable organization. But once hospitals became affluent and had more funds, we gradually lost that immunity from suit. Of course, after that we had to buy insurance, and once you start buying insurance, then people are more inclined to sue or at least file claims. It just develops. It's the same way with the federal government. Prior to the implementation of Medicare, we were only answerable to the city of Decatur and the state of Illinois for building codes. Once we started accepting federal funds for construction as well as for Medicare, then we came under the guidelines of the Medicare legislation, and we had to conform to federal standards. That is how we got into difficulty with the life safety codes. For example, we built the Staley Pavilion. It was opened in 1968 and '69. We built according to the codes that were in force that the time the building was designed in 1965 and '66. The federal government modified its life safety codes, and we had to bring the building into some semblance of compliance. Here was a brand new building, practically, and yet it was out of compliance with the life safety codes.

Q. Isn't that changing the rules in the middle of the game?

A. It was changing the rules. There were many ramifications of it. Eventually, we negotiated it until the cost was high but not prohibitive. It was felt at one time that to comply with the life safety codes, we would have to gut the interior of the building and rebuild it, but fortunately, the federal government realized that the costs were going to be excessive when you looked at all the hospitals in the country that were built at that time or earlier. They then came up with a different system, an equivalency of the code. That's what we ended up doing in conjunction with a building program in the middle 70's.

Q. It's no secret that you had opportunities to go elsewhere probably about this time. I know that you were offered other positions and other opportunities. You were invited to join the Hospital Research and Development Institute at Pensacola, Florida. What is that? What were your feelings about all this? Was it just the attraction of Decatur, or what was it that kept you here?

A. It was a combination of things. There was a lot of growth opportunity there. Managers like growth. They like to manage growth. They like to build things. We like to see an organization grow. All during the '60's, we were in that growth mode. It was interesting. I'll tell you a side story to that. About the middle '60's we had a significant building program on the drawing board. I received a telephone call one day from a recruitment firm. They wanted to know if I was interested in a job in the Mid-West in a bigger hospital, probably at more money. I said, "No - I'm not interested. They've been treating me well here. I've only been on this job as administrator for a short period of time.

I've got a big building program going. I feel a commitment to the community."

They said, "Well, why don't you come to Cleveland, Ohio, for an interview? We'd just like to have your curriculum vital on file in case something comes up later on that you'd be interested in?"

So I didn't want to hurt their feelings, I didn't want to burn my bridge. So I went to Cleveland, Ohio. I arrived at the airport and checked in at a motel. The next morning they picked me up. We were obviously driving out of town instead of in town. I said, "Where are we going?"

They said, "We're going to Canton, Ohio." I said, "Canton, Ohio? I thought I told you that I was not interested in moving."

To make a long story short, they took me to a hospital in Canton, Ohio that was looking for an administrator. They wined and dined me. I kept saying, "But I don't want to move. I'm not looking for a job."

Before I left that day, they offered me the job. I came back to Decatur and didn't even consider it because, again, I felt I had a commitment here. They were treating me fairly and well. So I decided I would stay in Decatur.

Then, of course, as you grow older, then your opportunities to move lessen.

The Hospital Research and Development Institute is an interesting group. Their reason for existing was to create a forum where an orderly system for the exchange of information and advice among the practicing hospital administrators and the decision makers in the health-related industries could take place. In other words, it's a think-tank group.

Q. It sounds good!

A. There were 25 of us and at that time we had about 35 clients. Some of the giants in the health-care industry that were providing services to the health-care industry, such as the American Hospital Supply Corporation, such as Eli Lilly Company. We had one but not more than two of any one industry like Hill-Rom Company, which is a big manufacturer of hospital patient room furniture.

The idea was that they would test their ideas on us what we thought would be helpful in the market place. Then we were on the cutting edge of what was being developed by those industries and leaders in the health-care industry. So it was a two-way street, an exchange of ideas, but it always benefited the hospital and benefited us professionally because we knew what these companies had on the drawing boards. Many times we were able to participate in the early trials and experimentation of these devices. One of them I had a very important role in. Back in those days we had a lot of problems with patients falling out of bed. In most cases, patients went over the top of the side rails rather than getting out of bed voluntarily. It was felt that if they developed what they called a "safety side," which was a half a bed-rail, that it

would not preclude the patient who was determined to get out of bed, but it would keep the patient from inadvertently rolling out of bed. As a result, it cut falls from bed significantly. That was one; another one we pioneered was the intravenous stand. They used to be on casters, and the nurses were always looking for one. I said, "Why don't we just put this under the bed?" We developed a telescoping intravenous stand stored in a little trough under the bed.

Q. Every bed?

A. Every bed had one.

Q. So you didn't have to move them around?

A. Wherever the bed went, there was an intra-venous stand. There were a couple of holes in the spring, where we could just put the pole in.

So it was fun to be involved in those very simple but very important activities. We had one of the first voice-actuated nurse call systems, where the patient could talk to the nurse, and the nurse could talk to the patient without having to press buttons to talk and listen.

Q. A great help!

A. So there were a lot of experiments like that. This organization was also the think-tank for several other related organizations that I helped to found. One was "Voluntary Hospitals of America," which was started by thirty leading hospitals in America, who put together a shared service organization that would bring advantages to each of the member hospitals. That organization now has almost a hundred shareholders in it and about 700 related hospitals. It did everything from purchasing to managing nursing homes and helping such organizations. It still exists today. It's now about ten or eleven years old.

Another company I was involved in was an off-shore insurance company. During the malpractice crisis of 1975, a group of hospital administrator friends of mine went down to Bermuda and got a charter to start an insurance company in Bermuda and another one in Grand Cayman. Two years later, our hospital came into it when I was on the Board of Directors of that company and the one in Grand Cayman, which insured doctors. That was the only way we could make malpractice insurance available to hospitals and doctors in some parts of the country. That company today has transformed into a U. S. based stock company. I'm the chairman of the board of the company, which is now called the "M. M. I. Companies." Last year our gross written premiums was over 100 million dollars. It has 165 employees. It's based in Chicago, Illinois, and we have a subsidiary in London, a subsidiary in Grand Cayman, and a subsidiary and life insurance company in Kansas City. It's developed from a small start to a significant organization.

Q. This Hospital Research and Development Institute, then, wasn't a full-time job, but you just did that part-time in your so-called leisure?

A. Actually, it required very little of our time. The philosophy was that it should not interfere with your work. It was something to do

after-hours, in your days off and vacations, so it was not a very intense activity. There were no written reports and nothing that was very time-consuming. A couple of times a year we did sit down with clients and had an educational session and swap ideas.

Q. It sounds like an ideal organization! Moving on, we've had a good deal of discussion of nurses' training in Decatur, at Decatur Memorial Hospital and other places. Could you give us a little survey of the way that nurses training has developed in Decatur?

A. Actually, the School of Nursing started almost before the hospital was opened. They took the first class in 1915, and the hospital opened on January 1, 1916.

Q. They needed nurses before they could have a hospital?

A. That was the reason. They needed nurses, and they realized that they had to train a local supply.

So the school was founded. Interestingly enough, it was founded by Dr. Barnes, who was the prime mover, but the first director of the school was from Boston, Massachusetts.

Of course, Dr. Barnes had been trained in Massachusetts. He had contacts, and he brought Ethel Goss to run the School of Nursing. It was a very fine school. It was closed for a short time during the depression and then was re-opened, when it ran continuously until Millikin University started a program leading to a Bachelor of Science Degree in nursing close to ten years ago. At that time we phased out our school at the hospital. In some respects it's too bad that we did because the baccalaureate schools are not turning out enough nurses to meet the demand and the cost of a bachelor of science degree in nursing is much more than the traditional two year nurse program at the hospital because the hospital subsidized it.

There was a lot of pressure from nursing organizations to make nursing a profession, and they felt that any nurse that did not have a degree was not truly a professional.

To fill some of the void a school for practical nurses was started by the Decatur School System. It is still operating today.

So the two primary sources of nursing personnel in Decatur now are the Millikin University School of Nursing and the licensed practical nurse school. Now there are some other schools in surrounding cities but our primary source are those two.

Q. But the hospital also supplies home care, too, doesn't it?

A. Yes, in the late '70's and early '80's there was a significant trend towards getting people out of the hospital and keeping them in the home or in some other institution. It started by taking people out of the hospital and putting them in nursing homes. Then they found the nursing homes were not the best solution to that problem, and the Visiting Nurses' Association started to provide some home health care. But that

didn't accelerate fast enough. Then in recent years, as a result of Medicare Programs there has been a proliferation of home health care.

Before I left the hospital, we started a Home Health Care Program, which is doing very, very well. It's a follow-up in meeting the needs of patients. In this way you can get patients out of the hospital faster.

The hospital is the most expensive form of care in the health care system. Home health care is not only less expensive, but it keeps the patient in his own home environment. They do better, especially older patients who might become disoriented in an environment they aren't familiar with. So it has proliferated and it's been a good thing.

There are many other ways hospitals have diversified, also durable medical equipment, such as canes, crutches, wheel chairs, and all those things a patient needs at home are available through the hospital.

Q. Well, we certainly know the part that nurses play in health care, but it does seem, from what we read in the papers and hear about, that there is a shortage of nurses. Is that true?

A. Yes, there is a growing shortage of nurses. Many people in the field feel that it is going to become critical in the very near future. The root cause of some of the problem is that prior, you might say, to the liberation of women, a young woman went into teaching or nursing or got married and raised a family. With the changes in the educational system and more opportunities for women, women became lawyers or doctors and engineers and pilots and everything else. It's taking that pool of people and diverting them away from some of the traditional careers in the health care field. We have always had some men in nursing, but they have been in the minority. They still are the minority.

But now the schools are unable to attract as many nurses as they had prior to the change in the social structure. It's going to create a severe problem.

The other problem is that we still haven't faced up to the recognition of the value of the nurse. They are somewhat comparable to a school teacher except that school teachers in some respects have easier environments to work in, unless you are in a big city. Nurses work 24 hours a day, seven days a week.

Q. It's hard work!

A. Yes, it's hard work. It's highly technical. It's very intensive. Many nurses suffer "burn-outs" for they work in intensive care units. Really, there is nothing left in the hospital now except intensive care of patients who are critically ill, and that puts additional pressure on the nurse. So the health care field is going to have to come up with some way of solving that problem. Part of the solution will have to be better compensation, better recognition of the value of a nurse- which can lead to increased cost.

Q. Right! But if it brings more nurses into the system, it would be worth it.

A. There has to be a solution to the problem, and there has to be a magnet that attracts people to any profession, whether it's medicine or airline pilots or engineers. People are not going to choose a less rewarding profession if they have a choice of a more rewarding one, both financially and professionally.

Q. Well now, there is another group of people we haven't acknowledged yet, and that is the volunteers. You rely very strongly on the volunteers in your hospital work, don't you?

A. Oh, yes. Volunteers are a very, very important part of the health care scene, not only in the hospital itself but even in the home health care and some of those programs. A lot of people think that volunteers started in World War II, but actually there were volunteers in our health care institutions going back from their inception.

Q. Florence Nightingale?

A. Florence Nightingale, although she was not a volunteer, she was very close to one. After World War II there was a big resurgence of volunteer groups. That resurgence hit Decatur and Macon County Hospital with the founding of the so, called Women's Auxiliary in 1954. It's a reincarnation of some of the guilds that had existed in previous years. Of course, there were two people who were very, very important in that movement. One was Mrs. Carl Dick, Sr. who was a fabulous woman and the person who brought the idea to Decatur. Then, of course, there was Fanny Bassett, Mrs. Fraser Bassett, who recently passed away, who was the first acting president of the auxiliary. These women got it off to a great start. They are very important in many ways, They have many excellent service projects. They are excellent in explaining the hospital to the community and the community relations. They are good in fund-raising, both direct and indirect. When I say that, I mean that they raise funds through the Fun Fair, through gift shops and thrift shops, but in addition to that, there are many women, and men now, in the auxiliary who explain the hospital story to people in the community who have wealth to leave to someone. There are many people who have substantial wealth but no heirs to leave it to and, as I always say, they either have to leave it to the church, the university, or to the hospital. Through good relations, with the help of people who belong to the Auxiliary, the hospital is the benefactor of many fine bequests.

When men came into the auxiliary, the name was changed from the Women's Auxiliary to the D. M. H. Auxiliary back in the 1970's. We have many men who volunteer and do a good job. We refer to the Auxiliary as the hospital's "Annuity." They were a valuable resource that produced benefits year in and year out, just as a fine annuity would.

Q. What do you see for the future of Decatur Memorial Hospital?

A. Well, Decatur Memorial Hospital is like many hospitals in the country in that it is suffering from major changes in the delivery of health care. As I said before, there has been a lot of emphasis on getting the patient out of the hospital sooner, keeping the patient from going to the hospital unless he or she has to, and that has had a marked effect

on utilization of the hospital as well as the financial side of the hospital.

The health care industry is a 500 billion dollar a year industry. It's huge. It's growing at a rate comparable to the gross national product, but it is being spent in very, very different ways.

We now have surgery centers and emergency centers outside of hospitals. A lot of things are being done in doctors offices. A lot of things are being done on an out-patient basis instead of an in-patient basis. We have better clinic and better highways so that people can get to tertiary care centers and as new technology and new techniques develop, patients benefit - for example - by-pass surgery for heart problems. We do not do that in Decatur. It's being done in Springfield. A lot of those patients, before they could have that type of surgery in Springfield, stayed in Decatur. They were in the Cardiac-care unit; they were treated medically; they were kept in bed until they got better. They didn't go out of town. Now if a patient is suspected of having a heart attack or having some problems in circulation in his heart, he is packed up and shipped to Springfield or somewhere else. That's just an example of some of the major changes. Decatur is going to have to find its own niche, such as in cancer care, in order to retain its viability in the future. The hospital now has on an average more than a hundred patients per day less than it had in the late '60's and early '70's. Fortunately, it is caring for many of those patients on an out-patient basis. For example, I can remember when, if you had cataracts, you came into the hospital. We operated on them manually, put the patient in bed with sand bags on both sides of his head and kept him immobile for the better part of two weeks. Now he walks in in the morning; we take off the cataract with a laser beam, and he walks out the same day. You can imagine what that does to hospital utilization.

It's the same way with a hernia operation. I had a hernia repaired in 1965 and stayed in the hospital for five days. Why did I stay for five days? Because stitches came out at the end of the fifth day. Now, the patient can come in, be operated on, and go home the next day, or the same day in some cases.

Maternities - it's the same way. Mothers used to stay in the hospital ten to fourteen days. Now in many areas of the country, they come in, deliver, and go home. Decatur is not quite at that level yet, but it's down to three days.

So these are all affecting hospitals. Another big effect in the future of a hospital is the aging population. By the year 2000, 60% of all in-patients will be attributed to the over age 65 group.

I'd like to go back and review some factors that will influence Decatur Memorial Hospital, along with other hospitals in the country. This is from a report by McManus Associates which was recently presented to the Board of Directors of our insurance company, which outlines some of the major health care trends.

McManus Associates is a consulting firm in Washington, D. C. considered to be one of the leaders. Some of their predictions are that there will

be continuing cost-containment pressures. The soaring cost of health care and the staggering national debt will force the federal government to curtail support of the national health care system. Despite the fact that the United States spends more per capita - which is approximately $2000 for health care - than any other nation, U. S. health statistics are among the worst of the industrialized nations. Then there is also the pressure from corporate America, which is demanding containment of health care costs. Major corporations have opted to self-insure. There is a trend to shift the cost and the risk of health car
Under the original Medicare legislation, Medicare paid the hospital its costs. So it was a cost-arrangement. Now, they are putting it on diagnostic-related groups, and industry is picking this up. So industry says, "We will pay this much, and you figure out how you are going to provide it for that price."

So the burden will fall on the health care providers to offer the most cost effective care possible, while still maintaining high standards for quality, and hospitals and physicians will be looking for more new joint - venture partners to help syndicate or underwrite the financial risk.

Q. Do you think it will be possible to maintain the high standards that the profession would want and at the same time contain the cost?

A. That's a big debate that is going on right now. Yet there are other countries, as I've said, that have better records than we do for far less money.

I can't tell you where it's going to come from, but there is the feeling that we can do a good job for no additional cost if not for less cost. We've done this to a certain degree already by shifting care from the hospital to an out-patient setting, shifting it to the doctor's office and to the home. The problem we're having is that we keep bringing up new technology, which is accelerated. Only the hospitals which keep pace with the new technology are going to be the survivors. The small ones that can't afford the technology or don't have the resources for the new technology are the ones who will be the losers and will end by closing. It's estimated that by 1990, there will be approximately 700 hospitals that have closed in the country. Several have closed recently in Illinois.

But there is a heightened awareness of quality as McManus has pointed out. The problem is that we haven't defined quality yet. We can measure quantity. We can measure quality, but in the eyes of the patient or consumer, quality has generally meant good food, a clean room, medication on time and that type of thing.

There is a growing trend with the Joint Commission on Accreditation of Health Care Facilities, which is the official accrediting body of hospitals and nursing homes, to look at results, to be more results-oriented in measuring quality, not telling you what you have to do to make a patient well, but measuring how well the patient is after he or she goes home after an episode of illness - what period of time it takes and at what cost it can be done. That will be the challenge.
New technology in hospitals has been additive. We create the catscanner, but we don't do away with the x-ray machine. There are some other

examples of technology, however such as the lithotripter, as I just showed you that electrode. The lithotripter has practically eliminated the need for surgery for kidney stone. Now they are coming up with a lithotripter which will do the same thing for gall stones. The question is the relative cost. The patient is better off.

However, the lithotripter is probably more expensive in actual hospital cost that the surgical procedure. For the individual, when we consider the loss of time, time away from the job, and the recuperative period, it's far less expensive than the old method of doing it surgically. If we can do that for gall stones, we can do it for many, many more difficulties- on a non-evasive basis rather than doing the repair on an evasive basis, as in surgery. It all leads to quality, but it also leads to increased cost.

Coming down the road, we'll see hospital failures, as I mentioned before. We'll see pressures to merge and to consolidate. Just recently, a prominent attorney in this community said to me, "Tony, we really need only one hospital in this town, don't we?"

Q. That sounds like the completion of a circle! They started with one hospital and decided they would build another.

A. That's correct. Recently, two hospitals in Danville, Illinois, have consolidated. Two hospitals in Rockford, Illinois, are trying to merge. For the first time, the Justice Department is coming in and saying, "You can't do it!" They filed suit against the two Rockford hospitals to keep them from merging.

Q. Why?

A. Because they would eliminate competition. The new organization, the two hospitals that would mergen, would have too big a share of the health care market in Rockford from a restraint-of-trade point of view.

So there are all sorts of social factors, economic factors, political factors that are involved in trying to make the health care system more effective - both quality-wise and cost-wise.

There are more doctors. There is more competition among doctors. There is more competition between doctors and hospitals.

It's just a fantastically changing world out there. I'm sure eventually it will all sift out into something that is practical and reasonable.

Q. What are your personal plans for the future?

A. I enjoyed my 35 years with the Decatur Memorial Hospital and all of my time in the health care field. A lot of my friends say I left at the right time. Others say it's changing, but there are a lot of opportunities out there. I think I've reached the stage and the age when I'm happy to be doing what I'm doing. I want to remain active, as I mentioned previously, I'm the chairman of the board of an insurance company in Chicago. That doesn't take too much of my time, but it keeps my interest. I'm doing some consulting for three or four firms who sell

services or products to the health care industry. I'm playing a little golf. We plan on remaining in Decatur. We hope that we can spend some of our winter months in a warmer climate, but we have lived in Decatur longer that we have lived anywhere else in the country. We would like to do a little traveling with the work that I do.

Q. Now, you do have children?

A. Yes, I have two daughters. One is an investment banker. In fact, she was just written up in City and State as having the only woman-owned investment banking firm in the country.

Q. Good for her!

A. My younger daughter is married and has two children.

Q. Where is the banker located?

A. The banker is located between San Jose, California, and Philadelphia, Pennsylvania. She has an office and an apartment in Philadelphia and a house and an office near San Jose, California. She has done very, very well and she is a very capable young woman with a Master's Degree in Business Administration from Vanderbilt.

Q. Very good! And you were telling us you have another daughter?

A. Yes. The younger daughter lives in Los Angeles. She is married and has two children. She has been in the travel industry primarily.

Q. Fine! So you will visit grandchildren?

A. We hope to. We don't see them as frequently as we would like to.

Q. Well, you certainly have contributed a great deal to Decatur in your work in the hospital and in other ways. We wish you well in your future years, Mr. Perry. Thank you very much for sharing your reminiscences with us.

You have been listening to the experiences of Mr. Anthony J. Perry, former administrator with the Decatur Memorial Hospital. This is Betty Turnell speaking for the Decatur Public Library.

Very Good!

A. Thank you.