A Half Century in Retrospect
Hospitals, medicine, manners and customs
as the Association was growing to maturity

EIGHT MEN ARE IN A ROOM AT
Cleveland's Colonial House.
Chairman James S. Knowles calls
the meeting to order. Eight men—
four from Cleveland, two from
Detroit and one each from Ann
Arbor and Pittsburgh—have spent
a year planning and laying the
groundwork for a new organization.

That day and the next they talk
about a constitution and by-laws,
about aims and purposes. When
they adjourn, the Association of
Hospital Superintendents has been
created. The year is 1899; the dates,
September 12 and 13.

This organization was the first
step toward recognition of hospital
administration as an independent
science. Until that time it had
been primarily a by-product of ad-
vances in medical science. Medi-
cine's trials and errors, in unre-
lated sequence, had dominated
hospital-organization.

This superintendents' association
was the first move to separate
medical science and hospital ad-
ministration. This was the associa-
tion that in 1906 was to become
the American Hospital Association
of the United States and Canada.
The organization was born into
an atmosphere of change and pro-
going—industrial, political, scien-
tific. The year of its first meeting,
Dr. Walter Reed and his associates
began the study that was to give
mosquitoes the blame for transmit-
ting yellow fever. It was the year
that Adm. George Dewey, hero of
the Spanish-American War, sailed
home from Manila to announce his
willingness to run for the presi-
dency. It was also the year that
Columbia University offered the
first course for nursing superin-
tendents.

TERESE S. SNYDER
AMERICAN HOSPITAL ASSOCIATION
CHICAGO

In the 50 years before this Cleve-
land meeting, medical science it-
self was taking on a professional
stature. Doctors and scientists be-
gan to take Leeuwenhoek's micro-
scope (1833) seriously and apply it
to medical practice. Bacteriology
emerged as a practical science.
When it did, medicine, surgery,
medical education and hospitals
changed drastically.

By 1899, Louis Pasteur, who had
given great impetus to the findings
of bacteriology, had been dead
four years. He left to the medical
profession preventive treatment of
hydrophobia and vaccination for
anthrax in addition to the bac-
teria-destroying heating process
that bears his name.

In 1899 Robert Koch was deliv-
ing into the origin and treatment
of malaria. His earlier work had
included isolation of the bacilli
causing tuberculosis and anthrax.
The second half of the nine-
teenth century also marked almost
revolutionary changes in medical
care and treatment. Operating
room technique began to have sig-
nificance after Morton demon-
strated anesthesia in 1846 and Lister
turned attention to asepsis with his
carbolic spray in the 1860's.

Out of the Civil War had come
new emphasis on surgery and a
number of excellent American
surgeons. With the use of anes-
thesthesia, surgery had progressed far
from the barber and bleeders days
of earlier centuries. The "Auto-
crat of the Breakfast Table," Oli-
vier Wendell Holmes—doctor, phil-
osopher, statesman—had proved
that the physician, by cleanliness,
could aid in prevention of puer-
peral fever.

Koch and his associates had per-
fected steam sterilization in 1881,
and five years later had adapted
steam sterilization in surgery. By
1891, modern standardized pro-
cedures of boiling and exposure to
steam under pressure had been de-
veloped. It was then that surgeons
first wore rubber gloves.

With the development of sur-
gery and with doctors turning
their thoughts to preventive as
well as curative techniques, lab-
oratory research in bacteriology,
biology and pathology became
more important. As knowledge in-
creased, the need arose for hospi-
tal facilities for research and edu-
cation, and for new procedures to
keep pace with medical expansion.

Something was happening to
hospital construction at the turn of
the nineteenth century. Previously,
both the medical profession and
laymen had been convinced that
diseases came from emanations
on the soil and that the air sur-
rrounding hospitalized patients was
do
cious and dangerous. The bar-
racks system of construction had
been devised with this in mind.
Hospitals consisted of groups of
low wooden buildings, completely

WITH automobile storage batteries, New
York surgeons in 1903 supplied power for
heaters in homes of their patients who did not
have electricity. (Bettmann Archive photo.)
disconnected. From time to time such buildings were destroyed and replaced because demolition was thought to be the only sure way to eliminate sources of infection.

Then came a conviction that fresh air and sunshine would prevent infection, and the pavilion type of hospital building began to appear. Johns Hopkins Hospital, completed in 1889 after 16 years of planning and study, was a pioneer American example of such construction. The original Hopkins consisted of seven buildings for patients and 10 service buildings, all connected by unenclosed passages.

One of the first and most influential advocates of the pavilion type of construction was England's "lady with the lamp," Florence Nightingale. Following her experiences in the British Army hospitals of the Crimea in 1854-56, she became one of the foremost European authorities on hospital construction. Her principles of sanitation and hygiene, developed during the Crimean War, were the basis of her approval of the pavilion. Miss Nightingale was convinced that infection was airborne and that it would not spread if there were plenty of fresh air, sunshine, soap, and water.

Miss Nightingale, who was called the founder of modern nursing as well as an authority on hospital construction, also was responsible for many of the advances in nursing that had taken place by the time the superintendents met in 1889. In 1859 she had established the first training school at St. Thomas's Hospital, London. She had planned the curriculum that included theory and practice in nursing; she had arranged that students live in quarters at the hospital; she had made it possible for women of education and breeding to train for nursing careers.

The St. Thomas's plan spread rapidly throughout Europe, then to the United States. Hospital schools of nursing mushroomed between 1890 and 1910. Many of these schools later were closed and some of them merged with other schools. By the time the Association completed its first half century, there were 1,342 accredited schools of nursing in the nation.

By 1899 the first university school of nursing—the John Sealy Hospital School at the University of Texas—had been open for two years. In 1898 nurses served with the United States Army in the field for the first time. Though some volunteers had worked with Clara Barton during the Civil War, graduate nurses in base hospitals were unheard of until the Spanish-American War. By 1901 the Army Nurse Corps had been activated.

Several nurses' organizations had been formed before the first superintendents' meeting. The American Society of Superintendents of Training Schools for Nurses was founded in 1894. After a reorganization in 1912, its name was changed to the National League of Nursing Education. The Nurses' Associated Alumni was formed in 1896. After a reorganization in 1911, it became the American Nurses' Association.

Nursing as a profession was well established by 1899. With development came control. The first state law for registration of nurses was passed in North Carolina in 1902. Still to come were licensure of graduate nurses and accreditation of schools. Visiting nurses did not appear to any great extent until 1905; public health nursing came a few years later.

Before the twentieth century, no one had given much thought to statistical reports on hospital facilities. The initial report, made by the U. S. Bureau of Education in 1873, listed 178 hospitals. This census, however, probably was incomplete. American Medical Association records show that 661 hospitals existed before 1875 and by 1900 there were 2,970 hospitals.

During the first 10 years of the twentieth century, almost all of the new hospitals were built to care for patients suffering from some specific disease. Such facilities soon were found to be too limited, and there began a new trend toward construction of hospitals for various age and sex groups. This practice, too, proved to be too limited, and by the end of World War I, construction of the short-term acute facility was under way.

The raising of standards of medical education, started by the American Medical Association when it was reorganized in 1901, also changed the hospital picture. Early nineteenth century medical schools had low standards, no hospital affiliations and no formal curriculum of study.

Improvement began with the Civil War, and the construction of Johns Hopkins Medical School in connection with Johns Hopkins Hospital added impetus to the new concept of medical education. Two years before the superintendents' Cleveland meeting, the first journal dealing with hospital problems, the National Hospital and Sanitarium Record began publication. In 1909, the name of the magazine was changed to the National Hospital Record. Its editor was Del T. Sutton, one of the first
honorary members of the superintendents' association. Between 1900 and 1907 this publication was the Association's official journal. Another professional publication that appeared in 1900 was the American Journal of Nursing.

As these things happened in and around hospitals, the life of the average American had been changing too. The years between 1899 and 1908 were the days of the Gibson girl and the handlebar mustache. The bicycle vogue, at its peak early in the century, was receiving its first challenge from the infant automobile industry.

The first American-made car had been driven successfully in 1892; by 1903 Henry Ford had entered the field with the first low-priced car. The first automobile show was held at New York City in 1900, the year also marked the start of mass production.

At the beginning of the twentieth century, Wilhelm Roentgen's discovery of x-ray was five years old and the Curie's isolation of radium was two years old. In 1896, Michael Pupin found secondary x-ray radiation and developed the means for short exposure x-ray photography by interposition of a fluorescent screen. Three years later the first recommendation that diabetics avoid sugar was published.

To appear before 1909 were the Wasserman test and salvarsan (Ehrlich's 606) treatment for syphilis. Before then, the Federal Food and Drug Act had been passed, and John D. Rockefeller had made a seven-million dollar grant for tuberculosis serum research.

All of these medical changes were important because they helped to convince the men who served in hospitals that there was need for some central organization. Such an organization would provide a medium for the exchange of information and for the development of new ideas and procedures. The eight superintendents who met in 1899 had those needs in mind.

The need for such an organization was reflected in the rapid membership growth and the widening of Association interests. Administrators a half century ago faced many of the same problems that puzzled administrators in 1848. One example could be found in the appointment, in 1902, of a committee to study a system of uniform accounting for the United States and Canada. The Association's first accounting manual was published 20 years later.

Convention programs of the young association included presentation of such diverse subjects as "Uses and Abuses of Dispensaries" in 1903 and "Mental Wards in General Hospitals" and the "Purchase of Hospital Supplies" in 1904.

Medical staff and hospital relationships were the informal theme of the 1905 meeting. Medical organization of the hospital, discipline, functions of the medical staff and internal appointments were discussed.

Business sessions at the annual conventions were important. All official business was discussed and voted on by the membership. Anything approved did not go into effect until the succeeding year's convention.

By 1906, the membership of the Association of Hospital Superintendents had grown to 254. At the convention that year, approval for admitting associate members was voted. That year, too, a committee was appointed to consider further development of the Association's work. At first it was thought that federal assistance would be needed. If the scope of activity was broadened, this proved to be unnecessary.

The committee, which consisted of Dr. Sigismund S. Goldwater as chairman, George H. M. Rowe, J. N. E. Brown, Charlotte A. Aiken, and Dr. Henry M. Hurd, reported at the ninth annual convention in Chicago.

It recommended opening the membership to hospital trustees. It asked for a new name to fit the expanding organization. That name was the American Hospital Association of the United States and Canada. Many later Association activities were suggested in Dr. Goldwater's report. Among his recommendations were: Establishment of a representative governing body, active Association councils, expansion of national interests and some kind of geographical divisions within the organization.

The program of the 1907 meeting included papers on a number of subjects. Listed on the program were "Organization of a Teaching Hospital" by E. S. Gilmore; "Employees and Their Selection and Management—Comparison of Hospital Payrolls" by Asa S. Bacon; "Report of a Subcommittee on Hospital Services, Hospital Finances and Economics of Administration" by Dr. Goldwater. Jane Addams of Chicago's Hull House gave members a "Layman's View of Hospital Work Among the Poor."

THE SECOND DECADE

The Association entered its second decade with 596 members—an increase of 553 over the registration at the end of its second year. Its name had been changed, its purpose expanded and its membership requirements broadened.

Twentieth century progress moved rapidly between 1910 and 1919. Medicine and surgery continued to make gains. Specialization became more popular. Research in allergies, preventive techniques and basic food requirements was under way.

Throughout the nineteenth century, the hospital often was looked on as a place to die. As standards of medical care rose and mortality rates went down, the public attitude toward hospitals gradually changed. Improved medical and hospital techniques discouraged the old attitude, and more and more people willingly went to hospitals for care. Increased facilities to take care of the demand re-
sulted. In 1900, for example, there was one hospital bed for each 200 persons. By 1948 the ratio had risen 100 per cent to one bed for each 100 persons.

During the second decade, the pattern of life in America changed, too. The kitchen range, the vacuum cleaner, the refrigerator, the dish washer and the daily bath were introduced into the average home. The price of automobiles had dropped to a point where a car was no longer a luxury to the upper middle classes. The day of the bicycle was over and the Model-T Ford rolled off the production line. In 1911 the first transcontinental plane flight—New York to Pasadena in 84 hours, 2 minutes—was made.

A number of organizations allied with the American Hospital Association were formed during the second decade. First was the American College of Surgeons, organized in 1913. Five years later the college used its minimum standards for rating hospitals for the first time. Of 692 hospitals visited, only 89 had the qualifications necessary for college approval. The 1947 report listed 3,143 approved hospitals out of a total of 3,900 visited by college representatives. These approved hospitals had 75 per cent of the available beds.

With the entrance of the United States into World War I in April 1917, the association organized its War Service Committee. The committee cooperated with military authorities in allocating hospital facilities for civilians and the military. It worked with the American Red Cross in devising a plan for use of volunteer hospital aides.

Use of auxiliary nursing service was not a new idea with the Association during World War I. Its 1907 study of nursing problems had brought forth several recommendations. One of these advocated setting up three grades of nurses: Executives or teachers, bedside nurses, and attendant or subsidiary workers.

**THE THIRD DECADE**

The final year of World War I brought a new era to the Association as well as to the nation. At the Association’s eighteenth convention at Philadelphia in 1916, the foundations for extensive organization changes had been laid. Two years later, members voted approval for a new constitution and by-laws.

Other important changes in the Association’s framework had been suggested and approved in 1916. These included setting up a five-member Board of Trustees, authorization of a full-time permanent paid executive secretary and establishment of a bureau of hospital information. A decision also had been made to open permanent headquarters at Chicago.

At the first meeting of the Board in 1919, Dr. A. R. Walker was made executive secretary, and he was the first of four to hold that position. To follow him were Dr. W. H. Walsh in 1925, Dr. Bert W. Caldwell in 1928, and George Bugbee in 1943. In June 1945 the title was changed to executive director.

Institutional members were accepted by the Association following the constitutional changes in 1918. During the first year 98 hospitals joined the Association. Two years later the Ohio Hospital Association became the first geographical section to be granted affiliation.

After the war came the roaring 20’s. Hospitals, along with the rest
of the country, came into an era of prosperity and expansion. President Warren G. Harding had been elected to office on his platform of “normalcy.” The radio and the talking picture had appeared.

The 20's were the days of the tin lizzie, women in the barbershop, crossword puzzles, short skirts and the first of the crooners.

The 20's also brought important changes in Association policy, modern concepts of hospital care, and a new idea for meeting hospital care costs—prepayment.

New Type Buildings

A major change in hospital construction was accomplished by 1925. By the end of World War I, architects had a clearer picture of what administrators thought and what they wanted of a hospital. Research had proved that pavilion-type hospitals were not essential for preventing the spread of infection. Early in the decade the first multi-story hospital had been completed—the 10-story Fifth Avenue Hospital at New York City. After that, skyscraper hospitals, along with skyscraper offices gained in popularity.

The early 1920's, the Association's third decade, brought a number of changes to the organization. In 1920 the first headquarters was established at 22 East Ontario Street, Chicago. In 1926 the staff moved out of this rented space and into the Association’s own building at 15 East Division Street.

When the Association moved, the Hospital Library and Research Bureau went along. The bureau had originated in 1919 when the American Conference on Hospital Service, including delegates from 15 groups interested in hospitals, had been organized.

At the 1920 convention, Association members were told that the Rockefeller Foundation had offered a $15,000 grant for establishment of a hospital reference library. The foundation would furnish funds of $3,000 for each $1,000 supplied by the Association.

Members approved the arrangement and the library which one day was to own the largest collection of hospital literature in the world was started. In 1929, the American Conference on Library Service released its control over the library.

The library was formally dedicated in 1940, when the name was changed to the Bacon Library in honor of the late Asa S. Bacon, Association treasurer from 1907 until his retirement in 1943. To avoid confusion, the Board of Trustees in 1948 authorized another change in name to the Library of the American Hospital Association—Asa S. Bacon Memorial.

The beginnings of voluntary prepaid hospital insurance came late in the 1920's. The stockmarket crash in 1929 ended the postwar boom. Hospitals reflected the problems of the worst economic depression in history. Early in the 1930's, many hospitals were forced to close as more and more people found themselves unable to pay the cost of medical or hospital care.

Baylor University Hospital, Dallas, was low in occupancy and funds in 1929. In trying to improve conditions, hospital and university administrators started an experiment which involved enrollment of groups for service at the hospital on a prepayment basis. The first to sign up were 1,500 Dallas teachers who paid $3 a semester for 21 days of hospital care a year.

The prepayment idea proved popular. Plans were organized in St. Paul, Sacramento and New Jersey. By 1933 the Association had taken official recognition of the trend by appointing a committee to study prepayment. The same year the Association's Board of Trustees endorsed the principle of voluntary hospital insurance.

At the Association's 1936 convention, a special report included an announcement that the Julius Rosenwald Fund had granted money for the establishment of the Commission on Hospital Service, later to be known as the Blue Cross Commission. Two years later the Association Council on Hospital Service Plans was appointed to work with the commission.

Between 1938 and the end of the Association's first half century, the Blue Cross Commission underwent several organizational changes. In 1941 the Association council was dissolved and the commission organized as the Hospital Service Plan Commission. In 1946 the name was changed to the Blue Cross Commission of the American Hospital Association. At that time Blue Cross plans in the United States and Canada were divided into 12 districts, each of which was given one representative on the Blue Cross Commission, the plans’ governing body.

THE FOURTH DECADE

The Association's fourth decade was a period of national economic change. With the inauguration of President Franklin D. Roosevelt in 1933, social legislation assumed more importance in the national scene. Laws creating social security and unemployment compensation and minimum wage and hour standards were passed; the Na-
n national Labor Relations Board was set up. Through numerous government agencies — W.P.A., P.W.A. and C.C.C. — the federal government tried to create jobs for the millions unemployed.

In 1934, in the middle of economic turmoil, Association members again considered a change in the basic organization. Sixteen years had passed since any major alterations in the Association structure had been made.

**New Constitution**

A Committee on Membership Structure was appointed that year to consider revision of the constitution and by-laws. Named to serve were Dr. Harvey Agnew, Asa S. Bacon, Dr. Robin C. Buerki, Graham L. Davis, the Rt. Rev. Msgr. Maurice F. Griffin, James A. Hamilton, John N. Hatsfield and John R. Mannix. The committee met several times a year between 1934 and 1937. Constitutions of other organizations, especially that of the American Bar Association, were studied carefully. At meetings that often lasted through the night, drafts and redrafts were written. In 1937, the proposed constitution and by-laws were presented to members attending the annual convention. They went into effect in 1938.

Before adoption of the new constitution, all Association members were entitled to vote on matters of official business introduced at sessions during the annual convention. An increasing number of institutional and personal members and the lapse of time between meetings made this system clumsy and unsatisfactory. The new plan set up a House of Delegates to inaugurated and pass on official business. House membership was based on institutional and active personal membership within each state.

Six Association councils were created in 1938 as part of the new structure. They were: Administrative practice, professional practice, hospital planning and plant operation, public education (later public relations), government relations and association development (later association relations).

The Committee on Coordination of Activities, composed of the president and council chairmen, also was authorized. Membership of the Board of Trustees was increased from five to 13, and rotating terms were established.

Sweeping changes were made in the membership structure. Four types of institutional memberships were provided. Personal members were classified as: active, associate, life, honorary and subscribing. Dues for institutional members were set at from $10 to $75 a year, depending on days of patient service. When institutional membership had been authorized in 1918, dues had been from $10 to $50 a year, depending on number of beds. Personal memberships were set at $3 and $10 a year, an increase over the 1918 rates of $5 and $8.

One of the major Association services inaugurated during the fourth decade was publication of an official journal. The Association had published Transactions of its convention proceedings since 1902. A Bulletin of the American Hospital Association had been published quarterly since 1927, but no official journal had been issued since 1912 when publication of the old National Hospital Record had been taken over by the Modern Hospital Publishing Company.

The Board of Trustees authorized a monthly journal in 1935, and in January 1936 the first issue of Hospitality was published.

By the end of the Association’s fourth decade, there were fewer hospitals but they were larger. In 1909, the nation had 4,339 hospitals with a total bed capacity of 421,633. Before collapse of the boom of the 20’s, 6,852 hospitals with 892,934 beds were in existence. By 1939, the American Medical Association listed 6,226 hospitals in the nation. These hospitals, 626 fewer than 10 years before, had a bed capacity of 1,185,026.

The peak year for hospital capacity did not come until 1945, when 1,738,944 beds were available in the nation’s 6,511 hospitals. At this time 705 federal hospitals were in operation, many of them temporary Army and Navy facilities. Peak year of federal hospital management was in 1943 when 827 hospitals were federally controlled. Ten years earlier, there had been only 330 of these hospitals.

**THE FIFTH DECADE**

War came with the 1940’s and brought with it a state of turmoil that was to outlast the Association’s first half century. Hospitals seemed to be ridden the lash of a restless whip. In a period of 10 years, they suffered successively from closed beds, from overcrowding, and again from closed beds. They completed the cycle from deficits to comfortable margins for expansion, to deficits brought on by inflation.

Part of the turmoil resulted directly from all-out effort to win the war, part indirectly from a general disturbance of old balances.

The first effect of total war had been to stimulate hospital patronage while draining off both the professional and nonprofessional employees needed to care for the great influx of patients. Doctors, nurses and dietitians began to disappear soon after Pearl Harbor, most of them headed for military service. There were not enough interns and residents to go around. Clerks, maintenance men, maids and orderlies became scarce—some going into service and the rest into highly paid war work.

Particularly painful was the loss of nurses. The American Red Cross produced a small army of nurses’ aids. Other volunteers were recruited. Retired nurses were begged...
to come back, and many of them did.

It soon became evident that more heroic efforts would be necessary. Not only were registered nurses leaving their old posts, but students were not coming into the training schools.

Out of this crisis came the Cadet Nurse Corps in 1943. The U. S. Public Health Service, nursing organizations and the Association worked out a series of campaigns in which girls were attracted to the schools by special uniforms, maintenance and pay while they learned. This came close to filling the classrooms and averted what would have been a crisis had the war lasted longer.

The war was not very old before Association leaders recognized the necessity of another great organizational change. At the 1942 convention at St. Louis, work was started on a vast expansion program which was set in motion a year later. At Buffalo in 1943 the House of Delegates approved a dues increase of some 300 per cent.

The institutional membership fees ranged from $5 to $75 a month, and this produced two results: The Association was no longer so heavily dependent on revenue from convention exhibits, and it was able to finance new services that had been wholly beyond reach.

For the first time it became possible to provide the councils with paid secretaries. The first of these even preceded the dues increase. At convention time in 1942 it had become evident that members needed some special guidance if they were to cope with wartime controls. Through voluntary pledges, several member hospitals financed the establishment at Washington, D. C., of the Wartime Service Bureau. It was put under the Council on Government Relations and was directed by the first paid council secretary.

Later the bureau was brought under the Association budget, and eventually its name was changed to the Washington Service Bureau. Meantime other council secretaries were employed and the expanded program put under way.

Specialists were added to the staff. The first American Hospital Directory was published in 1945. Trustee, the Journal for Hospital Governing Boards, was launched in 1947. An architect's approval program was adopted in 1945. Two new councils—international relations and education—were created. A year-round institute program was still expanding as the fiftieth anniversary approached, and these were only indications of what became possible with the 1943 dues increase.

Indirect Effects

If the direct effects of war were more perplexion, the indirect effects were longer lasting. Long before hospitals had finished struggling with mobilization and de-mobilization, they were confronted with a number of problems that had been in the making for years. At last five of these turned the 1940's into a decade of great uncertainty.

1. When the prepayment movement had been young and hospital beds empty for lack of patronage, steady expansion of Blue Cross enrollment was unquestionably a boon. But the time came when a majority of hospital patients were being serviced under contract. The beginnings of inflation had elevated operating costs, and hospitals found an even smaller percentage of patients for whom rates could be raised in an effort to produce the necessary revenue.

Blue Cross plans generally raised their own subscriber rates in order to increase hospital payments, but they found it hard to keep pace with the continuing rise in hospital operating costs. During this time enrollment increased (30,000,000 in 1948) and this aggravated the problem.

The old machinery for governing hospital—Blue Cross relationships became out-of-date, and many efforts were made to replace it. By 1947 it had become necessary for the Association to establish a Council on Prepayment Plans and Hospital Reimbursement.

Along the way, another growing pain had been encountered. Medical care prepayment plans had been slow in developing. For the most part those in existence operated independently of Blue Cross plans in the same area. The public was anxious to have its hospital and medical coverage in a single package. Blue Cross plans found themselves at a disadvantage in not being able to offer companies with employees scattered over the United States a single contract that would provide the same benefits everywhere.

By 1948 the Blue Cross Commission and the Association, through its new council, were deep in negotiations aimed at single package coverage for patients and nationwide coverage for large employers.

2. One great uncertainty of the 1940's had its roots in both World Wars. Back in 1921 the Veterans Bureau, predecessor of the Veterans Administration, had been organized to care for the casualties of World War I. An attempt had been made in those days to work out an arrangement whereby veterans needing hospitalization would be cared for in existing hospitals by physicians as part of their regular practice. The attempt failed when no satisfactory formula for reimbursement could be found. The wide variety of rates charged by individual hospitals, and a similar variety of physicians' fees, led to a belief in Washington that veterans should have their own hospital system.
Congress authorized construction of a chain of veterans' hospitals. These facilities sprang up all over the country, for the most part in response to political pressures. In theory, they were for veterans with service disabilities. In practice they came to serve all veterans who would declare themselves unable to pay.

As World War II came to an end, this pattern was perpetuated. With 20,000,000 men and women eligible for care, it became evident that Veterans Administration hospitals offering free service eventually would damage if not destroy the entire structure of voluntary hospitals. By 1948, Congress had authorized construction of veterans' facilities to a total of approximately 151,000 beds to be completed by 1951.

More than a year earlier, the Association had proposed to the government that the whole veterans' hospital program be reviewed. It had been proposed that no further construction be authorized and that action be initiated in Congress to set the veterans' program into a carefully planned nationwide network of hospital service without duplication of facilities. Whether this could be accomplished was a question still to be answered as the Association ended its first half century.

3. In the days of Gray Ladies and cadet nurses, it had been fondly supposed that demobilization would end the shortage of nurses. The immediate problem had been to find enough pairs of hands and feet to augment professional nursing service. New assignments for volunteers were invented. A wide assortment of paid nurses' aides came into existence.

When the war ended, the shortage of professional nurses continued. This created a momentary mystery. Some thought that nurses coming out of service were taking a long rest. Some thought they were going into industry as nurses or otherwise. Some thought marriage was claiming a great number. Eventually the real explanation came out in statistics: There was a permanent demand for more nursing service than ever before. The year 1940 found a peak number of nurses on duty, and still there were not enough.

Problem Source

This seemingly permanent shortage of nurses was not only a problem in itself, but it aggravated other problems:

1. It made evident the need for qualified nurses' aides. At that time there was no recognized standard for assigning duties. There was no standard for adequate training. The designation "nurses' aide" covered everyone from a super chambermaid with two weeks of on-the-job training to women who had spent two years in preparation and were ready to take over many routine duties of the professional nurse.

2. During a time of inflation, nurses generally were dissatisfied with the tradition of service which called for long hours and comparatively low pay. Out of this came the American Nurses' Association program of economic security based on collective bargaining. Most administrators and governing boards recognized the need for improving the nurses' lot but found their hospitals in a poor position to grant all the benefits demanded. Shorter work weeks called for more nurses, who could not be found. Higher and higher pay schedules called for more revenue at a time when repeated increases in rates for patient care had failed to erase operating deficits.

3. For many years nursing organizations had been interested in raising the educational and professional standards of their members. Leaders were anxious that this process or elevation be a part of the nurses' postwar readjustment.

In 1948 the big questions were: Would nurses elevate themselves out of bedside nursing? Was it good or bad to open the way for a new army of nurses' aides? Could professional prestige be maintained in an atmosphere of collective bargaining?

Among other things that circumstances crowded into the decade of great uncertainty was a necessary change in the hospital's attitude toward the care of indigent patients. Tradition had it that hospitals extend charity to the indigent, that government and public welfare agencies represent only the indigent and that hospitals extend charity rates to government and public welfare patients.

Back in depression days, hospitals could afford to care for many such patients at less than cost. While they were not happy about this arrangement, they naturally found it better to have the beds occupied by patients whose way was paid partially than to have the beds empty.

Government and welfare agencies also were affected by the depression and were anxious to hospitalize as many patients as possible with their limited funds. The result was inevitable. Hospitals found themselves bidding against each other for the privilege of losing more and more money on their service to these patients.

FIVE PRESIDENTS who held office during the Association's first 25 years still are living. They are (left) Dr. F. A. Washburn, 1913; Dr. Winford H. Smith, 1914; Dr. Joseph B. Howland, 1920; Dr. George O'Hanlon, 1922, and Dr. Malcolm T. MacEachern, 1924.
In 1898, a joint committee of the Association and the American Public Welfare Association reviewed and reported this situation. Soon thereafter the economic upturn and the spread of Blue Cross coverage began to fill more hospital beds with patients who could pay their own way. Then came war; empty beds no longer were a problem.

Along with the war came a program of the Department of Labor's Children's Bureau. This was the Emergency Maternity and Infant Care program, in which obstetrical service without cost was extended to wives of service men in the four lowest pay grades.

The Children’s Bureau was anxious to deal with hospitals everywhere and to work with some kind of uniform rate schedule. So it was in 1942 that the EMIC formula was developed. Based on the Association’s accounting procedure, the formula’s purpose was to pay each hospital its exact cost in caring for these obstetrical patients.

Because of falling traditions and customs, the EMIC formula was not universally satisfactory, but it represented a historic beginning. It tended to recognize a hospital’s right to receive costs for patients being cared for under a contract with government agencies.

Along the way, other federal agencies wishing to use voluntary hospital facilities accepted the theory of justifiable cost. These were the Veterans' Administration and the Office of Vocational Rehabilitation. In 1947, the Association and those federal agencies worked out a revision of the EMIC formula in such a way as to meet the old objections. When approved all around, this became known as the government reimbursable cost formula, and the hospital’s right to receive cost for such service became established.

Meanwhile, state and local government agencies were finding it hard to abandon the old tradition. When operating deficits reached alarming proportions in 1946 and 1947, hospitals in most communities recognized the necessity of increasing their revenue from all government patients. As the first half century neared its close, efforts were being made to establish the government reimbursable cost form-

### Some Significant Events

- **1899**
  - Eight men, meeting at Cleveland, September 13-15, organized the Association of Hospital Superintendents.
  - First course for nurse superintendents conducted at Columbia University.
  - Blood grouping discovered by Landsteiner.
  - American Nurse Corps created.
  - American Medical Association reorganized and its Council on Medical Education and Hospitals formed.

- **1902**
  - Hospital association committee appointed to study a system of uniform accounting for the United States and Canada.
  - Association published Transactions of the 1902 convention.
  - Wright Brothers completed their first successful plane flight from Kitty Hawk, N.C.
  - Association constitution amended to provide for three vice presidents instead of one.

- **1903**
  - Association published Transactions of the 1903 convention. The first medical specialty board (ophthalmology) organized.

- **1917**
  - War declared on Germany by the United States in April.
  - Vitamin D extracted and formulated from cod liver oil.
  - Association's War Service Committee formed.
  - First “Standard Curriculum” for nurses published.

- **1918**
  - Youngstown Hospital Association accepted as the Association’s first institutional member.
  - Armistice for World War I effective on November 11.
  - Association personal membership dues raised and institutional membership authorized.

- **1919**
  - Dr. A. R. Warner appointed first Association executive secretary.
  - Association Board of Trustees met for the first time.
  - First Daily Bulletin published at the Association’s Cincinnati convention.

- **1920**
  - Permanent Association headquarters established at 22 East Ontario Street, Chicago, in October.
  - Ohio Hospital Association accepted as the Association’s first affiliated state group.
  - Hospital Library and Reference Bureau established at Association headquarters in October.

- **1921**
  - Association incorporated in the State of Illinois.
  - U.S. Veterans Bureau created at Washington.

- **1922**
  - Accounting manual published by the Association.

- **1924**
  - American Protestant Hospital Association formed.
  - B.C.G. used to vaccinate children against tuberculosis.

- **1925**
  - American Medical Association amended to set up a five-member Board of Trustees.
  - Antitoxin for gas gangrene introduced by Bull.
  - First sectional meeting at the Association’s Philadelphia convention.

- **1926**
  - First medical specialty board (ophthalmology) organized.
  - Federal eight-hour working day law passed.

- **1930**
  - United States entered World War II.
  - Association’s Educational Service organized.

- **1943**
  - Hospital personnel committee formed.
  - Influenza epidemic was traced to Philadelphia.

- **1944**
  - United States entered World War II.
  - Influenza epidemic was traced to Philadelphia.

- **1945**
  - Hospital personnel committee formed.
  - Influenza epidemic was traced to Philadelphia.

- **1946**
  - United States entered World War II.
  - Influenza epidemic was traced to Philadelphia.

- **1947**
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  - Influenza epidemic was traced to Philadelphia.

- **1948**
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- **1949**
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- **1950**
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- **1951**
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- **1976**
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- **1984**
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- **1996**
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- **1997**
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- **1998**
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  - Influenza epidemic was traced to Philadelphia.

- **1999**
  - Hospital personnel committee formed.
  - Influenza epidemic was traced to Philadelphia.
Along the Association Way

1927
Official insignia of the American Hospital Association adopted.
International Hospital Association organized.
The Quarterly Bulletin, containing official reports and news of Association activities, published.

1929
Association assumed complete control of the Hospital Library and Reference Bureau in July.
Stock market crashed in October.

1933
Principle of prepaid hospital insurance approved by the Association’s Board of Trustees.
Hitler became chancellor of Germany.
American College of Hospital Administrators organized.

1934
Association Committee on Membership Structure appointed to study problems of expansion.
First university course in hospital administration offered at the University of Chicago.
Adequate health care for everyone suggested in the final report of the Association’s Committee on the Costs of Medical Care, made at the Philadelphia convention.

1936
Hospitals published in January as the official journal of the American Hospital Association.
Hospitals Service Plan Commission appointed at the Association’s Cleveland convention.
Sulfinilamide used successfully for the first time in the United States at Johns Hopkins Hospital.

1938
New constitution and by-laws adopted by the Association during the annual convention at Dallas.
A House of Delegates, with power to vote on official Association business, created under the new constitution.
New classes of institutional and personal Association membership set up and dues increased.
Six Association councils and the Committee on Coordination of Activities provided for in the new constitution.
First Wagner bill for compulsory health insurance introduced in Congress.

1939
Board of Trustee membership increased from five to 21 and rotating terms of Board membership set up.

1940
The Association’s first annual Award of Merit presented to Dr. Malcolm T. MacEwen during the convention at Toronto.

1940
Am S. Bacon Library formally dedicated in February.
Nursing Council for National Defense organized to help in allocation of nurses for emergency.

1941
Penicillin used successfully in treatments.
Inter-American Hospital Association organized.
Pearl Harbor attacked by the Japanese in December.

1942
Establishment of the Association’s Wartime Service Bureau authorized during the annual convention at St. Louis.
Withholding system of income tax deduction started.
First Association full-time paid council secretary appointed.

1943
Emergency Infant and Maternity Care program put into effect in July.
At the Buffalo convention in September, a dues increase of almost 300 per cent was approved and an expanded program adopted by the Association.
A four-point program leading to adequate health care at the Association’s Buffalo meeting.
Cadet Nurse Corps created by the Bolton Act.
Association’s institute program inaugurated.

1946
Publication of the first edition of the American Hospital Directory.
First atomic bomb released over Nagasaki in August.
Architects Approval Program inaugurated by the Association.

1946
Hill-Burton Act for hospital survey and construction signed by the President in August.
Commission on Hospital Care report published in September.
Sepsispyxin used for the first time.
The Association’s Joint Commission on Education established for a two-year study of university teaching in hospital administration.

1947
Trustee, the Association’s journal for hospital governing boards, published in September.
The Taft-Hartley labor law, with a clause removing hospitals from the jurisdiction of the National Labor Relations Board, passed by Congress.
First meeting of the International Hospital Federation at Geneva.
Surgical operations televised successfully for the first time at the September clinical congress of the American College of Surgeons.

1948
National Health Bill introduced into Congress.
First state law for licensing administrators passed in Minnesota July 1.

1949
Association Board of Trustees approved a national public relations program to begin January 1, 1949.

mula as the basis on which all indigent patients under contract would be accepted.

4. Finally, there was the farthest reaching problem of all. Like some of the others, its roots reached back into an earlier decade.

In 1934 the Committee on the Costs of Medical Care completed its report after a five-year study. In general, it concluded that existing custom and practice deprived too many citizens of the medical care they needed.

This was at a time when reform was in the air. It was the day of legislative rights—for organized labor, for the unemployed, for the aged and dependent. The merits and demerits of what was commonly called socialized medicine had been evaded for many years, but it was not until the day of reform that any great number of people looked on adequate medical care as a right.

So it was that in 1938 Sen. Robert F. Wagner of New York sponsored a bill which called for compulsory health insurance. It called for taxation of all employed persons to finance a program of medical and hospital care which would be as plentiful and as free as public education.

Between then and 1948 a proposal aimed at this same purpose was before Congress continually, and it came to be known as the Wagner-Murray-Dingell Bill. Until 1943, the American people had no alternative to offer. It was that year the Association drew up its four-point program, which was to serve as a rallying point for all who opposed and feared the consequences of federal compulsory health insurance.

In three of the four points, the Association suggested: That the federal government assume some financial responsibility for building the new facilities necessary to meet the vast expansion in demand for hospital services; that the federal government encourage enrollment in prepayment plans and so make adequate care more satisfactorily available to those who could pay their own way. The fourth point recommend-

SEPTEMBER 1948, VOL. 22

65
ed that social security benefits be extended to employees of nonprofit institutions.

Out of this program came the Hill-Burton Act in 1946. This hospital survey and construction law partially carried out the first objective of the Association's program. The federal government was authorized to match funds with state and local governments and with nonprofit hospitals to build the most needed facilities.

This insistence on building strictly according to need was historic in itself. There was another development in which the Association played an active part. As far back as 1941, the Board of Trustees initiated action toward making a survey of existing facilities and the need for expansion. From this came the Commission on Hospital Care, which was to make an independent report.

The commission spent two years on its job and reported in 1948. Its recommendations served as the basis for a nationwide construction program that would place the right facilities in the right places and eventually produce a carefully integrated system. Although a considerable amount of preliminary work was necessary by mid-1948, 302 construction projects had been approved by the U. S. Public Health Service. Representing the federal government, the Public Health Service assumed the role of coordinator for 49 statewide plans.

Out of the Association's 1943 program also came the Taft National Health Service Bill. This had been introduced in 1947, and if enacted, would have implemented the second objective of the program. It also called for a matching of federal and local funds.

Both the Taft and Hill-Burton measures were designed to minimize federal control. Together they were expected to make adequate hospital and medical care available while preserving the traditional doctor-patient relationship, the hospital-community relationship, and the individual responsibility of those who could pay.

It was characteristic of the 1940's that Congress and the American people had before them this clear choice for the future: To make adequate hospital and medical care available, would it be necessary to accept a vast program of socialized medicine, or could this same end be achieved without abandoning the several freedoms that had been established while Americans had grown to be the healthiest people in the world? As the Association reached its fiftieth anniversary, the Wagner-Murray-Dingell Bill and the Taft National Health Service Bill were both before Congress.

The eight men who gathered at Cleveland in 1899 could not have foreseen what challenges would be met by the Association before the end of its first 50 years. But they and the men and women who came after them faced and solved the problems that arose with each new decade. As the Association was about to enter its second half century, its membership would continue to stand ready to meet the issues of the 1940's and whatever else might lie ahead.