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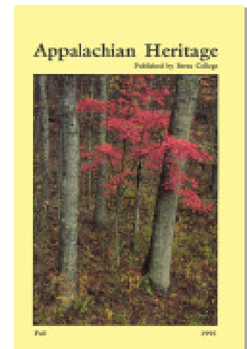

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Original Hospital at Hazard

Hospital is a word that conjures up some truly disparate mental images. Safe haven, cold complex, center of hope, den of despair, bastion of science, or the road to financial ruin, physicians, nurses, surgery: these are but a few of the thoughts that race across many a mind's eye when regarding hospitals. Yet the usual reference point is the hometown hospital, housing the best means of care a given community has to offer. In central Appalachia, such thoughts often translate into one of the several hospitals of Appalachian Regional Healthcare, Inc. The hospitals, clinics, and other institutions and services falling under the Appalachian Regional Healthcare umbrella form an integral part of the economic, social, cultural, political, and educational fabric of the region and the communities they inhabit. Examining the historical underpinnings of the

Richard C. Smoot, Lexington, Kentucky, is a research associate for Appalachian Regional Healthcare, Inc., and is also a freelance writer, editor, and consultant.

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corporation opens avenues of understanding to the company's past, present, and perhaps even its most probable future.

Appalachian Regional Healthcare, or ARH, did not construct the original system hospitals. They grew out of the struggles between the United Mine Workers of America (UMWA), the union's president, John L. Lewis, and the coal industry operators. Following the 1946 coal strike and federal seizure of the bituminous coal mines, President Harry S. Truman ordered Secretary of the Interior Julius Albert Krug to negotiate a contract with the UMWA. The Krug-Lewis agreement of 1946 created, among other things, the UMWA Welfare and Retirement Fund, financed initially by a five-cents-per-ton royalty paid by operating managers on each ton of coal mined. The agreement also ordered a study of the coal mining industry, focusing on the medical, sanitary, and daily lifestyle conditions in the coal mining communities.

Survey reports confirmed the worst. In *A Medical Survey of the Bituminous Coal Industry: Report of the Coal Mines Administration* (1947), commonly called the *Boone Report* after the study's director, retired Rear Admiral Joel T. Boone, M.D., the hospitals, public health, housing, sanitary facilities, and even leisure conditions of coal miners and their families were scrutinized. While some enjoyed fine medical care, more were found in need, their health system described as "very poor" in the *Boone Report*, and its acceptance "a disgrace to a nation to which the world looks for pattern." After a few more years of observing these conditions, the UMWA Welfare and Retirement Fund and UMWA President Lewis announced plans to construct ten new hospitals in central Appalachia to serve its mining communities there. Following careful geographic and demographic consideration, hospitals sprang up in Hazard, Harlan, Whitesburg, Middlesboro, McDowell, South Williamson, and Pikeville, Kentucky; Beckley and Man, West Virginia; and Wise, Virginia. Dedicated officially in 1956 (although four actually opened in 1955) as the citadels of the Miners Memorial Hospital Association (MMHA), the union hospitals were an impressive achievement. They represented the country's first hospital system to be built from scratch, and promised a new era in Appalachia for access to medicine, specialized medical treatment, and other health services previously unavailable locally.

But the costly realities of modern hospital care quickly consumed the miners' hospitals. Physicians, nurses, technicians, and other health care personnel were recruited into the region with a missionary philosophy—and a high salary. Miners wasted little time in using their new hospitals, but they were not the only ones underserved in the region. Soon others

in need flocked to the MMHA facilities. Many were poor, many were destitute, many had nothing with which to pay. Absorbing these losses proved very expensive. More problems arose, such as the terrible flood of 1957, which caused extensive damage to some of the hospitals. A drop in coal production hurt, too, because that meant less money in royalties from coal operators. Miners were asked to pay into the Welfare Retirement Fund, and did so, but lower coal demand and mechanization of the mines cut deeply into employment figures.

It soon became evident that the hospitals were just too expensive for the UMWA Welfare and Retirement Fund to handle. In 1962, the fund's director, Josephine Roche, announced plans to close four Kentucky hospitals (Hazard, McDowell, Middlesboro, and Whitesburg) by July 1 of the following year. The announcement came as a shock not only to the miners, but to all the others who, for one reason or another, were tied to the hospitals. Crisis conditions ensued. Jobs would be lost, as well as health benefits and access to medical care. Psychological damage issued from this seemingly callous abandonment and default upon the sacred trust of the mine workers. Violence erupted in the coal fields.

In Harlan, the Reverend Samuel McMaster Kerr, minister of the First Presbyterian Church, decided to take action. The United Presbyterian Church, U.S.A., had a long history of running hospitals, just as did other religious groups in America. Kerr wrote an appeal to his church leaders to consider purchasing the hospitals. His concerns were taken up by the United Presbyterian's Board of National Missions, the internal church body concerned with hospitals, and from there inquiries were made to Roche and the UMWA Fund.

Much negotiating took place, involving the many interested parties from all over the region. In April 1963, Roche agreed to a $9.6 million price tag for all ten hospitals. The bulk of the money for the purchase would come from the U.S. Area Redevelopment Administration. Several political celebrities involved themselves in the negotiating process, including Franklin D. Roosevelt, Jr., son of the late president, Daniel Patrick Moynihan, later a U.S. senator from New York, and President John F. Kennedy. But that is a story for another time. The important point here was that the sale of the hospitals to the Presbyterians proceeded. The first four hospitals changed hands in June 1963. The six remaining hospitals would be transferred on or before July 1, 1964.

The Presbyterians formed a new corporation to accommodate the transfer of ownership and operational administration of the hospital system. Appalachian Regional Hospitals, Inc., was formed on June 28,

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1963, as a not-for-profit corporation with responsibilities including access to and delivery of various health and medical services, scientific research, and educational activities, without regard to race, creed, religion, color, national origin, or ability to pay. In this whole process, the Presbyterians viewed themselves as the "enabling agent" in saving the hospitals from closure. Now this new independent corporation would pick up where their Board of National Missions left off, taking responsibility for the ownership and operation of the whole hospital system.

In spite of all these glowing corporate goals, objectives, and ideals, everything would fall apart unless something was done to generate sufficient operating capital. The hospitals were broke, with the drains till running in indigent care, staff costs, maintenance, and so on, and with few means of recourse apparent to correct the problem. Prospects appeared bleak, when into the breach stepped Bert T. Combs, governor of Kentucky. Combs had been intimately involved in the negotiation process to save the hospitals from closure. He understood the hardships that would follow such an event. Then too, his own Eastern Kentucky roots undoubtedly made him more sensitive to the area's needs than might otherwise have been the case. He went before Kentucky's General Assembly and appealed to legislators to assist in saving the hospitals and the new corporation. Objections were heard from other hospitals hungry for funds, and from those arguing that money to the Presbyterian-formed corporation violated the separation of church and state. But the funds were granted, and the hospitals and their people gained some much-needed breathing space.

Problems remained to be solved, of course. The ARH system emphasized the community hospital aspect of their organization. According to historian Charles E. Rosenberg, author of *The Care of Strangers: The Rise of America's Hospital System* (1987), community hospitals are just that: institutions encouraging an integral community involvement, a participatory spirit toward the hospital's general well-being and current affairs. Much of that participatory spirit, according to Rosenberg, is aimed toward the local physicians. MMHA had alienated many local practitioners by refusing them hospital privileges, by granting MMHA physicians on-site hospital offices, and by bringing in so many medical outsiders. Under ARH, most practices objectionable to the physicians ended. Time eventually healed most of these wounds and brought the local physicians and their patients into the ARH facilities.

In its desperate search for revenues, ARH left few stones unturned. One route included the sale of the Pikeville hospital to the Methodists, a move later regretted by many in ARH. Staff reductions took place to

save money, as did certain salary adjustments (downward). Some staff waged fund-raising campaigns. Kentucky continued its generosity, supplementing the ARH coffers in the early years with grants to offset indigent costs. On another occasion, the governors of Kentucky and West Virginia received permission to redirect federal funds (Appalachian Regional Commission) to help the Williamson ARH Hospital expand, a striking example of two states cooperating for the common good of an area and its citizens without regard to borders. (Officially named the Williamson ARH Hospital for Williamson, West Virginia, the hospital actually sits in Kentucky.) More funds eventually came in the form of grants from the U.S. Department of Health, Education, and Welfare, and the Appalachian Regional Commission. Federal Hill-Burton dollars allowed for expansion of the system and its physical structures, but gave not a penny to operations. Private financier Garvice Kincaid of Lexington loaned essential operating funds at a most delicate point, and was promptly named chair of the ARH Board of Trustees!

Money problems plagued ARH for years. Not until 1979 did the corporation finally record a profitable year. After more than fifteen years of deficit operation, perhaps the most impressive observation here is that ARH had survived and continued to operate. Labor disputes caused still more difficulties, with strikes authorized and unauthorized, or wildcat, occurring in 1964, 1968, 1970, 1971, 1973, 1974, 1976, and 1986. On more than one occasion it appeared that the whole corporate structure might collapse as a result of the strikes. But again, the company pulled through and continued to deliver services in the region.

In a 1973 feature article in the Louisville *Courier-Journal Magazine*, Bryan Woolley observed that the "hospitals have survived because the federal government has become more and more deeply involved in the funding of health-care projects during the years since ARH began. The government," he wrote "through the Appalachian Regional Commission, provided eighty per cent of the money for nearly all of the hospital chain's new construction and medical projects." Twenty-five per cent of ARH's services were purchased by Medicare, Woolley noted, with another twenty-five per cent coming from Kentucky through Medicaid payments. UMWA Welfare and Retirement Fund patients made up thirty per cent of the payments to ARH, with another ten per cent coming from other third-party payers, such as insurance companies, workmen's compensation, and vocational rehabilitation services. The remaining ten per cent was accounted for in charity and bad debt cases.

But these dark moments did not exist in a vacuum. Bright spots, always there, began to grow brighter and more numerous. Certainly one

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bright spot, notable from the beginning, has been the direct participation of many highly talented individuals determined to see the health care enterprise succeed. ARH presidents clearly number among these talents, five men uniformly dedicated to the health interests of the people in Appalachia. Karl Klicka, M.D., the first ARH president, served from 1963 to 1967. T. P. Hipkins came next, staying on until 1974 when he handed the reins over to David Heydinger.

Klicka and Hipkins guarded the working foundation of ARH, keeping the hospitals open and as up-to-date technologically as funds permitted. Hipkins and Heydinger dealt with some very trying challenges in financing the operation, and worked directly with several tough labor disputes. Robert L. Johnson, whose activities with ARH actually stretched back to the MMHA negotiations, succeeded Heydinger in 1978. It was under Johnson that ARH began to see black instead of red on the balance sheets. Johnson's tutelage ended in 1993, and Forrest W. Calico, M.D., was chosen to lead the corporation. Calico takes over during a particularly tumultuous period in the industry, and faces challenges from an ever evolving health system, new scientific discoveries, and rapid technological advancements.

ARH's Board of Trustees also has had some highly talented individuals among its ranks. All accomplished in their own right, the trustees themselves might single out a few for extraordinary contributions, such as Howard Bost, Al Smith, Cecil Underwood, Tom Dupree, "Buck" Harless, and Garvice Kincaid, but this is to name only a very few. Many other distinguished leaders, from the ranks of government, medicine, nursing, technological fields, service and clerical workers, maintenance workers, and volunteers, have given an important part of their expertise, experience, and knowledge to one or more of the several levels of operation at ARH.

In order to guard against a shortage of qualified personnel, ARH continued several educational programs instituted by MMHA, while adding new programs of its own. Nurses, medical specialists, technologists, and technicians have been trained and employed by ARH. Physician residency and intern programs brought young medicos into the hill country. Cooperative health care ventures with such medical schools as West Virginia University, Marshall University, the University of Louisville, and the University of Kentucky have benefited all participants.

Company statistics became, so favorable, in fact, that in 1986 the corporate name changed from Appalachian Regional *Hospitals* to the more descriptive Appalachian Regional *Healthcare*. More specific numbers improved on the bottom line, making the cumulative corporate

figures rather impressive. From 1963 to 1994, ARH recorded 1,291,740 inpatient visits and 18,833,345 outpatient visits to hospitals and clinics. During the same period, ARH personnel delivered 110,979 newborns, serviced 3,092,445 emergencies, recorded 5,565,606 X-rays, performed 481,602 surgical procedures, and made 1,908,950 home health visits. Employees now number 4,272 total, with 572 medical staff (active physicians, 355; courtesy/consulting physicians, 217), 868 registered nurses, 509 licensed practical nurses, and 313 nurses aides. ARH's payroll for fiscal year 1994 was over $115 million. The corporate operating budget for fiscal year 1995 is approximately $300 million.

Eleven hospitals now make up the ARH system, with the addition of Morgan County (West Liberty), Kentucky, and Summers County, West Virginia, ARH hospitals. ARH clinics also total eleven: Kentucky facilities are Cumberland Valley Primary Care Center in Lynch, Homeplace Clinic in Ary, June Buchanan Primary Care Center, Hindman, the Phelps Clinic, the Salyersville Clinic, and the Hazard Family Health Services Clinic; West Virginia hosts the Matewan Clinic, the Delbarton Clinic, and the Man/Accoville Clinic; Virginia facilities include the William A. Davis Clinic in St. Paul, and the Gladeville Clinic in Wise. In addition, ARH has four psychiatric facilities, three associated medical clinics, a central laundry facility, a central purchasing facility, and numerous related service ventures. Home Health Services are an indispensable part of ARH today, with seventeen home health agencies and sixteen home care stores scattered across three states.

Change will continue within ARH and in Appalachia. "To have real change," remarked ARH President Calico, "we're going to have to rethink our culture, our fundamental characteristics." The voice of present and future direction in the corporation, Calico hopes to maintain positive practices while opening channels to improve in other areas. "My hope for medicine is that we will value people's *access* to appropriate care more than we value the autonomy of the providers."

"Our current health care system in the U.S. favors the rights of the providers over people's access to care. I think the system is out of whack. You see, I believe we have rights, but we also have obligations. But the way we approach things in the U.S. now, including medicine, favors individual rights at the expense of responsibility. In that way, I think our fundamental societal value system mitigates against meaningful reform."

In an effort to correct such imbalances, Calico recently outlined three "major, inseparable components" for ARH policy. One goal is closer social and economic ties with the local communities. Another

objective calls for continually improving the accessibility and the quality of local health care services. Finally, all health care providers must be willing to work together, to "collaborate to succeed," in the delivery of health care services in central Appalachia.

Many questions in the American health care system remain unanswered. National health insurance, euthanasia, abortion, genetic engineering, and patient and physician rights and responsibilities stand out as only the most obvious question marks on the health care landscape. Consolidations and merger mania continue unabated in the industry. Perhaps the only certainty we have is that change is under way and will continue. What directions such changes might take and what their effects might be remains unanswered questions. ARH, for its part, will remain committed to providing accessible health and medical care to the people of Appalachia.

On the Way to Rehabilitation