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“A fitting tribute would be to keep the hospital open.”

Alachua General Hospital memory wall, 2009

**Foreword**

I have never been a patient, nor set foot on AGH’s premises, before writing this thesis. Somewhat ironically, I became interested in the story of AGH as it was nearing its end in 2009. I followed the story of the closing of AGH in the *Gainesville Sun* with fascination during winter break. The closing of the hospital seemed to provoke a visceral outcry from some and apathy from others.

I became excited by the idea of uncovering a trajectory that pointed to reasons for the hospital’s closing, and comparing AGH to other hospitals, specifically, Shands Teaching Hospital, the academic research hospital affiliated with the University of Florida, which is belongs to the same corporate parent. What I ended up working on is a critical history that may indeed point to reasons for the hospital’s closing, but more importantly, develops a theory of how the community hospital functions as a mediator of medicine and society.

Once I delved into the history of AGH, I realized that the story of AGH was much more than just the story of a cluster of buildings that made up the hospital campus. The lifelong friendships and pride in displays of compassion revealed a deeper connection to the community than I guessed. The story of AGH was the story of Gainesville itself—a small Floridian town that is living out the changes that liberalizing forces (from the University of Florida), a more pronounced market economy, and social trends have wrought on the “old-time” way of living.
Thus, my goals in writing this thesis are two-fold. First, to bring hidden stories to light: to show how AGH’s staff, administration, and productions were shaped by sociopolitical factors that influenced perception of medical care in the community. Second, to suggest that the past shapes the future: that a historical approach to healthcare, with an emphasis on local texture, can and should be considered in healthcare policy.

Gainesville is a town in flux. Many relatively new residents, like me, were never patients at AGH and never experienced “family-like” care at the hospital, and in all likelihood, will not remember AGH. But those who did certainly will. While it is not possible to bring AGH back, this thesis is my contribution to the hospital’s story, and to the people who love it still.
Introduction

Beyond the chain link fence and cracked asphalt, tangled metal rods rust next to piles of dusty brick. Buildings that look bright and functional on one side have gaping holes and shattered windows on the other. Bits of plaster are heaped next to live oak trees that sag with Spanish moss; a resting backhoe completes the scene. What is most jarring is the absolute stillness in this moment of destruction—just a few months ago, this same view would have been filled with patients, doctors, nurses, volunteers, and employees coming and going from the hospital.

Alachua General Hospital (AGH) served Gainesville, Florida and the surrounding area of North Central Florida from 1928 to 2009. The hospital grew alongside Gainesville, and saw it through times plentiful and lean. AGH fashioned itself as a hospital that provided family-like loving care based on expert medical knowledge and old-time values. In 2008, AGH’s parent corporation Shands HealthCare announced that AGH would be closed the following year because of financial difficulties. When AGH closed, Gainesville lost a historical institution and source of medical care for many of the county’s poorer residents.

At a tribute ceremony for the hospital a month before its closing, Mayor Pegeen Hanrahan, who was born at AGH herself, proclaimed October 9th Alachua General Hospital Remembrance Day. Dr. Richard Anderson, who practiced at AGH for over 40 years, said of the hospital’s closing, "I'll try not to cry. I feel like I'm losing my hospital."

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1 Gainesville shares many of the same anthropological characteristics of other small southern college towns, with one observer noting its “evidences of the past, a stagnant downtown with a surrounding area of [black] quarters and modest homes, but a plethora of university-spawned suburban housing developments, quick-food establishments, and shopping centers.” T M Johnson and G H Stein, “Politics and personality in medicine: genesis of an indigent clinic.” American Journal of Public Health 65, no. 3 (March 1975): 253-259.
home...I was born there, my grandmother died there, my father died there, and I figured eventually I would die there. But I don't want to speed up the process just because they are closing the hospital." The emotion, mostly of gratitude and fondness, which characterizes memories of “our AGH,” has much to show us about the mythos of community hospitals in small communities.

This thesis intends to explore, through an ecological framework of healthcare, how the history of AGH reflected trends in community hospitals in the United States. My retelling of the history of AGH, filtered through my understanding of works in Science and Technology Studies, history, sociology, and policy, is intended to shed light on how community hospitals and the actors therein define and manage or provide community-based medicine, and thus how the hospital mediates medicine and society.

**Background and Aims: Hospital as Mediator of Medicine and Society**

Over the last three centuries, popular perceptions of American hospitals have been transformed from that of holding pens for the destitute and deranged to prestigious, technologically rich institutions that specialize in advanced medical treatment. As standard bearers for the medical field, hospitals have become the gatekeepers of illness.

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2 See Picture 15 in Appendix 3.
4 Robert Starke defines “instrumental case study” as a “study undertaken to provide insight into a particular issue or refinement of theory, case of secondary interest and looked at in depth, its contexts scrutinized in order to help us understand the external interest.” The SAGE Handbook of Qualitative Research, 3rd ed. (Thousand Oaks: Sage Publications, 2005): 236.
classifying who must be quarantined from society. Hospitals occupy a privileged position in enforcing socially acceptable codes of health, and propagating medical power over the lives of patients and employees alike.⁶

Roles within the hospital are often rigidly defined so that the institution runs at maximum efficiency. Those who have the (professional) authority to judge meanings of healthcare—and this category has changed over time—establish power hierarchies that determine who may judge institutional policy. Namely, the hospital has become a stronghold of medical expertise, its policies heavily dependent on the decisions of its medical staff. Robert Wilson describes the hospital as a “riotous profusion of personnel” and a “self-contained social universe.”⁷

However, hospitals do not make decisions in a vacuum. Rosemary Stevens writes that hospitals are “organizational chameleons” that adapt to external pressures.⁸ In more recent history, hospitals have become a site of entangled decision-making between medical professionals and the public. Politics, ethics, and economics are integral to hospital decision-making—end-of-life discussions, medical care of undocumented workers, and healthcare reform are important not just to hospitals, but government officials, consumer advocates, and the public. As Charles Rosenberg argues, hospitals have a bifocal awareness: an inward vision and an outward gaze that give them a dual

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⁶ Though certain hospitals, especially mental hospitals, might be described as “total institutions,” AGH was not one of these. Goffman, in describing authoritative mental hospitals, indicates that there must be authority that transcends specific aspects of “inmate” life, total control over their behavior and ability to mete out punishments, a vacuum from the outside world, “mortification” process by which inmate succumbs to this view of the world. Madeline Karmel, “Total Institution and Self-Mortification,” Journal of Health and Social Behavior 10, no. 2 (June 1, 1969): 134-141.


identity of self-reliant bureaucracy and community institution.\textsuperscript{9} Society’s expectations for hospitals have changed over time, but the intensity of these expectations, whether they be medical, economic, or emotional, have not.\textsuperscript{10}

My overarching goal is to show how an ecological framework can elucidate the financial, professional, and social factors that make the hospital a mediator of medicine and society, and how these considerations can be beneficial for policy points. Specific social, political, economic, and technological situations have influenced the development of specific hospitals, and it is important to consider the social function of each community hospital. I examine AGH within the context of its specific situations and local culture—for instance, the influence of “Old Florida” culture, the rate of uptake of medical technology, and its inextricable ties to a sprawling university hospital.

These are the major questions that guide my exploration of how the scientific and the social interacted at AGH:

*What were the power relationships that affected the hospital’s operations?* What was the impact of the medical profession’s specialized body of knowledge in relation to other groups, such as hospital administrators? What was the role of the “forbidding aura of technical complexity”—the legitimating power of science and technology?\textsuperscript{11}

*How was the hospital managed?* How did the hospital’s organizational structure reflect its goals? Did scientific management and bureaucratic models affect its structure?

*What was the hospital’s reaction to external actors?* For example, how did other institutions—such as competing hospitals—and social pressures from the Gainesville


\textsuperscript{10} Rosenberg compared hospitals to the “ship of fools that symbolized man’s ineradicable frailties in early modern Europe…the hospital can be seen as a late 20\textsuperscript{th} century symbol of the gap between human aspirations and necessary human failings.”\textsuperscript{10} To Paul Starr, however, the modern hospital is “no longer a well of sorrow and charity but a workplace for the production of health.” Charles E Rosenberg, The Care of Strangers: The Rise of America’s Hospital System (New York: Basic Books, 1987): 4; Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982): 146.

\textsuperscript{11} Rosenberg, The Care of Strangers, 4.
community affect AGH’s actions? How did government support and regulation affect AGH?

*Was there an AGH ideology, and if so, what were its features? While not all members of the hospital community may have fully ascribed to the same ideological principles, was there a general sense of uniqueness on which AGH ideology was founded? How did it manifest in patient care and interactions among doctors and other staff? What political consequences did it have?

The sum answer to these questions is unique to AGH. Architect Michael Guggenheim writes, “Once a building is built, by being used in specific ways and by being locally stable and thus connecting to its changing environment, it inevitably acquires a biography that makes it distinct from all other buildings.” AGH, by virtue of being locally stable, and responsive to a specific combination of social, political, and economic factors in Gainesville, acquired a unique biography. It is my hope that the story of AGH brings out a voice in the narrative of American hospitals that has been underrepresented in the literature.

**Advantages of the Ecological Approach**

The overarching framework of this thesis is the ecological approach, which is crucial to understanding the manifold and shifting connections between the hospital and its broader environment. The ecological approach assumes that AGH had an internal ecosystem—the systems, people, and services encompassed within the hospital itself—and was a part of larger ecosystems—healthcare chains, communities, counties, etc. People inside and outside the hospital claimed authority in hospital policy, and the ecological approach allows us to appreciate the power dynamics behind those claims, and
how AGH defined the boundaries of its identity and function through the negotiation of those claims.\textsuperscript{13}

The ecological approach is most fundamentally about co-existence and interconnectedness, and therefore, accommodates a broad variety of useful theoretical points.\textsuperscript{14} I synthesize ideas on boundary work, organizational ecology, positionality, and co-production that point to the hospital as a hybrid site of the medical-social, the public-private, and the lay-professional.\textsuperscript{15,16} The ecological approach integrates the useful elements of all of these concepts into a model of institutional dynamism that accounts for how power relationships induce that dynamism.


\textsuperscript{13} Here, one is reminded of Bourdieu’s concept of the habitus, the “internalized dispositions” that reside within individuals and are learned through formal education, experience, and the inculcation of social relations. The habitus is a milieu created by social expectations and history. This is equivalent to a social environment, which is more passive than the term “ecosystem” implies. While the hospital could arguably be conceptualized as the intersection of multiple Bourdieusian fields, or a trading zone, or even simply as a mirror of the society in which it is embedded, there are specific reasons why I believe the ecological approach is more comprehensive and accurate.

\textsuperscript{14} In The Ecological Thought, Timothy Morton writes that “Thinking the ecological thought is difficult: it involves becoming open, radically open—open forever, without the possibility of closing again.” (8) Although Morton’s agenda is somewhat different from my other sources (he is interested in the Nature-unnatural dichotomy and philosophical, aesthetic, environmental, and political implications), his book is a interesting contemporary introduction to the style of thinking that I have in mind. Timothy Morton, The Ecological Thought (Harvard University Press, 2010).

\textsuperscript{15} “Ecological theories of social form, instead define the features that make organizations distinct from another as socially constructed cognitive maps used by interested audiences to categorize and thus draw distinctions in the organizational landscape.” “The Comparative Analysis of Organizational Forms: Considering Field and Ecological Approaches” Omar Lizardo, “The Comparative Analysis of Organizational Forms: Considering Field and Ecological Approaches,” in Studying Differences Between Organizations: Comparative Approaches to Organizational Research (Emerald Group Publishing, 2009), 117-152: 119.

There are four major advantages to analyzing AGH as an ecosystem of healthcare. First, the ecological approach differentiates actors within the system through the making of quantifiable niches. We can organize groups within the hospital, such as the staff, employees, patients, and volunteers, in an ecological web. The cataloging of different groups necessarily means that we will examine the ideals and professional standards and behavior of these groups (boundary work is especially useful here). Once groups within the ecosystem are defined, we can consider how group dynamics affect the institution. As Boeker writes, ecological models of organizations assume an explicitly dynamic process of environmental change and competition, essential to both business models and ecological models. In addition, we can link outside groups, such as regulatory government bodies, to internal hospital dynamics.

One of the major consequences of competition is adaptation of group goals and behavior. The ecological approach portrays adaptation not a state of being, but an active process of continual adjustment that is as relevant to hospitals and other scientific institutions as any other firm or agency. We do not assume that every group within the hospital has a permanent strategy, but rather, that specific strategies were deployed depending on the situation, and that the ability to adapt determined the hospital’s survival. This dynamic process makes the events contingent on the local conditions at that particular moment in time.

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These local conditions were the hospital’s “environment,” the technological and organizational milieu that informed the hospital’s decisions. In this thesis, I consider two levels of environment. The first is the local: values, culture, people, and physical makeup of Gainesville and North Central Florida. The second is the national: policies and legislation that affect healthcare at the local level. Social patterns in Gainesville hybridized with national organizational models to co-produce power structures within the hospital. Beliefs about professional standards, race, and gender impacted who was granted authority to practice scientific medicine, how the community was allowed to participate in hospital affairs, and how patients received care.

Finally, the ecological approach emphasizes the integration of as many viewpoints and perspectives as possible, including those that may have been suppressed in popular memory. This approach incorporates the “n-way nature of the interressement”—shifting, politicized linkages—on which power relationships are based.\(^\text{19}\) I do not presuppose the epistemological superiority of any one group of people, be they administrators, physicians, or clerical workers or cooks, or even patients. By acknowledging the assumptions and driving forces behind certain perspectives, we can achieve a richer vision of the hospital.\(^\text{20}\)

\textit{Partial perspectives in methodology}

\(^{19}\) Star and Griesemer, 1989, 389.
\(^{20}\) Critical history is a tool for deconstructing the assumptions about life at a given point in the past. This is especially useful for institutions such as hospitals, which can have parallel, deceptively comprehensive, histories of technology, specific people or groups within the hospital, or even bricks and mortar descriptions. That being said, in this thesis, my aim is not to construct a new, supposedly more accurate truth of the hospital. Rather, I unpack the assumptions that surround the hospital and place it in a critical framework that allows for comparisons with other institutions and policy points.
The ecological approach corresponds to that of the critical historian’s in its demand for the analysis of distribution of power, and the perspectives that have been understated in traditional historical narratives.21 American historian Joan Scott summarizes the critical historical perspective on history-making as “the establishment…and protection [and contestation] of hegemonic definitions.”22 The Northeastern urban hospital is the hegemonic model for hospital growth and development; the literature on southern hospitals, and Florida in particular, is sparse.23 This leads to inconsistencies in expected institutional behavior when looking at small, Southern community hospitals such as AGH.

My research has been made possible by the work of scholars of history of medicine and specifically hospitals, such as Charles Rosenberg, Rosemary Stevens, David Rosner, and Guenter Risse.24 Frank Rathbun’s Proud of Our Past, Proud of Our

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22 A fuller quote reads, “By ‘history,’ I mean not what happened, not what ‘truth’ is ‘out there’ to be discovered and transmitted, but what we know about the past, what the rules and conventions are that govern the production and acceptance of the knowledge we designated as history…history is inherently political…this process is about the establishment…and protection [and contestation] of hegemonic definitions of history.” Joan Scott quoted in Gaye Tuchman in The SAGE Handbook of Qualitative Research, 2005, 317.

23 The American Hospital Association (AHA) compiled a list of the histories of individual hospitals in 1988. California, New York, and Massachusetts hospitals, not surprisingly, make up the bulk of these histories. There were 16 histories of Floridian hospitals, 10 from Alabama, 13 for Georgia, and 0 for Mississippi, compared to 78 for Pennsylvania and 103 for New York. There are several notable histories of small hospitals in Jacksonville. Center for Hospital and Healthcare Administration. “United States Hospital Histories” July 20, 2010. Charles Rosenberg has acknowledged that there is a dearth of historical work on Southern and Western hospitals because of their relative newness and consequent lack of information, although this is certainly not the only factor. Charles E Rosenberg, The Care of Strangers: The Rise of America's Hospital System (New York: Basic Books, 1987): 253-263.

24 Much of the work related to hospitals in the last 30 years has specifically focused on the cost of hospital care, or workplace tensions between different hospital personnel—in short, specialized topics that do not aim to provide a sense of how contemporary debates surrounding hospitals are historically based.
Future is a local history of AGH that I cite extensively.\textsuperscript{25} Many of my primary documents come from the archives of the Matheson Museum of Gainesville and include newspapers, hospital administrators and trustees’ records, personal documents and newsletters, oral histories of former staff and volunteers of the hospital, hospital-produced literature, etc.\textsuperscript{26} My idealized model is that of bricoleur. As Denzin and Lincoln have written, the bricoleur interviews and reads, observes and interprets and engages in self-reflection; works with differing and overlapping paradigms, and aims to create a “bricolage, a complex, dense, reflexive, collage-like creation that represents the researcher’s images, understandings, and interpretation of the world or phenomenon under analysis.”\textsuperscript{27}

The peculiarities and quirks of what made AGH the hospital that it was became clear through personal interviews with former staff and healthcare professionals in Gainesville. These people had strong emotional or professional attachments, or both, to AGH, and painted a colorful, lively picture of the hospital and its inner workings. The techniques I learned from the transcriptions of oral historians were invaluable in guiding me to create my own survey instrument and learn interview etiquette.\textsuperscript{28}

However, one must always be wary of bias, positive or negative. Barbie Zelizer writes that collective memories allow for dynamic reinterpretation of the past, often

\begin{footnotesize}
\begin{enumerate}
\item[25] Frank Rathbun was a professor of journalism at the University of Florida. His history of AGH was written to commemorate the 1978 50-year anniversary of the hospital, and contains fascinating anecdotes and folk sayings that breathe life into the history of AGH.
\item[26] In particular, transcripts of oral histories at the Matheson Museum allowed me to learn about the individual perspective of many of Gainesville’s leading men and women from the first half of the twentieth century.
\item[27] The SAGE Handbook of Qualitative Research, 3rd ed. (Thousand Oaks: Sage Publications, 2005): 2-3. As an amusing note, Woolgar et al. cite Max Travers as stating that the business of STS is to be awkward, offensive, and difficult. I hope to have made the history of AGH a little more problematic so that it provokes discussion about its philosophy and practices and the future of hospitals like it. Steve Woolgar, Catelijne Coopmans, and Daniel Neylands, “Does STS Mean Business?,” Organization 16 (January 1, 2009): 5-30.
\end{enumerate}
\end{footnotesize}
pushing aside “accuracy and authenticity so as to accommodate broader issues of identity formation, power and authority, and political affiliation.”

“Cultural features of accounts [of the past] are not simply the product of individual authorship; they draw on general cultural repertoires, features of language and codes of expression.” Therefore, in studying the history of AGH, it is important to be aware of the pervasive influence of dominant culture in forming the very vocabulary and shaping the mindset in which the actors involved perceive the hospital.

Donna Haraway has written eloquently on the utility of partial perspectives in story telling, and in accordance with her prescriptions, I have tried to select broadly, and acknowledge speakers’ backgrounds when possible. Recognition of one’s alignments is itself the best antidote for historical oversight. This story is necessarily told from the

28 James Hoopes, Oral History: An Introduction for Students (Chapel Hill: University of North Carolina Press, 1979). In addition, my advisers gave me very practical advice about interviewing others that helped me out.


30 In a book written to explain the peculiarity of Southern history, C. Vann Woodward wrote, “Every self-conscious group of any size fabricates myths about its past: about its origins, its mission, its righteousness, its benevolence, its general superiority.” Woodward argues that more than other region of the country, the South clings to a popularized genteel nostalgic vision of itself. C. Vann Woodward, The Burden of Southern History, 3rd ed. (Louisiana State University Press, 1993): 12.

31 The Popular Memory and Narrative Study Group at the University of Warwick quoted in Markovitz, xxii. Similarly, In individual accounts, Tammy A. Smith argues, one’s memory is often rewritten by post-hoc social forces and categories. Tammy A. Smith, “Remembering and Forgetting a Contentious Past,” American Behavioral Scientist 51, no. 10 (June 1, 2008): 1538-1554.

32 In Ludwig Fleck’s terminology, “style of thought.” In Pierre Bourdieu, “The specificity of the scientific field and the social conditions of the progress of reason,” Social Science Information 14, no. 6 (January 1, 1975): 19-47. These caveats of interpreting history apply not only to the oral interviews I conducted, but also the documents I used, especially those from hospital administrators and trustees, which were written with the self-conscious desire to present the hospital in the best possible light.


34 What information has been filtered out by a generous selective memory? In the research process, it became clear that the history of AGH was inseparable from the history of Gainesville itself, and that for many local residents AGH was not only a part of community history, but their individual life history as well. There were certain people who mythologized AGH as an archetypical community hospital, and others
perspective of administrators, physicians, and government officials because of their prominence in the historical record and ease of accessibility. It is not possible to examine all visions equally in this thesis.\footnote{There are several aspects of AGH’s history that this thesis did not address. One of these is the perspective of allied health professions, such as nurses, or the more recent nurse practitioners and physicians’ assistants. I would have liked to spend more time on the historical black experience at AGH. I spoke primarily with primary care physicians, and it would be interesting to see if specialists’ perceptions of the hospital differed. In addition, the role of private health insurers and pharmaceutical companies at the hospital are unclear. These topics are essential to explore in future research.}

It must be understood that the discussion of AGH that follows is my own understanding of its history and significance, and that I myself am not immune to people’s love for the hospital in the Gainesville area, which remains strong. As Diane Vaughan has written, “The solidification of argument and the dropping of ambiguity that go into negotiation and document creation affect not only the audience but the creator: the author becomes committed to a rendition of the world.”\footnote{Diane Vaughan, “The Role of the Organization in the Production of Techno-Scientific Knowledge,” Social Studies of Science 29, no. 6 (December 1999): 913-943; 930.} Disclaimer: I am committed to my own rendition of AGH’s history, but support the principles of individualized patient care and community engagement that shaped the hospital’s ideology.

**Specific theoretical frameworks and organization of the thesis**

In 1850, Dr. Harvey Cushing noted that each hospital has a “personality,” a particular emotional atmosphere, traditions, and tempo of work.\footnote{Robert N. Wilson, “The Social Structure of a General Hospital,” Annals of the American Academy of Political and Social Science 346 (March 1963): 67.} Each hospital’s personality is uniquely determined by its individual efforts of bridging medicine and society. However, in the twentieth century, it is generally acknowledged that there are who scoffed at it as a somewhat run-down former public hospital. These views often corresponded to the length of time lived in Gainesville, cultural and social values, and affiliation to the hospital. Hospital Auxilians told a different story from former hospital executives, and physicians differed on descriptions of the hospital atmosphere and factual information.
three major historical periods in the second half of the twentieth century that shaped the community hospital.38

1. Professional dominance combined with localized control (1945-1965)


3. Increased reliance on market mechanisms (1983-present)

This thesis shows that AGH followed these generalized trends, and that to some extent, professional dominance, federal (and local) involvement, and market mechanisms have always been important factors in shaping the hospital’s operations and goals.

There are four main frameworks that I use to interpret the history of AGH, which correspond to chronologically organized chapters that roughly follow these generalized trends. I have chosen to study AGH from 1945 to 2009 because I believe that the origins of the modern hospital lie in (1) the linkage of the hospital with scientific research (2) post-WWII mass consumer ideology that changed public perceptions of and expectations of healthcare.39 Within each chapter, I have tried to select what I consider to be the most crucial themes of that time period, and sometimes take liberties by including events that are just slightly out of the range of that time period.

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38 Martin Ruef and W. Richard Scott, “A Multidimensional Model of Organizational Legitimacy: Hospital Survival in Changing Institutional Environments,” Administrative Science Quarterly 43, no. 4 (December 1998): 877-904. The importance of these factors is contingent upon the local politics, culture, and resources of the individual hospital, and the matter of which is the most important factor at any given time depends on the story one wishes to tell.

39 The federal government’s efforts to build healthcare revitalized hospitals, and with new advances in antibiotics, surgical techniques, and the transportation of the sick and wounded, hospitals gained more scientific legitimacy. White speculates that even the space program of the 1960s contributed to medical science. (43-44) In addition, the 1950s heralded a new ideology of mass culture that resulted from economic prosperity and population growth after the war. This mass culture conflated patriotic citizenship with consumer habits, which I believe changed how people perceived hospitals. Incentives for new medical technology turned hospitals into deliberately showcase-like institutions that made them sources of civic pride for towns like Gainesville in a way that they had not been before. See: Charles H White, The Hospital Medical Staff, Delmar series in health services administration (Albany, NY: Delmar Publishers, 1997). Robert (Robert Griffith) Griffith and Paula Baker, Major Problems in American History Since 1945, 3rd ed. (Houghton Mifflin, 2006).
Chapter 1 covers the post-war period of growth, 1945-1963, and presents the setting for the growth of AGH: benevolent funding from the federal government and enthusiasm for technology. Through the filter of boundary work, this chapter explores the importance of the local medical community to the hospital ecology. Susan Leigh Star and Thomas Gieryn’s works on the power of classification and the mapping of credibility, respectively, are the major theoretical sources. The development of niches of the other major holders of power in the hospital—the board of trustees and the hospital administrator—is also discussed.

Chapter 2, 1964-1976, examines the relationship between AGH and the government—the local government’s attempts to control it, and the federal government’s legislative requirements. This chapter presents the relationship as one of attempted control and expected submission on the part of AGH, and as such, relies greatly on Michel Foucault’s theory of governmentality and institutional self-discipline. I will examine the struggles between the medical staff and the county commissioners as a struggle for professional autonomy. The civil rights movement and federally mandated desegregation provide insight into how racial relationships in broader society co-produced power relationships and black-white health disparities within the hospital. Therefore, I also take some time to discuss the state of healthcare for African-Americans in Gainesville and how the civil rights movement impacted AGH.

In Chapter 3, which covers 1977-1995, AGH’s adoption of the corporate model had minor consequences for its daily operation but larger consequences for its mission and potential. AGH developed a formalized bureaucracy, a mimicking of the
organizations found in other corporate firms, in order to capitalize on the prestige of private institutions. I examine the effects of privatization on AGH. Works in organizational ecology, notably, Powell and DiMaggio’s discussion of institutional mimicry, help us understand the strategies AGH employed to sustain its position in the larger ecology of Gainesville. At this time, other hospitals began to compete with AGH for the same patient population, and an ecological understanding of interconnectedness informs the discussion of hospital competition.

The last chapter closes AGH’s history, 1996-2009. This time period marks Shands Healthcare Inc.’s purchase of AGH, and eventual closing of the hospital in November of 2009. Here, I analyze the underlying ideological commitments of the hospital, drawing upon the works of Daniel Mulkay, Mary Douglas, and Steve Shapin. Institutional memory created the metaphor of family as a response to perceived outside threats. The closing of AGH is at once an example of the modern medical marketplace at work, and a symbol of change in a southern college town, a place where progressivism is popular, but tradition still matters very much.
World War II brought thousands of Air Force families from nearby Camp Blanding, and tens of thousands of white GIs seeking education at the University of Florida to Gainesville, as well as physicians returning home from military service. AGH’s growth, driven by an abundance of federal resources, paralleled that of Gainesville’s during these two decades. This chapter discusses how, in this rich environment, hospital expansion was complicated by power struggles between the trustees and local government, and medical staff, who used different claims of expertise to negotiate new boundaries of their professions.

Physical expansions were an attractive opportunity for physicians and hospital administrators to establish specific areas of professional expertise and authority. In Florida, the early twentieth-century ideal of the “country doctor” was replaced by the new expectation of doctors as men of science armed with better knowledge and tools. I use the concept of boundary work to explore professionalization of medicine in Gainesville. Boundary work is a process in which certain groups make exclusive claims on specialized knowledge in order to legitimate autonomous practice, drawing boundaries between themselves and other groups in the process.40

Expansion was also affected by local standards of technological adoption. A broad definition of technology will allow us to consider the full range of technological advances made at AGH during this time and in the following decades. Joel Howell, writing specifically on medical technology in hospitals, argues that the best way to

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40 Thomas F. Gieryn, Cultural boundaries of science: credibility on the line (University of Chicago Press, 1999), xv.
conceptualize medical technology is to consider it in three parts: a physical artifact, an activity or method, and scientific validation of the knowledge of that technology. Full understanding of the medical technology in question has power implications for healthcare providers in relation to administration and regulatory bodies.41

National scientific optimism spurred funding for the creation of hospitals and medical technology. However, at AGH, despite the same enthusiasm for technological solutions, the actual rate of uptake of technology was slow compared to national patterns. The hospital’s local environment affected implementation of technology at the hospital, which in turn affected the hospital’s care-giving strategies and self-perception as a community hospital that provided personalized patient care.

The role of the federal government: expansion of facilities and population

After WWII, the federal government surpassed private contributors and religious organizations as the largest financier of endeavors in hospital building nationwide. It was driven by what one hospital architect, Isadore Rosenfield, described as the desire for constructive democracy, a “popular clamour for a better post-war world...in all departments of human need.”42 One of the biggest departments of human need was that of healthcare—individuals’ physical health became a metaphor for the success and stability

of the nation.\textsuperscript{43} Thus, improving hospitals through technological and physical expansion was a logical extension of the federal agenda.

Local advocacy for hospital expansion made the community hospital a metric not only of physical healthiness, but social health. A well-run hospital was a benchmark of a well-functioning community. Henry J. Southmayd of the Commonwealth Fund commented, “a community hospital is something to be proud of as evidence that the community has achieved stability and foresight, and as insurance against the threat of disaster.”\textsuperscript{44} Federally financed hospital expansion provided a way for citizens to express their civic pride in their hospitals, which conferred benefits to the hospitals: besides greater resources for treating more patients, there was community-wide admiration of the hospital and satisfaction with the state of their local healthcare institution.

In the 1940s, AGH successfully appealed to the Alachua County Commission for funds by capitalizing on national enthusiasm for hospital-building. It reminded citizens that it set the standard for medical care in North Central Florida through its faithful service to the community. A 1946 \textit{Gainesville Daily Sun} editorial implored, “in planning for hospital additions, let us bear in mind that no public institution, unless it be the schools, has served the entire population of the county so often and so well.”\textsuperscript{45}

Private contributors were a highly visible source of financial support that, in requiring the collaboration of multiple social groups, reaffirmed the community’s united goal to strengthen the hospital. During and immediately after the war, local leaders

\textsuperscript{43} One might characterize this as an extension of the concept of the “body politic”—the health of individual bodies affected the health of the social body, and manipulations of individuals could have implications for society, and vice versa. The use of the human body as a litmus test for the wellbeing of the state has a long history, from Protagoras to Hobbes to Foucault.

\textsuperscript{44} Henry J Southmayd, Small Community Hospitals (New York: The Commonwealth Fund, 1944): 8.
maintained community support for AGH by invoking patriotic and charitable sentiments. In 1943, M.M. Parrish, Jr., and Harry C. Duncan, prominent local business leaders, collaborated with the Gainesville Airport to drop 10,000 leaflets over Gainesville to raise money to match the PWA grant: “National health is our first line of defense…give our sick ones at least a fighting chance for health.” In another example, when an increased demand for whole blood became apparent by May of 1948, Dr. W.C. Thomas, local medical patriarch, mobilized his social and medical connections to work with the Alachua County Medical Society to establish a blood bank at the hospital. Under the auspices of the Alachua County Medical Society, with seven other men, he purchased a building from Camp Blanding and accepted donations of equipment from the Junior Welfare League. The blood bank opened in July of 1949 amid much fanfare from The Gainesville Daily Sun as the John Henry Thomas Memorial Blood Bank, named after a prominent financial supporter (no relation to Dr. Thomas).

Popular support allowed the hospital to fundraise from the community and the government; AGH also took advantage of its institutional network to expand its technical core by initiating projects with partners in the government and the community. The most important project was the inception of the Alachua County Hospital School of Nursing in 1945, created with support from the US Cadet Nurse Corps, under the auspices of the US Public Health Service. Nurses were sorely needed; although the hospital reported a bevy of enthusiastic female volunteers, it hoped to attract nursing students who would stay

46 Personal communication, physician
48 Ibid, 24
full-time after being trained. The first class graduated in 1948 with twelve nurses, most of whom stayed at AGH. AGH demonstrated a dexterous coordination of governmental resources with human resources to create an institutionally beneficial addition, with the stipulation that nursing students in the federal cadets program could be called into service if the war continued.

The federal government’s most important contribution to hospitals at this time was direct funding. The Business Census of Hospitals shows that already in 1935, almost one-third of national hospital income came from federal or other governmental sources. Two federal programs provided grants for hospital growth: the Public Works Administration (PWA) during the 1930s, and the 1946 Hill-Burton Act (formally known as the Hospital Survey and Construction Act). Between 1947 and 1971, the $3.7 billion distributed by Hill-Burton contributed to 30% of all hospital projects and provided, on average, 10% of hospital construction costs.

The PWA funded a desperately needed 1943 addition at AGH that raised bed capacity to 116—just in time, since the PWA was dismantled that same year. The hospital was so overcrowded that patients were transferred to the new building before it was officially completed. AGH also applied continually for Hill-Burton funds, although, similarly to the PWA grant, years after the program’s inception. Hill-Burton money enabled the construction of a new tower that was completed in 1960 and later called the

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49 AGH was called Alachua County Hospital from 1927-1947. The name was changed to Alachua General Hospital in 1947.
50 See picture 4 in Appendix 3
51 In 1935, Roosevelt’s New Deal policies and the work of the Committee on Economic Security led to the passage of the Social Security Act. This Act restored many programs stipulated in the Sheppard-Towner Act, and expanded healthcare for children and mothers under the Children’s Bureau.
Harry C. Edwards Tower after a beloved trustee. This seven-story concrete tower loomed over the original building, thereafter referred to as the “1927-1943 building,” and added 176 new patient beds. These large expansions would not have been possible without government grants—about $1.8 million in total.

In addition to financial resources, the federal government also made an unintentional human boon to AGH: a deluge of military families who settled in North Central Florida after the war. The population of Camp Blanding, the primary Army training site for Florida, made it Florida’s fourth largest city during the war. It is estimated that during the war, over 800,000 soldiers received training there; in addition, the majority of the 4,000 POWs held in Florida during the war were kept at Camp Blanding.\(^\text{54}\)

The 55,000 military personnel and 21,000 laborers, cooks, and nurses recruited from throughout the Southeast had a seismic effect on Gainesville’s population, and therefore, hospital census. During the war, AGH operated past maximum capacity, in spite of the 2,051-bed hospital located on Camp Blanding’s premises. During a seasonal influenza outbreak, Nurse Superintendent Gertrude Overstreet reported that patients were being sent to Jacksonville because of the overcrowding at AGH.\(^\text{55}\) Even nursing students, who were supposed to receive lodging in the hospital, were boarded at nearby private homes to make room for patients.


\(^{55}\) Rathbun, 17
These effects continued to resonate after the war’s end. The University of Florida (hereafter referred to as the University) brought more than 4,700 veterans to the campus in the first year of the implementation of the GI Bill.\textsuperscript{56} Physicians, too, took advantage of the GI Bill: at least two out of 20 practicing Gainesville doctors in the 1950s had gone to medical school with assistance from the GI Bill. Table 1 shows that this initial census spike laid the groundwork for a steady flow of new residents into Gainesville and Alachua County over several decades.

\textbf{Table 1: Population Growth of Alachua County and Gainesville, 1940-1970}\textsuperscript{57}

<table>
<thead>
<tr>
<th>Year</th>
<th>Alachua County</th>
<th>Gainesville</th>
</tr>
</thead>
<tbody>
<tr>
<td>1940</td>
<td>38,607</td>
<td>13,757</td>
</tr>
<tr>
<td>1950</td>
<td>57,026</td>
<td>26,861</td>
</tr>
<tr>
<td>1960</td>
<td>74,074</td>
<td>46,146</td>
</tr>
<tr>
<td>1970</td>
<td>104,764</td>
<td>64,150</td>
</tr>
</tbody>
</table>

The potential patient population was proportionately even greater than it had been in earlier years because of nation-wide patterns of health insurance coverage—by the end of 1954, over 60 percent of the country was covered by hospital insurance.\textsuperscript{58} The military-driven population surge perpetuated enthusiasm and necessity for the expansion of AGH as patient census continued its upward trend towards maximum capacity. The

\textsuperscript{56} Gannon, 333  
\textsuperscript{58} Maggie Mahar, Money-Driven Medicine: The Real Reason Health Care Costs So Much, 1st ed. (HarperBusiness, 2006): 10. This thesis, for the most part, leaves out discussions about health insurance companies, which were surely vital to the hospital’s success. This is an unfortunate exclusion resulting from the dearth of information about AGH’s dealings with health insurance companies. There is some intriguing evidence of the personal negotiations between AGH administrators and Blue Cross/Blue Shield executives in the 1970s and early 1980s in the Board of Trustees meeting minutes; however, these are referred to in passing and any conclusions about the hospital and insurance companies’ concerns would be speculation based on national patterns.
number of patient beds reflects AGH’s impressive growth: AGH opened in 1928 with 58 beds, and in 1960, it boasted at least 354.

Postwar AGH actively accumulated greater resources, both financial and human, that led to the general strategy of “build more, build bigger,” for the next two decades. (This recurring cycle of crisis in patient overload followed by hospital construction, temporary relief, and the gradual increase of patients would extend into the 1980s.) The population boom of North Central Florida intersected with the growth of AGH in a positive feedback loop that perpetuated construction and the search for money to support this construction: demographic changes directly affected the hospital’s growth.

One may ask if there were any restrictions on hospital growth, and the short answer is, very few. There were no quantifiable national standards of performance and healthcare delivery. There is no mention of inspections to make sure Hill-Burton codes were enforced at AGH.59 Potential sources of regulation—local civic groups and the government—were most concerned with the lack of hospital beds. Nowhere was there mention of economizing resources (which would become the dominant paradigm of the 1980s). Hospitals fortified themselves to accommodate an upward-spiraling patient population without consequence.

59 Obtaining Hill-Burton funds was just as much a matter of demonstrating community needs as currying favor with a legislator who held the power of voting for funds. Supposedly dispassionate criteria for evaluating eligibility for construction funds were in reality coated with layers of interests. Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982): 349.

However, hospital expansions in the 1950s were a double-edged sword: this advantage would later cause hospitals, and the government, grief in more frugal decades. The cost of construction doubled, and consequently, so did the cost of treatment in hospitals nation-wide. However, the only solution seemed to be, build more. This was the logical strategy given the volume of patients that the hospital was responsible for, the increased number of practitioners who wanted to be actively involved in the hospital, and medical educational opportunities.

Hill-Burton overwhelmingly favored hospitals over clinics or independent practices as recipients of funding. Hospitals, already considered the most prominent healthcare centers in their communities, were boosted to even greater heights of medical celebrity. However, close to $2 million in government money made AGH more dependent on the county commission, which matched Hill-Burton funds for hospital expansion. Its contributions entitled the county commissioners to participate to a greater extent in discussions of medical affairs, which as we will see in the next chapter, caused tensions that threatened the ecology of healthcare at AGH.

More immediately, physical expansions meant not only more patient beds, but also more room for technological wonders to treat the sick. Hospitals across the country scrambled to normalize to contemporary standards of medical technology, and AGH was no differently motivated. This led to a program of expansion whose vigor would be periodically renewed over the next few decades when calls for progress (equated with expansion and modern technology) were sounded.
Standards of medical technology adoption at AGH

The federal government cultivated hospital expansion and encouraged technological innovation. In his 1945 report to President Truman, titled “Science The Endless Frontier,” Vannevar Bush declared, “Scientific progress is one essential key to our security as a nation, to our better health, to more jobs, to a higher standard of living, and to our cultural progress.”\(^{60}\) The New Scientist speculated that in the 1950s, “as never before science appeared as a magic wand” for solving the problems of the whole nation.\(^{61}\) “Big Science,” heavily funded scientific research for the advancement of, among other things, medical treatment, was romanticized as the solution to postwar medical problems in America.\(^{62}\)

Medical technology is an important element of the ecological role of hospitals. In 1979, Louise Russell, a researcher for the Brookings Institute, outlined a “technological model” of the hospital that presents hospitals as mediators of medical technology that is produced by medical schools and corporations and passed down to consumers.\(^{63}\) Analysts have pointed out that technological dominance is one method by which hospitals can control their turbulent healthcare environment.\(^{64}\) The hospitals that captivated national attention were showcases of high technology. For example, Kaiser Permanente produced a promotional video clip in the 1950s of an ultramodern hospital, “the answer to a doctor’s prayer,” that boasts of well-secured babies stored in sliding bassinets and a

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\(^{60}\) Vannevar Bush, Science: The Endless Frontier (ACLS History E-Book Project, 1999).

\(^{61}\) Reed Business Information, New Scientist (Reed Business Information, 1981): 490.

\(^{62}\) A. M. Weinberg, “Impact of Large-Scale Science on the United States: Big science is here to stay, but we have yet to make the hard financial and educational choices it imposes,” Science 134, no. 3473 (7, 1961): 161-164; Leighton E. Cluff, “America's Romance with Medicine and Medical Science,” Daedalus 115, no. 2 (Spring 1986): 137-159.

$25,000 combined fluoroscope and X-ray machine imported from Holland.\textsuperscript{65} The assumption that medical technology is a motivator of hospital growth is fundamental to research on hospitals past and present.

In spite of these stainless steel dreams, I argue that this traditional narrative of postwar scientific conquest in medicine is not universally applicable because it does not hold true for AGH, and most likely, other hospitals similar to AGH. Rather, borne out of a context of wartime shortage and financial limitations, AGH worked around the dearth of new technology by repurposing existing technology and asserting its position as a local technological leader. The hospital’s preexisting social, financial, and physical conditions set local standards for its adoption of medical technology.

During World War II, most Gainesville physicians went into military service. The remaining physicians reduced their house calls and moved equipment into the hospital. They encouraged patients to go to the hospital in order to save time and energy.\textsuperscript{66} Doctors could do urinalysis and blood counts in their offices, but more complex blood chemistries—for diabetes and kidney failure, for instance—would have been done in the hospital laboratory. Doctors relied on the hospital more and more, and discovered the convenience and efficiency of centralizing services.\textsuperscript{67} This pattern cemented AGH’s position as the authoritative medical center of Gainesville.

\textsuperscript{65} 1950s Hospital Of The Future, With Sliding Baby Drawer, 2008, \url{http://www.youtube.com/watch?v=h8-cuWqyqKM&feature=youtube_gdata_player}.
\textsuperscript{66} Dr. J. Maxey Dell, Jr., Hazel Dell, interview by Joyce Miller, January 25, 1977, transcript, Matheson Museum Oral History Archive, Gainesville, FL: 6.
\textsuperscript{67} Cowan describes the co-dependence that technology creates with its users: more technology makes the users more dependent on that technology, and each other. Ruth Schwartz Cowan, A Social History of American Technology (Oxford University Press, USA, 1997): 68
However, anyone at the time would have pointed out the limitations of medical technology. Dr. Dell recalled of faulty hospital equipment in the 1940s, “You got shocked every once in a while with the open wires in those machines.”68 Lula Moser, an AGH X-ray technician, reported that she sometimes worked without photographic film; even the envelopes that stored negatives had to be reused. Barium for gastrointestinal procedures was mixed with buttermilk to make it somewhat more palatable. In these pre-disposable days, cotton tips, gauze pads, cotton balls were handmade by employees, and enemas and needles were sterilized before being reused.69 Local historian and journalist Frank Rathbun reports that the state of medical equipment was “lagging behind the rapidly advancing state of scientific and technological progress and production.”70

However, the very idea that AGH “lagged behind” other hospitals presupposes a standard of technological adoption that was based on other hospitals’ behavior.71 Contrary to the assumption that all scientific institutions normalize to the same standards of technology acquisition, the literature suggests that historical, social, and economic factors influence hospitals’ differential uptake of medical technology.72 Since the adoption of medical technology “actually requires the creation and maintenance of a particular set of social conditions as the operating environment of that system,” we must

70 Rathbun, 26
71 Major hospital histories focus on urban hospitals in the Northeast, which have a greater rate of modernization than hospitals in the South and West. See: Charles E Rosenberg, The Care of Strangers: The Rise of America's Hospital System (New York: Basic Books, 1987).
72 Peter C. Coyte and Dave Holmes, “Health Care Technology Adoption and Diffusion in a Social Context,” Policy, Politics, & Nursing Practice 8, no. 1 (February 1, 2007): 47 -54.
examine elements of variability in technological adoption that contributed to AGH’s individual case.\(^{73}\)

Daniel Mulkay argues that scientists transfer general social values to science in order to legitimate scientific activities: this creates the perception of scientific norms in that mirror cultural values.\(^{74}\) Our perspective is grounded in a history in which American cultural values of righteous democracy and materialism find expression in scientific endeavors in medicine and the hospital. Thus, depending on one’s biases, it would be tempting to view AGH as a backwater hospital because of its material deficiency, or alternatively, free of the dehumanizing influence of money-driven postwar technology.\(^{75}\) Therefore, there is no norm of adoption, but the stories of hospitals that have a greater capacity to adopt medical technology obscure the stories of hospitals like AGH that have different technology requirements and would not have necessarily benefitted from greater technology use anyway.\(^{76}\)

AGH’s major institutional characteristics and geographical location determined its standards. Economic researchers have found that diffusion rates for medical technologies are strongly correlated with a “common factor” that is associated with historically

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\(^{74}\) Mulkay applies the strong programme concept of “repertoires of justification” to express the framework of biased language that allows scientists to co-opt relevant social values to garner support for scientific endeavors. In describing the particulars of “scientific ideology,” he cites Greenberg’s analysis, which includes ideas such as “society should support, but not govern, science; that all mature scientists must have complete independence...” etc. (Mulkay, 649) Meyer and Rowan likewise argue that organizations imitate the other organizations that they interact with in order to gain legitimacy. This will be a major point in the third chapter. See: Michael J. Mulkay, “Norms and ideology in science,” Social Science Information 15, no. 4 (January 1, 1976): 637 -656; John W. Meyer and Brian Rowan, “Institutionalized Organizations: Formal Structure as Myth and Ceremony,” The American Journal of Sociology 83, no. 2 (1977): 340-363.

\(^{75}\) A. M. Weinberg, “Impact of Large-Scale Science on the United States: Big science is here to stay, but we have yet to make the hard financial and educational choices it imposes,” Science 134, no. 3473 (7, 1961): 161-164.

\(^{76}\) Peter C. Coyte and Dave Holmes, “Health Care Technology Adoption and Diffusion in a Social Context,” Policy, Politics, & Nursing Practice 8, no. 1 (February 1, 2007): 47 -54.
consistent quicker or slower adoptions of technology. Hospitals with higher common factors—those that adopt technology more easily—tend to be major teaching hospitals, to have higher patient volume, and to be located in states with higher average income.\(^77\) AGH most likely would have had a low common factor due to its lack of these three attributes: it was a publicly owned community hospital in semi-rural Florida.

In addition, medical practitioners are a major decision-making group. Teplensky et al. suggest that hospitals are driven by desire for clinical excellence, technological superiority, and in the last three decades, profit maximization.\(^78\) All three of these factors are associated with a hospital’s survival strategy of attracting patients and physicians. Physicians who are more liberal in their practices are more likely to embrace “dynamic,” still-developing technology, while physicians who are more conservative tend to hold off until the technology’s efficacy is established. AGH’s medical staff seems to fall into the latter category.\(^79\)

Above all, a comparative lack of financial resources most likely determined the adoption of new technology. AGH was relegated an annual budget by the county commission. In 1947, this budget was $360,000. This budget was expected to cover all of the hospital’s expenses—pay for student nurses and employees, physical plant maintenance, food, and supplies for patients. Although AGH was reimbursed for care of

\(^79\) Ann Greer, an innovation-diffusion researcher who interviewed several hundred community doctors for her paper, discusses how medical practitioner organization at the local level impacted the rate of technology uptake. Local tradition and ambition are important factors. In addition, the proven efficacy of a technology is important to winning physicians’ trust: is a technology established, or still in the “dynamic” process of being tested? Ann Lennarson Greer, “The State of the Art Versus the State of the Science: The
indigent patients, these rates were below what private insurers paid. The $25,000 X-ray and fluoroscope machine would have been a risky purchase.

The lack of technologies, even non-medical, defined everyday practice and inspired creative solutions. Maintenance men repurposed ¾ galvanized pipes and fittings to make orthopedic traction equipment. In a time that lacked air-conditioning, Miss Lillian Merry, LPN recalled that it was so hot surgeons asked nurses to bring them basins of ice for them to stand in the OR. Likewise, one doctor recalled that one nurse was always in attendance at surgeries to make sure the doctor’s sweat didn’t drip into an open wound. As Ruth Schwartz Cowan observed, “new environments create new opportunities for people to modify their old tools so as to sustain and maintain themselves in new ways.”

Pride in personal qualities and folksy anecdotes contributed to an integration of the hospital with its local environment. Dr. J. Maxey Dell, Jr., somewhat humorously opined that while making X-rays, “With those lead gloves on, many times I would be wringing wet…[but back then] there was nobody who had air conditioning. [Now] we are getting weak.” AGH employees and physicians had to find creative solutions to


80 Ibid. The hospital’s 1943 addition came with air-conditioning, which surely brought some relief to hospital workers and patients.


83 Frank Rathbun documents one hospital employee who recalled fishing in a small stream that ran past the hospital with doubled No. 8 surgical thread tied to a stick. Frank Rathbun, Proud of Our Past, Proud of Our Future: The Story of Alachua General Hospital, Inc. (Gainesville, Florida: Alachua General Hospital, Inc., 1978): 25. Although there was a coldwater spring under the hospital that periodically flooded the basement, no attempt was made to block it, since people enjoyed having this novelty.

84 Dr. J. Maxey Dell, Jr., Hazel Dell, interview by Joyce Miller, January 25, 1977, transcript, Matheson Museum Oral History Archive, Gainesville, FL: 18.
patients’ medical needs, and their ability to do so played with the historical Southern frontier tropes of Florida—self-reliance, ingenuity, and grit.

This alternative approach to technologically intensive medicine shaped the hospital’s approach to providing care. AGH focused on using social ties among staff and patients to promote a philosophy of providing attentive personal care, which did not depend on emotionally distancing medical technology.85 This philosophy freed AGH from worries about competition on a national level and reaffirmed its local commitment to the community and especially indigents, which had historical significance for the hospital’s enduring ideology.

The “Big Science” materialistic mentality that pervaded medicine put hospitals such as AGH at a comparative disadvantage, and currently works to obscures social and historical patterns that explain how hospitals adapt to their particular environments. Sheila Jasanoff’s presentation of technology as both “facts and artifacts that reconfigure nature” and the “equally human [technology]…that order or reorder society” such as laws, regulations, and bureaucracies, is important to the understanding that technology and environmental conditions “underwrite each other’s existence.”86 Technology was one way in which social and scientific values interacted to create a unique standard of medical practice at AGH. At the expense of being downgraded as a hospital that “lagged behind” the technological curve, AGH stuck to its mission as a community hospital whose strategy was to economically serve the greatest number of people possible.

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85 Cowan cites the widely documented association between technology and impersonal medicine: “Those physicians who wanted their profession to become more scientific favored the use of the measuring device…widening the physical and emotional distance between doctor and patient.” Ruth Schwartz Cowan, A Social History of American Technology (Oxford University Press, USA, 1997): 203
Boundary work in the community of medical practitioners at AGH

Paul Starr writes, “The ideology of scientific medicine after World War II upheld the authoritarian role of the doctor as expert.”87 Empowered by the aura of technical proficiency, the medical profession continued a trend towards becoming a self-conscious, self-interested political and scientific group. Ideology is rooted in customs, cultural understandings, and social structures—doctors actively shaped these in order to legitimate themselves as scientific experts. The AGH medical staff, which was composed of local respected community practitioners, engaged in boundary work that benefitted their practices and elevated physicians’ political power in the hospital.

Boundary work is a useful theoretical framework in this case for understanding niche creation, how different groups used resources to stake professional claims, and created standards to legitimate their identities and practices in a dynamic and contestable way. Boundary work is the process by which a group claims expertise of scientific knowledge and other differentiators (such as skills or training) in order to gain autonomy, and convince others that that autonomy is justified.88 It provides a model for professionalization of medicine, as physicians redefined the significance of medical training, practices, and technology with the aim of increasing their own authority.

The foundation for boundary work is a defined “community of practice” that can draw up boundaries through self-affirmed standards.89 Sociologist William J. Goode noted that a community of practice has a sense of identity and defined roles, little

86 Jasanoff, 17
migration, common values and specialized language, and clear limits that place boundaries on its members—it is a little world within a world that creates its own value system and regulations. While the term has been used to mean different things in different studies, here I use community of practice to refer to a group of people with a common profession who informally share knowledge, build a social identity, and from that, grow social capital towards common goals.

The medical community in Gainesville in 1945 possessed similar social characteristics. They organized through the Alachua County Medical Society, which was established in the late 1800s met monthly and had social functions for its members and their wives. Physicians subscribed to an ideology of the Southern “country doctor.” The infrastructure of this group was shaped by the fraternal closeness of small, semi-rural towns and family ties. In 1954, there were only about 20 doctors in Gainesville, and according to longtime practitioner Dr. Dell, doctors who came to Gainesville between 1945 and 1960 did so almost exclusively because they were returning home.

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92 Outside of medicine, Gainesville physicians had many other roles—fruit growers, Masonic leaders, and occasional mayors, to name a few. The social capital derived from these involvements meant that the medical men of Gainesville possessed not only scientific knowledge, but also social authority over their patients.
93 Ora L. Bradley, a Georgia physician’s wife, provides a 1920s view of the Southern doctor: “If the old-fashioned doctor could not do the patient any permanent good, in a physical sense, just talking, looking wise and sympathetic always had favorable results psychologically. The doctors of today [1940s] are too busy to stop and waste time in “convivial confab of nonsense...[The old-fashioned doctor] was never too busy (though he was always busy) to lay his hand on your shoulder and talk with you. He was really interested in everyone’s welfare.” (97-98) Ora Lewis Bradley, The Country Doctor's Wife (New York: House of Field, inc, 1940).
94 Dr. J. Maxey Dell, Jr., Hazel Dell, interview by Joyce Miller, January 25, 1977, transcript, Matheson Museum Oral History Archive, Gainesville, FL; Dr. John Crago, interview by Robert Clayton, June 14, 1999, transcript, Matheson Museum Oral History Archive.
Physicians mediated another boundary through expertise (and thus control of) medical technology at the hospital. As discussed previously, during World War II, physicians realized the conveniences of centering their practices at the hospital. One doctor recalls that jaw fractures were treated exclusively at AGH because it was the only place to get a general anesthetic. New features generated by scientific medicine were important in anchoring the medical community to the hospital and reinforcing boundaries of medical practice.

The leader of this community for the first half of the twentieth century was Dr. W.C. Thomas—a requirement for practice was “his sanction or his blessing. [No one] would have opened an office in Gainesville unless they had his tacit approval.” New initiates had to gain entry into the community by traversing the referral network: “The new doc would get referred a lot of the old crocks and no-pay patients.” To attempt a subversive strategy, such as ignoring referrals from other doctors would probably have been to commit professional and social suicide because of the stakes of belonging to the medical community.

Boundaries at AGH were thus shaped by the pre-existing social characteristics of the medical community in Gainesville: professionalism revolved around notions of cooperation and familiarity, and physicians maintained boundaries in order to sustain their autonomous practices. These boundaries were maintained through professionalization, which Powell and DiMaggio define as “the collective struggle of members of an occupation to define the conditions and methods of their work, to control

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95 Dr. Gordon Schwalbe, interview by Joyce Miller, February 17, 1977, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
96 Dr. George Leonard Emmel, interview by Robert Clayton, April 24, 2002, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
'the production of producers’ and establish a cognitive base and legitimation for their occupational autonomy.' Standards of practice, credentials, and technical expertise helped the medical community establish the bounds of their profession.

Many scholars agree that in the first half of the twentieth century, the hospital served as a “doctor’s workshop” whose functions and values revolved around the need of physicians. The physicians at AGH transferred the internal standards of the pre-hospital medical community into the hospital. Hospital privileges were given based on a general level of aptitude (a license and letter of endorsement) and the rapport that a new physician established with the older physicians. A physician’s behavior was firmly monitored by his colleagues. Emphasis was placed on mutual cooperation, adherence to established rules, and attention to social familiarity, and transgressing physicians were disciplined by their colleagues.

These boundaries were cemented in the formalized bodies of physician self-governance. At AGH, external professional regulation came in the form of the Alachua County Medical Society, and the AGH medical executive committee carried out internal professional discipline. As William J. Goode wrote, the local rules of the profession, because of their personal enforcement “exact a higher standard of behavior than does the

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99 In the 1961 case of Dr. Thomas Snow, who “willfully ignored” the rule of giving a pre-surgical consultation to a patient (Snow didn’t feel that inguinal hernia was a major procedure and thus didn’t need to follow the rules) the Executive Medical Committee made the unanimous decision that his surgical and assisting privileges be suspended for 90 days. Alachua General Hospital, Meeting Minutes of the Board of Trustees, February 21, 1961.
However, strict discipline could result in very impressive communal efforts; this is demonstrated by Gainesville’s medical response to WWII. A former nurse recalls that when the US entered the war, virtually every able doctor signed up for service, except for an agreed-upon small number that stayed behind to tend to the local population. In a time of stress, the community of doctors transformed itself into a project team for the benefit of those it served.

Strict self-governance revealed itself as a strategy to maintain professional autonomy and simultaneously upheld scientific standards. Gieryn and Figert argue that self-imposed regulatory structures promote professional autonomy and public image of the profession, which in this case, paradoxically allowed the strictly self-regulating AGH medical staff great freedoms of practice within the hospital. One indication of this is that even by the end of the 1950s, over half of the physicians with hospital privileges continued lively private practices, and about 10% of the staff were designated “courtesy,” which meant that they could be called upon to substitute for attending staff but did not have assignments within the hospital. Although the comingling of private practice and hospital practice was to decline over the years, the mobility accorded to the doctors by this system served as a point of difference between them and other workers such as nurses, who were rooted to the hospital. Paul Starr affirms that this mobility mutually benefitted the hospitals and doctors in the post-WWII general hospital.

Physicians used their professional authority to weigh in on issues outside the practice of medicine per se. The legitimacy of the medical executive committee was

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based on the implicit assumption that physicians, as medical experts, knew what was best for all aspects of the patient experience, from medical treatment to payment methods to built environment. These representatives brought resolutions to the board of trustees, who lacked the expertise to challenge physicians (trustee membership requirements were changed in the 1940s to represent charitable lay interests and prevent a physician stranglehold).

Although physicians asserted the boundaries of medical versus non-medical practice, within the medical profession, the boundaries of practice among specialties were less clear. The potential divide between the medical staff and the surgical staff was lessened by the fact that a substantial fraction of the medical staff also had some degree of general surgical training, which was a common feature of rural practitioners. Furthermore, while professional standards legitimated a doctor’s practice, social interactions among the Gainesville medical professionals could either enhance the importance of or mitigate regulation of these standards.

In the early 1950s, local doctors recall that there out of about twenty practitioners, three or four were certified specialists, and the rest were general practitioners (who may have had some specialized training, especially in obstetrics). In 1961, out of a staff of 58, there were 15 general practitioners; all specialties had less than five doctors—with the exception of general surgery, which had nine—and there was a lone pathologist.¹⁰³ The smaller number of specialists could have theoretically allowed these specialists to define how they were different from other doctors and capitalize on their specialized

¹⁰³ Oral histories; Alachua General Hospital, Meeting Minutes of the Board of Trustees, February 21, 1961.
knowledge. However, in practice, physicians did not engage in making sharp boundaries based on specialty because of the pre-existing social structure of the medical community, specifically, its emphasis on sharing and cooperation, overlap of technologies and procedures, and above all, the identity of the community doctor.

The boundaries between community doctor and academic doctor became important when the University of Florida opened a teaching hospital in 1958. The UF Teaching Hospital, renamed W.A. Shands Teaching Hospital (Shands Hospital) in 1965, was built on Archer Road, the largest local road in Gainesville, next to the College of Medicine and less than a mile from AGH’s prime downtown location. Shands Hospital was part of the J. Hillis Miller Center, a health complex that included the Pharmacy Research Wing, Children’s Mental Health Unit, Human Development Center, and the Richardson Eye Clinic. The doctors who were employed at Shands came largely from outside North Central Florida, and included several foreign medical graduates.

Some feared that these new doctors would draw patients away from private practices. Dr. Henry J. Babers, a former AGH physician, wrote, “[Physicians at AGH] had vague fears of a monolithic congregation of ‘medical geniuses’ completely

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104 This specific knowledge would give doctors the power to make medical diagnoses. May (1993) defines disease as a professional construct that reflects the highest state of a physician’s knowledge (White, 38). Likewise, Charles Rosenberg argues that the specificity of medical diagnosis is the cornerstone of a physician’s authority. Charles H White, *The Hospital Medical Staff*; Charles E. Rosenberg, “The Tyranny of Diagnosis: Specific Entities and Individual Experience,” *The Milbank Quarterly* 80, no. 2 (2002): 237-260.

105 The College of Medicine was opened in 1956. William A. Shands was leader of the “pork chop gang,” a group of North Florida senators who represented “Old Florida” values and maintained control of the Florida legislature until court-mandated reapportionment in 1968. The story of how he successfully fought for a teaching hospital to be placed in Gainesville instead of Jacksonville, Tampa, or Miami is a fascinating one in its own right, and demonstrates the impact of political legislative power on the topography of healthcare facilities.

106 By 1980, over 60% of the doctors in Gainesville had an affiliation with Shands.
overwhelming them in Gainesville." To mitigate the concerns of local physicians, Dr. George Harrell, the first dean of the medical college, recruited young doctors instead of a cadre of well-known doctors that could have overshadowed local doctors in expertise and reputation. Though the AGH medical staff feared the University’s encroachment on their patient base, Shands Hospital doctors actually helped to relieve the crushing patient load for private doctors. In a later oral history interview, Dr. Babers concluded: “I could see we [community doctors] were so dad-gummed over-worked, that I would have sold my soul to get some new doctors here.”

The University’s program did outcompete AGH in quantity of service, technological expertise, and ability to attract government funding. One prominent example is the University’s College of Nursing, which opened in 1956. The nursing college, led by a passionate group of health planners and nurse administrators, established radical programs that adapted professional organization and behavior for nursing. It received funding from the state department of public health and the University. Shands had greater resources and organizational structures oriented around medical education and research. This translated to fewer nurse students and poor long-term outlook for the nursing school at AGH, which closed the next year. Thus, depending on the institution’s

107 Henry J Babers, “‘The Impact of a Medical School on the Private Practice of Medicine in the Community’,” Journal of the Florida Medical Association 67, no. 3 (March 1980).
108 While Harrell presented it like this to the private practice physicians, Shands doctors and Harrell himself also recruited young doctors to build a reputation for excellent growth at Shands. Harrell looked for the next generation of leaders in their respective specialties whose blossoming careers would reflect positively on Shands. See: Dr. William Enneking, interviewed by Julian Pleasants, January 12th, 2001. UF Oral History Collection; also oral histories of Dr. George Harrell, Dr. Richard P. Schmidt, Dr. Edward R. Woodward.
110 For accounts of some of these practices, see oral histories of Dorothy Smith, Betty Hilliard, Iona Pettengill in the UF Oral History Collection. Attempts to professionalize nursing were controversial, and protested by some of the university physicians. A disappointed 1970 letter written by Dorothy Smith shortly before her resignation shows that these reforms were curbed.
position in the cartography of healthcare in North Central Florida, institutional boundaries were reinforced: AGH was a community hospital that promoted its local knowledge of the community’s inhabitants, whereas Shands Hospital was an academic research hospital that promoted its more sophisticated scientific knowledge to patients.

When boundaries were defined, it depended on whom they were defined in relation to. While physicians maintained cordiality with their patients and other hospital employees, when negotiating with other leaders in the hospital, such as the trustees, they hardened professional boundaries and asserted their medical knowledge in order to advocate for themselves. The hospital allowed physicians to engage in boundary work, and complicated the kinds of boundaries that physicians drew—or chose not to draw—around themselves when interacting with other groups in the hospital. Professionalization and daily practice constantly transformed linkages among physicians and other groups, resulting in a mutable ecology of power relationships at AGH.

**Gendering specialization in the field of hospital administration**

Other groups strove to imitate physicians’ professionalization in hopes of garnering similar prestige. One example is the hospital administrator. Though younger than medicine, and different in terms of responsibility, training, and occupying a different coordinate within the hospital, hospital administration’s professional rise paralleled that of medicine’s, capitalizing on the principles of scientific management and self-regulation to justify its own legitimacy.\(^{111}\) Hospital administrators stressed that their field, and their

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field alone, was a necessary intermediate between physicians and hospital owners. In consolidating the standards of their field, a minority of male administrators reappropriated the profession as a male one, and thereby linked the scientific work of professionalization with masculinized expectations.

The historical linkage with gendered parental roles colored the field’s professionalization. Nineteenth century observers used the analogy of the family to describe hospital administration: the male superintendent as a strict father, the matron as a caring mother, and patients as children. Arndt and Bigelow argue that by the 1920s, the role of hospital superintendent was perceived as a gender essentialist role—a woman’s inherent capabilities as a nurturer and household manager made her a better fit to oversee a hospital. A 1921 survey found that 79 percent of small hospital superintendents were female.

In accord with the direction suggested by physicians and hospital trustees, a small but vocal group of male hospital administrators advocated for ideals of Taylorized principles of employee productivity, precise efficiency, and competitiveness, in spite of the continuing reality of the need to facilitate communication and balance out inefficiencies. It was the growing number of male administrators who benefitted from the

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112 In the early 1900s, journals such as Modern Hospital were established to cater to the interests and concerns of hospital administrators across the country, and allowed administrators to share advice and create a common culture of management. Hospital administrators consolidated specialized knowledge of governance in educational programs; the first graduate hospital administration program was founded at the University of Chicago in 1934. One doctor in 1943 described the theoretical relationship: “The whole relationship may be summed up as one of cooperation and coordination. Through the administrator the medical staff is responsible to the governing body for the clinical and scientific work of the hospital.” Arthur Charles Bachmeyer and Gerhard Hartman, Hospital trends and developments, 1940-1946 (Commonwealth Fund, 1948), 200.
113 Timmermans and Berg, 63
114 Ibid.
scientific seductiveness of these principles and gained professional authority. A Dr. Parnall writing in *Modern Hospital* in 1920 expressed the growing sentiment that hospital administrators should be “he—and never she, for no matter how able and highly trained as a superintendent a nurse may be, she is never as satisfactory as an executive as a man.”116 Professionalization in hospital administration from the late 1800s through the end of World War II reconceptualized administration as a male profession: not fatherly, but as scientifically informed organizational experts.

The superintendents at AGH were selected from a pool of nurses who had gained organizational experience. Gertrude Overstreet was a notable superintendent who served from 1931 to 1947 through the end of the Depression and the strained times of WWII. During her tenure, the budget of the hospital had increased from $54,000 to $360,000, the number of employees increased from 30 to 140, and there were 60 new beds added. The general opinion of the hospital was that “her tenure, which won acclaim many times from physicians, trustees, and county commissioners, was a historic prologue to the years immediately ahead in which many of the old challenges were to appear with greater consequence than ever before.”117

In Overstreet’s place, from Albany, Georgia, H. Louie Wilson began his tenure as hospital administrator in 1947 under the title of “administrator.” Though the actual task of managing AGH did not change, the shift of terminological standard was indicative of

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116 Ibid, 244. At this time, an organizational metaphor of the administrator as the factory manager was gaining traction, and administrators latched on to the idea of running a hospital like a business. However, as Southmayd asserts, the application of this metaphor is harmful to the running of a hospital, an institution that differs from a private business—it warps their judgment of budgetary questions and causes automatic deferment to doctors whom they imagine to have more expertise in matters of healthcare delivery. Henry J Southmayd, *Small Community Hospitals* (New York: The Commonwealth Fund, 1944): 52. Arndt and Bigelow also point to various inconsistencies between hospitals and private enterprises: public acceptability of profit motivation, charity care, and control over credentialing of the employees.
the acceptance of the legitimacy of the new precepts of hospital management. The shift in superintendent to administrator was embedded in the prevailing gender dichotomy of the female homemaker and the male business manager. Although Overstreet occupied a vital managing role as superintendent, she was conceived of as a facilitator of the operations of the hospital—ensuring that the facilities were maintained, that doctors’ needs were met, that employee satisfaction remained high—rather than a symbol of control.

The professionalization of the role of hospital superintendent/administrator thus relied on boundaries of participation that were defined by gendered notions of hospital stewardship. In the medical field, boundary work was conducted by physicians who differentiated their professional group through certified medical knowledge, scientific authority and new technologies, and socialized standards of practice. In hospital administration, a male minority within the field constructed boundaries in a similar way.

**The hospital board of trustees and the local government: layperson governance**

Two other important groups who carved out roles for themselves were the AGH hospital board of trustees and the Alachua County commissioners. The trustees and commissioners both used the prerogative of representing the public interest to define their roles at the hospital to varying degrees of success. The AGH board was a collection of local citizens, usually prominent in some aspect of business, academia, or civic service,

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117 Frank Rathbun, 26. See picture 6 in Appendix 3 for picture of Overstreet, Dr. W.C. Thomas, and Dr. Cullen Banks.

118 Timmermans and Berg define four kinds of standards: design, terminological, performance, and procedural. A terminological standard refers to the way in which definitions of function are used consistently and uniformly. Though there is little evidence for how Wilson’s job may have changed at
who were selected by the board of county commissioners to direct the activities of the hospital. The trustees were expected to apply their knowledge to the hospital’s functions—for instance, there was usually at least one trustee with business accounting experience. The board of trustees’ monthly meetings amounted to “credibility contests” in which medicine, administration, and government made claims for proper management of AGH.\textsuperscript{119} All members of the community, including government officials, special interest groups, bidders, and journalists, were permitted to attend meetings, making the trustees’ meetings a true intersection of medicine and society.

The trustees faced a difficult balancing act of reining in doctors’ enthusiasm and also providing an attractive environment for practice. Malcolm Wiley, a hospital administrator, wrote in 1942, “The trustee must avoid the serious error of appearing, as a layman, to intrude in professional matters.” However, in the very next line, Wiley wrote, “On the other hand, too many boards believe they have provided a good hospital plant as the ‘doctors’ workshop.’”\textsuperscript{120} Trustees had to balance professional and non-professional interests, complicated by their own status as laymen. This necessitated their attention to the smallest details and individual physicians—they were at the heart of the hospital’s ecology.

The political maneuvering at AGH that trustees experienced, though fractious, was not unique. Nation-wide, trustees, medical staff, and administrators struggled to define and justify their place in the hospital environment. The literature of the time certainly supports this. One hospital administration student role-plays as a trustee: “…if I


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expect the loyalty of the administrator, I, in turn, must be loyal to him. By recognizing where his responsibility begins and respecting that line by never overstepping it, an effective and mutually satisfying basis for carrying out the hospital’s mission would be been established."121

In spite of their specialized knowledge, physicians were still part of the same social fabric as the administrators and trustees. The roles of hospital administrators, medical staff, and the board of trustees could not be broken down into impermeable categories with mutually exclusive interests. Each occupied a different niche of power, but they were interdependent, which made boundaries fuzzy. A doctor might be made a trustee in his later years. A trustee might be treated at the hospital, or in the same social club as the hospital administrator, and so on.

These close social ties, combined with the proximity in which these men worked, resulted in a self-limiting power situation at the hospital: each group asserted its unique claim to authority in its effort to control hospital policy, but also sometimes deferred to other groups to maintain congeniality. This need for cooperation, however, did not apply to the county commissioners. Because of their off-site governance of AGH, they were perceived as a threat to the hospital’s functions and the interests of the groups therein.122

By contrast, the county commission, which approved AGH’s budget and medical equipment purchases, gave reimbursements for county indigent care, was seen as a distant governing body that did not participate directly in hospital ecology, and their lack

122 Bourdieu’s concept of a field, a domain of society that consists of associated players and operates on internal logic, spatially orients the commissioners’ relationship to AGH. Less spatially proximate players are less likely to cooperate, and AGH trustees were not shy about being uncooperative. Pierre Bourdieu. Science of science and reflexivity. Polity, 2004, 15.
of visibility made them lose credibility with the medical staff. The commissioners’ power apparently rankled the hospital trustees and the AGH medical staff, who feared that government regulation would decrease the autonomy of individual groups in the hospital.

In 1952, the hospital trustees resigned en masse in protestation of what they perceived as county commission imperiousness. Rathbun explained this as “the classic pattern that exists whenever one body of overseers, dedicated to improving professional service and proficiency, is yoked in what is sometimes a galling harness with another body of men, responsible for levying and disbursing funds for several departments of government.”\(^{123}\) Another way of saying this is that the trustees, accustomed to direct management of the hospital and feeling that they had its interests at heart, differentiated themselves from the county commissioners and made claims of closer connections with staff in order to preserve their authority as the governing body of the hospital.

One dramatic example of the contestation of boundaries between the trustees and commissioners occurred in 1953, when the commissioners agreed to apply for funds through the Hill-Burton Act, and put a $1 million bond issue in the October 1954 election for hospital expansion. (This would fund the 1960 Edwards Tower.) However, the commissioners and the hospital trustees squabbled over where to put the Hill-Burton financed addition, and furthermore, who had the power to appoint members of the board of trustees: the commissioners or the governor.\(^{124}\) Trustees fought to preserve what they perceived as their authority as the more direct managers of hospital policy. In May of 1959, it was officially decided that county commissioners could appoint the hospital.

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\(^{123}\) Frank Rathbun, Proud of Our Past, Proud of Our Future, 28.

\(^{124}\) Ibid, 27.
trustees. Only after this contestation of powers ended was a referendum submitted for a $700,000 bond for construction of a new hospital wing.

When politicians attempted to intervene in hospital affairs, staff physicians and hospital trustees relied on medical boundaries to protect the physicians’ professional autonomy. Trustees argued that county commissioners’ actions created too much administrative hassle (because they were not present at the hospital), and that the trustees had a more intimate knowledge of hospital functions; they furthermore implied that county commissioners were violating the legislative charter under which the hospital had been founded.125 County commissioners, on the other hand, used their ownership of the hospital and control of the budget as justification for their actions.

The hospital, as a site of multiple and interdependent processes of boundary work, demonstrates the ability of an organizational ecosystem to serve as a common framework that accommodates a cacophony of meanings in different social worlds. Where boundaries overlapped, AGH found its common ground—in success rates of treatment, patient satisfaction, and community engagement. This commonality is crucial: a hospital must find cooperative ground in order to be stable enough to carry out its functions. Although matters as diverse as bids on medical equipment to budgetary considerations to staff appointments were discussed at board of trustee meetings, the overarching concern from all parties with these aspects of the community limited the specialization of each profession or layperson group.

Conclusion

The post-war years demanded progress on a multitude of fronts, and it seemed that technical innovation and utilization were the surest route to national improvement. An ecological consideration of the different professionalizing groups at the hospital, population growth, and local technological standards show that the march towards progress was fraught with local politics and particularities that complicate a normalized, positivist vision of the history of AGH. The pre-existing social characteristics of the medical community combined with new waves of medical technology and government-funded opportunities to formalize expertise in a move towards professionalization that cemented physician dominance in the ecology of AGH.

Boundary work, performed by commissioners, trustees, administrators, and doctors, created professional niches that staked a claim of authority in say over how the hospital was to be run. Using principles of scientific organization, doctors, hospital administrators, and others at AGH made standards for practice and administration. In particular, physicians aligned themselves with scientific medicine, which served as a model for the establishment of specialized niches that claimed territories of authority at AGH. The multiple processes of boundary work in AGH are a reminder that medicine in the context of the community hospital is not an “esoteric science” that has little direct public interference, and shows how professional behavior was affected by preexisting social conditions.126

As a result of greater government involvement, post-World War II AGH saw increased friction between the local government, which controlled access to Hill-Burton funds, and the governing bodies of the hospital. The county commissioners, who officially held responsibility for the hospital, used their authority in matters related to the state to participate in discussions of healthcare delivery at the hospital. The federal government largely determined the rich environment that provided financial, technological, and human capital to AGH. Federal legislation dramatically increased public investment in AGH, but also increased the potential for regulation. As we will see, a growing undercurrent of national reform shaped the next decade of the hospital’s history.
Chapter 2: Reform and Governmentality, 1960-1969

On August 21st, 1960, over 2,000 people formed a line to view the new concrete tower that would be called the Edwards Tower. As the Gainesville Sun reported, “It’s a lot of hospital.” The tower housed 176 patient beds: 58 private, 74 semi-private, 44 ward beds, and 32 bassinets for newborns. There was a new recovery room for patients waking up from anesthesia. In 1959 the old hospital had seen 7,900 admits, 12,934 in the ER, and 1,583 deliveries.127

None of this growth would have been possible without Hill-Burton dollars, but tacked onto the monetary price was the requirement to adhere to federal standards of inclusion. Government itself can be considered a form of technology: “the regulation of conduct by the more or less rational application of the appropriate technical means.”128 The uptake of this technology—which included Medicare and Medicaid, and the Civil Rights Act—changed preexisting power relationships, most notably, in the black-white race relationship at the hospital at the same time that broader social activism was challenging power relationships in other facets of society.

Foucault’s influential theory of governmentality provides insight into the effects of increased federal social reform. Governmentality is a broad term that refers to the power relationships created by the triangulation of discipline, sovereignty (domination), and government.129 It is a condensation of the ways in which dominating and dominated

127 Rathbun, 41.
129 McNay in Dave Holmes and Denise Gastaldo, “Nursing as means of governmentality,” Journal of Advanced Nursing 38, no. 6 (6, 2002): 557-565; Robin Bunton, Foucault, health and medicine (Psychology Press, 1997).
groups use technologies of government and/or are subjected to technologies of
government. Although governmentality does not refer exclusively to the power that the
state holds over its subjects, forms of state control impact how control is exerted at a
private level.

Power is productive: it is defined relationally and flows between different groups;
each group must have strategies to capture this power.\textsuperscript{130} I argue that social change in the
1960s created a redistribution of social, economic, and medical resources that increased
the federal government’s governing power in healthcare—governmentality tested the
professional standards at AGH that had been established after World War II. Federally
mandated reforms oriented hospital policy towards a national standard and less towards
local physicians, or even the local community’s, interests.\textsuperscript{131}

The federal government played the decisive role in desegregation at federally
funded institutions across the country, particularly in the South. Critical to the
desegregation process was the government’s initiative of healthcare payment programs.
Medicare and Medicaid, like a landslide, altered the topography of the healthcare
environment in hazardous and beneficial ways. I suggest that Medicare and Medicaid
were biopolitical tools of governmentality that created new bureaucratic structures in

\textsuperscript{130} Thomas Lemke, “Foucault, Governmentality, and Critique,” in (presented at the Rethinking Marxism
Conference, Amherst, MA, 2000), 1-14.
\textsuperscript{131} Because this chapter is concerned with AGH’s institutional relationship to the federal government, I do
not address how AGH may have governmentality over its patients or within the medical field itself. There
is much literature on governmentality at the individual level and within specific professions. For example,
see Dave Holmes and Denise Gastaldo, “Nursing as means of governmentality,” Journal of Advanced
Nursing 38, no. 6 (6, 2002): 557-565.
both government and hospital that primed the hospital for greater compliance with government regulations.132

In order to address the history of desegregation and the impact of government reforms, it is important to first step back and examine the preexisting infrastructure of healthcare in the African-American community and points of intersection with AGH.

*The black network of healthcare, pre-1965*

Racial discrimination was integral to governmentality on a national scale that widened health disparities. North Central Florida was part of the Jim Crow South and, as a geographical region that codified racial segregation in law, relegated blacks to the position of second-class humans, and enforced harsh penalties for deviance. These laws impacted all areas of life, including healthcare. For example, an Alabama law forbade any white female nurse, in hospital public or private, from entering a ward that housed a black man.133 Although discriminatory practices in healthcare were by no means limited to the geographic South, they were especially visible because of legislated segregation—

132 This kind of coercion through federal insurance programs would be part of biopolitics. A biopolitical paradigm is a framework which, using Epstein’s definition of “inclusion and difference” articulates how organizational mechanisms are used to address issues of health, medicine, and medical governance in overlapping realms of biomedicine and state policy. Rose contends that due to the medicalization of government—through emphasis on individual responsibility for health, medical self-advocacy, and bureaucratized medical relationships between doctor and patient—we do not engage in politics anymore so much as biopolitics. However, I do not see the pattern as government becoming medicalized so much as medicine becoming governmentalized—through programs such as Medicare, which forced medicine to adapt to bureaucratic styles of patient, and even disease, classification and accounting, medical professional autonomy has had to reconcile with the sphere of government concerns about public health. See: Steven Epstein, Inclusion: The Politics of Difference in Medical Research, 1st ed. (University Of Chicago Press, 2007): 17-29; Nikolas Rose, The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century, annotated edition. (Princeton University Press, 2006).
the biopolitical power of the state over the bodies of its non-white subjects had social and health consequences.\textsuperscript{134}

The black community in Gainesville struggled to contest legislation that affirmed their second-class status and adapted to exclusion by devising alternative healthcare strategies with what resources they had. This created a black healthcare network that had proportionally higher needs, fewer providers, and constant challenges from the pressure of racial discrimination in all aspects of life. The history of the black health network in Alachua County reveals real social causes of racial patterns of health that are often obscured by moralistic arguments about the inherency of biology.\textsuperscript{135}

The history of race-based health disparities is stark. A 1947 national report observed that blacks had twice the rate of tuberculosis and maternal death of whites, and that in the 1940s, there was a ratio of 1:3,377 for black doctor to black population, compared to 1:750 for whites.\textsuperscript{136} In 1963, the Florida Advisory Committee to the US Commission on Civil Rights reported that black residents of Alachua County, who comprised 26\% of the population, had higher rates of disease—pneumonia, hypertension, intestinal disease, tuberculosis, and syphilis—than their white counterparts.\textsuperscript{137}

\textsuperscript{134} Melvin Leiman, The Political Economy of Racism (Haymarket Books, 2010): 47.
\textsuperscript{135} James argues that racism itself is a cause of ethnic/racial health disparities, and that without that recognition, we cannot begin to create equality in healthcare. Sherman A. James, “Confronting the Moral Economy of US Racial/Ethnic Health Disparities,” American Journal of Public Health 93, no. 2 (February 2003): 189.
\textsuperscript{136} In the South, the ratio for black doctor to population increased to 1:4900. President's Committee on Civil Rights, To Secure These Rights: The Report of the President's Committee on Civil Rights (New York: Simon and Schuster, 1947).
Furthermore, according to US Census data in 1960, there was one black doctor, one dentist, five RNs, and three LPNs for approximately 19,260 blacks in Alachua County.\(^{138}\)

In the previous chapter, I discussed the community of practice that supported physicians at AGH. Black caretakers occupied a different community that formed in response to professional exclusion. There were a small number of licensed black physicians and other healers in North Central Florida from the late 1800s until the 1950s.\(^{139}\) In the early 1900s in Gainesville, the downtown home of a black woman named Jenny Rose served as a black clinic and birthing center.\(^{140}\) Midwives—whether or not they were licensed—constituted a major fraction of black health practitioners, probably due to the less regulated, and more accessible, nature.\(^{141}\) Three black physicians—Robert B. Ayer, Sr., Julius Parker, and Cullen W. Banks practiced in Gainesville from 1877 onward.\(^{142}\)

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\(^{138}\) The number of health practitioners is reported by the Florida Advisory Committee for 1963. I used 1960 US Census data for Alachua County, which shows that there were 74,074 total residents.

\(^{139}\) Here, the major distinction between physicians and other healthcare providers is professional credentials. Black physicians still had greater medical authority because of their medical training. Even though the black network of care was defined by race, there were still professional differences that created higher and lower positions in this network.


\(^{141}\) In fact, licensing black midwives, many of whom were informally trained, was a problem for the public health department of Alachua County. Nurse Iona Pettengill recalls visiting midwives to make sure their instruments were sterilized and that they had a basic level of literacy to fill out the birth certificate, which shows the extent to which government regulated black health practices as well as whites’. Pettengill worked with several AGH doctors to have a young black woman, Geneva, trained as a midwife at AGH. Geneva seems to have disappointed her mentors by returning to her nearby hometown of Micanopy. Iona Pettengill, interview by Ann Smith, October 1 2001, transcript, Matheson Museum Oral History Archive, Gainesville, FL.

\(^{142}\) Dr. Ayer and Dr. Parker practiced concurrently, and Dr. Ayer’s son and Dr. Banks practiced later in the 1950s. Nurses, who could not open their own practices, were bound to the hospital (and so did not work in Gainesville until the early 1930s). Medicine seems to have been a family tradition: Dr. Robert B. Ayer Sr., the first black licensed doctor in Gainesville, practiced in Gainesville for 37 years beginning in the 1920s and two of his sons and grandchildren followed in his footsteps. Lizzie PRB Jenkins, Alachua County, Florida, Black Americ (Charleston, South Carolina: Arcadia Publishing, 2007).
Black physicians in the South were often barred from practicing in hospitals and had little opportunity for post-graduate training or making professional connections through local medical societies.\footnote{In medical education, too, black students faced double-edged expectations from their white professors and attendings. One Shands physician called the first black medical student, Faye Harris, “unsuccessful” because she didn’t socialize with the other students—it seems that he did not consider factors that might have excluded her from their study groups. Richard P. Schmidt, interview by Samuel Proctor, January 16 1992 and February 10 1992, transcript, Matheson Museum Oral History Archive, Gainesville, FL.} A 1943 survey of black doctors in Florida reveals deep-seated worries about professional isolation, frustration with lack of access to hospitals and adequate medical technology, and fear of racial violence.\footnote{Sarah Vinson, “The Racial Integration of Postgraduate Medical Integration in Florida” (Powerpoint, University of Florida, August 24, 2006).} For increased financial stability and political support, black health practitioners often collaborated. In Alachua County, Dr. Parker and Dr. Cosby, a dentist, shared a practice that was a block away from the Jenny Rose house. In addition, local civic groups and churches provided layperson support to healthcare.\footnote{In Alachua County, there were at least two groups that contributed to health practices and pallbearing. These groups were great leadership opportunities for women. Bruce Ergood, “The Female Protection and the Sun Light: Two Contemporary Negro Mutual Aid Societies,” The Florida Historical Quarterly 50, no. 1 (July 1, 1971): 25-38.}

In lieu of a black hospital, and with limited options at AGH, blacks ostensibly sought treatment from black physicians, white physicians, or home remedies.\footnote{Many blacks—and poor whites—also turned to traditional remedies. Dr. J. Maxey Dell, Jr. identified two of the remedies that the “colored folks” used in the 1930s: mustard plasters and turpentine compresses that “didn’t have very much scientific basis to them.” Dr. J. Maxey Dell, Jr., interview by Joyce Miller, January 25 1977, transcript, Matheson Museum Oral History Archive, Gainesville, FL.} White physicians provided healthcare to blacks, though this was highly variable and depended on the beneficence of the individual doctor.\footnote{Vihlen, 17. There was a curious pattern of black patient-provider relationships: while some blacks always went to see the black physicians, others sought out black physicians only in mild cases and went to white doctors otherwise.} Black patients, who entered a doctor’s office through the back door and sat in separate waiting rooms, did nonetheless
sometimes establish good relationships with their white doctors.\textsuperscript{148} However, Dr. Cullen Banks, the first black doctor to gain full privileges at AGH, stated that when he moved to Gainesville to practice in 1954, one white doctor told him “he was glad I was here because he was tired of taking care of all of the black people.”\textsuperscript{149}

Medicine in the black community in Gainesville did not have a centralized site of practice comparable to AGH. Vanessa Northington Gamble argues that the formation of black hospitals provided care of patients who couldn’t get it otherwise, and protection to black professionals.\textsuperscript{150} Brewster Hospital in Jacksonville, 80 miles to the north, was the closest all-black hospital to Gainesville. In the 1950s, five black Gainesville ministers formed a board and proposed an all-black hospital to be named Seagle Memorial Hospital. Over twelve years, $8,000 was raised, but these funds were inadequate and the plan failed for lack of capital and physician support.\textsuperscript{151}

Paul Starr shows that the “equal but separate” clause in Hill-Burton was creatively interpreted when applied to non-white patients: some hospitals provided segregated wards, while others refused to admit black patients entirely.\textsuperscript{152} Hospitals internalized

\textsuperscript{148} One white AGH physician remembered that the first day he began practice in Gainesville, he heard a knock at his back door. Upon opening it, he found a black man holding his hat in his hands, who asked him if he took black patients. Luckily for this man, the doctor did. (personal communication)
\textsuperscript{149} Dr. Cullen W. Banks, interview by Bob Clayton, August 13 2003, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
\textsuperscript{151} Cullen Banks did not support the plan for a black hospital, because as he told the group, they had enough money for a “one-bed hospital”—a hospital bed in those days cost $10,000-$12,000. Vihlen, 97. Doris Chandler, “‘Seagle Memorial Hospital Was a Dream that was Never to Be’,” The Gainesville Daily Sun (Gainesville, Florida, February 19, 1974).
\textsuperscript{152} Initially, Hill-Burton gave funding to segregated hospitals with the superficial requirement of “separate but equal” facilities, using the language “equitable provision.” Different hospitals defined “equitable provision” differently, however; the results were wide-ranging. When the courts ruled in Brown’s favor, hospitals that had taken federal funds were obligated to comply with the court’s rules—in 1965, the Department of Health, Education, and Welfare stated that hospitals had to be in compliance with Title IV of the 1964 Civil Rights Act to be eligible for federal assistance or participate in the Medicare and Medicaid
racial policies to different extents, based on specific sociopolitical contexts. Many whites in Gainesville took pride in the fact that AGH treated people of all racial backgrounds. As an orthopedic surgeon phrased it, “we never turned anyone away, no matter who it was—black, white, or green.”153 By way of comparison, only two out of seven hospitals in Jacksonville treated blacks until the passage of the Civil Rights Act.154 However, Nurse Iona Pettengill recalled that blacks did not seek care at AGH often, even for routine reasons such as childbirth.155

The black section of AGH was added in the 1930s—an unoccupied space on the first floor behind the boiler room. Two wards, divided by sex, had nine beds each, and when overcrowded, patients were moved into the hallway on screened cots. There were also three rooms that were used for quarantine cases or birthing rooms.156 Nurse Florence Woods called it “hot as fire” in the summertime, when temperatures could reach 115 to 120 degrees (and dip below freezing in the winter.)157 In a Gainesville Sun article, a black woman recounts that she was forced to give birth in a room shared with a dying

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154 Sarah Vinson, “The Racial Integration of Postgraduate Medical Integration in Florida” (Powerpoint, University of Florida, August 24, 2006).
156 This is especially troubling given the rapid expansion of AGH during the 1940s and 50s. In a hospital with almost 200 beds, about 18 were available to blacks.
157 Vihlen, 29
This disparity in treatment shaped the separate ecology of healthcare for blacks.

In a 1963 letter to the Gainesville Bi-Racial Committee, the board of trustees reported that there were 360 employees, 130 of whom were black, and that blacks received the same wages and benefits as whites. However, the story of Florence Woods, a black nurse at AGH, shows that the hospital workplace could be difficult. Woods received no specialized training or opportunities for promotion, was sometimes belittled by white nursing students under her supervision, and was on twelve-hour shifts six days a week in the black wards by herself (as was the night shift nurse who came after her). There was no regular doctor on call until Dr. Banks’ arrival in 1949.

Based on this evidence, I speculate that the racial stratification at AGH must have led to racial disparities in health outcome. Patients who were housed in understaffed, cramped, unventilated wards could not possibly have received the same professed quality of care as patients attended by multiple doctors and nurses a few floors above. Black employees and professionals at the hospital faced daily discrimination and poor working conditions that were a reflection of professional exclusion. It must be stressed, however, that conditions at AGH were similar to that of other hospitals across the United States—a national environment of racial discrimination affected how individual hospitals such as AGH were expected to behave.

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159 She was told by white patients to “keep your black hands off me” and avows that the only reason she stayed at AGH was because she needed the money to raise her four children. Florence Woods, interview by Joel Buchanan, May 10, 1983, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
Desegregation in Society and Hospital

On August 18, 1964, the Senate and House passed Public Law 88-443, which omitted the “separate but equal” facilities clause from Hill-Burton. This seemed to be a success for advocates of integrated hospitals. Problematic as its implementation was, Public Law 88-443 was one of the major steps towards desegregation of American hospitals, and is also an example of the way in which the federal government imposed its standards on institutions that it funded.\textsuperscript{160} Although AGH managed its own medical and institutional affairs, it was also subject to the financial and legislative authority of the federal government. Furthermore, the government’s use of public authority inspired community activists to use their social clout to pressure the hospital to fully desegregate.

The civil rights movement was a politically tense and awkward time for the board of trustees, and doubtless also for the staff, employees, volunteers, and patients who walked the hospital’s halls. The diplomatic wordings of the board of trustees’ monthly meetings indicate self-censoring and careful attention to appeasing civil rights advocates who protested segregation within the hospital.\textsuperscript{161} In education, busing, and service in businesses, activists protested segregationist policies; these national threads of social agitation resonated in Gainesville.\textsuperscript{162} Gainesville groups such as the Gainesville League of Women Voters took up the call for civil rights. These activists picketed restaurants; some were arrested and beaten and one activist’s house was destroyed by arson. In

\textsuperscript{160} Vihlen, 110-111. Enforcement was lax, the Department of Health, Education, and Welfare only withheld funds in 100 cases, and did not actually cut funds off from any hospital in the years 1964-1966
\textsuperscript{161} Alachua General Hospital, Meeting Minutes of the Board of Trustees, June 20, 1961.
addition, some white businesses in the black district were firebombed.\textsuperscript{163} Oral histories recall the importance of the relatively liberal University of Florida in civil rights activism.\textsuperscript{164}

After it received letters and in-person visits from several organizations, including the Gainesville Bi-Racial Committee, the hospital took a first step by allowing blacks into previously white-only areas in 1963. In 1964, the trustees released an important statement on the hospital’s stance on race in response to the amendment of Hill-Burton. This statement shows that sufficiently vague language allowed both the hospital and policymakers to skirt around delicate, emotionally provocative issues of justice and rights, or in this case, providing medical treatment in mixed facilities. An excerpt follows:

It should be remembered, however, that the operation of a hospital is in no way similar to that of a school, or other public institutions. The primary responsibility of the Hospital Trustees is to see that good hospital and medical care are provided the patients. \textit{Nothing should be done that would be a disturbing influence, or impeded the recovery, of any patient}...We will continue to use the facilities in the present manner; however, the administration will, on request, assign Negro patients to other floors, or white patients to the third floor, provided that suitable space is available. \textit{In the interest of the welfare of ALL patients, we have no plans to assign Negro and white patients to the same room;}\textsuperscript{165} (emphasis added)

While the hospital insisted that it would comply with federal Hill-Burton regulations in terms of racial integration, it also seemed reluctant to enforce integration, perhaps due to fear of backlash from unwilling parties of both races, and made the assumption that

\textsuperscript{163} “The Morning Record - Google News Archive Search,” n.d., \url{http://news.google.com/newspapers?id=6yVIANAAAiBAJ&sjid=WAAANAAAiBAJ&pg=2292,966567&dq=gainesville+florida+civil+rights+history&hl=en}.

\textsuperscript{164} For example, medical students at Shands Hospital played a role in desegregation in that hospital by ripping down signs that designated separate white-black areas. Richard P. Schmidt, interview by Samuel Proctor, January 16 1992 and February 10 1992, transcript, Matheson Museum Oral History Archive, Gainesville, FL. Michael Gannon recalls marching in Jacksonville and riots that followed.

\textsuperscript{165} Alachua General Hospital, Meeting Minutes of the Board of Trustees, March 17, 1964.
rooming whites and blacks together would be detrimental to the healing powers of the hospital.

On January 12th, 1965, the hospital revised the wording of its policy to reflect that room assignments would be made regardless of race, nationality, or creed. By 1966, the hospital administrator had guaranteed that all patients were to be assigned to color-blind rooms.166 Local groups used their social significance as organized community representatives to wield power in desegregation debates at AGH, which shows how the ecology of healthcare at AGH relied on and responded to public opinion.

However, sometimes unwillingness to integrate was very real, and this strained trustees’ conflicting obligations to the government and to the comfort of their patients.167 Dr. Banks reported that frequently when a white patient was roomed with a black patient, “The family of the white patient would be crying and carrying on because they didn’t want their family member to have to be here in a room with a black patient. One way they could change this was to claim psychological reasons for moving their family member.”168

During the civil rights movement, in order to preempt withdrawals of support from local political groups, AGH became accustomed to negotiating with groups with competing agendas who challenged the hospital’s racialized structures of care. Thus, power dynamics expanded to include community groups that claimed a stake in the hospital’s policies, and the way in which AGH handled desegregation can be seen as an

166 Ibid, March 15, 1966. In 1966, when AGH became fully integrated, the federal government required signs to be posted stating, “This is a desegregated hospital.” The physical layout of the hospital and its visible markers reflected a new political vision of integration. The power of the government was literally inscribed on hospital grounds.
adaptive response to this broader definition. AGH policed itself to avoid potential
negative public feedback, and remain eligible for federal funding programs—Medicaid
and Medicare. These two programs were the greatest motivator for this self-enforcing
compliance with federal orders, which ties together racial attitudes and financial
incentives under the authority of the federal government.

**Federal healthcare payment programs: Medicare and Medicaid**

Despite popular political pushes towards integration, Medicare was what really
cemented integration at AGH: the fraternal twin of civil rights legislation was a
healthcare payment system that the government used as a tool of enforcement.\(^\text{169}\)
Medicare gave hospitals reimbursements for a desirable patient population, but required
all hospitals to comply with the Civil Rights Act of 1964.\(^\text{170}\) If the state had asserted
biopolitical control over its people through segregationist legislation, then these programs
heralded the beginning of biopolitical management of health that created new
administrative responsibilities for hospitals such as AGH.

Federal support for healthcare has a long history. In 1798, the Congress passed
“An Act for the Relief of Sick and Disabled Seamen” which established a maritime
hospital and paid for merchant seamen’s health expenses. The 1921 Synder Act

\(^{167}\) Dr. Max Seham, an advocate for integrated facilities, reported one private hospital in Athens, Georgia,
that refused to integrate even when a government inspector arrived at the hospital’s front door. Max Seham,
\(^{168}\) Vihlen, 129
\(^{169}\) Robert and Rosemary Stevens have pointed out that the distinction between social insurance for those
who worked to deserve “entitlement” to health insurance (Medicare) and public assistance for the needy
(Medicaid) have dominated healthcare policy after 1965. In this discussion, I focus on Medicare because
Medicaid policies vary from state to state and prevent detailed national comparisons. Physicians are much
more likely to discriminate against Medicaid patients than Medicare patients because of Medicare’s
comparably higher reimbursement. E. Richard Brown, “Medicare and Medicaid: The Process, Value, and
established health coverage for American Indians (however sparse).\textsuperscript{171} The system that was to become the US Department of Veterans’ Affairs originated in veteran health insurance benefits after World War I, and calls for national health insurance had existed at least since the Great Depression. As many scholars have documented, the United States’ piecemeal extension of healthcare benefits has been less than effective in comparison to other countries’ programs.\textsuperscript{172}

The government-mandated healthcare payment programs of 1965 signaled a growing trend towards third-party payment that clashed with traditional concepts of medical payment and charity.\textsuperscript{173} Dr. Gordon Schwalbe, one of the “triumvirate of Gainesville dentistry” in the 1950s, listed some of his payments for dental exams: “I’ve taken hams and chickens and ducks and eggs and vegetables and rabbits.”\textsuperscript{174} This experience was not atypical of rural practitioners. Although physicians could and did drop patients who consistently did not pay their bills, the socially salient relationships

\textsuperscript{170}Starr, The Social Transformation of American Medicine, 350
\textsuperscript{171}Doris Nelson, “The American Indian Health Care System” (The League of Women Voters, 2010).
\textsuperscript{173}Starr chronicles the rise of private insurance in America. In 1934, the AMA stated that no third party should come between doctor and patient in rendering of payment (299). However, World War II-time wage benefits greatly expanded the number of people who had health insurance. As more and more commercial insurers entered the market, established nonprofit insurers such Blue Cross, who had used community ratings, began to exhibit competitive, for-profit like behaviors. (328) However, these behaviors created a pool of Americans who could not get health insurance, and also drove up the costs of healthcare, worsening the health insurance industry’s position (333). Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982).
\textsuperscript{174}Gordon Schwalbe, interview by Joyce Miller, February 17 1977, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
that developed over time between doctor and patient did much to mitigate the lack of steady financial transactions.\textsuperscript{175}

In line with the establishment of professional boundaries, it is not surprising that physicians collectively invented guidelines for charity work.\textsuperscript{176} Gainesville physicians seemed to make special allowances for the elderly, other physicians’ families, and exceptional medical cases. One former AGH physician, who practiced for over 40 years at the hospital, stated that patients covered under Medicare would have been considered charity cases who would not have had to pay anyway.\textsuperscript{177}

AGH, as a county-owned hospital, was obligated to treat anyone who walked through its doors, and received reimbursements from the county for indigent cases. Since its inception, AGH had maintained financial stability, and even reported surpluses in some years, despite providing a relatively large number of charity cases. Charity in 1966, even after the passage of Medicare, was estimated at 9.4\% of total treatment costs (treatments covered by private insurance accounted for 25.7\%).\textsuperscript{178}

Medical services had been viewed in economic terms before the advent of government social insurance programs, but the size and new source of financial authority (the federal government, not physicians), contributed to the commodification of medical services. This commodification had several consequences: new forms of classifying

\begin{footnotesize}
\begin{enumerate}
\item[175] Richard C. Reynolds, Sam A. Banks, Alice H. Murphree. The Health of a rural county: perspectives and problems (Gainesville: University Presses of Florida, 1976): 65. There are accounts of patients who provided free labor to doctors, and the implication is that patients were in some way accountable, if not financially, then socially. The indebtedness of his patients increased the social authority of the small-town physician. Banks wrote that patients may ascribe to the physician “authority in areas completely outside his field of knowledge, and [endow] him with the ability to address issues in religion, finance, and world affairs.” (66)
\item[176] For instance, the 1848 AMA code of ethics contains detailed instructions on treating other physicians’ families, specifically, that it should be courteous and free of charge. “1848 American Medical Association Code of Ethics,” 1848.
\item[177] personal communication
\end{enumerate}
\end{footnotesize}
patients, new accounting practices, and an effort by physicians to reassert what they perceived as a loss of professional autonomy. The government’s tools of power, as was the case for desegregation, created visible practices that were sympathetic to the long-struggling political vision of greater access to medical treatment.

After 1965, insurance status or Medicare/Medicaid status was a crucial element of the patient’s information. AGH administrators stressed the importance of determining eligibility, because if this was not correctly done, the hospital stood to lose a portion of payment or possibly the whole bill. Eligibility was fairly easy to determine; the major factor was age. However, several years later, AGH began to submit chart reviews of beneficiaries in order to double-check eligibility, an example of an administrative practice that stemmed from the need to classify patients by government-specified criteria.

One example of how Medicare affected administrative practices, and in doing so, created distinctions among the medical staff, is billing practices. Prior to 1965, no matter the type of service provided, one office managed all hospital billing. However, national professional organizations encouraged specialists to use direct billing instead of billing through the hospital to reduce paperwork hassle for the doctors. For example, the radiology department reported that they had been advised by the American College of

178 Alachua General Hospital, Meeting Minutes of the Board of Trustees, July 20, 1966.
179 Alachua General Hospital, Meeting Minutes of the Board of Trustees, March 15, 1966.
180 Dr. Edward Woodward, who practiced at UCLA before coming to Shands Hospital, remembered that UCLA patients were separated into paying and non-paying wards. Non-paying patients were only seen by residents, whereas paying patients were only seen by attending physicians. No treatment stratification of this kind existed at either AGH or Shands as far as the records show. Edward R. Woodward, interview by Samuel Proctor, October 23 1993, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
Radiologists to use direct billing, since under Medicare, hospital and professional charges had to be separated. The board of trustees drew up new contracts for all specialists in 1966 to reflect this change in billing procedure. When individual doctors learned to practice these new classifications, they internalized federal guidelines for patient admittance and payment.

Medicare also affected AGH’s relationship with its previous largest third-party payer, Blue Cross. Blue Cross enjoyed a special relationship with many community hospitals, including AGH, because of its reputation and use of “community ratings,” which was a form of social insurance tailored to individual communities. Before Medicare, 38.4% of AGH’s business came from Blue Cross patients. Like 90% of hospitals in America, AGH nominated Blue Cross as its fiscal intermediary—to deal with the Social Security Administration—under Medicare. However, immediately after Medicare was implemented at the hospital, the number of Medicare patients became 30.5%, and Blue Cross patients dropped to 27.1%. By late 1967, over 40% of AGH patients were on Medicare. Thus, Blue Cross found itself renegotiating rates with AGH in a less favorable position, in a less community-specific context that was focused more on payment for medical services that imitated government standards for reimbursement.

Reflecting the standardization of payment was the use of national statistics that introduced an element of self-conscious statistical comparison to other hospitals nationwide. In 1966, Hospital Administrative Services, a branch of the AHA (American

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182 AGH administrators attended conferences sponsored by Blue Cross to determine rates and exchange information about hospital management. There is evidence that the hospital administrator was on a first-name basis with the Blue Cross executive for Florida. Board of Trustees meeting minutes.


184 Alachua General Hospital, Meeting Minutes of the Board of Trustees, July 20, 1966.
Hospital Association), offered AGH a comparison to other similar hospitals throughout the country by means of data processing to give the hospital a “more realistic view of financial operation and cost accounting of the hospital.” Furthermore, AGH volunteered to participate in HAMP, a Florida Hospital Association study that measured “personnel utilization and efficiency.”

The incentives to participate in studies were two-fold. AGH gained an understanding of how it stood compared to similar institutions and could make internal adjustments. It also gained clinical prestige as a hospital that actively participated in critical comparison, in a climate that rewarded hospitals that met standards of performance with recognition and funding opportunities. Hospitals still differentiated themselves based on their offerings of medical expertise and technology, but now they could also cite their statistically proven merits as well. AGH acquired more and more numbers and comparative descriptions to define itself by, to extend its boundaries of expertise: this is apparent in the increasing number of spreadsheets and statistical reports attached to board meeting minutes.

One consequence of federally sponsored health insurance was categorical thinking; another was a keen awareness of the financial benefits that stood to be reaped from the government. The national average of per capita expenditure on community hospitals from 1950 to 1965 rose from 8% a year to 14% a year. AGH opened in 1928 with rates of $2.50/day for wards and $4.50/day for private rooms; by 1967, AGH rates had risen to $18/day for a bed on the ward and $27.50/day for a private room,

\[\text{185 Alachua General Hospital, Meeting Minutes of the Board of Trustees, June 21, 1966.} \]
\[\text{186 Starr, 384} \]
respectively. Medicare allowed private providers to set their own rates, which, like an example from a textbook on supply side economics, allowed national prices of hospital services to skyrocket without immediate consequence.

However, healthcare providers were still dissatisfied with inefficiencies of the system. AGH set up a utilization review committee in 1965 to determine how these could be reduced. If 1967 is any indication, Medicare caused more difficulties for AGH than benefits. AGH trustees reported in 1967 that the American Hospital Association “has been fighting with Congress all year” to get a more equitable payment on Medicare patients. In 1967, earnings for services increased $78,000 while costs increased $183,000, resulting in a net loss of $104,000. The budget shows that in this year AGH lost $83,158 in gross revenue from Medicare reimbursements. Medicare reimbursements were less than what had been expected: AGH was reimbursed for about 60% of the fees requested for Medicare patients (this rose to 87% in the mid-70s, which seems to have been decent for a community hospital).

Medicare payments, while keeping some patients off the charity list, were not enough to keep up with the increasing costs of medical care caused by overutilization and the payment buffer created by third-party payers, and may have actually hurt the hospital financially. This meant that in order to meet necessary income levels, AGH, which was not-for-profit, would have to find new ways to stay afloat. Because of the ways in which hospitals received payment for patients who used Medicare, patient volume became the

\[\text{\textsuperscript{187} Rathbun, 13}\]
\[\text{\textsuperscript{188} Monica Noether, “Competition among hospitals,” Journal of Health Economics 7, no. 3 (September 1988): 259-284.}\]
\[\text{\textsuperscript{189} Alachua General Hospital, Meeting Minutes of the Board of Trustees, August 2, 1966.}\]
\[\text{\textsuperscript{190} Ibid, June 30, 1969.}\]
\[\text{\textsuperscript{191} Ibid.}\]
most important factor for the hospital to financially succeed. The need to accommodate a greater volume of patients made physical expansion of the hospital a desired investment.

 Luckily for AGH, patient volume was high because of the still-growing population of Gainesville and an influx of new patients who sought medical care now that their treatment would be covered by Medicare or Medicaid. Patient census increased 33% over the previous year. On November 26 1968, Administrator Conroy said AGH had only 1 vacant bed and had made special arrangements with Shands to accommodate ER patients. In February 1970, the hospital had been on emergency admission status since December of the previous year.192

 In spite of the positive effect that Medicare had on patient volume, some practitioners believed that the new insurance programs tarnished the traditional doctor-patient relationship. The sudden deluge of new, paying patients narrowed the definition and inclination for charity work. Henry J. Babers, a local solo practitioner, wrote in the *Journal of the Florida Medical Association*:

> [The doctor] developed his fees based upon what others charged, actually, and he charged what he thought was fair…in 1965 when Medicare came along…we got paid for people we had never even thought about charging before. As a matter of fact, the medical profession said, “We do not think you ought to do it this way,” but the Federal Government did it, and so doctors started making a lot more money.

> Dr. Babers concluded, “The relationship between what it cost to practice and a decent profit and the insurance deal just lost all relevance.”193 He blamed contemporary accusations of physician greed and callousness towards patients on a federal program that supplanted the professional authority to determine one’s own charity cases and instead

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192 Rathbun, 52.
193 Henry J Babers, ““The Impact of a Medical School on the Private Practice of Medicine in the Community”,” *Journal of the Florida Medical Association* 67, no. 3 (March 1980): 10.
made physicians focus on how much they would be reimbursed for services. There was a sense among physicians that the noble profession of medicine was becoming a handmaiden to government health initiatives, but that on the other hand, they could benefit financially from this changing relationship.\textsuperscript{194}

For example, the emergency room staff seemed to feel that the demands to provide the same quality of treatment to a tremendously increased indigent patient pool—whose care was reimbursed at a lower rate than that of Medicare patients—was unfair and brought their complaints to the trustees. They asserted that they were asked to care for more patients without having a say in how they treated those patients:

\begin{quote}
The Emergency Room Committee would like to point out that under the present social structure the determination of who is to furnish medical care for indigent patients is rapidly becoming a responsibility of the federal, state, or local governing body. The care of a large number of indigent patients for whom no professional fees are paid is a con…Today’s professional man has to run faster and faster to maintain his own status quo.\textsuperscript{195}
\end{quote}

The ER Committee furthermore threatened resignations if the workload continued to increase. The statement from the ER doctors implied that that less physician decision-making would harm patient outcome, an implicit threat to those who might try to wrest control from physicians’ hands: if we cannot determine our own standards, we will not be able to practice as effectively and patients will suffer. This reflects a national trend of physicians who reacted to the increasing importance of the federal payment structure by reasserting their professional power. The AMA—which during this time period, included

\textsuperscript{194} In reality, physicians’ groups had a strong voice in the passage of Medicare, which complicates the application of governmentality at AGH. Paul Starr calls negotiations surrounding Medicare the “politics of accommodation,” which set the tone for “dominant private institutions in medical care allowed them to pursue their own internal priorities.” (Starr, 387)

\textsuperscript{195} Alachua General Hospital, Meeting Minutes of the Board of Trustees, July 29, 1966.
roughly 75% of licensed physicians in the country—made sure that members’ interests were protected to actively shape healthcare policy.  

Medicare reimbursements made the care of indigent patients even less desirable in a hospital setting. Responsibility for assuming management of the new problems in payment for indigent services at AGH was passed around like a hot potato. The staff demanded that the trustees fix the gap between services rendered and payment. The trustees suggested that the County Commission assume responsibility of paying for the indigent patients and set up a fee schedule with minimum payments. The county commission responded that it would do what it could, but that fiscal responsibility lay with the board of trustees.

Rosemary Stevens has described what has been observed at AGH during this time on a national scale: hospitals became more focused on immediate goals of expanding physical facilities, being favorably compared in studies, and exploiting government programs for financial gain. Stevens and other scholars come to the conclusion that Medicare led to market-based hospital system we have today: “opportunistic and unsettled, ebullient and nervous; politically attuned and market-oriented.” More fundamentally, the 1960s were witness to a profound change in the understanding of the federal government’s role in setting hospital policy and rates and signaled a change from community policy to public policy.

As this part of AGH’s history shows, government power commodified relationships between groups at the hospital, especially the provider-patient relationship.

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197 Stevens, 274
198 Stevens, 283; see also Karen Davis, 1972, cited in Stevens, 283.
The federal “conduct of conducts” shifted what had previously been medical authority to the administration and government by contractually obligating AGH to provide certain services and adopt certain forms of information classification. Consequently, the changes rendered through desegregation and government payment at AGH privileged those with “expert knowledge” of federal policies—such as the county commissioners.¹⁹⁹

*Tensions between the medical staff and local government*

When physicians felt that the federal reshaping of healthcare encroached upon their territory, they reacted strongly to local government attempts to control healthcare—as an individual medical staff, they could not determine national policy, but they could directly deal with local government. Conflict, especially over indigent patients, escalated in the late 1960s and 70s; the most adversarial of these was the AGH outpatient clinic. Both groups claimed to represent the interests of the community—the physicians, through benevolent medical authority, and the county commissioners, as elected officials of the public will.

Some observers explicitly acknowledged that physicians and county commissioners had different perspectives on what course of action would most benefit the community’s health. Dr. J.W. Andrews, an AGH physician, commented at a trustees’ meeting that underlying differences in conception of the needs of the average indigent patient may have affected the county commission’s proposals of what facilities and equipment were necessary to provide care. He implied that the county commission “had a different kind of patient care in mind,” one that provided only the most rudimentary

¹⁹⁹ Thomas Lemke, “Foucault, Governmentality, and Critique,” in (presented at the Rethinking Marxism Conference, Amherst, MA, 2000): 5
healthcare services and didn’t require the hospital’s extensive facilities. However, the acknowledgement that there were differences in these perspectives did not yield compromises. Physicians and commissioners adopted entrenched political positions, turning their disagreements into a competition over the authority to distribute healthcare resources in an environment fraught with professional-government tensions.

In 1966, the Alachua County commissioners vocally expressed their intent to directly oversee the healthcare administration of all the county’s indigent patients. In a letter to the county commission, Edward H. Clarkson, then-hospital administrator, defended the hospital’s dominion over the distribution of healthcare, for patients of all paying abilities. He implied that the county commissioners best ought to take a hands-off governing approach to the hospital:

The hospital functions in the same manner toward the medical staff as the court house functions in relation to the courts and to the lawyers. It is conceived of as a place where justice is rendered. [Medical equipment is not furnished for doctors’ needs.] The hospital is a place where healthcare is rendered. If the County Commissioners are advancing the premise that it is their responsibility to furnish medical care to all, this is a new concept.

This conflict between the county government and physicians intersected with the establishment of a new AGH adult outpatient clinic. The clinic, which began as a charitable enterprise between AGH and the Junior Welfare League in 1961, was assumed by the county, and funded by county money and Medicaid in 1965. The county proposed to expand the clinic’s hours, hire new personnel, and make the pediatrics clinic part of the adult clinic and allow Shands residents to see pediatrics patients.

The presentation of this plan to the local doctors was disastrous. The director of the Alachua County Health Department was an unlicensed physician, whose lack of

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200 Alachua General Hospital, Meeting Minutes of the Board of Trustees, July 28, 1969.
credentialing was a source of skepticism among the AGH staff. The AGH medical staff bristled at the idea that they could not select the new clinic doctors, and the pediatricians protested the combination of the pediatrics clinic with the adult clinic. This was a matter of medical authority—two anthropologists at the University of Florida reported that in spite of the benefits this clinic would bring, “local physicians were aghast because at no time were they actually consulted in the planning” and felt the commissioners were trying to take away “their baby.”

When confronted with the opposition of 83 AGH physicians, Sidney Martin, a commissioner, asserted that the care of indigent people was the responsibility of the county and not the hospital, and therefore the commissioners would run their own clinic, regardless of whether the hospital started their own. In January 1969, when new clinic opened, the county commissioners directly inserted itself into the internal politics of the hospital by voting to put two of its members on the hospital board of trustees. One commissioner, G.M. Davis, tried to create reconciliation by saying that the board had been doing a good job but needed more supervision; however, a letter was received soon after from the Gainesville Area Chamber of Commerce offering to mediate this situation. The physicians expressed their consternation with this development, calling it a “political take-over” at a meeting several days later.

Between the imposition of the new clinic and the commissioners who were now part of the hospital governing body, the physicians decided that enough was enough. The 75 staff physicians who attended this meeting called for a 10 to 15 member “independent

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201 Alachua General Hospital, Meeting Minutes of the Board of Trustees, August 2, 1966.
and non-political” board of their own. They formed the County Medical Services Association (CMSA), which consisted of about 90% of the practicing doctors at AGH, and in the eyes of the commissioners, operated dangerously close to the definition of a union.

At the May 5th board meeting, chief of medical staff Dr. Charles Pinkoson reported that the CMSA would not practice in the outpatient clinic until its administration was returned to the board of trustees. It is important to note that the CMSA refused to sign a formal contract that stipulated itemized services and costs of units per service. They also refused to approve the county’s application for a federal grant to support the clinic—this was their form of protest against “federal control” of medical care. On the other hand, the county officials perceived the CMSA as profit-driven doctors who did not want rules to get in the way of making as much money as possible. The context of federal government intrusion into medicine polarized the physicians and the commissioners; this political maneuvering reduced the efficiency of care for indigent patients, which had a negative effect on the overall ecology of care at AGH.

True to its word, the CMSA boycotted practice at the clinic for over a year. In order to resolve the situation, Ralph Turlington, of the Florida House of Representatives, at the behest of the doctors, stepped in and proposed that the board be increased to a seven-man group, and that “the appointing authority should not be on the same board and turn around and review the work of the board they appointed.” By late July 1970, a new
board, sans county commissioners, had been appointed, representing a diverse range of social backgrounds, including the first woman trustee, Jean Chalmers, a community activist.\textsuperscript{207}

The AGH staff won out by invoking their medical expertise as a trump card over the county government, both in terms of knowledge about healthcare delivery and political power. Eventually, all groups reached the agreement that control of the outpatient clinic would be turned back to the AGH trustees, and that a sum of money would be set up by the county to pay for expenses incurred by the outpatient clinic, including doubled pay for pediatrics residents.\textsuperscript{208}

This episode shows that physicians rebelled against government interference at the local level, perhaps spurred on by their resentment against federal actions. Even as hospitals absorbed new government standards, they used professional authority to manipulate these standards to protect their institutional autonomy. When it was clear that the county government planned to implement their own changes, AGH physicians refused to participate in these programs, using their medical expertise as leverage. The power relationships between government and medical professionals were never unidirectional. Each side held some advantage over the other; authority had to be renegotiated under each specific set of circumstances.

\textsuperscript{206} The county scrambled to find replacements. One pediatrics doctor supervised Shands pediatrics residents and simultaneously ran the entire clinic, until he resigned due to a personality conflict with the county health department director. Ibid, 257.
\textsuperscript{207} Alachua General Hospital, Meeting Minutes of the Board of Trustees, July 28, 1968.
\textsuperscript{208} Johnson and Stein provide an illuminating look into the different perceptions of the commissioners, health department officials, and local physicians who were involved in this controversy.
Conclusion

In 1949, AGH administrator Louie Wilson told the Gainesville Rotary Club that “people should consider the hospital as ‘their hospital’ and not as just another county institution.” The social activism and federal reforms of the 1960s did allow people to claim AGH as ‘their hospital,’ though perhaps more forcefully than Wilson had envisioned. The government became an indispensible part of AGH ecology: federal standards of racial policy and hospital payment reflected biopolitical authority. AGH aligned to government standards to receive funding and support from community activists. This resulted in the internalization of the government’s standards in individual physicians, trustees, and commissioners.

Social activism in the 1960s made it clear that political community organizations had a stake in hospital desegregation, which complicated notions of who could determine standards of treatment and classificatory structures. However, if we extrapolate from other dimensions of society, most notably education, and the history of alternate black healthcare strategies, the disparities wrought by a history of segregation would remain and complicate the new political vision for racial equality in medical care.

Where social pressures could not sway the hospital’s reluctance, federal insurance incentives did. AGH quickly changed its policies to participate in government programs like Medicare, proving Stevens’ point that “hospitals have long been exquisitely attuned to fiscal incentives,” and the point that money was just as important to hospital politics as

210 Joel Buchanan, interview by Gayle Yamada, February 12 1984, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
social standards—after all, these were different facets of capital that the hospital was able to utilize.\textsuperscript{211}

Government-physician tensions highlight the difference between community health programs and public health programs. Physicians and actors within the hospital controlled community health programs, and used professional authority to assert the legitimacy of these programs, but the government controlled public health programs, and used financial leverage to coerce hospitals and providers to accept these programs. Ultimately, the events of the 1960s show that the hospital mediated multiple institutional and social interests by asserting institutional legitimacy, the right to professional self-regulation, and gaining sensitivity and willingness to adapt to changing standards. Particularly, the antagonism towards governmental interference in previously autonomous medical decisions was a major factor in the hospital trends of the 1970s and 1980s: hospitals as private entities and corporatization.

\textsuperscript{211} Stevens, In Sickness and in Wealth, 338. Sally Vihlen more vehemently states this point: “Greed often accomplishes what respect for human decency cannot.” (127-128)
Chapter 3: “We believe healthcare is more than just a business:” Competition and Incorporation, 1976-1996

In 1978, AGH incorporated under the parent company AGH, Inc., and in 1983, was purchased by SantaFe HealthCare, Inc. AGH used privatization as a strategy to become a more competitive institution that could operate independently of the county commission, which as we saw in the last chapter, often clashed with AGH in a contest for authority in hospital decision-making. However, business values complicated, and in some cases, seemed to trump, the hospital administration’s balance of scientific and social influences. Was the hospital really “more than just a business?” This chapter examines how AGH responded to challenges (competition from other hospitals) and seized opportunities for growth (privatization, new technology) while adapting principles of business management to its specific needs.

Unlike the more ebullient post-World War II years, the 1970s and 1980s were marked by an ethos of restraint and cost containment in response to national inflation in 1974. According to Alexander et al., there was “a reorientation in public policy from ensuring access to care to containing hospital costs through competitive mechanisms resulted in increasing competition for patients, physicians, and dollars.” In a marketplace that increasingly favored agile, aggressive organizations, successful hospitals were those, usually private, that squeezed out competitors for scarce, politically contingent resources. The combined pressures of technological consumption, commodification of medical services, a shift from cost to prospective payment,

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212 SantaFe HealthCare brochure, Matheson Museum, Gainesville, Florida.
fragmentation of physician power, and competition from for-profit hospitals caused hospitals on a national scale to blatantly pursue efficiency and competitive business-oriented ideals.\(^{214}\)

In 1986, Russell C. Coile, Jr., a respected healthcare management consultant, confidently predicted that hospitals of the future “will not just cope with environmental change but will master it.”\(^{215,216}\) AGH did not master its environment, but rather, mimicked corporate organizations to survive. Institutional mimicry is the imitation of formal organization, philosophy, and practices of organizations in other fields.\(^{217}\) As DiMaggio and Powell put it, institutional mimicry produced “organizations responding to an environment of organizations’ responses.”\(^{218}\) For AGH it was, at its most fundamental level, a form of governmentality that corporate structures imposed on the healthcare field; hospitals voluntarily disciplined themselves to strive for efficiency and information management.\(^{219}\) Furthermore, incorporation legitimized the hospital to engage in competitive behavior that would have been expected of other corporate firms—thus making the rational and efficient management of the hospital all the more urgent.\(^{220}\)


\(^{218}\) Ibid.

\(^{219}\) Ibid.

\(^{220}\) Meyer and Rowan, and Daniel Mulkay, have argued that organizations seek legitimacy by incorporating structures that match widely accepted cultural models. For example, Mulkay has made the case that American science presents itself as democratic and dispassionate because it can justify its behavior and gain popular support if viewed through this lens. AGH sought institutional legitimacy by using standards of
Ecological theory suggests that to sustain its niche, AGH had to respond to other hospitals’ responses. In 1986, the president of the Lutheran Hospital Society of Southern California predicted, “Like the airlines, banking, and communication industries, hospitals are entering the white water of competition.” Hospitals became obsessed with differentiating their products of healthcare, and staying one step ahead of the other hospitals in their local market. AGH was preoccupied with the two other hospitals in Gainesville—Shands Hospital and North Florida Regional Hospital (NFRH)—and how to keep patients and doctors at AGH.

“Alachua General is your ONLY community hospital:” inter-hospital competition

Although this is a history of only one hospital, the story of AGH is incomplete without a discussion of its relationship with two other prominent hospitals in Gainesville: Shands Teaching Hospital and North Florida Regional Hospital (later North Florida Regional Medical Center). Each hospital occupied a “position of possibility” contingent on environmental or competitor-induced changes. As environmental conditions constrained their possible actions, or opened up new opportunities for market competition acceptable in the corporate world, which was very successful then. John W. Meyer and Brian Rowan, “Institutionalized Organizations: Formal Structure as Myth and Ceremony,” The American Journal of Sociology 83, no. 2 (1977): 340-363; Michael J. Mulkay, “Norms and ideology in science,” Social Science Information 15, no. 4-5 (1976): 637 -656.

221 Coile, The New Hospital, xi.
223 North Florida Regional Hospital (NFRH) became HCA North Florida Regional Medical Center in 1986, Columbia North Florida Regional Medical Center in 1995, and finally, North Florida Regional Medical Center in 1998 (NFRMC). The other major healthcare institution was, and continues to be, the Veterans’ Administration Hospital, which was founded in 1967 and has some teaching responsibilities from Shands. However, there was little institutional interaction between the V.A. Hospital and AGH, and according to one former hospital employee, the V.A. Hospital “is like an island.” See picture 12 in Appendix 3.
expansion, the hospitals increasingly competed for the same human resources—physicians and other healthcare workers, and patients.

AGH, Shands, and NFRH drew on their unique attributes to fight for possession of these resources. There are profound differences in organization and mission between for-profit and not-for-profit, community and teaching hospitals. AGH was a not-for-profit community hospital, Shands was the teaching hospital associated with the University that opened in 1958, and North Florida Regional Hospital (NRFH) was a for-profit hospital founded in 1972 by an alliance of Hospital Corporation of America (HCA) and some local physicians.

In the late 1960s, a faction of AGH physicians began discussing the building of a new community hospital in Gainesville with HCA. Why would physicians at AGH support the founding of a new hospital in Gainesville? There are two possible, and not mutually exclusive, theories. One longtime doctor perceived younger doctors as “ambitious go-getters” who thought that AGH was “behind” and wanted to have a faster pace of practice and more equipment. More significant was the sentiment that AGH’s

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225 Rosemary Stevens describes teaching hospitals as models or “biomedical showcases” taking on the sickest patients, employing them in clinical trials, training medical students and presenting at national conferences, and choosing not to focus on community health problems or studying the effects of social factors on the field of medicine. They were, and continue to be defined by technical wizardry, specialized treatment, and scientific management. Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century (New York: Basic Books, 1989). Also see: D S Bolon, “Bureaucracy, institutional theory and institutionacruacy: applications to the hospital industry,” Journal of Health and Human Services Administration 21, no. 1 (1998): 70-79.


227 personal communication
squabbles with the county interfered with doctors' practices, while HCA allowed
physicians to govern their hospitals, and were more “physician-friendly.”

The AGH board of trustees strongly campaigned against a new hospital on the
business principle of over-utilization—they argued that another community hospital
would affect the ongoing expansion of private rooms and special procedures rooms at
AGH. At the North Central Florida Health Planning Council, a community-based
representative body of healthcare officials, trustees railed against the hospital that would
become NFRH. They argued that it would duplicate services already offered at AGH and
scrutinized its hospital’s Certificate of Need, which was required to build in an area with
already existing hospitals. The trustees attempted to stall NFRH’s planning by sending
an AGH representative to a health planning council meeting to attack it point-by-point
during a presentation on its potential benefits.

Trustees also worried that a for-profit hospital, in addition to drawing money
away from AGH, would reduce the social welfare of Gainesville by placing stockholders’
interests over those of tax-paying citizens. In an impassioned, but representative
statement, trustee Jean Chalmers said:

There is no doubt that a lot of money will be drawn out of Gainesville by this Kentucky
Fried Chicken hospital, and the citizens of Gainesville will have to no say in the policies
of an institution which so intimately affects their life and death, will have to make up for
it with their new taxes.

228 personal communication. For more perspectives on the founding of NFRMC, see Doris Chandler,
“Medicine: Shands, North Florida Regional open | Gainesville.com,” The Gainesville Daily Sun
(Gainesville, Florida, July 28, 2004), 1st edition, sec. A,
229 The North Central Florida Health Planning Council is still in operation, although its functions and
structure have changed. It is now a private, not-for-profit 501(c)-3 that operates out of Gainesville, Florida
under the name of WellFlorida Council. The organization advocates for community health programs in
North Central Florida and coordinates efforts to increase funding for community health measures. See:
www.wellflorida.org.
230 Chalmers also condemned the advent of the private hospital as the “single most repressive thing in
healthcare.” One can only speculate what she would have said had she known that only a few years later,
In spite of the fierce opposition at the administrative level, physicians’ overall opinions about NFRH seem to have been ambivalent. Pro-AGH and pro-NFRH doctors attended the same county medical society meetings, and alliances based on hospital of choice were not absolute. Many community doctors saw no conflict of interest in holding privileges at both AGH and NRFH, and a few had concurrent teaching duties at Shands. Most physicians justified this vacillation as tending to their patients: if a patient wanted to be treated at one hospital over another, a doctor with privileges at more than one institution would be able to accommodate that patient.

In spite of AGH’s best efforts, NFRH opened in late 1972 with 125 beds and, among other things, a CT scanner, the first in Gainesville. The average monthly census at AGH fell from 238 in January of 1973 to a low of 160 in December 1974. NFRH’s gleaming new facilities and attractively landscaped campus stood in contrast to AGH’s worn buildings (although a new tower was under construction). As one AGH administrator sourly pointed out later, “It’s amazing how many people make their healthcare decisions based on a pretty duck pond out front.”

However, NRFH did not become a serious threat until it successfully applied for a 150-bed expansion in 1980. After this expansion was completed, NRFH was large enough that physicians could practice there full-time. A sizeable fraction of the internal medicine specialists became full-time at NRFH; others, like the orthopedists, continued

AGH would become an incorporated hospital. Alachua General Hospital, the Meeting Minutes of the Board of Trustees: March, 26, 1970.


232 One doctor who followed the development of NRFH explained that initially, NRFH was denied this expansion, but through “legal shenanigans” the hospital gained permission to build 97 or 98 beds, and this became 150 through further minor renovations. (personal communication)
to split their time between the two hospitals. By late 1982, over 75% of the physicians at AGH had taken privileges at NRFH, which meant that they had joint appointments with NRFH, left AGH to practice exclusively at NRFH, or practiced exclusively at Tower Medical Group. AGH trustees’ worst fears were materializing.

While AGH could not dominate the material aspect of healthcare, it did assert superiority over NFRH from an ideological standpoint as the more community-friendly institution. 233 The AGH board of directors thus characterized NFRH’s board in 1983:

The NFRH all physician board was dominated by hard core NFRH committed physicians who actively worked to keep AGH in an atmosphere of turmoil. It was a forum for disruptive proposals, constant criticisms, and similar “stir the pot” tactics. The AGH loyalists, on the other hand, were a less cohesive group, primarily due to their more independent natures. 234

The AGH board portrayed divisive, unprofessional behavior at NFRH that conspired to disrupt physician practices at AGH—NFRH was vilified, and AGH physicians were linked with the nostalgic model of independent solo practitioners. Other accounts stressed that AGH was much more community-friendly because of its local management and accessibility. One champion of AGH wrote in 1977:

Alachua General is your ONLY community hospital. It is NOT a referral hospital [Shands]. It is NOT a hospital for veterans only [the VA]. It is NOT a proprietary hospital which can close a service simply because it doesn’t make enough money to satisfy stockholders who live in other cities and states [NFRH]. 235

Although NFRMC and AGH competed directly as community hospitals, Shands Hospital, an academic hospital, complicated this relationship by also going after community patients in the early 1970s. At the time of Shands’ founding, in 1956, AGH

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233 Ideology has a powerful narrative effect that differentiates institutions that serve the same function, and are usually comparative; institutions are positioned in relation on each other on an ideological landscape. Alan D. Meyer, “How Ideologies Supplant Formal Structures and Shape Responses to Environments.” Journal of Management Studies - Wiley Online Library, Journal of Management Studies 19, no. 1 (January 1982): 45-61.

234 “Historical Review,” Board of Directors’ Retreat at Innisbrook, June 1982. From the Shands Arts in Medicine archives.
and Shands had defined themselves in terms of very different goals. As explained in Chapter 1, the deans at the UF College of Medicine pledged to respect the established referral patterns of community doctors. After all, a teaching hospital had different motives than a community hospital.

However, Shands eventually revealed greater ambitions that set local physicians on edge. In February of 1980, Shands Teaching Hospital and Clinics became Shands Hospital, a private not-for-profit hospital operated by Shands HealthCare, Inc. Its initial lease did not confine the hospital role and mission to teaching and tertiary care, and only after AGH directors applied political pressure to state officials was Shands’ mission of tertiary care included. Dr. Henry J. Babers recalled that Shands administrators “had reassured most of us that the medical school was not going to be anything but a help. I do not know what [they] would say about the things that are going on right now…”

AGH and Shands engaged in contests of undermining and blocking expansion to assert dominance in the field of community care. When Shands sought state permission to add new beds, AGH objected. AGH enraged Shands officials by running advertising that hinted that Shands was in danger of losing its accreditation. One writer explicitly called it a “medical arms race,” and criticized both hospitals’ practices of duplicating services.

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236Dr. Henry J. Babers, interview by Dr. Charles Pinkosl, August 6th, 1995, transcript, Matheson Museum Oral History Archive, Gainesville, FL.
237One physician who had practiced since the 1950s said that when he began, “advertising was an anathema,” and historically, only “quacks” had advertised, but it is apparent that by the 1970s, hospitals were running pointed public campaigns in the newspapers and through self-published brochures. The conception of hospitals as businesses that needed to differentiate their products spurred changes in professional and institutional behavior that changed professional values. (personal communication)
238“A logical merger,” The Gainesville Daily Sun (Gainesville, Florida, July 13, 1995), sec. F. Furthermore, Shands and NFRMC also competed. Shands blocked a 44-bed expansion at NFRMC, while NFRMC drained paying patients from Shands, “leaving indigent and Medicaid patients in the community to be served by Shands.” Diane Chun, “Competing for Patients,” The Gainesville Daily Sun (Gainesville, Florida, October 1, 2003), 1st edition, sec. A.
In the competition for community patients, Shands possessed material advantages over both AGH and NFRH. It was affiliated with a statewide referral network—Shands was part of the UF Health Science Center, which was to join with six UF colleges in the 1970s, and also operated several clinics and a hospital in Jacksonville.239 The hospital could mobilize the University’ financial resources. In addition, the large number of academic physicians at Shands meant that more patients could be seen. In 1980, 60% of the practicing docs in Gainesville had ties with the UF College of Medicine. These factors contributed to Shands’ financial and institutional viability.

Shands’ private organization allowed it to make decisions more quickly. One example is each hospital’s effort to build an outpatient clinic. In 1964, Shands founded a clinic in rural Mayo, Florida (the Mayo Clinic, as it was called, tongue-in-cheek) that was opened after several years of detailed planning by a University committee.240 The clinic was conceived of as an “experiment” with broadening students’ clinical experience with rural medicine; greater accessibility to healthcare occurred as an externality. Shands’ compliant staff guaranteed that the clinic would be well staffed, and that interference from outside planning groups would be minimal. By contrast, as the last chapter described, AGH’s attempt to maintain a county clinic in 1969 engendered controversy.

239 The University’s steady fortification of its health programs gave Shands a wide-reaching network of resources to draw on. In 1956, UF opened a College of Nursing (which directly competed with AGH’s School of Nursing), and in 1959, a College of Health Related Professions; in 1972, the College of Dentistry was established. In 1958, Shands opened an outpatient clinic on its campus. A 1962 grant provided a 10-bed Clinical Research Center. In 1967, the Veterans’ Affairs Hospital was built; a tunnel between the VA hospital and Shands was constructed in 1976. The Jacksonville Health Educational Program, Inc. became the first long-distance medical division of the University in 1969. One example of the specialized University investments was the Microsurgery Education Center in 1975, which taught surgeons how to perform brain microsurgery. In 1985, University Hospital of Jacksonville, which had long had teaching associations with Shands, (later part of Shands Jacksonville) became affiliated with the University of Florida. “Decades of Discovery and Decisions.” www.shands.org/about/history.pdf.

240 Paul Starr notes that many hospitals built satellite clinics to ensure themselves referrals. (Starr, 426) Thus, it is possible that the clinic served a third purpose of networking, of providing a route to bring rural patients to Shands Teaching Hospital.
and personal feuds. AGH faced the problem of claims of ultimate authority from county commissioners, doctors, trustees, and the public in whatever health planning decisions it made. Although both hospitals were at the time linked to state or local government, its research and education-intensive mission buffered Shands from external regulation.

Shands and AGH did collaborate in symbiotic projects that made use of AGH’s patient population and Shands’ medical education programs. Shands’ training programs improved the competence and quality of practicing physicians, as well as nurses at AGH. One prominent development was the creation of a family medicine residency program, which was operated in conjunction with the University and Shands. The Gainesville Family Care Center, the clinic at which family medicine residents were trained, opened in July of 1973 (and moved into a larger, $750,000 building in 1977). Both Shands and NRFMC provided referrals for AGH. These three institutions provided a much stronger network of care for Gainesville than any one of them could have done individually.

_The process of incorporation, AGH, Inc., 1976-1978_

1978 marked the 50th anniversary celebration of AGH. The theme, “proud of our past, proud of our future,” reflected the love for the hospital and hope for its continued success as a site of community healthcare. Hospital officials planted one dogwood tree for the hospital and one for the 25-year old volunteer Auxiliary. Hospital trustees, physicians, and Gainesville dignitaries praised the hospital’s dedication to the community. Rathbun writes, “It would have been difficult to determine which of two
sentiments was the more pronounced at the meeting—pride in the 50 plus 25 years of
service or happy anticipation of a still brighter future.”

On this anniversary, AGH undertook a radical move towards this still brighter
future: it created a citizen’s parent corporation, AGH, Inc., to govern AGH as a private,
not-for-profit hospital. With the blessings of the county commission, and after lengthy
deliberations with the county attorney, AGH made the switch from its status as a county-owned hospital to an independent not-for-profit hospital in 1976. Alachua General
Hospital, Inc. was registered with the Florida Secretary of State in 1977 and began
leasing the hospital from the county the next year, assuming official ownership.

Incorporation was a response to the rising costs of healthcare and attempted
government regulation. No one could deny the expeditious growth of the healthcare
sector. In the 1930s, the average accounts payable per month was $1,400 at AGH; in
1973, this same amount represented accounts payable in 1 ½ hours. Due to widespread
inflation in the early 1970s, the federal government imposed stricter regulation on
hospitals; doctors’ fees were limited to a 2.5% increase, and hospital charges to a 6%
increase until 1974, a year after they were lifted for many other industries. However,
ten years later, inflation in the hospital sector was still increasing three times faster than
the overall rate of inflation, and cost containment remained a worry for hospitals,
regulators, and patients.

\begin{footnotes}
\item 241 Rathbun, 69.
\item 242 Untitled speech to United Methodist Church, 1977, manuscript, Shands Arts in Medicine archive.
\item 243 Paul Starr describes how growing healthcare regulation defied two commonly held theories of
regulation: that regulation originates in efforts of producers to use the state to exclude competition, or
initiated by liberals unsympathetic to private enterprise. “Paradoxically, the efforts to control expenditures
for health services stimulated corporate development.” (Starr, 428)
\item 244 Starr, 399.
\item 245 Stevens, 323.
\end{footnotes}
Federal regulation affected the hospital’s physical growth. Nixon’s price freeze “threw a monkey wrench into all of the careful financial plans which the AGH board had made” and resulted in a $1 million loss in fiscal year 1976.\textsuperscript{246} Even years later, a section in a 1980 issue of the AGH employee magazine, \textit{Sunburst}, is telling: employees who offered the best suggestions to save the hospital money could win cash prizes of up to $500.

Chairman Harry Edwards stated that the increasingly specialized nature of medicine required a governing body that would able to respond immediately to problems and focus all its attention on the hospital (which the county commission could not).\textsuperscript{247} By separating from the county, AGH also hoped to shed any stigma of being a public hospital and restraints on its practices. Dissociation from the local government would allow AGH to reinstate “physician confidence” in hospital management, and return the hospital’s obligations to the community (and not the public).\textsuperscript{248} A 1977 manuscript put it bluntly:

\begin{quote}
The division of responsibility which existed between the board of trustees and the board of county commissioners, combined with the political restraints of being a county hospital, made it almost impossible to reach a quick final decision about anything... a government or “public institution” [has] come to mean charity or second rate to many people. That is not the case at Alachua General, but as long as it was a county hospital, the stigma was still there...\textsuperscript{249}
\end{quote}

From 1976-1983, AGH implemented small, formal gestures towards a bureaucratic structuring of roles and employee behavior to maintain control over all

\begin{flushleft}
\textsuperscript{246} Historical review at Innisbrook, 1982
\textsuperscript{247} Rathbun, 66.
\textsuperscript{248} I made this distinction between the community and the public in Chapter 2 when referring to changing notions of medical charity. “Community” is a privatized term that is self-formed and based on a defined set of specific interests, needs, or characteristics. By contrast, the public is the sum total to which the government is responsible—that is a more heterogeneous mix of interests, identities, and affiliations that often contradict each other.
\textsuperscript{249} Unnamed manuscript, 1977.
\end{flushleft}
levels of hospital performance. In 1976, administrator Edward C. Peddie began to issue formal yearly reports that summarized accomplishments, changes in revenue and equipment, patient compliments, and offered suggestions to economize for the next year—these yearly statements followed standards of corporate memos and focused on statistics. In 1977, the hospital began a general orientation program for new personnel comprised of eight hours of education about AGH history and philosophy, rules and regulations, first aid, and topics such as “Integrity, Awareness, Self-Esteem, Safety, Courtesy, Enthusiasm.” This program inculcated core values and appropriate behavior into the hospital’s employees, which was meant to instill a sense of professionalism in all employees that had previously been limited to doctors and to a certain extent, nurses.

Corporate language promoted the perception of expertly managed, commodified medical services, not a county-owned public healthcare resource. The hospital was managed by a “citizen board” that wanted to train a “skilled and professionally prepared management team,” and cultivate highly skilled physicians, the key to their “marketing plan.” Rathbun wrote, “The patient is the only shareholder in a not-for-profit…Referenced studies that show that hospitals everywhere are making to provide drastically modified health delivery systems of the future.”

This manipulation of language in the management of medicine is also evident in the elimination of old titles and creation of new ones. These new titles drew on the corporate world to legitimize the hospital as an institution that was capable of managing

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251 Furthermore, Rathbun cited joint purchasing and long-range program planning as factors to consider in the coming years. Rathbun, 67.
its own affairs, and quite economically, too.\textsuperscript{252} In 1976, then-hospital administrator Raymond Wright stepped down, and Edward C. Peddie, who had a Master’s degree in hospital administration from the University of Minnesota, was named CEO of the board. Four Vice-President positions were created—for Fiscal Management, General, Support, and Nursing Services—with Peddie as the President. (Wright stayed on as the first vice president of fiscal services.) In addition, the board of trustees was renamed the “board of directors.” Although this did not change their everyday responsibilities, it did alter the tone of how hospital affairs were handled, and changed the relationship that the CEO now had to the board of directors. The president was the manager of the hospital, and the board of the directors, though unelected, represented the bureaucratized community to which this president was accountable.

During this time, physicians were increasingly aware of their own consumer power. One California hospital administrator estimated that doctors drove 75-80\% of spending in hospitals nationwide.\textsuperscript{253} The ethos of cost containment changed the medical staff’s conception of its role and responsibilities. For example, one AGH physician commented at a board meeting, “Because the physician’s training enables him to evaluate the quality of services rendered, to some degree you might say that the physician acts as the patient’s purchasing agent. It is our responsibility to choose wisely what services are purchased.”\textsuperscript{254} This comment reveals a self-perception that medical expertise entitled

\textsuperscript{252} Extrapolating from Arndt and Bigelow’s discussion of hospital superintendents and hospital administrators. Also see: Leslie S. Oakes, Barbara Townley, and David J. Cooper, “Business Planning as Pedagogy: Language and Control in a Changing Institutional Field.”

\textsuperscript{253} White, The Medical Staff, 4

physicians to act as rationers of medical care. This created a new economical claim in the
doctor-patient relationship that reinforced the doctor’s medical authority.

While I use the term “bureaucracy” to describe the effect that privatization had on
AGH, it is not accurate to say that AGH created a bureaucracy in the Weberian sense. Far from being an “iron cage,” AGH exhibited flexible personnel relationships and a
generally caring administration. While the administration of AGH did have specific goals
in mind—patient satisfaction and cost containment, measured in statistical data—not bureaucrat domination was unwelcome and organizationally undesirable in a
community hospital such as AGH. Although the AGH administration did attempt to
systematically manage its people and resources, it did not exhibit an ideal bureaucracy for
two reasons: the resiliency of the medical profession, and the size of the hospital.

Community physicians controlled both supply and demand. As we have seen in the past, the medical community resisted changes that they felt would adversely affect their ability to provide care. While physicians asserted that they could ration care for patients, domineering attempts to ration physicians’ resources were met with resistance, or more damaging, physician flight. During these decades of uncertainty about the viability of stand-alone hospitals, in a turbulent, competitive environment, it was more

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255 The Weberian definition of bureaucracy consists of a rational administrative structure based on legal domination that is directed towards the attainment of specific goals. Gloria V. Engel, “The Effect of Bureaucracy on the Professional Autonomy of the Physician,” Journal of Health and Social Behavior 10, no. 1 (March 1, 1969): 30-41.

256 This is an important issue because classical bureaucratic behavior would predict certain changes in the management and delivery of HealthCare at AGH: sharper hierarchical relationships, increased power of the administration in daily affairs, and a bent towards rationalizing of resources. This is a narrative that has been delivered by scholars of hospital history as far as urban teaching hospitals are concerned. See: Paul Starr, The Social Transformation of American Medicine; David Rosner, A Once Charitable Enterprise.
advantageous to retain non-rigid, informal administrative mechanisms that could respond quickly to physicians.257

In addition, AGH’s personality and size contributed to a relaxed, relatively informal atmosphere. “Everybody knew everybody else” and relationships and roles were less than hierarchical.258 One doctor recalls that the hospital was close-knit and encouraged creative teamwork rather than mechanically following orders. An Auxilian remembered that the hospital administrator could sometimes be found rocking babies or taking calls at the information desk, and that employees frequently stepped out of their roles. This was confirmed by a social worker who said that she sometimes did orderly work and assisted nurses.259 Therefore, a more appropriate description for AGH’s organization under AGH, Inc. is “fraternal” rather than the traditionally “hierarchical” bureaucracy. Ben-David makes this argument when he shows that hospital management is a particular brand of management science that called for specialized expertise and cooperation, as opposed to a mass of workers blindly following superiors’ orders.260

As an open system that required constant feedback from and response to its environment, AGH made a painstaking effort to include community representatives in the process of incorporation. The incorporation decision was approved by the county commissioners and endorsed by the Gainesville Chamber of Commerce, the ACMS, and the AGH Auxiliary.261 According to chairman Harry Edwards, the board held many

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258 Personal communication
259 personal communications
261 Rathbun, 62. In response to fears that the hospital would become a profit-seeking institution, the hospital pledged that it would not turn away any patient, regardless of ability to pay, no matter the public or private designation.
consultations with local businesses and civic groups in Alachua County before incorporating. Furthermore, the board’s composition reflected continuing commitment to broad representation from the community. No more than 25% of the board could be from the same profession or background (although 25% of the board was required to be physicians). The first board of directors in 1978 included an education professor, a bank executive, an ophthalmologist, and a farm equipment businessman; two women, one of them African-American, were on the board.

Within the confines of a more bureaucratic model, the role of laypeople changed from passive recipient of healthcare to active member of a healthcare corporation. This was not only an act of corporatizing the hospital, but corporatizing a community function. Edwards spoke at the anniversary celebration in 1978: “The hospital has always been ‘for the people.’ Now that it is operated by a community corporation it is also ‘of the people and by the people.’” Anyone could purchase membership in the corporation for $15 a year or $1000 for life and vote on hospital policies, accounts, and management philosophies of the hospital. The economic overtones were especially relevant to the growing dominance of market forces in the healthcare environment.

Ultimately, incorporation and the mimicking of bureaucratic organizations were strategies for the hospital to regain administrative autonomy. The hospital administration used claims of expertise in hospital management to dissolve the linkage between local

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263 Ibid, 72.
264 As Nikolas Rose discusses, the biopolitical paradigm deals with how issues of biology are contested in the political sphere. This section shows that rather than biological citizen, the average layperson could be conceptualized as biological stockholder in a corporation that managed the house of healing. In Chapter 4, I suggest that in a small, ideologically driven hospital such as AGH, the metaphor of family, with all its implications of discipline and sociological ties, is a complementary perspective on how laypersons were incorporated in the hospital setting. See: Nikolas Rose, The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century, annotated edition. (Princeton University Press, 2006).
government and AGH, which transferred more power to the hospital administration itself. Although power was redistributed, roles remained relatively stable. Incorporation did alleviate the political battles between the staff and the county commissioners, but it also opened up questions about how to manage a hospital as a business and at the same time incorporate physician and patient wishes.

The growth of medical and informational technology

Hospital competition was measured along several axes, including revenue generated and patient satisfaction, but one of the most important was technology adoption. Medical technology was an important element of the hospital environment that gave doctors both greater control in treating the patient, and greater dependence on the hospital as a concentrated site of technology. Just as important, new advances in information technology supported the previously mentioned corporate structuring and complexified AGH. AGH more readily adopted competitive standards of technological utilization in order to keep up with Shands and NFRMC. Although commentators warned of over-utilization and rising costs, technology became a prerequisite for legitimacy in the hospital community: as innovation spreads, a threshold is reached beyond which uptake provides legitimacy rather than improves technical performance.\(^\text{265}\)

Eduardo Marbán’s periodization of major technological shifts in cardiology is useful for putting AGH in context: the pre-1970s Classical Age, the 1970s-1980s

Interventional Age, and the 2000s Translational Age.\textsuperscript{266} The 1980s saw the rise of techniques and technologies that specifically aimed to cure disease, for example, bypass surgery and stents. The desire to actively treat disease was predicated on what Leighton Cluff has called an American romance with biomedical science, propagated by the popular media, which ascribed god-like power to the curative works of science.\textsuperscript{267} With a greater sense of urgency than post-World War II, AGH capitalized on the charisma of science by investing in technological equipment and acceding to doctors’ requests for greater technological support.

These technological additions were not cheap. The board reported in 1973 that a new procedures room for heart catheterization cost $426,246; an expanded Heart Station with a new echocardiogram machine and exercise system with electrocardiographs, $73,964; monitoring equipment for operating rooms was $159,000; and kidney dialysis equipment, $10,488.\textsuperscript{268} From 1978 to 1983, the hospital spent $9.4 million on equipment. The cost of technological equipment was absorbed into the hospital’s never-ending debt.

Technological growth was largely driven by a positive feedback loop with specialization at the hospital. Medical specialization was economically advantageous and prestige driven: the greater the degree of specialization, the higher one’s place in the totem pole of the profession. Charles Rosenberg on technology’s grip on the popular imagination: “Science and the scientific spirit were becoming synonymous with specialization.”\textsuperscript{269} Doctors noted that during this time period, there was a rapid increase in

\begin{footnotesize}
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\item 267 Leighton E. Cluff, “America's Romance with Medicine and Medical Science,” Daedalus 115, no. 2 (Spring 1986): 137-159.
\item 268 Rathbun, 57.
\item 269 Rosenberg, The Care of Strangers, 171.
\end{itemize}
\end{footnotesize}
the number of subspecialists practicing at AGH, and linked this phenomenon to technological innovations that made specialties like radiology and anesthesiology possible. 270

This was reflected in the amount of space allocated: the radiology department gained five times its previous space, pathology tripled, and surgery doubled. 271 In fact, yearly physical expansions needed to accommodate the new equipment resulted in specialized, physically separate facilities. In 1987, a Neuroscience Institute was created (and an MRI imaging lab in 1988); in 1989, a cancer care center, and in 1990, a neonatal intensive care unit. Each function in the hospital became defined by the technology that permitted its operation, and was contained in its own physical space. 272

These advances also demanded the general expansion of the hospital. 273 In 1975, the $12.9 million W.C. Thomas Memorial Tower opened to house most of AGH’s diagnostic and treatment facilities. The number of beds doubled to 453. In addition, all patient rooms were made private or semi-private with “medically pure” air. The total value was estimated at $35 million. 274 Even given this generous addition, more renovations were made in 1979, 1980, and 1986; the demand for more was insatiable.

270 Personal communications
271 Ibid.
272 One exciting change was the implementation of the STAT-Flight helicopter program in 1981, which meant that AGH could receive patients by helicopter, and also that a landing pad had to be built on the roof of the hospital. AGH actually shared the helicopter with Shands, since it would have been too expensive for both to have their own helicopter, but both did not want to go without one.
273 The continually burgeoning population of Gainesville did not hurt the case for expansion, either. By 1974, the growth of Gainesville was estimated at 15% a year, as opposed to 8% a year in 1971. Alachua General Hospital, Meeting Minutes of the Board of Trustees, December 19, 1974. As a note for the future, the hospital continued to grow with additions in 1979, 1980, 1986, and 2002. Renovations from the mid 1990s through the mid 2000s helped AGH to stay viable and serve the community through most of 2009. Ponik Var Architectural Associates Plan for Alachua General Hospital, 2009. The Matheson Museum, Gainesville, Florida.
274 Rathbun, 60.
every addition that AGH made only exacerbated the need for more space, more staff, and more paying patients.

At an administrative level, technological changes streamlined information processing, improving the efficiency of the hospital. Coile paid homage to the power of these organizational technologies when he said, “Health is an information industry.”

Seemingly mundane administrative technologies such as computer programs and fax machines provided tools for administrators and specialists to exert control in specific ways. The TQM (total quality management) movement, which gained popularity in the late 1980s—and was implemented at AGH in 1991—inspired devoted use of these technologies and spoke to the historical drive to create efficient, scientific management through new technologies.

The hospital had actively sought opportunities to acquaint itself with modern administrative technologies at least since the 1970s. For example, the business office and newly formed data processing department converted inpatients accounts from a manual receivable system to a computerized system and Medicare information was encoded in cathode ray tube terminals instead of punched paper tape. Administrator Raymond Wright reported attending a seminar entitled “Data Processing for the Lay Person” in

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275 Coile, The New Hospital, 78.
276 Joel D Howell, Technology in the Hospital: Transforming Patient Care In the Early Twentieth Century: 32-45. Risse argues that while scientific management would beget discrete, reproducible results, clinical practice does not because conditions are always changing. Furthermore, patients evaluate their experiences and can self-advocate. Thus there is always a place for subjective professional, medical discretion. Furthermore, Powell writes that TQM itself does not produce competitive advantage, but rather, the tacit behavioral changes associated with TQM are what benefit a hospital, and it is possible to instate these behaviors without the explicit use of TQM principles. Guenter B Risse, Mending Bodies, Saving Souls: A History of Hospitals (New York: Oxford University Press, 1999); T. C Powell, “Total quality management as competitive advantage: a review and empirical study,” Strategic Management Journal 16, no. 1 (1995): 15–37.
California in 1974. These technological pursuits legitimated AGH in the community’s view as an informed, well-organized hospital.

The example of the credentialing office shows that technology both empowered and restricted the hospital’s procedures. In the late 1980s, the Internet emerged as a versatile technology of organization and communication. An employee within the Credentialing Office recalls before, physician profiles were kept on 4x6 index cards within the office; the amount of time and frustration that the Internet saved employees was “mind-boggling.” While the Internet allowed the credentialing staff to check paperwork against national databases and force staff to account for every year of service in electronic applications, it was itself forced to follow an exact procedure for fear of litigation against the hospital. In addition, the credentialing office implemented a “core privileging” system—in order to receive hospital privileges, physicians had to agree to perform a core set of services.

Informational technology also strengthened the hospital’s connection to the general public. Lifeline, incepted in 1980 and Tel-Med (a library of health information tapes created in 1978) improved public access to medical knowledge. In its first two years, Tel-Med received over 40,000 calls. Lifeline in particular provided not only medical reassurance, but also social comfort to its subscribers. One hospital Auxilian recalls that there was “more talking than checking machines,” and recalled one instance in which a Lifeline user in 1980 thanked him for calling and told him, “I haven’t talked to someone in two weeks.” Medical technology and informational technology both contributed to the improvement of patient care.

277 Personal communication
278 personal communication
However, high-cost technology complicated existing relationships among staff, administrators, and patients. The importance of medical technology gave physicians, the interpreters of diagnostic data, more professional authority. At the same time, physicians were constrained by new technologies—as Joel Howell succinctly put it, “access is not power.”

Physicians could treat ailments that previously would have been considered death sentences, but also found their diagnostic powers limited by the results of lab tests and scanning machines.

The investment in and use of new technologies also made the hospital more dependent on new experts: tax and bond advisers, corporate lawyers, software specialists, and management consultants. Hospital consultants were one type of expert whose entire profession revolved around the hospital, and who capitalized on competitive paranoia. AGH had maintained correspondence with at least one hospital consultant since 1963 to make long-term plans for the hospital’s growth (the outcome of this consultation was the W.C. Thomas Memorial Center).

These experts now had their own stakes in the hospital, and their involvement is an example of how new forms of expertise were accepted based on environmental conditions, and expanded the hospital’s ability to privately regulate its affairs.

AGH’s economic investments showed an expectation of transference of capital: technological capital would recapitulate economic capital. Technologically intensive

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279 Howell, Technology in the Hospital, 234; Stevens, In Sickness and In Wealth, 323.
280 Oakes, Townley, and Cooper note that long-term business planning is coercive in that it sanctions new forms of discourse and mechanisms of passing on knowledge. Leslie S. Oakes, Barbara Townley, and David J. Cooper, “Business Planning as Pedagogy: Language and Control in a Changing Institutional Field.”
281 One critique that may be made of this thesis is that it contains Bourdieusian concepts without explicitly referring to them. For example, Bourdieu’s concept of the external field and the internal habitus seem very similar to the external and internal ecosystem of AGH that I discuss. Here, Bourdieu’s writings on capital, and how different forms of capital are converted, are useful in conceptualizing why technological
medicine lent itself to the commodification of new categories of medical services and
disease itself based upon specific tests and machines. For example, the implementation of
diagnostic DRGs in 1983 translated medical conceptions into financial classifications for
purposes of cost containment. The conceptualization of medical services as packages of
quantifiable goods, to be bought and sold was easier to make with the introduction of new
technologies. Vast sums of money were spent to develop specialty departments through
technological investment, and comparable returns, in patient census and satisfaction,
were expected.

AGH’s implementation of new technology during the 1970s and 1980s was more
aggressive than the uptake of new medical technology after WWII, and more enmeshed
with the goal of attracting paying patients to achieve financial well-being. Rosemary
Stevens has written, “By emphasizing technology rather than the expansion of
community service, for which reimbursement was largely unavailable, hospitals also
bought into the technological conception of capitalism.” While AGH did not
necessarily sacrifice community service for technological acquisition, its attitude shows
that it, like many hospitals, bought into the perception of high-quality medical care with
commodified, information-driven medical and administrative technology.

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282 On the implementation of DRGs, Rick Mayes wrote, “For the first time, the federal government gained
the upper hand in its financial relationship with the hospital industry. Medicare’s new prospective payment
system with DRGs triggered a shift in the balance of political and economic power between the providers
of medical care (hospitals and physicians) and those who paid for it - power that providers had successfully
accumulated for more than half a century.” Rick Mayes, “The Origins, Development, and Passage of
Medicare’s Revolutionary Prospective Payment System,” Journal of the History of Medicine and Allied
Sciences 62, no. 1 (January 1, 2007): 21 -55. At the same time, DRGs were not a permanent solution to cost
containment— As Stephen Shortell commented, “people are ingenious, and this fact makes regulation very
difficult.” American Hospital Association Symposium on the American Hospital in the 1980’s, Hospitals in
SantaFe Healthcare, Inc. and Vertical Integration

Five years after incorporation, AGH “was sold for a dollar” to SantaFe HealthCare, Inc., a vertically integrated corporation founded by then-hospital administrator, Edward C. Peddie. SantaFe HealthCare relieved the county of $27 million in debt when it assumed ownership of the hospital, which most likely made the transaction smoother. Most of the staff members found no conflict with the transaction and continued about their daily business, but the hospital now mediated an external corporation’s business interests with its medical and social concerns, which reduced its institutional autonomy.

Vertical integration was a phenomenon in the healthcare sector that emerged in an environment of intensified competition and allowed corporations to control the entire process of healthcare. Hospitals built on previous relationships with third-party companies and elements such as utilization review to fully realize vertical integration.284 SantaFe HealthCare, Inc. evolved from a hospital laundry service company into what was, for a decade, the largest regional provider of rural healthcare in North Central Florida. Peddie had a vision for an integrated healthcare provider that could provide patients insurance, hospital services, and more. In the 1980s, SantaFe bought three small rural hospitals: Starke Hospital, Lake City Hospital, and Live Oak Hospital (all within a 60-mile radius of AGH). It then established Vista Florida Recovery Center, a

283 Stevens, In Sickness and In Wealth, 301.
rehabilitation hospital, and bought AGH. In 1986, SantaFe set up AvMed, an HMO program for North Central Florida.

A former board member of SantaFe stressed that the reason for integrating AGH into the SantaFe system was to provide “synergistic” management of healthcare in North Central Florida. Vertically integrated hospital systems, as both financiers and providers, theoretically provide more efficient care, and as Ruef and Scott write, are “not simply coordinated by physicians but organized so that greater economies can be realized.” Multi-institutional companies, whether they are horizontally or vertically integrated, achieve a new scale of economy in their formation, fundamentally changing the characteristics and interdependency of the components therein.

Jeffrey Goldsmith has diagrammed the typical setup of a vertically integrated healthcare corporation, which impresses upon the viewer the complexity and connectedness of each facility. (Figure 1) I have also included a diagram from the AGH board of trustees’ notes that represent AGH’s structural connections pre-SantaFe. (Figure 2) Providers at different levels were all linked by the hospital in a theoretically symbiotic relationship; the vertically integrated corporation is an ecosystem unto itself with the hospital at the center; if the center of the system were ever to shift away from the hospital, then the hospital would suffer from reduced resources.

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285 Personal communication
287 Adapted from Figure 7-4 in Jeff Charles Goldsmith, Can hospitals survive?: The new competitive health care market (Dow Jones-Irwin, 1981): 143.
Whatever the bureaucratic structure of the hospital, it had to preserve ideological unity among the employees, the foundation of the hospital’s internal

**Figure 1**: model of a vertically integrated hospital corporation (Goldsmith, 1981)

**Figure 2**: model of AGH outpatient clinics prior to 1983. Note the patient flow between the hospital, county clinics, physical therapy, laboratory, and other facilities.
ecology. Since the administration did not lay off employees or restructure departments, the general bonhomie of the hospital remained. Peddie remained hospital administrator and executive, and gained the role of conglomerate executive, ex-officio. However, SantaFe did bring about changes that focused on increasing AGH’s competitiveness: implementing new requirements for physicians, and tweaking the hospital’s public image.

Decision-making was distributed among ad hoc committees. The AGH board of directors was required to submit final administrative decisions to the SantaFe board of directors. Furthermore, the outcome of administrative professionalization in the 1980s was that administrative officers who exhibited “sagacious conformity,” the ability to read trends in healthcare and plan accordingly, had the responsibility to successfully steer their institutions through the system, not physicians or other groups.\footnote{John W. Meyer and Brian Rowan, “Institutionalized Organizations: Formal Structure as Myth and Ceremony.”} They controlled the organizational ecology of AGH under vertical integration with more power than ever before.

Data became vital to decision-making, more so than personal appeals. If the yearly business reports are any indication, there was, as Rosenberg described, a “pious and unrelenting invocation of numbers.”\footnote{Rosenberg, The Care of Strangers, 291.} Even narrative accounts of the bad debts list show adherence to a script of trying to get the money back rather than individualized considerations.\footnote{For instance, one patient who owed $8157.84 was an “ER admission, multi-trauma. Patient is totally disabled at this point and we cannot talk to him. At first VA was going to pay bill but after much research and letters, VA said they would not pay because accident not service connected. Filed for county assistance but on 9/3/82 county advised they could give no assistance because he was not a resident. Also upon discharge explained to patient about SSI and filed SSI lead-in. November 24, 1982 received inquiry from Social Security of no record of patient follow-up. Tried to phone patient again, no answer, sent}
The corporate practices under SantaFe changed traditional perceptions of charismatic physician-leaders who were unchallenged masters, free from surveillance. In exchange for greater privileges, such as space at the Ayers Medical Center, physicians had to meet more stringent requirements. For example, doctors were required to have malpractice insurance before being given privileges at AGH. Control of the hospital became more formalized, which decreased the bargaining power of the physicians.

In 1982, there were over 600 members of the Corporation who could vote on hospital issues at corporation meetings. This kind of diffuse ownership limited the ability of physicians to individually talk to trustees and develop the kind of secure relationship with the administration that it had in the past. On the other hand, some knowledge was kept from the public view. Representatives from the media were no longer allowed at board meetings, which as one doctor pointed out, had been a competitive disadvantage for AGH all along—it gave NFRH insight into AGH’s plans.

Practices formalized under SantaFe management confirmed the importance of quantifiable measures of performance, which led to a greater reliance on statistics of patient census and reimbursement, especially compared to other institutions. Behaviors such as greater censure of physicians, corporate memos and the bevy of statistical rundowns that accompanied each month’s board meeting minutes averred hospital

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PDL.” Alachua General Hospital, Meeting Minutes of the Board of Trustees, January 1983: “Bad Debt Accounts over $3,000.00.”


292 Personal communication
services as a commodifiable good rather than a gift from a charismatic practitioner, in order to provide a basis for evaluation and comparison among healthcare institutions.

**Conclusion**

As the writers of AGH’s view book wrote in 1973, “Like the optical illusion which can be seen from many different perspectives, providing adequate healthcare for every person in this community is a complex problem.”

Under the stress of new threats, like competition for patients and physicians and cost containment, AGH strove for the illusory perfect equilibrium that would satisfy the account books, the demand for more technology, cries to preserve quality of care. AGH used several strategies to compete for diminishing resources: self-promotion, institutional mimicry, technology acquisition, and vertical integration.

Coile predicted that unlimited growth, “the golden age of hospitals,” was over, and that business strategies such as nichemanship, retailing health care, and developing contingency plans for price wars would allow the prototypical “New Hospital” to weather economic and social changes.

The hospital’s fierce resistance against the entrance of NFRH and Shands is an indication of the intensity of hospital competition and the limits of public regulation (through mechanisms like certificates of need). Competition drove both differentiation and institutional mimicry at AGH—the hospital marketed itself as a true community institution that was physician-friendly, and at the same time, kept up with the level of innovation at NFRH (and Shands to a certain extent) and copied managerial philosophies from the corporate world.

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294 Coile, The New Hospital, 41
Technology was one way in which hospitals measured themselves against peer institutions, and in this more competitive environment, AGH assimilated to external standards of technology adoption more quickly. Hospitals were guided by the belief that more medical technology would generate more revenue, which in turn would serve as capital for further hospital expansion and market dominance. Just as important, however, was the revolution in information technology that gave hospital administrators greater control over the structure of practice at AGH and the hospital’s organizational ecology.

Privatization at AGH was part of a national response against government financial regulation. Hospitals claimed that they were capable of self-regulation, and turned to seemingly rigorous scientific management to justify this claim—at AGH, the rhetoric of efficient and market-driven behaviors was in place, but actual organization was perhaps more fraternal than hierarchical. However, when the hospital became vertically integrated into SantaFe, stricter guidelines of practice that gave corporate management greater control over the hospital’s activities were implemented. AGH was not just a business, but by 1983, it was a subsidiary of one. In the face of this, we will see in the next chapter that the providers, patients, and volunteers of AGH used the hospital’s ideology as a strategy to preserve community and claim political legitimacy.
In 1996, AGH was sold to Shands Healthcare, Inc., the parent company of Shands Hospital. Shands Healthcare’s purchase of AGH and several other SantaFe facilities, for over $100 million, was the largest university medical center acquisition up to that time. The hospital was renamed Shands at AGH, but with few exceptions, personnel and services remained unchanged. However, over the course of more than a decade, the two hospitals’ differences in organizational culture and mission would create strains on both sides that reduced the benefits of being in a multihospital system.

This chapter examines the external and internal pressures on AGH that led to its demise, and what role institutional ideology, particularly the metaphor of family, played in the hospital setting. I argue that AGH ideology made use of empiricist “repertoires of justification” to assert historical standards of care and clinical autonomy.\textsuperscript{295} I examine one of the strongest promoters of AGH ideology: the Auxiliary, a predominantly female volunteer organization that represented the generational worry about the decline of a particular kind of community spirit with the closing of the hospital.

The hospital’s closing was not inevitable, but rather, a failure to adapt to a set of constraints set by the general environment of practice and broader social factors.\textsuperscript{296} The


\textsuperscript{296} As philosopher Ian Hacking would interject, there is no such thing as “inevitable.” In The Social Construction of What?, Hacking posits that to argue something is socially constructed is to show that it is not inevitable, that theories and facts are contingent on social, political, and historical processes and do not always have a fixed, singular outcome. This is a perfect way of summing up why I examine the factors that led to the closing of AGH: the closing of AGH was not inevitable, but due to pressures that
“financial problems” that demanded AGH’s closing were just as much problems of corporate focus on financial sustainability, greater ER utilization, a less desirable patient population, and the decline of downtown Gainesville.\textsuperscript{297} The closing of AGH is a poignant example of the way in which, guided by national trends, local social and scientific forces in the hospital were rationed by the constraints of the corporate environment.

\textit{“Together We’re Better:” the Shands Healthcare Inc., acquisition in 1996}

AGH’s physical structure was deteriorating years before Shands acquired it—peeling walls, cracked floors, and what one interviewee described as a look from the 1960s both in terms of aesthetics and functionality.\textsuperscript{298} Since the late 1980s, the hospital’s performance had been faltering, and in 1995, bed occupancy was just 32.7%.\textsuperscript{299}

Besides the massive physical repairs that would have been required, SantaFe experienced a conflict of mission between AGH and AvMed, its HMO.\textsuperscript{300} On the one hand, AvMed tried to keep people out of the hospital; on the other hand, AGH and several rural community hospitals tried to increase patient census. Boston Consulting can be uncovered through a historical lens, and perhaps highly advantageous to certain parties in the given circumstances.

\textsuperscript{298} personal communication
\textsuperscript{299} Jud Magrin, “‘How will hospital merger affect health care in area?’,” The Gainesville Daily Sun (Gainesville, Florida, July 16, 1995), 1st edition, sec. A.
Group, a prominent marketing consultant firm, urged SantaFe to sell its hospitals in order to concentrate on developing its HMO.  

This is not to say that SantaFe’s mission to provide access to healthcare was compromised by a ruthless business philosophy. Columbia/HCA, which already owned NFRH, offered SantaFe Healthcare $111-128 million for AGH alone (NFRH became North Florida Regional Medical Center, NFRMC, in 1998). However, SantaFe executives worried that Columbia/HCA would close the hospital in order to increase the profitability of NFRMC, and took the offer from Shands HealthCare instead. The non-profit alignment was more appealing than the offer of more dollars.

In July of 1995, Edward Peddie, the CEO of SantaFe Healthcare, and Paul Metts, the CEO of Shands Healthcare, signed a letter of intent to sell AGH and several other facilities to Shands Healthcare. Several months before AGH officially joined the Shands network, administrators hung banners around the hospital that read, “Together We’re Better;” AGH and Shands employees also wore buttons with this slogan as they passed blue Shands balloons in the AGH lobby. The staff and employees of Shands at AGH were “guardedly optimistic” by the Gainesville Sun’s account. Gary Terry, a nurse technician, was hopeful that the acquisition was “going to be better for the community and the employees,” and Dr. Bruce Stechmiller, an oncologist, expressed

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301 BCG recommended developing a niche by focusing on health insurance, and predicted that SantaFe would need to have 500,000 enrollees in its AvMed insurance plan by 2001 in order to be financially viable. AvMed, as of 2010, has 320,000 enrollees and continues operations. See website FAQ.

302 HCA had also attempted to purchase AGH in 1978, when the hospital first incorporated, with an offer of $21 million. Both offers were refused. The County Commission assented, voting not to sell or lease the hospital to any profit-making corporation. The board of trustees were concerned then, too, that HCA would close AGH in order to make NFRMC the only institution in the community hospital niche. In fact, one board member suggested, only half-jokingly, that AGH look into the feasibility of purchasing NFRMC. For HCA’s controversial business practices, see: JD Kleinke, “Deconstructing the Columbia/HCA Investigation,” Health Affairs 17, no. 2 (March 1998): 7-26.
faith, saying, “I give it 100 percent and take Shands at their word that they want it to succeed.”

The 6-month long negotiations with Shands HealthCare to acquire AGH were fraught with tensions, and show how non-medical experts such as corporate negotiators, executives, and lawyers controlled the terms of negotiations. The negotiators battled over issues ranging from whether Lake Shore Hospital would be included in the package, to semantics (whether a space in front of Vista Hospital ought to be called a “depression” or a “sinkhole”). The final agreement was complicated by a lawsuit initiated by a UF law professor and two retired physicians, who alleged that the 90-day confidentiality agreement violated Florida’s Sunshine Law on disclosure to the public. (The lawsuit was rejected, but not before costing Shands HealthCare an additional $500,000 in held-up loan payments.)

The lawsuit points to the disadvantage of Shands HealthCare’s double identity as private enterprise and government instrument. One Shands HealthCare executive described the hospital and university’s relationship as: “Is Shands a private not-for-profit? Yes. Are Shands and UF [a land-grant state university] attached at the hip? Yes.”

While Shands Hospital received taxpayer dollars and was exempted from

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304 Each side hired a corporate negotiator to represent each side’s interests—Gerald McManis represented SantaFe HealthCare, and Josh Nemzoff represented Shands HealthCare. Just as an indication of the personalities involved in the acquisition, Josh Nemzoff reportedly came into the closing wearing flannel shirt and jeans, while Gerald McManis remained in suit and tie. The closing dinner was pizza. Jud Magrin, “Impact Will Be Felt for Years,” The Gainesville Daily Sun (Gainesville, Florida, February 4, 1996), 1st edition, sec. A.

305 Ibid. The plaintiffs’ attorney, Joe Little, charged that “AvMed and Shands decided to pay whatever price…and keep the public interest secret.” (4A)

306 The split identity of the corporation is symbolized in its management: the University of Florida appoints the Shands Hospital board of trustees, and the President of the University was also the President of Shands HealthCare (though recently, this post has been passed on to the University Health Affairs
certain requirements made of other public institutions—such as the full application of the Sunshine Law—Shands HealthCare was subject to scrutiny from individuals made on behalf of the public.  

The acquisition followed a trend of consolidation in the 1990s that Charles H. White, medical staff executive at a hospital in California, termed “from hospitals to systems.” Healthcare experts hailed the acquisition as a “strategic alliance that would allow for greater coordination of care and consolidated resources in the Shands HealthCare system.” To borrow a phrase from Nikolas Rose, the “virtuous alliance of state, science, and commerce in the pursuit of health and wealth” at Shands HealthCare created a mutually beneficial relationship that increased the stakes of academic research and revenue generation. However, AGH struggled to find a sustainable role in this system.

Acquiring AGH and other SantaFe hospitals allowed Shands to expand its referral network geographically, moving from a model of centralized healthcare in one institution to a synergistic, dispersed health network: mobility allowed Shands to tap vice-president). See chart for delineation of management positions [Shands Healthcare Management hierarchy]

307 From 1991-1995, Shands spent $750,414 in lobbying the State legislature, which demonstrates how a private non-profit corporation can function much like a for profit, and also benefits from receiving taxpayer dollars from the State legislature and being affiliated with the state university. Judd reports that one official described it as Shands trying to “have it both ways” using a “show of force” to persuade legislature. Shands also courted favors by using its helicopters to fly legislators directly into the hospital. Alan Judd, “Hospital Wields Political Power,” The Gainesville Daily Sun (Gainesville, Florida, April 20, 1996), sec. A.

308 White, The Medical Staff, 19.

309 These business transactions, though they have monopolistic tendencies, are rarely viewed as antitrust cases. Alison Evans Cuellar and Paul J. Gertler, “Trends In Hospital Consolidation: The Formation Of Local Systems,” Health Affairs 22, no. 6 (November 1, 2003): 82.

into more parts of the ecosystem and build its command of resources.\textsuperscript{311} As seen in Table 2, Shands HealthCare went from having one hospital to having five hospitals, a homecare service, and two special facilities.

**Table 2: Hospitals in the Shands Healthcare network, 1996**

<table>
<thead>
<tr>
<th>Hospital (Location)</th>
<th>Number of beds</th>
<th>Number of employees</th>
<th>Type of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shands Hospital*</td>
<td>576</td>
<td>4,000</td>
<td>Academic medical center</td>
</tr>
<tr>
<td>(Gainesville)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGH and Ayers</td>
<td>423</td>
<td>1,324</td>
<td>Comprehensive medical center</td>
</tr>
<tr>
<td>Medical Plaza</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Gainesville)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bradford Hospital</td>
<td>54</td>
<td>115</td>
<td>Primary care</td>
</tr>
<tr>
<td>(Starke)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lake Shore Hospital</td>
<td>128</td>
<td>220</td>
<td>Acute care community hospital</td>
</tr>
<tr>
<td>(Lake City)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lake Shore HomeCare</td>
<td>--</td>
<td>110</td>
<td>Patient home care in 17 counties</td>
</tr>
<tr>
<td>Suwannee Hospital</td>
<td>30</td>
<td>74</td>
<td>Primary care</td>
</tr>
<tr>
<td>(Live Oak)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UpReach Hospital</td>
<td>40</td>
<td>120</td>
<td>Physical rehabilitation hospital</td>
</tr>
<tr>
<td>Vista Hospital</td>
<td>83</td>
<td>44</td>
<td>Mental health care center</td>
</tr>
</tbody>
</table>

*only Shands Healthcare holding prior to acquisition

As the years went on, and AGH’s imminent demise became more and more of a reality, members of both AGH and Shands relied on organizational ideology as a way

\textsuperscript{311} It is worth noting that privatization was not just a trend, but a wide-spread strategy among hospitals. In 1996, there were over 300 mergers and acquisitions of hospitals. In 1995, 28% of nonprofit hospitals had local system partner, compared with 43% in 2000. In 1995, 27% of teaching hospitals were parts of systems locally, compared with 55% in 2000. (Cuellar, 80) When AGH was acquired by Shands Healthcare, it joined a growing number of hospitals that belonged to multihospital systems. David Mechanic notes that academic hospitals were 14% more expensive than comparable community hospitals; reasons cited were more intensive, specialized procedures. See: Alison Evans Cuellar and Paul J. Gertler, “Trends In Hospital Consolidation: The Formation Of Local Systems,” Health Affairs 22, no. 6 (November 1, 2003): 77 -87; Robert Mechanic, Kevin Coleman, and Allen Dobson, “Teaching Hospital Costs,” JAMA: The Journal of the American Medical Association 280, no. 11 (1998): 1015 -1019.
to position themselves in the coming storm.\textsuperscript{312} However, the majority of interviewees expressed stronger criticism, perhaps shaped by the history since then, of the acquisition.\textsuperscript{313} In order to understand the emotion that surrounded the eventual closing fifteen years later, we turn to a discussion of the hospital’s ideology of family as a political strategy of self-preservation, and an attempt to reassert the hospital’s own autonomy in a healthcare system increasingly dominated by corporate players.

\textit{The AGH family: a metaphor manifest in layperson involvement}

The metaphor of family has historical and sociological significance in hospital culture.\textsuperscript{314} Charles Rosenberg has suggested that in the late nineteenth century, patients were conceptualized as children, whom the fatherly doctors and motherly nurses cared for.\textsuperscript{315} In 1961, social anthropologist Esther Lucile Brown wrote, “the family, the home and normal community activities seem to furnish a frame of reference against which [patients] measure or seek to interpret many aspects of their hospital experience.”\textsuperscript{316} At AGH in the 2000s, “the family” was still the rhetoric that shaped the experiences of patients.

\textsuperscript{312} According to Mirvis (1985), social identity theory posits that in an organization, employees react to institutional threats by making a positive position for their own group. Strong ingroup/outgroup biases thus generate serious interorganizational conflicts. Myeong-Gu Seo and N. Sharon Hill, “Understanding the Human Side of Merger and Acquisition,” The Journal of Applied Behavioral Science 41, no. 4 (December 1, 2005): 422-443.

\textsuperscript{313} One woman said, “It was the best kept secret in town that Shands planned to close AGH from the start.” Personal communication.

\textsuperscript{314} According to Meyer, ideology is “a mix of historical facts, wishful thinking, and retrospective justifications that are manifested in organizational structure and individual narratives.” Hospital ideology was shaped by institutional factors, but also individual patient experiences (and the revision of those experiences) that then contributed to a popular narrative of the hospital’s culture and organization. It was built on external social ties, attitudes towards medical care, staff and employee cohesion, and the physical features of the hospital. A D Meyer, “Reacting to surprises: hospital strategy, structure and ideology,” Health Care Management Review 6, no. 4 (1981): 25-32.


patients, providers, and volunteers. AGH supporters portrayed long-standing
community values of Gainesville—family, kindness, and comfort—as the AGH way.

This rhetoric kept AGH connected to the broader environment of Gainesville
and supported the hospital through environmental fluctuations. At AGH, ideology
provided comfort and served as an emotional and social anchor during the Shands
acquisition, which some locals saw as an affront because of AGH and Shands’ prior
competitive relationship. The ideology of family relationships and unique
commitment to community care was reinvigorated as “romantic image of kinship
bonding and shared struggles against adversity.” AGH’s ideology can be viewed
as a technology of resistance that accentuated the hospital’s priority on community care
and defended against intervention from Shands HealthCare.

Ideological commitments reveal the dominant culture and the stakeholders of
that culture, who lost institutional legitimacy when the hospital closed—solo
practitioners, those who had established a base of authority at the hospital, and older
generations who ascribed to a certain vision of community. AGH’s self-written history

317 LaCapra’s five features are: 1. Mystification (illegitimate masking in the interests of legitimacy); 2. Serving the interests of part of society when it purports to serve all; 3. Presenting what is historically variable as universally timeless; 4. The result of hegemony of one group; 5. Attempt to see “meaningful order” in chaos. Dominick LaCapra, “Culture and Ideology: From Geertz to Marx,” Poetics Today 9, no. 2 (January 1, 1988): 377-394.

318 AGH culture was polite, folksy, and loving—and also conveniently shed history of professional arrogance, racism, and economic struggles. It is dangerous to take ideological renderings of history at face value, and to assume that ideology is a completely accurate reflection of historical events. Mary Douglas wrote that an institution with a strong cultural memory causes its members to “forget experiences incompatible with its righteous image, and it brings to their minds events which sustain the view of nature that is complementary to itself. It provides the categories of their thought, sets the terms for self-knowledge, and fixes identities.” Mary Douglas, How Institutions Think, 1st ed. (Syracuse, N.Y: Syracuse University Press, 1986): 12.

319 Casey writes that “The family is also hierarchical, repressive, paternalistic, and deferential to higher external authorities.” (162) The “discursively constructed corporate family that elicits and simulates warm feelings of bonding and belonging simultaneously functions as a regulatory and disciplinary device—a discursive “colonization.”” (159) However, these terms seem harsh when applied to AGH, which did not have rigid hierarchies, and for all its corporate bearings, was influenced by its small-town
was rooted in the following sociological elements: a relatively stable, committed core of staff with family ties, a concrete tradition of practice that emphasized personalized care, and a committed volunteer base.  

As far as the rhetorical family was concerned, the “nuclear family” consisted of employees and staff. Employees felt protected by their supervisors. One woman, who worked in AGH’s pathology lab for twenty years, said, “No matter who you were, you were never like a little peon.” The AGH ideology of family gave a sense of solidarity and belonging to providers and patients alike. From the pen of an employee who worked at AGH for only three years: “the tight quarters, the sparse services, the ever-worrying budget, all were issues but seemed small in comparison to the needs of the patients.” Even relatively new employees identified with the priority of improving patient experience over scientifically efficient patient management, which enabled resistance to attempted corporate management.

The number of biological families that populated the hospital was an important factor in creating a family atmosphere. One major category of patient was the “old-time” families who had lived in Gainesville for at least three generations and protected their kind, if not in person, in memory. As one woman said, “you could be treating one man, and the next week his wife would come in, and it turned out their

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320 Ideological commitment provides social and psychological benefits to those who embrace it. At AGH, as at other institutions, it is apparent that there was a “core” of people who strongly believed in the hospital’s historical mission and its exceptional nature. There were also those who did not. As one interviewee put it, “some left for Shands, others came from Starke to work at AGH.”
321 Ibid.
322 Personal communication
323 For example, at the entrance of the hospital was a portrait of the venerable Dr. W.C. Thomas; Auxilians arranged fresh flowers under it every week. An Auxilian recalls that over twenty years ago,
granddaughter worked in the cafeteria…everyone knew everyone else.” One hospital laboratory employee said that the hospital’s attitude towards patient care was a matter of asking, “what would I do if the patient was my mom?”

The dense social networks that underwrote provider-patient relationships at the hospital created a positive feedback loop of patient trust and personalized, attentive care from a committed group of providers. The tradition of trustworthy patient-provider relationships at AGH was a distinguishing mark of the AGH institutional ecology. By privileging patient experience, AGH took to heart Guenther Risse’s pronouncement that “trust in people, not spreadsheets, remains an essential healing ingredient.”

The memories of AGH supporters are a testament to the ideology of family. In the weeks before the hospital closed, over 100 memories were gathered on an AGH “Memory Wall” from passers-by in the hospital lobby. Here are two memories which speak to the intense dedication and love that staff, employees, patients, and volunteers felt:

1. We are a family at Shands AGH. We know the names of the people working in the cafeteria and they know how we like our sandwiches grilled. People in medical records know who you are when you call to get a chart…People truly care about patients and each other, and will do whatever they can to help each other.

2. My two oldest girls were born there…Losing Shands AGH is losing a part of my children's memories - losing a part of their past. As I had also worked there, during renovations, a patient who was a friend of the Thomas family complained that the usual flowers at the portrait of Dr. W.C. Thomas had not been lain out and threatened to notify the family.

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324 Personal communication
325 personal communication
326 This translated into heroic and one might say, paternalistic, medicine. AGH practitioners also worked creatively to find culturally sensitive solutions. One social worker explained that if patients who ate large amounts of greens needed to be put on blood-clotting medication, instead of Warfarin a weaker drug or lower dose was used so that patients would not overdose (greens are a popular regional food and high in Vitamin K, a blood-clotting factor).
327 Risse, 683. This trust applies not only to how the scientific community for the production of scientific knowledge, but also to how the community creates institutional knowledge as well. Steven Shapin, A Social History of Truth: Civility and Science in Seventeenth-Century England, 1st ed. (University Of Chicago Press, 1995).
it's also losing a place I called my second home. There's a lot of love in Shands AGH.328

These tributes show that devoted providers, patients, and volunteers maintained “ideal” narratives of care giving: an emphasis on the rewards of the relationship between caregiver and recipient, and willingness to overlook the negatives.329

Formal elements of community-building supported the internal social cohesion of the hospital.330 For example, the “keys for success” program celebrated employees who demonstrated extraordinary patient care as role models and gave them keys, material rewards for emulation of the AGH way.331 Hospital-wide gatherings such as the yearly Hospital Week tent parties broadly distributed social capital across profession and pay grade. These parties featured barbecue luncheons at which “everyone sat together; the nurses and doctors and X-ray techs” and, in a carnivalesque twist, the administrators served food. Social activities thus made linkages across the hospital stronger, while defusing hierarchal power relationships. Physically, the layout of the hospital fostered a culture of togetherness for the medical staff.332 After the 1975 addition, the doctor’s lounge, positioned at the entrance of the hospital, served as a

328 See Appendix 1
330 “There needs to be an analogy by which the formal structure of a crucial set of social relations is found in the physical world….when the analogy is applied back and forth from one set social relations to another and from these back to nature, its recurring formal structure becomes easily recognized and endowed with self-validating truth.” Mary Douglas, How Institutions Think, 48.
331 One employee remembered that a nurse was given a key for washing a patient’s clothes in her home because the patient didn’t have enough clean clothes.
332 Sloane: Evolving Design of Hospital, Sloane discusses in the competition for patient services, architecture is used as a way to attract patients (and by extension, doctors). In particular, he suggests that hospital architecture is a mimicry of suburban shopping malls, a symbol of the materialism and designed to create comfort in healthcare consumers. David Charles Sloane, “Scientific Paragon to Hospital Mall: The Evolving Design of the Hospital, 1885-1994,” Journal of Architectural Education (1984-) 48, no. 2 (November 1994): 82-98.
physical nexus of medical social interaction. Physicians felt supported by a community of medical practice.

AGH proponents contrasted the organizational culture of Shands and AGH to resist assimilation to Shands— incompatible cultures legitimated separate spheres. If AGH was a family, then Shands was an impersonal medical factory. However, as one executive commented, Shands was really more of a “neighborhood, because it is still possible to get that family feeling, but in pockets or departments as opposed to the entire hospital.” These differences were partially due to hospital mission. Whereas AGH was exclusively committed to patient care, Shands juggled research, medical education, and patient care, which led to differences in attitudes and practice. Utilization rates also created differences between the two hospitals. Shands, as a major tertiary care center, took patients from all over the Southeast, whereas AGH took mainly area patients.

Therefore, in the more chaotic environment of Shands Hospital, more rigorous standards of practice were enforced. AGH, especially as patient census declined in the last few years, could afford to have a more relaxed pace of operation. This had implications for provider behavior. At Shands, a social worker commented, she felt that asking for help outside of formal relationships was looked down upon as unprofessional, and that by contrast, at AGH she “could easily step outside of roles” and that AGH “gave a lot of flexibility to me as a licensed professional.”

The perceived cultural differences led to Shands-AGH animosity. Core AGH physicians saw Shands as an unhealthy practicing environment, and core Shands

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333 personal communication
physicians felt as though they were subsidizing AGH’s existence, allowing those community doctors to “use the Shands brand.” Thus, the productivity of AGH and Shands’ partnership was reduced because AGH and Shands Hospital remained distinct entities with different visions for healthcare. Collaboration was limited; the exchange of resources that could have occurred was greatly dampened.

Proponents of AGH ideology attempted to preserve the relationships and ecology of the hospital by creating a sense of timelessness. The logic of the unity of generations went, my parents were born here, I was born here, my children were born here, my parents died here, I will die here, my children will have their children here, ad infinitum. As Jess Davis wrote in the foreword to Rathbun’s history, “Alachua General Hospital is a living spirit. It’s our neighbor and our friend…It is there. It is always there.” The ideological implication was that AGH was unchanging in the face of societal, political, and economic change, which was comforting to people adjusting to the changing nature of broader society.

AGH ideology asserted the hospital’s uniqueness in the healthcare ecosystem as a bastion of small-town gentility and attempted to claim authority in matters of charitable care and how to provide better patient experiences. They invoked

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334 personal communication
335 personal communication
336 Physicians at AGH and Shands also apparently didn’t mingle as one staff. Although the Medical Executive Committee, which wrote the new medical bylaws for AGH, served as a bridge between the two staffs, communication remained minimal. One employee summed up the result of this attitude by making the analogy of different university campuses, with Shands doctors working at the Shands campus and AGH doctors working at the AGH campus—the doctors “never quite got it” that they were supposed to be one staff. One executive recounted that at a staff meeting, one Shands physician stood up and said that if the AGH physicians wanted to leave, they could, and no one would miss them. (personal communication)
337 Rathbun, prologue
338 Gainesville and North Central Florida share more in common with Georgia than they do with the history and politics of South Florida, and have a historical bias towards conservatism and preservation of
historical tributes to the hospital’s faithful dedication to the community. The next section discusses an organization that tirelessly championed AGH’s ideological commitment to community engagement and perpetuated the ideal narrative of the hospital: the AGH Auxiliary.

“Angels Gather Here:” the AGH Auxiliary, 1953-2009

The mother of the AGH family, to extend the metaphor of family, was the AGH Auxiliary. The Auxiliary served as a bridge between the hospital and Gainesville and between healthcare professionals, employees, and patients within the hospital. The AGH Auxiliary members translated their interest as charitable ladies into hospital esprit de corps. As an overwhelmingly female organization, its activities speak to how gender roles were constructed in the hospital, and how the scope of activities that its women volunteers became responsible for empowered both the hospital and the volunteers themselves.

In the first part of the 20th century, women, as moral guardians of the domestic sphere, were expected to nurture the public sphere as well through civic values. David R. Colburn writes that “Florida has been two states—one that extends south from the Georgia border to Ocala and that has identified with the South and its racial and social traditions and another south of Ocala that has little association with the South and that views the state as part of a national and, indeed, international economy.” (Colburn, 344) Michael Gannon, The New History of Florida, 1st ed. (University Press of Florida, 1996). For example, the hospital newsletter, in Jan. 1960, featured a trivia quiz on Gen. Robert E. Lee, and humorously wrote that for “Rebels—8 [correct answers] is excellent…for Yankees—3-4 excellent.” See also: Richard Reynolds, Sam A. Banks, and Alice H. Murphree, The Health of a rural county: perspectives and problems (Gainesville: University Presses of Florida, 1976).

339 One Auxilian’s story struck me: a patient came up to her and teasingly asked her what AGH stood for. “Why, Alachua General Hospital,” she replied. The patient shook her head. “No. Angels Gather Here. That’s what you all are.” (personal communication)

340 Rathbun, 37.
The traditions of Progressive feminine philanthropic work and post-World War II community enthusiasm made hospital volunteerism one of the major developments of the 1950s. Volunteerism was a particularly important outlet in a time period that glorified feminine domesticity, it was difficult for women to seek professional advancement in many disciplines, particularly medicine.

This history, and the gendered expectations that resulted, would impact the Auxiliary’s composition through the 1970s—the historical association between volunteering and femininity would not be easily broken. In 1960, patients had begun referring to Auxiliary members affectionately as the Pink Ladies. The Auxiliary membership was entirely female until 1972, when Ron Bennett, the husband of one of the committee chairs, joined. Although the men protested the term “Pink Ladies”—as one male Auxilian said, “We weren’t ladies, and we didn’t wear pink”—the name stuck. At its peak, in 2009, males constituted 10% of the total membership.

The Auxiliary served a powerful social function for its female members. The most common reason for joining the Auxiliary was, as one former Auxilian explained, “it was the thing to do and I was new in town.” Therefore, a substantial fraction of

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341 Stevens, Glaser, American and Foreign Hospitals
343 Some of the assumptions made of women in the 1950s are summarized in this passage: “Experience indicates that after the first shock of novelty a woman can serve acceptably as resident in most communities…that a young man who brings his wife with him usually brings complications with her (although residents’ wives occasionally fit very comfortably into the nursing, technical, or office staff).” (Southmayd, 64) Dr. Justine Vaughn, a physiatrist, is believed to be the first female doctor to practice at AGH, in 1961. Her husband was an orthopedist at the hospital. As a complete tangent, licensed medical women practitioners were not common in Northern Florida. One of the most prominent women, Dr. Deborah Coggins, in 1956 was embroiled in an infamous controversy in which she was fired from her position as Jackson County public health director for “breaking bread with a Negro.” See: Jerrell H. Shofner, “Custom, Law, and History: The Enduring Influence of Florida’s "Black Code”, “The Florida Historical Quarterly 55, no. 3 (January 1, 1977): 277-298; “THE SOUTH: Fire Her! Fire Her!,” Time, October 8, 1956, http://www.time.com/time/magazine/article/0,9171,824399,00.html.
Auxiliary members were women invited to join by friends who reconstituted social relationships within the bounds of hospital activities. Also included in its ranks were women who had relatives in the hospital and wanted to give back, and women who had pursued nursing careers but never completed. These women exemplified a diverse community of practice that reproduced their relationships socially.

Although Gainesville women had a long history of philanthropy and volunteering for healthcare, the AGH Auxiliary was not founded until 1953. At the Kickoff for the AGH Auxiliary at the Gainesville Golf and Country Club, Mrs. George Evans stated, “Believing that the women of Gainesville and Alachua County can render service to Alachua General Hospital and promote goodwill in the county for the hospital—we are met today to cooperate. We are a distinct group and composed of individuals interested in the furtherance of our institution—to build in every way.”

And build they did. The enterprising nature of the Auxiliary leadership quickly led to the creation of committees with complex and useful tasks, showing how the organization adapted according to the hospital’s needs. The Finance Committee raised funds to be applied to purchases for the hospital, be it equipment, amenities for patients, or scholarships for nurses. From 1953-2009, the Auxiliary donated over $2 million, for causes as diverse as radiology equipment, patient room televisions, Lifeline, and a

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344 Rathbun, 37
345 Ibid. The Auxiliary also ran a Future Nurse’s club at Gainesville High School. These activities made the hospital run more smoothly, and domesticized the hospital environment.
346 Early attempts at a women-run initiative to support the medical community surfaced in 1913, when a group of women raised money to buy a deed for a new hospital site, though it was never actually finished (Rathbun, 32). The idea of the Auxiliary first formed in the same social group of doctors’ wives who gathered at the Gainesville Country Club at meetings of the ACMS; this same group also chartered the Alachua County Medical Auxiliary in 1928. In the late 1800s and early 1900s, several women ran “hospitals” out of their homes, or served as midwives and untrained volunteer nurses. See picture 2 in Appendix 3.
347 Rathbun, 31.
Auxiliary members directed patients and family members around the hospital at the Information Desk. The Pinkie Puppet Committee—which made puppets for children waiting in the ER—was formed in 1956 by Mrs. S.H. Kerr (Mrs. W.A. Shands, the wife of the senator who had lobbied for the University’s teaching hospital, was in charge of distribution).

The Auxiliary was a powerful actor in hospital politics. As one executive said, Auxilians knew that they were lay service providers, and could not fill the roles that medical and administrative professionals did. Interestingly, the Auxiliary appealed to Southern feminine graciousness: as one executive said, “Southern women have their way. They were a strong right arm, but never tried to muscle.” The very nature of the Auxiliary’s informal authority was linked to the organization’s femininity and its espousal of hospital ideology.

Acting on behalf of AGH, the Auxiliary made a link between the health of the hospital and the health of community, and in so doing, promoted the hospital’s ideology of caring. As the Auxiliary wrote in 1969, “Every hour we spend making AGH a little bit nicer also makes our community a little bit nicer.”

The “We Care” program started in the 1960s allowed Auxiliary members to give follow-up phone calls to

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348 A tea social held in 1953 raised enough money to put a “shopper’s guide” in every patient’s room. At the end of the first year of its existence, the Auxiliary had also donated an Isolette for premature babies purchased books for the student nurses’ library. One of the most popular contributions the Auxiliary made was the Baby Project: birth certificates bearing the baby’s footprint and mother’s thumbprint was signed by the hospital administrator and attending obstetrician, and together with a picture of the day-old infant, was sold to parents. Rathbun, 32-42.

349 ibid.

350 As Krogstad wrote of Norwegian hospital volunteers, “they [were] the most stable group in hospital wards, representing long experience...about their local patient groups as well as the hospital organization.” Unni Krogstad et al., “Predictors of job satisfaction among doctors, nurses and auxiliaries in Norwegian hospitals: relevance for micro unit culture,” Human Resources for Health 4, no. 1 (2006): 3.

patients who had been discharged, and the inception of LifeLine in 1981, as indicated in Chapter 3, provided support to elderly patients living by themselves. Their unwavering support anchored the hospital in compassionate ideology, and provided a bridge between different professional groups at the hospital, and between the hospital and the broader community.

The Auxiliary’s golden age faded by the 1990s, for reasons that appear to be linked to broader social movements and the decline of the hospital itself. The hospital’s tradition of volunteerism was comparable with patterns of general civic participation, which declined on a national scale. One woman who was an Auxilian for 45 years attributed decline in new membership to the increased numbers of women in the workforce, popularity of social clubs, and the decline of the hospital itself.

While the number of younger volunteers increased, these volunteers were not able to commit as much time to the hospital as the Auxilians. There was a profoundly sad sense among the Auxiliary members with whom I spoke that “the passing of an institution meant the passing of community spirit”—these volunteers feared the decreasing importance of community trust as a standard of performance, and what it meant for the hospital’s future.

352 When AGH closed, there were 85 Auxiliants remaining, many of them long-time volunteers, serving on 8 active committees. In 2009, the Auxiliary donated its remaining assets, $234,000, to Santa Fe College for health-related profession scholarships.


354 Robert Putnam, Bowling Alone.
The decline of AGH

When Shands purchased AGH in 1996, it was clear that AGH had been suffering financially since at least the mid-1990s, and some would argue earlier than that. Under the management of a vertically integrated corporation and an academic medical system, AGH had lost some autonomy, and cycles of patient payment that had supported the care of the indigent. In the early 2000s, in an environment of “turbulent cycles of expansion and contraction…a cacophony of sales pitches,” AGH had few sales pitches of its own and survived on infusions from Shands HealthCare. There were two main reasons for its declining competitiveness: physician flight and increasing numbers of uninsured and underinsured patients.

Many believed that Shands HealthCare, with no prior experience in running a community hospital, had unrealistic expectations for its four community hospitals. Overtones of scientific management persisted under the rationale of economic efficiency. However, AGH supporters alleged that there was a difference between running a structured, compartmentalized academic medical center and running a more flexible and adaptive community hospital.

Shands HealthCare’s divided attentions, like SantaFe’s, were problematic.

Shands HealthCare’s primary concern from 2001-2004 was not AGH, or even Shands

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355 Jud Magrin, “How will hospital merger affect health care in area?,” In addition, Shands estimated it would lose $18 million in reimbursements in 1998 alone, and a total of $87.2 million from 1998-2002 due to Medicare cutbacks. In 2000, there was a 34% Medicare share of patients at AGH. The situation was more dire at Shands’ rural hospitals: Starke’s Medicare share was 78.8%, Live Oak’s was 84.2%, and Lake Shore’s was 52%. Doris Chandler, “Hospitals Feeling Cutback Squeeze,” The Gainesville Daily Sun (Gainesville, Florida, May 2, 2000), sec. A.

Hospital, but the bailing out of the University’s hospital in Jacksonville.\textsuperscript{357} During these three years, Shands HealthCare managed to make $140 million to refinance the Jacksonville hospital’s bond, but at the expense of close management of AGH. Shands HealthCare had built a powerful medical network, but also had to juggle a greater number of logistical issues, local environments, and interest groups.

A decline of “doctor-friendliness” was the main cause of AGH’s physician bleed-out. Although physicians were less politically active, physicians still held the trump card of medical expertise, and furthermore, were conceptualized as the hospital’s most important consumers of services.\textsuperscript{358} AGH, as a community-based hospital, needed to attract community-based doctors. However, one private-practice physician noted that Shands HealthCare didn’t understand how to court community doctors: “they weren’t in the catering business, even though they needed to be.”\textsuperscript{359} This was attributed to the academic mentality of Shands Hospital, which put research and educational interests before private practice interests.

In light of these difficulties, a number of doctors opted for NFRMC, which had a board of doctors as directors, instead of a board appointed by University of Florida officials. From 2008 to 2009 alone, twenty to twenty-five doctors left AGH for NFRMC. Shands specialists, for the most part, were hesitant to use AGH facilities. “If

\textsuperscript{357} Shands HealthCare bought two struggling hospitals in Jacksonville in 1999 and combined them into the Shands at Jacksonville Medical Center. “Hospitals Now a Part of Shands,” The Gainesville Daily Sun (Gainesville, Florida, September 22, 1999), sec. A.
\textsuperscript{358} Though physicians had long been perceived as the most important group to attract to keep hospitals financially viable, the 1980s commodification of medicine had a strong impact on this trend. If medical services were discrete goods to be bought and sold, then physicians were the purchasers of these goods. Jeff Charles Goldsmith, Can hospitals survive?: The new competitive health care market (Dow Jones-Irwin, 1981); S M Shortell, M A Morrisey, and D A Conrad, “Economic regulation and hospital behavior: the effects on medical staff organization and hospital-physician relationships,” Health Services Research 20, no. 5 (December 1985): 597-628.
\textsuperscript{359} personal communication
the hospital stays, it’s important that the neighborhood be substantially improved and redeveloped,” Bruce DeLaney, assistant vice president for real estate with the University of Florida Foundation, said in 2003 to the Gainesville Sun. “Patients and their families have to feel safe when they come for care.”\(^{360}\) NFRMC was an attractive option to community doctors who became disenchanted with AGH’s tired facilities because it had a “more pleasant practicing environment” with newer facilities and office parks.\(^{361}\)

Physician flight resulted in the breakdown of the feedback loop between patient payment and hospital performance. Historically, sources of large income, such as elective surgeries, had underwritten the hospital’s treatment of the indigent and uninsured/underinsured populations—lucrative specialties allowed the hospital to do charity work and maintain financial solvency in a kind of redistribution of healthcare resources. However, when doctors left AGH for NFRMC or private practice, they took their patients—their money and insurance—with them. AGH’s competitors, who were both more aggressive and possessed more material resources, left AGH with unsustainable demand for care at the bottom of the healthcare chain.

After the Shands acquisition, AGH became saddled with the obligations of a county hospital though it had the bottom-line agenda of a private corporation. In the last few years of its existence, the hospital had three core populations: the indigent, the chronically ill, and seniors. “Hospital dumping” from NFRMC and Shands Hospital created a feeling of inequality, and as a social worker said, a return to the “public


\(^{361}\) Personal communication
hospital” model rather than the “community hospital” model. This mismatch between individual mission and corporate mission—the simultaneous goals of providing friendly, expert care in a family-like environment to anyone, and staying a financially viable member of a multihospital system—made saving AGH a matter of making compromises that no one was willing to make.

Shands HealthCare made efforts to assimilate AGH to its model of specialist-oriented, financial self-sufficiency. Over twelve years, Shands infused $86 million into AGH and sent specialties to AGH to improve the hospital’s performance. In the early 2000s, some Shands orthopedic surgeons and cardiac surgeons—who already had outside professional ties with AGH surgeons—moved to AGH. In 2002, a successful hospitalist program was implemented to deal with the on-call service issue. Shands briefly put in a “children’s hospital” on three floors of AGH which essentially brought over the Shands pediatrics department to AGH in October 2006 (however, due to staff protest, pediatrics was moved back to Shands in 2008). Success of integrating AGH and Shands Hospital services was limited, and the hospital continued to bleed money. The comments from one Shands executive are telling: “no matter what they tried to do, everything went wrong. The rules are changing on us…the community focus was recognized and appreciated but couldn’t support the hospital financially.”

The hospital’s location was a crucial factor in its decline that was bound up in broader demographic changes. Faculty and employees at the University of Florida, as

362 personal communication
365 Personal communication
well as those who could afford to buy new suburban houses, followed the university as it expanded westward. Thus, so did AGH’s historical patient base. As early as 1982, the hospital board noted that the development of the University of Florida in west Gainesville foretold the downfall of the downtown area—new development, business, and construction were moving west with the university, away from the hospital, distancing it from resources.  

Fifty years ago, AGH’s location had been strategic because it was in the heart of the city. However, by 2000 its historical neighborhoods, clinging to the memory of the dignified homes of University officials that they had once been, were no longer considered respectable. A reader of the Gainesville Sun commented that “The only reason AGH gets a bad rap is because it is not located west of NW 13th St. and most people in this town think that anything east of there must be bad.”  

Table 3 shows that AGH provided technically less charity care than Shands Hospital, but saw a proportionally greater number of uninsured patients.  

366 Alachua General Hospital: Meeting Minutes of the Alachua General Hospital Board of Directors, December 12, 1982.  
368 One must also question the type of charity care that was provided—care that is more technologically intensive, or for which a larger medical team is required, is more expensive. As we have seen, AGH had a comparative technological disadvantage, and had adapted strategies to provide less technologically intensive care. As one hospital executive said, “they knew how to pinch every penny.” A more useful metric would be how many cases of charity care each hospital provided.
Table 3: Comparison of care at three area hospitals, 2009

<table>
<thead>
<tr>
<th></th>
<th>Shands</th>
<th>AGH</th>
<th>NFRMC</th>
</tr>
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<tbody>
<tr>
<td>Beds</td>
<td>660</td>
<td>367</td>
<td>325</td>
</tr>
<tr>
<td>Employees</td>
<td>5959</td>
<td>1053</td>
<td>2,090</td>
</tr>
<tr>
<td>Charity ($ millions)</td>
<td>43.3</td>
<td>10.9</td>
<td>14.2</td>
</tr>
<tr>
<td>Patients total</td>
<td>318,237</td>
<td>81,525</td>
<td>185,509</td>
</tr>
<tr>
<td>Uninsured patients</td>
<td>7.9%</td>
<td>12.5%</td>
<td>9.8%</td>
</tr>
<tr>
<td>(percentage)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual births</td>
<td>2,812</td>
<td>1,101</td>
<td>2,409</td>
</tr>
</tbody>
</table>

The hospital’s choice to remain rooted was important because of racial and socioeconomic implications that literally surrounded the hospital. The area around AGH had become predominantly black and low-income, and AGH served a great number of these patients. Physicians, executives, and volunteers argue that the hospital could have been saved if it had moved. In the years before it closed, AGH mulled over the possibility of moving to Northwest 39th Avenue near Interstate 75, a location that would have “concentrated medical care in the two corridors of Gainesville” and “allowed it to capture the growth” there. However, AGH management was resolute against moving because it felt that AGH would be abandoning its mission to serve the people of downtown and east Gainesville, who had less access to hospitals like Shands and NFRMC.

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370 Farley and Frey, demographic researchers at the University of Michigan, reported that Gainesville, like several other university towns, was relatively insulated from residential segregation. Farley and Frey show that Gainesville had an unusually low residential segregation score, and Wineberg (1983) shows that demographic changes at the university overturned the traditional pattern of residential segregation. (Black students and professionals lived in previously white neighborhoods commensurate with occupation and income). The index of dissimilarity for Gainesville in 1980 was 61, and 1990 was 54. For comparison, Chicago was 91 in 1980 and 87 in 1990; Jacksonville was 75 and 65, and Athens, GA was 53 and 54. (0=no segregation; 100=complete segregation) Reynolds Farley and William H. Frey, Changes in the Segregation of Whites from Blacks During the 1980s: Small Steps toward a More
In 2009, the ramification of closing the primary source of healthcare for east Gainesville, predominantly black and low-income, and other underserved areas was not lost on community activists. Former State Representative Ed Jennings Jr. called the closing of AGH “akin to the closing of Lincoln High School,” a black high school that was a nexus of black social and cultural activities, in its effect on the east Gainesville community.\textsuperscript{372} At a special County Commission meeting in mid-2009, several physicians and community members stated their concern with overcrowding at NFRMC and Shands, the lack of care centers on the east side of Gainesville, and the difficulty of convincing long-time AGH users to switch to another facility.\textsuperscript{373} The closing of AGH appeared to threaten Gainesville’s entire ecosystem of care.

In retrospect, the steps that AGH took in the 1970s to make itself a more competitive hospital had also made it more vulnerable to the whims of market changes when it held firm to its commitment to the local community.\textsuperscript{374} As Paul Starr has written, “The great irony is that the opposition of the doctors and hospitals to public control of public programs set in motion entrepreneurial forces that may end up

\textsuperscript{Racially Integrated Society (Ann Arbor, MI: University of Michigan Population Studies Center, September 1992).}
\textsuperscript{371} Personal communication, former Shands executive
\textsuperscript{373} The incidence of death from cancer and heart disease is around 24 percent higher for black residents than for white residents. In 2008, the diabetes death rate among black residents was nearly 211 percent higher than that of white county residents. In 2008, only 60.7 percent of black mothers received prenatal care in their first trimester of pregnancy, compared with 78.7 percent for white and 76.5 percent for Hispanic mothers-to-be. Black infants consistently were born at a lower birth weight. WellFlorida Council, Alachua County Health Needs Assessment (Gainesville, Florida: WellFlorida Council, March 2010).
depriving both private doctors and local voluntary hospitals of their traditional autonomy.\(^{375}\)

While some citizens implored the county to take the hospital back, the county pointed out that AGH had not been in county hands for decades, and that the county had no desire to take the hospital back.\(^{376}\) The hospital scrambled to keep up with national policy and regulation, and remain financially competitive, but the conditions and sentiment had become such that the different pieces of the puzzle no longer fit together. AGH could not separate the initial freedom of private governance from the business precepts that were linked to that structure of healthcare ecology.

"You can’t run a $200 million operation on nostalgia:" the language of the closing controversy.\(^{377}\)

The decision to close AGH was very emotional for personnel, administrators, and patients precisely because of the hospital’s deep roots in the community and its strong ideological commitment to care. The core community of AGH mourned the passing of a community institution, and with it, a way of life. Preexisting ideological, self-protective bias on both sides—AGH’s community commitment and Shands’ financial and academic justifications—appeared to play a part in these debates. There was conspiratorial talk that Shands had intended to eliminate AGH from the Gainesville

\(^{376}\) In 1996, Attorney Bill Andrews said that if AGH didn’t become not for profit in 1976 it would have gone under. After the hospital privatized, Alachua County had to pay less for indigent care; in the late 1970s, it was paying $400,000 for indigent care. Andrews said, “Most counties have to budget for indigent care. Alacha County doesn’t budget anything.” Jud Magrin, “Impact Will Be Felt for Years,” The Gainesville Daily Sun (Gainesville, Florida, February 4, 1996), 1st edition, sec. A. Also see: Alachua County Commission Special Meeting, May 5th, 2009. Charles H. White confirms this: in 1997, 53% of federal dollars went to inpatient hospital care, and 40% of state and local budgets. This was money that Alachua County did not have to spend. Charles H. White, *The Medical Staff*, 4.
healthcare system since 1996. One interviewee confided, “Maybe it took them fifteen years to get the guts to do it.” Employees criticized Shands’ physical renovations— replacing an old elevator in 2008, changing linoleum floors to marble, and even painting the walls two weeks before the hospital was due to close.\textsuperscript{378}

Personal interviews show that the Shands administration was genuinely sorry to lose AGH. However, the fact that AGH was an unsustainable venture was of greater concern. In 2008, AGH posted losses of $12 million, and it was projected that $50 million would be required to keep the hospital afloat for the next five to six years.\textsuperscript{379} The trends of physician flight and increasingly undesirable patient population showed no signs of changing. On October 22\textsuperscript{nd}, 2008, Shands HealthCare CEO Timothy Goldfarb announced that due to financial issues, AGH would be closed in a year.

The language of rational, efficient management allowed Shands Healthcare to justify their position by framing the argument in terms of finances and corporate efficiency.\textsuperscript{380} Timothy Goldfarb, the CEO of Shands Healthcare, defended executive decisions by saying in a \textit{Gainesville Sun} article that “To a certain extent, people have not been talking about the facts but about their feelings. Feelings are important, but the facts speak for themselves.” In addition, “the choice we made to close Shands AGH was a necessary business decision. It has a long and wonderful history and is part of the

\textsuperscript{378} personal communications
\textsuperscript{380} On language: work by Daniel Mulkay, Pierre Bourdieu, Edward Bloor, and Bruno Latour lead me to the conclusion that language is used by different groups to call attention to its strength to gain a more advantageous position in whatever political network they are embedded in; in healthcare institutions, this language is characterized by bureaucratic rationality and scientific efficiency. Depending on which view one takes, of course, changes the nature of the controversy, which shows the multiple interpretations that are at work in the management of medicine and healthcare made in the name of self-preservation.
heart and soul of the community” but in the “economic storm” that began in 2008, the aging facility was no longer financially viable.\footnote{Diane Chun, “Shands AGH closes on Sunday | Gainesville.com,” The Gainesville Sun, October 28, 2009, \url{http://www.gainesville.com/article/20091028/ARTICLES/910289873}.}

Shands HealthCare fell back on competitive marketplace language to exculpate itself from blame, and got support from local business leaders. This language had a long history of use in the healthcare field. In 1968, one hospital-planning expert summed up the comparative advantages that transition to larger, more modernized hospitals offered:

Hospitals are in a state of transition similar to that of the corner grocery store. The small family business was unable to survive in the face of fundamental changes in the production, marketing and distribution of food. And with the disappearance of the small corner grocery store came great innovations in food marketing and major reductions in cost—often obscured by inflation and other factors. Although few would miss the convenience of the corner grocery store, few would willingly give up the advantages of the supermarket.\footnote{Donald C Carner, Planning for Hospital Expansion and Remodeling (Springfield, Ill: C. C. Thomas, 1968): 92.}

This planning expert’s premonitory language rang true for hospitals like AGH: highly specialized, tertiary care at large hospitals outperformed primary and preventive care at small hospitals.

On the other hand, staunch AGH supporters framed their argument in terms of the fabric of community and the familial ideology of the hospital, and unjust uprooting by Shands. Dr. George Buchanan, an AGH physician for 28 years, said, “we have put our hearts and souls into our practice…now I’m being forced to make that decision (to move elsewhere).” Commissioner Rodney Long stated that “the way it happened makes it suspect to those in a community…[the hospital was created by a public entity], not by 10 or 15 people sitting in a room saying, ‘this is how it’s going to be.’”\footnote{Diane Chun, The Gainesville Daily Sun (Gainesville, Florida, October 29, 2009), 1st edition, sec. A.}
A more fundamental issue that worried community members, though, was something that few explicitly spoke about. The demise of the hospital was a sign of the demise of the social safety net for the indigent, the homeless, the unwanted of Gainesville. The privatization of what were considered community institutions seemed to remove executive responsibility for serving the community. As Marilyn Tubb, former Shands Healthcare Vice President of Community Affairs, said, “we are blessed with two excellent organizations and care will continue to be outstanding [at Shands and NFRMC]. It's just the sense of community ownership that is disappearing. And that's the rub.”

The closing of the hospital was not merely an institutional change, but a cultural change as well that signaled the end of a symbol of civic spirit.

**Conclusion**

The events of the last fifteen years of AGH’s existence brought long-standing cultural clashes and concerns about equal access to healthcare to the attention of the public. AGH’s ideology of family was grounded in real conditions—hospital size, history, and capabilities of care—that were naturalized as justification for AGH’s particular style and performance. While its ideology committed it to the historical charitable goals of a community hospital, AGH’s place in an academic medical system committed it to revenue generation; these goals were far from convergent. AGH also resisted assimilation into the Shands Hospital organizational culture, which allowed it to retain its cherished culture, but also deprived it of potential resources that might have saved it.

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384 AGH memory wall, 2009.
The hospital’s relationship with its community had changed greatly over the last twenty years of its existence due to broader demographic and social changes resulting from the University of Florida’s expansion. A core community of AGH supporters, most notably, the hospital Auxiliary, remained. This group protested the hospital’s closing passionately. Their language was framed in the ideological rhetoric of the destruction of family and community. However, executive decision was more convincingly able to frame the argument in financial terms, because of administrative authority, and the internalization of the corporate value of financial solvency in the public sphere.

Ultimately, AGH could not justify its position as a financially sustainable niche in the healthcare infrastructure of the Shands HealthCare network. It is possible that these patterns of decline might have been reversible if the appropriate efforts had been made, but in all fairness, each group of interested actors acted in the way it thought most appropriate based on its set of interests and organizational philosophy. The broad range of actors involved in the closing controversy shows how external social, economic, and cultural forces played into a supposedly dispassionate, business-driven decision.

No alternative solutions were found, though the language of accusation and self-defense heated up as the deadline to close AGH approached. No advantageous environmental conditions emerged, and AGH continued to bleed money and physicians. Floor by floor, beds were moved, and power was turned off. The trickle of patients, employees, and volunteers grew smaller and smaller. The last patient was
transferred out of AGH at 12:31 PM on November 1, 2009, and then, the hospital turned off its lights forever.
Conclusion: the future of healthcare in Gainesville and preserving AGH

The history of AGH reveals an institution that was by turns folksy and charming, stubborn and conflicted, and above all, adaptive to national and local pressures. The hospital’s unique character developed in response to specific social and economic contexts. The hospital juggled financial incentives, professional interests, and ideological commitments, and built strong community support on a mission that grew out of familiarity. When asked to describe AGH, one white-haired Auxilian, clad in her pink uniform, struggled for the right words, and said, with an air of finality, “It was a community hospital.”

Throughout this thesis, we have seen that the scientific and the social interact to define notions of “community” and “hospital,” which affected AGH’s institutional character and its ability to provide community-based care. The hospital functioned as a mediator of medicine and society by balancing scientific, corporate, and cultural values that were dependent on social conditions. In the last section of this thesis, I tie together the various theoretical frameworks that contextualize AGH’s history of practicing community-based medicine under the umbrella of the ecological perspective. After discussing the adaptations that Gainesville institutions have made after AGH closed, I also suggest some policy points that could provide for the personal care and concern for patient satisfaction that AGH practiced, which are essential in a diverse and changing healthcare environment.

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The ecological perspective considered how AGH’s social and geographical environment—for example, demographic changes, social reforms, race relations—guided the hospital’s strategies, and assumed that this environment was always dynamic and required constant response from the hospital. Within this perspective, my discussion of boundary work in the medical community in Gainesville in the 1950s established how groups set professional boundaries in order to legitimize their claims of authority in hospital affairs. The definition of these boundaries relied on the invocation of new forms of scientific expertise, whether biomedical or managerial in nature. Emerging groups such as administrators emulated the medical model of professionalization and challenged medical authority with their own organizational expertise.

Technology was one mechanism through which different groups negotiated expertise. Physicians used technical expertise to make demands on hospital trustees, but the hospital administration also used organizational technology to control the structure of practice at the hospital; this was especially visible when the hospital adopted new information technology systems in the 1980s. I have also shown that AGH’s rate of medical technology adoption was dependent on preexisting relationships and expectations of care at AGH. The hospital prided itself on its adaptability in providing creative, cheaper solutions to overcome a perceived technological deficit.

A major player in the hospital’s ecology was government. Foucault’s theory of governmentality, in conjunction with evidence of desegregation and the hospital’s response to Medicare implementation, demonstrates that the hospital preemptively adopted government standards in order to receive federal funds, and that this self-
discipline primed the hospital for future government regulation. The 1960s was a time when the hospital broke with local trends in racial dynamics and methods of payment for care through the internalization of federal standards on race and insurance programs. However, AGH simultaneously resisted local government intervention in its affairs. The struggle for ultimate authority between hospital trustees and doctors and county commissioners created so much antagonism that AGH wrenched itself out of county ownership through privatization. The hospital made a political claim about the legitimacy of self-regulation through private ownership in a complex, scientifically defined institution.

Privatization was a form of institutional mimicry that showed how hospitals disciplined themselves to emulate corporations. AGH used institutional mimicry to compete with Shands and NFRMC through service differentiation and community reputation on a broader ecological level of healthcare in Gainesville. AGH’s dynamics with Shands and NFRMC was a major source of frustration and strength—competitors like Shands Hospital and NFRMC drew paying patients away and caused great anxiety for AGH, but opposition to these competitors created support for an AGH ideology that cemented bonds among its staff employees, and volunteers. Over time, the power equilibrium disfavored AGH as medical and patient-based resources shifted to Shands and NFRMC.

AGH supporters rallied around internal hospital ecology by reinforcing nostalgic perceptions about the hospital. This was AGH’s great strength. AGH drew upon the knowledge and resources of the community by reaching out to laypersons,

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386 MW Legnini and Emily K. Waldman, Academic Medical Centers and the Culture of Local Markets (Economic and Social Research Institute: W.K. Kellogg Foundation, August 1999), 19.
who responded with dedication of time and effort to keep the hospital open. This fierce
loyalty to the hospital points to the continuing importance of hospitals as institutions
that both promote community and are replenished by the community.387

AGH was an institution that had pride in its history, connections with the local
community, a supportive practicing environment, and dedication to patient care. Over
the course of my research, I became convinced these features of AGH are essential for
maintaining diversity in the healthcare system of Gainesville, and ought to be studied
by other healthcare institutions, including the county health department. In a turbulent
healthcare environment, it is important to consider the lessons that the history of AGH
teaches about the nature of community hospitals and their interactions with the
community.388

Transition

On November 1st, the day that AGH closed, Reverend Richard Palmer of Grace
Presbyterian Church wrote in the Gainesville Sun, “As we approach the season of
Thanksgiving, near the top of my list I will give thanks that AGH was there, day in and
day out offering hope, compassion, healing, and yes, even the deepest of

387 Lois Wright Morton, “Small Town Services and Facilities: The Influence of Social Networks and
Civic Structure on Perceptions of Quality,” City and Community 2, no. 2 (6, 2003): 102-120.
388 Contemporary political debates about healthcare are too large a topic for this thesis. However, the
breadth of opinion and emotional vehemence in these debates are proof of the diversity of the healthcare
environment. A few key references include: H. Tilson and B. Berkowitz, “The public health enterprise:
Moscovice and J. Stensland, “Rural Hospitals: Trends, Challenges, and. a Future Research and Policy
problems - USATODAY.com,” USA Today, December 28, 2008,
http://www.usatoday.com/money/industries/health/2008-12-28-hospitals-list_N.htm; “National
http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm; Thomas S. Bodenheimer and Kevin Grumbach,
friends..." Reverend Palmer seemed to be finding a ray of sunlight in a cloudy sky. Others continued to mourn the hospital’s passing. As one woman lamented, “[Now there is] a literal and figurative hole in the center of the city.”

The razed land that AGH once stood on has already been slated for reuse. On November 29, 2010, Bernard Machen, President of the University, announced that a biotechnology research hub, Innovation Park, would be built on the site of AGH. Machen made a reference to the redirection of the former site of AGH: “The 20th century was a time when that property gave birth to babies. The 21st century is going to be where that property gives birth to companies.”

Machen’s comment marks scientific optimism and entrepreneurialism as the guiding forces of healthcare in the 21st century. “Big Science” is reemerging through privately funded, agile, specialized biomedical startups. Innovation Park, with street names like Innovation Drive and Progress Boulevard, promises the same technological improvement of life as Walt Disney’s World of Tomorrow. Scientific research has been, and continues to be, the path towards a brighter future (albeit a forgetful one). Innovation Park is predicted to bring 3,000 new jobs to the county; urban theorist Richard Florida has predicted that Gainesville will see a 17.7% increase in “creative class” jobs from 2008 to 2018, the largest growth of any U.S. metropolitan area.

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“Innovation Square will be the anchor for this employment renaissance,” current Gainesville mayor Craig Lowe said.\textsuperscript{392}

The repurposing of AGH grounds as the site of biomedical entrepreneurialism, instead of memorializing them, is a sign of how physical resources in healthcare can be recycled. Economical thinking—Taylorism, cost containment, or recycling—has remained a powerful force in the history of healthcare, and will be even more important in an era of presumed shortages and tight margins of financial viability.\textsuperscript{393} To assume the leading role in the eyes of the community, Shands Hospital is also trying to recycle AGH strategies of patient care and personnel cohesion. In May of 2010, Shands and UF announced a $540 million initiative on research and education to improve patient services. There is great interest, and political need, in preserving the kind of community loyalty that AGH fostered.\textsuperscript{394}

Human resources can also be moved around. AGH employees have mainly transferred into Shands—over 900 out of 1,156 AGH employees were transferred into Shands Hospital, nicknamed “big Shands,” or “the big house.”\textsuperscript{395} Shands executives made an effort to adjust AGH employees gently. For instance, administrators made efforts to give AGH nurses their top picks for nursing units and supervisors. Perceptions of the transition are mixed—while one interviewee described Shands as a

\textsuperscript{392} ibid.
\textsuperscript{393} It is predicted that 96\% of AGH’s bricks, mortar, glass, and steel will be reused in some way (newspaper article) Also see article “Shands AGH legacy of giving continues as healthcare system supports green practices.” Shands&UF News & Notes, Vol 5 No. 8 April 2010, 10-11.
\textsuperscript{394} Preserving the cultural and historical artifacts of AGH has been difficult, but relatively successful due to a few determined individuals. Rev. Richard Palmer reported that on his last day at AGH, “We found Lorena McAlpine down in the first floor basement going through 40-plus years of things that are too valuable to throw out, yet may not mean a thing to an outsider.” Many of these objects are kept in storage at Shands Hospital, at the Robb House Medical Museum, or the Matheson Museum. 11/01/2009, personal communication.
\textsuperscript{395} Personal communication.
“war-torn combat zone,” other physicians and executives called the transition relatively smooth. The second-most popular resettling site for former AGH employees and physicians has been NFRMC, which has grown substantially since the closing of AGH as demand for services increases. In addition, NFRMC, which now bills itself as “the only community hospital in Gainesville,” is undergoing a $100 million expansion that includes a new ICU and 92-bed tower. In some sense, there are pieces of AGH scattered throughout the healthcare setting of Gainesville—the overall system suffered a relatively small loss of resources.

The role of Shands Hospital

Shands Hospital has maneuvered to dominate the healthcare environment of Gainesville. However, it faces challenges as the largest provider of area charity care. The closing of AGH has caused a furor in the dynamics of healthcare in Gainesville, namely, an increase in the number of uninsured and indigent cases that Shands can expect to see. While Shands has a demonstrated record as a safety net provider, its

396 This hospitalist team was moved to Shands after AGH closed. The director of the program described the transition as “initially difficult,” but said that the hospitalists were adjusting to the new system and had coped well with the process. As of 2010, two of the nine hospitalists that transferred to Shands are now employed at NFRMC. (personal communication)
397 Two months before AGH finally closed its doors, admissions at NFRMC shot up by 6%; ER admissions were up 13% and six new ER rooms opened in November 2009. In 2010, occupancy was consistently at 110-120%. North Florida Regional Medical Center Community Benefits report, 2010. Gainesville, Florida. An NFRMC executive proudly told me that “there is not a single taxpayer dollar” involved in the financing of this project. (personal communication)
398 Shands also preemptively asserted its own claims to community engagement by publicizing its contributions through newspapers and in public meetings. In 2010, Shands provided $152.4 million in unsponsored community benefits, and was the second largest “safety net” hospital system in the state. Shands was one of the largest employers in Gainesville, with more than 12,000 employees.
399 Diane Chun and Cindy Swirko, “The End of AGH: A look at what's ahead,” The Gainesville Daily Sun (Gainesville, Florida, July 12, 2009), 1st edition, sec. A. A July 12th, 2009 Sun article quotes former Mayor Pegeen Hanrahan speaking in defense of the different obligations that for-profits such as NFRMC have from non-profits such as AGH and Shands: “A nonprofit is called a public charity because they are given a tax exemption and they are required to do a certain amount of charity work. North Florida
actions suggest that it is caught between its obligation to the entire community, and its drive to be a competitive, income-maximizing hospital.

Shands seems to define community care as providing care to economically disadvantaged individuals. It has made alliances with Solantic, a chain of walk-in urgent care centers. In late 2009, Shands and Solantic announced a new urgent care center in AGH’s former Ayers Plaza for patients with Medicaid, and for uninsured patients with co-pays of $1, 2, or 5. However, traffic at Solantic remains light compared to that of the new Shands Critical Care Center, which, although larger than the original Shands ER, has recently reported wait times of over twelve hours. Shands has plans to address the needs of east Gainesville by building a new Shands Eastside Clinic in 2011 and expanding the Shands Eastside Community Practice. Shands has also helped the Alachua County Health Department hold extended clinic walk-in hours.

Shands is pursuing two divergent but hopefully complementary goals: creating a strong base for community care, and also building specialty hospitals that are designed to bring in paying patients. In 2008, Shands sold its three rural hospitals to a for-profit hospital management corporation. Concurrent with the closing of AGH in 2009 was

Regional is our second highest taxpayer. I don’t feel that a private hospital has the same obligation to the community as a nonprofit hospital.” The distinction between not-for-profit and for-profit is tied to expectations of serving disadvantaged groups, and has financial implications.

Personal communication; this could not be verified in the literature. However, Florida ranks 43rd out of 50 states for ER wait times. One particularly concerning facet of this story is that 27% of ER patients are children; plans are in the works for a children’s ER at Shands with the establishment of a women and children’s hospital. A Pediatricians After Hours (PAH) clinic has been created, through the collaboration of Shands and community pediatricians, but this is not an emergency facility. Diane Chun, “ER care for kids "stinks"," The Gainesville Daily Sun (Gainesville, Florida, January 30, 2009), sec. A.

Shands Healthcare also sold the three rural hospitals that it had acquired from SantaFe: in 2008, Lake Shore, Live Oak, and Starke Memorial Hospitals were sold to Health Management Associates, Inc., a for-profit national hospital management firm known for its ability to “turn around” struggling hospitals. (Shands retained ownership of Shands Vista Rehabilitation.) Hospitals in Williston and Lake City have been closed for financial reasons, and Ocala Memorial Hospital is struggling to meet budgetary restraints, especially with a surge in the number of undocumented and uninsured patients. The story of rural hospitals is especially troubling—the lack of rural healthcare hospitals, and the dwindling number
the completion of the Shands Cancer Hospital, a $388-million, 192-bed facility with state-of-the-art technology across the street from the original Shands Hospital. In September 2010, Shands announced its intention to establish a women and children’s hospital within existing Shands space for $100 million.

Shands is not alone in its decision to return to the specialty hospital model of the early 1980s. In 2006, researcher Kelly Devers wrote of academic medical centers, “As the battle for doctors and patients become more intense, the mimicking and one-upmanship of the eighties is returning.”

The feedback loop in healthcare ecology can be preserved if technology-intensive, expensive specialty hospitals can provide the revenue necessary to replenish services that provide more uncompensated care. However, history shows that more often than not, competition drives hospital systems to invest ever more heavily in their prizewinner specialty hospitals, creating disparities in resources for healthcare institutions, and leaving general hospitals by the wayside—which ultimately hurts the health of the community.

Paying for Care

As Rosemary Stevens suggests, hospitals are self-regulating organisms driven very much by desire for financial preservation. The fundamental issue for Shands and NFRMC as they redefine community care in Gainesville post-AGH is how they are paid for this care. Payment determines which physicians and patients a hospital will try

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of rural healthcare practitioners suggests that rural areas will face greater problems in meeting healthcare needs in the coming decades unless changes are made to incentivize healthcare providers to remain in these areas. A just discussion of this topic would be an entirely different thesis.

to attract, how aggressively it will compete with other hospitals, and if and how it chooses to address healthcare disparities, all of which have implications for power relationships within the hospital and institutional goals. It is well established that hospitals do not operate purely on market forces, and I follow the reasoning that less “efficient” hospitals are not, and should not be, “naturally selected” against. Efforts to shift costs affect patterns of care—when costs are shifted to the patient or services are cut, the people who suffer most are often those with the least power to resist these cutbacks.

Given the specialization trend among academic medical centers, it is easy to see that general community hospitals in academic medical systems, like AGH, are at high risk for severe cutbacks or closing. Legnini et al. indicate that it is the delivery of clinical services, not teaching or research costs, that drive an academic medical center’s strategy for cost structure. In light of this, the fact that academic medical centers such as Shands, which make up 2% of the number of hospitals in the US, account for 22% of

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404 Stevens, 338
407 MW Legnini and Emily K. Waldman, Academic Medical Centers and the Culture of Local Markets (Economic and Social Research Institute: W.K. Kellogg Foundation, August 1999),
uncompensated care, suggests that these hospitals need to have outside reimbursement for self-initiated policies that address the needs of local disadvantaged groups.408

Standards of payment are now largely determined by national and state policy, which point to the importance of reestablishing trust and mutual decision-making in the government—not for profit hospital relationship.409 What is needed in this relationship is a return to the true definition of medical professionalism, as laid out by Timmermans and Oh:410

Professionalism is a social contract: claims for specialized and valued skills meriting legal protection provided by the state. In return for state-sanctioned economic market shelter and legal privileges of training and certifying new members, profession expected to focus on needs of clients using scientifically validated knowledge.411

Hospitals must demonstrate “specialized and valued skills” by providing a high quality of patient care, providing charity care when necessary, and promoting community and preventive health through community outreach. Hospitals must maintain the passion to pursue continual self-improvement, and have the courage to not fall back on justificatory language of unsympathetic, scientific management.412

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409 While hospitals negotiate with insurance companies, insurance companies base their rates off expected Medicare and DRG reimbursement rates. Greater federal oversight of healthcare may further alienate private institutions that were caught between the vicious debates between supporters of government reform and supporters of corporate medicine. The effects of the 2009 Affordable Care Act remain to be seen, and is a topic too complex for me to even speculate upon here.

410 Regulation is not enough—Crozier’s theory of a “bureaucratic vicious circle” predicts that regulation increases in intensity and detail until the institution is paralyzed: “Each attempt provokes a new effort to evade these controls, until concerns of quality and accessibility disappear under the pressures to rationalize physicians’ cost-inducing behavior.” Therefore, what is really needed is a redefine relationship that balances powers and responsibilities. (36) Crozier quoted on (186) David W. Young and Richard B. Saltman, The hospital power equilibrium: physician behavior and cost control (Johns Hopkins University Press, 1985).


412 In times of crisis, hospitals fall back on financial language to justify hardliner positions that prioritize corporate practices, patient volume, and cash flow over less tangible factors that are important to quality
The state, in return, must change the mechanisms through which it reimburses hospitals for providing care to disadvantaged populations. More specifically, at the state level, the Medicaid system needs to provide reimbursements equitable to those of Medicare if it is to be considered a desirable source of income for hospitals. Gamm and Benson have indicated that the government can coerce hospitals to become more charitable by challenging their tax-exempt status, though it is not clear how desirable this is. As AGH’s antagonisms with local government show, however, governmental changes must be sensitive to individual hospitals’ desires and claim of autonomy to avoid unintended consequences.

State support is unlikely in this climate of hardnosed fiscal conservatism. Alachua County does not have the financial resources necessary to incentivize local hospitals. More troubling, in May 2010, then-governor Charlie Crist elected to cut $9.7 million in state funding for Shands Hospital, which amounted to a total of about $21 million loss for 2010 for subsidizing the care of Medicaid patients. Furthermore, Rick Scott, current governor of Florida, called nonprofit hospitals “non-taxpaying hospitals” and described them as staid, inefficient, and totally out of touch with real-world

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of patient care. This is the hospital’s “survival mode;” the danger is that it is easy to think in terms of survival mode all the time and allow that thinking to influence core institutional philosophy.

In addition, Brown compares the history of Medicare and Medicaid and concludes that a national system must be implemented if the two populations of patients are to be treated equally. People don’t want to pay for healthcare systems that they don’t derive benefits from. E. Richard Brown, “Medicare and Medicaid: The Process, Value, and Limits of Health Care Reforms,” Journal of Public Health Policy 4, no. 3 (1983): 335-366.

Larry D. Gamm and Keith J. Benson, “The Influence of Governmental Policy on Community Health Partnerships and Community Care Networks: An Analysis of Three Cases,” Journal of Health Politics Policy and Law 23, no. 5 (January 1, 1998): 771-794. Gamm and Benson also suggest that single payer insurance could incentivize more medical students to go into family practice, and that community partnerships could monitor hospitals for corruption or wastefulness.
business concerns, which signals a more hostile attitude towards hospitals that deliver charity care.415

Preserving the spirit of AGH through community activism

The government only has incentive to change its behavior when its constituents threaten to withdraw political support. For those who mourn the loss of AGH, the most significant way to remember their hospital is to use the government as a mechanism to fight the factors that led to AGH’s closing. Already-existing groups such as the former AGH Auxiliary, the Shands volunteer base, and the Alachua County Medical Society seem like ideal leaders. To preserve community institutions of healthcare and create more trust in the provider-patient relationship, local citizens should advocate for social reforms in areas from healthcare to housing that will create healthier communities. Interventions such as rehabilitative programs, therapy, and more supportive care of these patients would have greatly reduced some of AGH’s need to care for patients that created revenue loss.

In addition, greater physician empathy for adverse social conditions might help reverse the disturbing trend of declining trust in medical professionals. Trust in physicians has been declining for decades—72% of patients said that they trusted their doctors in 1966, 37% in 1981, and even fewer in 1998.416 Empathy, cultural sensitivity, and structural changes that emphasize holistic care will provide the basis for more personalized “AGH-style patient care.”

415 It should be noted that Rick Scott is an ex-CEO of HCA/Columbia, forced to resign in 1997 during one of the largest federal investigations of fraud in the hospital industry in American history. See: JD Kleinke, “Deconstructing the Columbia/HCA Investigation,” Health Affairs 17, no. 2 (March 1998): 7-26.
As shown by the disparities in patient population caused by AGH’s geographical location, it is possible to map the health-related effects of historical racial and socioeconomic disparity.\textsuperscript{417} Work like that of Sara McLafferty’s speaks to the urgency of creating these dialogues. She has found that the most accurate predictor of hospital closures is the percentage of black neighborhoods that surround the hospital.\textsuperscript{418} AGH’s history and closing demonstrate, if anything, the powerful impact that racial and socioeconomic inequality can have on the financial viability of a community institution. We must ask how structures of racism and poverty interact to keep these communities disadvantaged. In my research, what I found most disturbing was the implication that AGH was doomed because of the largely black and poor neighborhoods that surrounded it, and the consequent stigma attached to the hospital. If the neighborhoods around AGH can be revitalized through local activism—and I believe that they can be—then AGH could have been, too.

\textsuperscript{416} Timmermans and Oh, S97.
\textsuperscript{417} In fact, some researchers already have. See: Chris Graziano, Nick Lehman, and Dani Cano, “Spatial Analysis of the Characteristics of Poverty in Alachua County” (PowerPoint, Gainesville, Florida, 2005), http://www.google.com/url?sa=t&source=web&cd=1&sqi=2&ved=0CB0QFjAA&url=http%3A%2F%2Fweb.dcp.ufl.edu%2Fjuna%2Fstud_work%255Cspring05%255Cteam4.ppt&ei=jYV5Tcu7BqrC00GFwp30Aw&usg=AFQjCNFsLPrS3S5UpdmP7g2Cv4Bx2OLw&sig2=h6rOm_LPp28pfVyt1nnQ.
\textsuperscript{418} While this analysis is disturbing for the causal links drawn between racial patterns of residence and institutional failure, it does point to the fact that disadvantaged minority and socioeconomic groups who most need access to care are the ones denied access. Sara McLafferty, “Neighborhood characteristics and hospital closures : A comparison of the public, private and voluntary hospital systems,” Social Science & Medicine 16, no. 19 (1982): 1667-1674. The literature suggests that hospitals in rural settings, that undergo management changes, and that face competition from free-standing nursing units are most at risk for closing. Technology and changes in physician makeup are protective effects. Hospital closings have an overall negative impact on total local resources, since any benefits may be nationally distributed. Ross M. Mullner et al., “Closure among U.S. Community Hospitals, 1976-1980: A Description and a Predictive Model,” Medical Care 20, no. 7 (July 1, 1982): 699-709; R Mullner, R J Rydman, and D G Whiteis, “Rural hospital survival: an analysis of facilities and services correlated with risk of closure,” Hospital & Health Services Administration 35, no. 1 (1990): 121-137; S Y Lee and J A Alexander, “Managing hospitals in turbulent times: do organizational changes improve hospital survival?,” Health Services Research 34, no. 4 (October 1999): 923-946; Cory Capps, David Dranove, and Richard C. Lindrooth, “Hospital closure and economic efficiency,” Journal of Health Economics 29, no. 1 (January 2010): 87-109.
Local health education could create bonds in the community for a stronger preventive care network and create culturally sensitive solutions. While AGH was able to devise these kinds of solutions (and saved money while doing it, no less), it remains to be seen if Shands Hospital will have the flexibility to care for those patients in the same way.\textsuperscript{419} Civic groups, even at the layperson level, can help fill this gap by offering local knowledge and political support for more personalized medical care.

At the level of the individual institution, Shands Hospital can improve the range and efficacy of its services to underserved populations by increasing the range of community partnerships, using informal mechanisms of community-building, and taking advantage of social connections to get better patient feedback. Shands should consider feedback not only from local clinics and charitable organizations like St. Francis House, but also the African-American Accountability Alliance and Rotary International. Furthermore, Shands should more strongly encourage its physicians to participate in the Alachua County Medical Society so that private and academic physicians can work together on solutions to the county’s medical needs. Shands studies on how to provide better healthcare to Alachua County should be continued.\textsuperscript{420}

\textsuperscript{419} For example, in the 2000s, patients who ate lots of greens, a food rich in vitamin K (a substance that contributes to blood clotting) were given reduced dosages of Warfarin, a blood-clotting drug. (personal communication)

\textsuperscript{420} One of the mechanisms by which Shands HealthCare received feedback was through Community Health Fellowships through the American Hospitals Association. Using a definition of community health—reading levels, graduation rates, obesity, and poverty levels—Shands conducted studies that led to the implementation of CHOICES, a program for uninsured residents of Alachua County.\textsuperscript{420} Although there is debate about the efficacy of the CHOICES program (which will be terminated in 2011), the
Final Thoughts

AGH negotiated the scientific and the social in its management, usage of technology and medical practice, and efforts to provide excellent patient care. Its story is an example of how general trends in healthcare were influenced by cultural, social, and economic factors at the local level, and how important specificity is to consider when analyzing hospitals. Different groups negotiated claims of power, balanced costs, and determined procedural standards as environmental challenges and opportunities arose. Above all, the hospital sought to increase its autonomy in the broader healthcare setting of other hospitals and government regulation by using organizational strategies like standardization, mimicry, and ideological self-promotion.

What will be remembered about AGH is its dedication to individualized care and its homey atmosphere, its creation of a stable community in the face of a turbulent healthcare environment. This thesis has attempted to turn a critical lens upon that memory to elucidate historical trends in healthcare and suggest, through an ecological perspective, ways in which that memory can be productively used to improve the state of healthcare in Gainesville.

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conversations sparked and the people who were helped by this program are a step towards equalizing access to healthcare.
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APPENDIX 1: TIMELINE OF ALACHUA GENERAL HOSPITAL

1905: the Odd Fellows’ Home allows medical doctors. At the time, there were at least four “hospitals” run out of people’s homes, a few of which specialized in obstetric care or African-American care.

1910s-1920s: public fundraising and appeals to the City led by a group of philanthropic ladies buys the land that AGH will stand on. The doctors of Gainesville agree to commit their services to a community hospital.

1926: County Commission authorizes a $150,000 bond issue for hospital construction to be added to $50,000 previously raised by the City of Gainesville; Board of Trustees is selected by County Commission

1927: hospital construction, funded by the City of Gainesville and Alachua County, is completed. The first patient is brought in on December 31st, 1927.

1928: Alachua County Medical Society gathers to pick staff for the new hospital; hospital opens in January.

1930: AGH is accredited by the American College of Surgeons. During the past decade, the Depression brought large numbers of charity patients and uncollected accounts, resulting in financial troubles for AGH

1943: new 44-bed annex, constructed by $100,000 federal grant and bond issue, opened

1945: First class of cadet nurses at the AGH School of Nursing begins training (the nursing school is discontinued in 1957)

1947: Gertrude Overstreet retires as hospital superintendent, Louie Wilson takes over as hospital administrator. Name changes from Alachua County Hospital to Alachua General Hospital

1949: Blood Bank is opened

1953: the hospital Auxiliary is established

1960: Edwards Tower is opened. Cost $3 million, 1.7 of it from Hill-Burton.

1965: AGH is officially desegregated

1965: psychiatric wing opened (22 bed unit on 4th floor of 1927 building for $95,000) (By 1973, a patient government in the psychiatric unit is set up, and patients are

Derived from a timeline created by the Matheson Museum, documents, and Rathbun.
allowed to have lunch and dinner in cafeteria, and all-day outside activity outside Gainesville)

1968: adult outpatient clinic is co-managed by the County and AGH trustees

1970: new ER with around the clock service; Family Practice Residency is initiated

1972: NFRH opens. The first male member of the Auxiliary is accepted.

1973: family medicine residency program with UF begins at AGH

1975: $12 million Dr. W.C. Thomas Memorial Tower is opened: 187 beds, 253,000 sq ft. The first open heart surgery at AGH is performed

1976: AGH is leased from the county by parent corporation AGH, Inc.

1977: Florida legislature allows the hospital to become a non-profit corporation

1978: County Commissioners vote not to sell or lease the hospital to any profit-making corporation. The hospital officially becomes Alachua General Hospital, Inc. after the bonds are refinanced.

1979: the AGH interfaith chapel is constructed. Shands Teaching Hospital becomes Shands Hospital and operated under auspices of Shands Healthcare, Inc.

1980: Hospice joins the list of Santa Fe holdings; the AGH Auxiliary donates $10,000 to Hospice.

1981: LifeLine is implemented. The STAT flight helicopter service, shared with Shands, begins.

1983: AGH is purchased by Santa Fe for $1 and the assumption of $27 million in debt. The county commissioners give up their interest in the hospital.

1986: $1 million renovation plan implemented, AvMed acquired

1987: new 10,000 sq ft. ER, Neuroscience, Cancer registry, 10-yr renovation completed with spacious cafeteria, post-partum unit, Cardia team uses TPA

1988: MRI acquired, imaging lab, newborn nursery

1989: CancerCare center opened

1990: Neonatal ICU opened
1991: 6 LDR birthing suites are renovated and opened, the QUEST program (total quality management) is implemented

1993: ground broken for cardiac services HeartCare Center

1995: Shands Healthcare, Inc. purchases AGH, along with Bradford Hospital, Lake Shore Hospital, Suwannee Hospital, and Vista Uprreach Rehabilitation Hospital for over $100 million, the largest acquisition by a university medical center in US history.

1996: AGH is acquired by Shands HealthCare, Inc. in part of a $100 million deal and becomes Shands at AGH.

1999: Shands partners with Jacksonville, Florida hospitals to establish Shands at Jacksonville.

2002: a hospitalist program is initiated in partnership with the UF Department of Community Medicine and Public Health

2006: an attempt to establish a children’s hospital at AGH is made (it returned to Shands Hospital in 2008). In the mid-2000s, the orthopedics department and cardiac catheterization unit are moved the AGH.

2008: On October 22nd, Timothy Goldfarb announces the closing of AGH

2009: On November 1st, AGH is officially closed. Over 900 employees are transferred to Shands; another 250 find placement in NFRMC, private practice, or elsewhere. Demolition begins shortly thereafter.
APPENDIX 2: MEMORIES OF ALACHUA GENERAL HOSPITAL


"AGH has been part of my life from the beginning! Dr. W. C. Thomas delivered me and, according to family lore, he was eating a tuna fish sandwich and smoking his cigar at the same time! Definitely a long time ago... Our first child, Katherine, was born at AGH I worked for Shands HealthCare after it acquired this community hospital [in 1996]. I’ve seen AGH from several perspectives, and I have the greatest admiration for the AGH people who have served this community so well. [After the November transitions of staff and services] care will continue to be outstanding "
Marilyn Tubb
former Shands HealthCare Community Affairs vice president, Gainesville

"I started working at AGH in 1975 while I was in nursing school. Not only did I learn how to be a nurse at AGH, I learned what it means to BE a nurse. I met my first husband and had my two children at AGH. One of my children was cared for in the AGH Intensive Care Unit. Loved ones have died at AGH, friendships have been made that have lasted for those 34 years and still counting, and my two girls have also learned how to be nurses at AGH "

Ellen Fesmire, CRNFA
former Shands AGH nurse, Alachua

"My first memory at AGH was an appendectomy at age 9. Many memories will remain with me, the most recent ones being the passing of both parents. What a blessing the staff was during those dark days. AGH will live on in the stories and memories of all of us whose lives have been touched by this grand old place. Rest in peace, old girl, you’ve earned a permanent place in the hearts of all who have entered your hallowed halls. You deserve a rest!"

Rose Fulcher,
Shands at UF Food & Nutrition Services dietetic tech, Gainesville

"AGH was where I practically lived from 1960 until my retirement in 1983. We were a county-owned hospital, and we never turned anyone away no matter who it was — black, white or green. I never had a patient who had a hard time getting into the hospital. Everyone was able to get care... It was a very friendly place — a big family "

Edward Kissam, MD,
the first orthopaedic surgeon in Gainesville, who worked at Shands AGH during segregation

"I was a nurse at Shands at AGH and was especially proud to work in one of only 52 hospitals in the country listed as a Planetree hospital and the only Planetree hospital in
the state of Florida. When a patient would comment to me how all the staff seemed so caring and helpful, I would proudly tell them about what it meant to be a Planetree™ hospital. It meant looking at the whole person and treating them mind, body and spirit. I worked on the oncology floor, and so I wanted each patient to feel special and loved. The patient’s family was also very much included in this Planetree plan of care, and they, too, appreciated the difference seen at Shands at AGH We all thank the many people that helped make it the great hospital that it was."

*Gloria Parker, RN, OCN,*  
*Shands at UF Women’s Health nurse specialist, Gainesville*

"I was born at AGH, and it’s the only place I have ever worked. It is hard to know where to begin after 31 years of memories. I have had the privilege of working with excellent people who have always treated each other as family. The compassion and caring exhibited here daily is just one thing that makes me so proud to be a member of our AGH family."

*Patti Osteen,*  
*Shands Interventional Rehab Clinic clinical coordinator, High Springs*

"My siblings and I were all born at AGH, so were two of my three children. I was also an AGH employee. Four years ago, a nurse came to work on 5 East. We became best friends and later realized we were crazy about each other and fell madly in love. We have been married two years and are still crazy about each other. Great things happened for me at AGH!"

*Laurel Shelton,*  
*former Shands AGH Unit 5 East clerk and Shands at UF Hematology/Oncology Unit clerk, Gainesville*

"I began my career at Shands AGH 29 years ago. The experience led to me choosing healthcare as a lifelong occupation. I have great respect and appreciation for the AGH family and will always feel I belong to that special group. My experiences at AGH taught me about service and compassion, it was a wonderful place to grow and learn. I believe that the things that help inspire and guide your work stay with you and you can apply them wherever you are to make a difference I feel lucky to have had that AGH experience and to keep it with me throughout the years."

*Janet Christie,*  
*Shands HealthCare senior vice president of Human Resources*

FROM: Memory Wall in the lobby of the hospital, October 2009
<table>
<thead>
<tr>
<th>My memory of Shands @ AGH is when I was in Highschool, I volunteered as a medical explorer. I enjoyed the 3 years I put in hours and shadowed nurses, and one of the nurses I shadowed was my aunt who worked for AGH for 18 years at nights on the labor and delivery floor. She put her heart into every hour she spent there. I loved being there the nights she worked as I volunteered. Now I am 25 and look back at the importance of what a great program AGH held for highschool students and the memory it left many people.</th>
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<tr>
<td>I have worked at Shands AGH for 19 years. Both of my children were born at SAGH and I went through both pregnancies with many great friends that I work with. That is what I will miss most. The people I work with. We are a family at Shands AGH. We know the names of the people working in the cafeteria and they know how we like our sandwiches grilled. People in medical records know who you are when you call to get a chart. Everyone knows everyone else. That is what has made SAGH such a special place. People truly care about patients and each other, and will do whatever they can to help each other. I am not only sad that I won't be working at SAGH, but I won't be with the people who have meant so much to me the past 19 years.</td>
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<td>AGH was the worst memories and experience of my life, my father almost die in your hospital care and because of the horrified care eventually he got his hand amputated. It was hard seeing my father almost deing because of the uncaring doctors you had working for you. And you guys knew it would be your fault if he die thats why you transfered him to the Shands Hospital. So thank God you guys are closing so their won't be no more killing or bad caring for patients. I really hate the memories that I have to remember every Thankgiving and Christmas when my father was under your care and almost deing, it would of been a terrible to bare. So once again I hope you never open again.</td>
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<td>My father was in Pharmacy school at UF. They lived in the flavets when I was born. They told me the story that the day I was born was the only class my Dad ever missed to come and see me after I was born. As I was growing up they often took me to Gainesville and showed me the hospital where I was born. Both my parents have passed away but they instilled in my a love for this hospital. My niece was also born there in 1983 and we share this special bond. I am hoping to be able to have a brick or a piece of something to remind me of where I was born and the love my parents had for UF and Alachua General Hospital as they always referred to it.</td>
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<td>AGH is truly a landmark in Gainesville. My Father was a patient at AGH as a child, I was born at AGH (delivered by Dr. Charles Gilliland) and my son was delivered there also (he also was delivered by Dr. Gilliland-one of the last babies he delivered before he retired). My grandmother and great grandmother were also patients there over the years. We've always received the best of care and the staff is the best!</td>
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<td>My son who was 9 months @ the time was have lots of trouble breathing. We called the ER &amp; the nurse told us to rush him to the nearest hospital or fire station because he didn't sound strong. After arriving at the ER, they immediately triaged him to find that his O2 sat. levels were 85% and below. He had pneumonia, and was admitted for a week. At one point his sat. levels dropped to 60% and were going down. Respirators were prepared, and the nursing staff were still encouraging me that he would be fine. The doctors were thorough &amp; the nursing staff was just WONDERFUL. I thank God for them all for saving my baby's life.</td>
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<tr>
<td>I was employed by Shands AGH for over 17 years. It was a wonderful experience. The staff are some of North Central Florida's finest people...caring loving and compassionate in their work. Thank you for that opportunity.</td>
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In 1986, I was a very young nurse who worked at North FL Regional Hospital. I was 16 weeks pregnant and I lost the baby. I was so distraught and told I needed to have a D&C right away. Everyone was so wonderful and treated me with such kindness and respect. I never forgot how the nurses, doctors and staff helped me through such a difficult time.

AGH has so many good memories for me. I worked there for 12 years. I was a Nursing Manager for most of those years. It is easy to recognize now that those indeed were the good old days. Everyone knew everybody; lab, xray, pharmacy, physical therapy, surgery, dietary, it mattered not. When the normal process did not work, you picked up the phone and called...almost always with results. It was a fun place to work and we as employees were respected in the community. It will always be special to me..as my own birth place, my work place as a young nurse, and where I had both of my children.

Child of a former employee...attended and graduated from the AGH nursery. Remember visits over the years beginning with the grand entrance water fountain art, massive lobby, small gift shop and underground tunnel journeying to the connecting building across the street. Remember High School years...Checking out the specialty sales events before school at the cafeteria...spending Thursday evenings at AGH as a Medical Explorer. Remember my college major volunteer stint in the Radiology file room. Remember taking trips to AGH for breakfast/lunch or dinner breaks while working nearby.

I was born there in 1985 after my mom had her tubal undone so she could have one more child! While I do not remember being born there, I was -- as were my eight brothers and sisters. With all those siblings, we spent many hours in the ER getting stitches and evaluating busted heads. I had my tonsils out at eight, and at 12 spent a week on the peds floor after a rock hit my eye and almost cost me my sight. Then, three of my four sons were born there, and the process started again. My grandmother died there completing a cycle. It has been part of our life.

When my first child was born at AGH in February of 1979, the oldest wing was being demolished. I remember my father-in-law visiting his new grandchild but more interested in watching the crane swinging a wrecking ball. It was hard to keep him from looking out the window! We teased him for years. Little did I know that 17 years later I would become a nurse and work here at AGH. It has been an honor to be a part of this hospital.

I had all three of my children at AGH. The first was a baby boy, 10 pounds and 3 ounces. There were problems during labor and he was taken by C-section. I was told later during the delivery the nurses were waiting to see whether or not he would make it. Finally the double doors of the delivery room came open and the nurse came out carrying my baby with tears streaming down her cheeks - he didn't make it. I was also told they wrapped him in a blanket and rocked him. This was in 1980, before the babies were brought to their mothers to help with the grief process. But still, they loved my baby and I have always been grateful for that. I had a beautiful baby girl in 1981. She was perfect but something had happened during carrying her and the fingers on her right hand were missing at the first knuckle. My concern was that she would not be able to play the piano ad that children would make fun of her. The nursery nurse that night told me she could play the violin - that was her bow hand! She does play the violin now - and the piano! In 1983 I had another baby boy - he was beautiful and perfect and that birth is even documented on video tape! The first memory is bittersweet but the last two are very sweet! The doctors and nurses were the very best! Thank you - to all of you.
My husband is a life long resident of Gainesville. He started his life at Shands at AGH Hospital, and I am told he almost arrived in the parking lot. Being 5 weeks early and just over 5 pounds I know his mother was thankful for the care they both received. Additionally, our son was born 31 years later at AGH. I recall many times over our sons 7 years, my husband has proudly mentioned "my son and I were both born at Shands at AGH. My son weighed in at 11lbs 7ozs, and was probably one of the biggest babies born at AGH. He was quite a popular fellow during our stay, and this mother is also very thankful for the care we both received.

I have been under the care of Dr. Steven Roark and his staff since 1996. In 2004, I required placement of a biventricular pacemaker with ICD - I was understandably nervous. When the staff at the Heartcare Center contacted my home, my message machine came on, which starts with "You have reached the home of Florida State Football fans Rich and Linda..........." When I got to the Heartcare Center for my procedure, the staff had posted Gator welcome signs on the door of my room!!! Then the EKG tech came in, saw what had been done, confessed he was also a Seminole fan and promptly covered all the signs up with toilet paper!!! I do not think the staff really realized how much that laughter put my husband and myself at ease - being a nurse myself, I really appreciated their efforts to make a very scary situation less stressful.

My children were both born there in 1958 and 1960 when Dr. W.C Thomas was still delivering babies. 4 bed wards were the in thing at that time. My 1st memory at AGH was an appendectomy @ age 9. Ether was the knock out drug of choice (Ugh). Many memories will remain with me, the most recent ones being the passing of both parents. What a blessing the staff was during those dark days. AGH will live on in the stories and memories of all of us whose lives have been touched by this grand old place. Rest in peace old girl- you deserve a rest!

My first great grandchild was born at Shands AGH. Fifteen years ago one of my grand daughters was born there. The difference was that this time I was blessed to be in the delivery room and witness the birth of this new baby boy. The nurses and doctors at AGH were so wonderful and accommodating. We had six friends and family members in the room and none of us were asked to leave. Our experience at Shands AGH was great and it would be a crying shame if this hospital were to close. I hope and pray that somehow this hospital that is so important to Gainesville will be able to stay open for business!

My first day on the job at AGH was the first day of the SantaFe HealthCare-AvMed union. I was a public relations coordinator, and it was also my first day in healthcare. So many employees stepped up to educate, train and enlighten me about their passion for their patients, about the amazing services and care provided, and the closeness that was AGH. I was immediately welcomed into my new family and loved it. One of my responsibilities was to support medical staff by writing articles about their achievements and services and taking photos of surgical procedures. One memory wears me out thinking about it: the opening of the new emergency department. Our administrator insisted on at least a dozen open houses at various times of the day and night--and I was responsible for each one being a success. I've since worked with AGH employees as an SHC HRD coordinator, and I'm still greeted as a family member. Some things never change!

I was born at AGH, and was delivered by Dr. Herbert, 21 years later and just over a year into my nursing career in labor and delivery at AGH, my daughter was born, and Dr. Herbert delivered her as well. Three years later Dr. Jordan, delivered my son, and I continued to work in L/D for the next 33 years. I have loved my time at AGH, and my experiences helping moms and dads bring thier little ones into the world. What I will miss most is that AGH family, and those everlasting
friendships I have made over the years...........

AGH was the first hospital I worked in after moving to Florida. I had surgery there and decided that I wanted to work with the people I met because they were all so nice to me. I started in the Acute Dialysis Unit and stayed there for nine years. Thanks for all the memories.

One of my very first childhood memories is standing on the AGH grounds near the flashing traffic light that had the "quiet" sign under it waving to my Mimi. She was recovering from gallbladder surgery and someone helped her to the window so she could see my sister and me. It was probably the last time I saw her and I still can remember the big oak tree and the yellow walls of the hospital and her waving back to us. This was in the summer of 1953.

A picture of me and a co worker baby that works in pharmacy was on pamphlets and bill boards for shands@agh for about 8 months. Everyone knows me from that, plus being employed @ agh on the motherbaby floor & l&d.

I will never forget the kindness and professionalism of the staff of Shands AGH. Two months after having my son at AGH in 2002, I had to be admitted into the hospital due to some health issues/surgery. During one of the procedures, complications arose, but thanks to the incredible staff, I was revived. Even when in the SICU, not once did I worry that I was in capable and loving hands. I will miss AGH and its staff, you are truly a shining example of excellence!

I was born at Shands@AGH in 1965. I remember my mother taking me to Shands@AGH to get my immunization shots, I think the Health Department was located at Shands@AGH. If I am wrong someone please correct me, but I remember getting my shots at AGH. I can never forget getting immunization shots.

AGH has been an integral part of my family for 50yrs. My mother went to the AGH Nursing school in the early 50's and worked at AGH all her nursing career, eventually becoming Director of Nursing before her move to Santa Fe Healthcare as a Vice President. My twin sister and I were born at AGH in 1957 and we practically "grew up" there. We were one of the first to be enrolled in AGH's daycare in the early 60's. We explored the world of nursing as candy stripers in the early 70's. Eventually at sixteen our first job was working weekends in the hospital daycare. As a senior in high school planned on becoming a pharmacist so I transferred to the pharmacy to work as a technician. There is where I met my wonderful husband, who was a Pharmacist on staff. We have been married 31yrs and have two sons who also were born at AGH in 1981 and 1984. My two sisters and I followed in our mothers footsteps and are all RN's and are working or have worked at AGH and Shands at different times during our nursing careers.

Well I am very sad to AGH go I wish Alachua County would take the hospital over this way it would be able to have people employment status saved as well as an institution for Healthcare remain intact in the community. My grandfather passed in Alachua General about 11 years ago and every time I go there I remember myself telling I love him for the last time.

My Grandmother was moved to AGH and then a Hospice room at AGH from a nursings home. Because it was convenient to work and home, I was able to stop by on my way to work and home every day. I will always be grateful for the opportunity to have those moments with her.
I was born here at AGH, and it's the only place I have ever worked. 31 years of memories, it is hard to know where to begin. I have had the privilege of working with excellent people who have always treated each other as "family". The compassion and caring that is exhibited here daily is just one thing that makes me so proud to be a member of our AGH family.

I was born at AGH on a cold January afternoon in 1967. Dr. James Bledsoe told my Mom "Dollie, you have a beautiful little girl". Mom told him "don't lie to me, you know I had another boy". The nurses and Dr. B, all laughed as he proved to her I was a girl. I heard this story many times during my life.

My family always went to Shands at AGH. They all loved the nurses and the care they received was beyond excellent. Many of relatives has stayed there and always complimented on the quality of care. Even though you waited a extremely long time when you did get seen the doctors gave you a complete examination and took there time with each patient.

I am writing this on behalf of my daughter who was the first baby to go home in a red christmas stocking. She was born a month early and babies were usually transferred to Shands but Dr Zavelson decided to keep her in the special care nursery at AGH and she did great. She was home by Christmas. I still have the brochure that her picture was in for the hospital news. With fond memories...

I worked at Alachua General Hospital for many years in the 1970's and 80's. When I lived in Gainesville my son was born there in a wonderful birthing room with a brass bed and beautiful wooden floors. What fond memories of working with patients and with a wonderful medical staff.

My son was born at AGH. At 19 years old I had never been to the hospital. Never had any type of surgery not even the first suture. The nurses and the doctor at Alachua General Hospital helped me bring my greatest joy into this world. For this I will be forever greatful.

I had my daughter, my first child, at Shands AGH. She was born on July 4th. It was such a beautiful experience. Everything was perfect and the staff were all a big part of that. I never did go back to let everyone know how much I think of those first three days of being a mother and how much I think of everyone that helped make that time in my life so full of wonderful memories. So if you were there and you remember: THANK YOU AND GOD BLESS!

On Mother's Day weekend I traveled to my mother's in Keystone Heights. She had a damaged mitral valve and was being treated with drug therapy by UF/Shands physicians. An antibiotic prescribed by a local doctor put her in renal failure and she coded Saturday night at Shands/AGH. However, through that horrendous night, Shands doctors saved her life, was blessed to be put on the Everest procedure list and through our Shands related doctor, Dr. Rourke, had her valve non-surgically repaired at Duke University. She flew up to Atlanta by herself for Easter this year. I'll never forget the love and kindness shown by everyone in the Emergency Room where even the maintenance man said he was praying for us. The doctors, nurses, physical therapists and social workers...all were so very kind, and became like family to us over those two initial weeks in early May, 2008. I know we won't have mother forever, after all she is 87. But through the compassion and dedication of the Shands team, our mother's life was given back to us, and her quality of life was even restored through the tremendous medical attention of Dr. Rourke's practice. I hate to think of AGH closing. I had a finger literally stitched back on at AGH when I was a student at UF in 1972. However, I also know that the excellent medical care afforded my mother was not because of bricks and mortar, but because of men and women who are committed to their calling in the medical profession, and because of their love for the patients they serve.
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<th>I have been working for AGH for twenty-six years. The stories and experiences that I have had there is no book big enough to cover it all. From all the learning and teaching from the doctors, to all the friendships that I have made with persons. I feel I have been so lucky to have experienced here with such great people. This is my home and it will always be home. I loved AGH.</th>
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<td>I would just like to say that when my son had surgery on his knee at AGH the care we received was great and the employees were awesome and I hate to see the doors close.</td>
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<td>My daughter was born there. The Staff and service was Outstanding. Many thanks and Blessings!</td>
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<td>My first child was born at AGH in 1998. The staff was impeccable and my experience was fantastic.</td>
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<td>I started working at AGH in 1975 while I was in nursing school. I have either been an employee or had staff privileges at AGH for the last thirty four years. Not only did I learn how to be a nurse at AGH, I learned what it means to BE a nurse. I met my first husband and had my two children at AGH. One of my children was cared for in the ICU at AGH. Loved ones have died at AGH. Friendships have been made that have lasted for those 34 years and still counting. My two girls have also learned how to be nurses at AGH. The day that door closes and the lights are turned out for the last time will be a tragic loss for this community.</td>
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<td>I love the fact that I gave birth to my first child in the same hospital where my mother was born and where her first, my sister, was born. Many family member were born there, throughout the years but, I especially love that I became a mother where she became a mother and where she, herself was born.</td>
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<td>I think Shands should ask Alachua County to take the Hospital over and instead of doing budget cuts Alachua County should offer all current Shands at AGH and all Sante Fe Health Care employees that worked for AGH that are still employed to buy back their time in which this will still keep many people employed. If this happens Alachua County unemployment rate will go down and would look very good.</td>
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<td>I was a nurse at Shands at AGH and was especially proud to work in one of only 52 hospitals in the country listed as a Plane Tree Hospital and the only Plane Tree Hospital in the state of Florida. When a patient would comment to me how all the staff seemed so caring and helpful, I would proudly tell them about what it meant to be a Plane Tree Hospital which meant looking at the whole person and treating them mind, body and spirit. I worked on the oncology floor and so I wanted each patient to feel special and loved. The patient's family was also very much included in this Plane Tree plan of care and they too appreciated the difference seen at Shands at AGH. We all thank the many people that helped make it the great hospital that it is and was.</td>
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<td>Our first, and long-awaited grandson was born there in May. My husband and I were very impressed w/the care our daughter-in-law and baby received. Thank you so much. I fell in love w/the hand-painted ceiling tiles. What will happen to them?</td>
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<td>I will never forget A.G.H' I will always retain this hospital in the mind. I have been in and out of A.G.H for nearly all my life. (Over 50 Years) Alachua General Hospital is The Best Hospital in Gainesville Fl. &quot;I mean the best&quot; I hope a blessing can save this hospital, I really do. There is no place like home. At A.G.H I feel at home, This just how the people make you feel' I am in tears as I type this message. God bless us all. I LOVE ALACHUA GENERAL HOSPITAL.</td>
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Having worked at AGH for 26 years, I have come to think of co-workers as my "family". Everyone knows each other, everyone is friendly and always says "good morning", or "how ya doing". I will never forget all the wonderful physicians, nurses, techs, etc. who made AGH the only place where I would want to take my family, if ill. Tent parties, Santa Claus, Duval kid's band and chorus, Christmas trees for needy families, ice cream socials, the great hospital auxiliary. All these things made AGH the place where I was proud to work.

Some of Gainesville's finest people were born there. I don't remember being born there but I have the paper work to prove it -as well my four siblings. I have many memories of visits to Alachua General Hospital over the years! I can remember one time visiting & we weren't allowed in to the room to see a new member of the family for some reason-so we all gathered outside on the huge grassy area below the window where my mom was staying (now the south west side parking lot) & we all waived up to my mom & the new baby.

My earliest memories of AGH start with Dr. W.C. Thomas. He was our family doctor, not just a "baby doctor". He delivered my sisters and brother here. His partners delivered my children here. He founded this hospital and was proud of it. I have worked here for 22 years. The AGH staff is a family, not just employees. I will certainly miss AGH and the family feeling. The community will miss AGH. Many fine doctors have called AGH home. The hospital may go but the memories will stay forever.

I had my gall bladder removed a few years ago. And I loved the surgeon. But my aftercare sucked. I dont know the nurses name, but she was rude and had no bedside manner.

I'm a nurse and did a lot of my training at AGH about 100 years ago (okay, it was just over 35 years). I later helped train others who worked in the OR. But my fondest memory is that I gave birth to my one and only daughter there. We incorporated the little t-shirt she got into a quilt. Now 27, she still has a tangible souvenir from the hospital.

AGH was the heart of health care I was born there. My 1st cousin was born there the same day. He worked with St. Francis House. I'm from a huge but close family and I spent so much time at AGH I still remember the phone number after 25 years away...I spent a summer there with a broken leg after 2nd grade..My dad passed away there after an automobile accident. Everyone was like family...so nice...many of our friends worked there. LOTS OF LOVE THERE!!!...I was there so much with family and such that I joked when I was there I was just doin the AGH shuffle...God bless all of you for caring about all the people in our area...Farewell Alachua General Hospital...Thanks for the memories! God Bless!

I was employed with AGH, an excellent place to work. The healing tree was lovely. Me and my daughter love their carmel frozen coffee. I had surgery and was on the 4th floor, the nurses were great, caring, and very helpful.

2 all who R a part of Shands AGH. FROM THE BOTTOM UP 2 THE TOP DOWN, TAKE CARE OF SHANDS AGH STAFF MEMBERS/NURSES/DOCTORS IN THE WAY THEY TOOK CARE OF SO MANY OTHERS! MY BROTHER WAS A DIALYSIS PATIENT AT SHANDS AGH 4 MANY YEARS. WHEN I THINK OF SHANDS AGH, THE ONE THING I REMEMBER HEARING THE MOST IS HOW ALL OF THE NURSES, DOCTOR'S AND STAFF MEMBERS TOOK GREAT CARE OF HIM. Thanks For Making a Difference In The Lives of So Many!

Ummm my memory about shands is like going there for surgery many times and being born there my mother sad that i was very big and yellow when i came out i think that was cool
I am happy that I have given birth to my three sons at AGH. I have been employed there as well. The past 8 years, being employed by a device company, I have been able to provide patient care at AGH. This will be a huge loss for our community and my family.

The staff in the Radiology/Mammography department at Ayers has always been so welcoming and friendly. The entire team made the mammography experience less intimidating and scary. Your kindness and attention has been so greatly appreciated. Thank you for truly caring for your patients! I know you will all take this compassionate care with you wherever you go. I sincerely hope you stay in the Shands system! Many thanks.

When my son was born 7 weeks early the NICU nursing staff were wonderful. They helped my husband and I understand what the treatments were and why they were being done. There was a nurse that took the time to teach us how to do infant CPR.

I had the privilege of working at Shands AGH for nearly 5 years. My two oldest girls were born there. I will never forget the wonderful care and service received from the staff on the Mother-Baby unit and every department. Losing Shands AGH is losing a part of my children's memories - losing a part of their past. As I had also worked there, it's also losing a place I called my second home. There's a lot of love in Shands AGH.

I came to AGH to deliver my first child. Upon registering I was taken to a labor room. I'll always remember this tiny, green-tiled cubicle. There was barely enough room to fit me into this space on a stretcher. The RN who monitored me and my husband who coached me had to keep changing places in the room as I progressed through my labor! What made the strongest impression, however, was the "window" - a lighted x-ray viewbox with tied-back curtains. My second son was delivered in 1984 - gone were the labor cubicles with "windows." One thing that remained the same for both delivery experiences, however, was the excellent care my family and I received.

I have precious memories of Shands at AGH because my sweet baby boy was born there. I had a wonderful experience there and the nurses and medical staff were great. I am very sad to hear of the closing because we no longer live in Gainesville and moved from there when my little boy was 14 months old. When we pass through again, I always wanted to show him where he was born but can't anymore because of the closing. I will always hold special memories of Gainesville and Shands at AGH because he was born there.

While an employee at AGH, I remember the fresh and breathtaking flower arrangements that Auxilians would assure would rest on the table in front of Dr. Thomas's picture in the Lobby. A respectful tribute to a man who did so much for AGH, and meant so much to our community.

I was born there so I am a native GATOR. I still live in and love Gainesville. Growing up I made a few trips to the emergency room and in 2008 I had reconstruction breast surgery and got to stay in the new wing. The nurses were great and the room was like being in a hotel. What a wonderful experience for a not so wonderful situation! With the closing of Shands AGH I will miss my hospital...

I worked @ AGH ER for about 17yrs. It was my home and the co-workers were my family. 4 generations were born @ AGH. My X-Mother-in-law, X-Husband, my daughter and her son. There was never a question where my family would go to seek medical care...AGH was our hospital. I will always have the memories but it is hard to say goodbye.
AGH has been part of my life from the beginning! Dr. Thomas delivered me and, according to family lore, he was eating a tuna fish sandwich and smoking his cigar at the same time! Definitely a long time ago...Our first child, Katherine, was born at AGH. In my 30-year career, I worked for North Florida, competing with AGH; then I worked for AvMed-SantaFe and my office was in Ayers Medical Plaza; then I worked for Shands HealthCare, after it acquired this community hospital. So I've seen AGH from several perspectives and I have the greatest admiration for the AGH people who have served this community so well. As we move to a two-hospital system, we are blessed with two excellent organizations and care will continue to be outstanding. It's just the sense of community ownership that is disappearing. And that's the rub.

All 3 of my girls were born at AGH. AGH is just a wonderful hospital and i am sad to see it close. I truly wish they will turn it into a birthing hospital...since the Ayers building is where most of the OB doctors are. I love AGH and will always remember them helping myself and my family!

Our adopted son was born at AGH in January of this year. It was an amazing time in our lives and the staff could not have been more welcoming of both our family and friends and that of his birth mother. We were given our own room and allowed to do everything as if we were his birth parents. The staff truly went out of their way to make sure our little man had the best start possible. He is now six months old and could not be more perfect. We will truly miss AGH and its dedicated and caring staff.

I worked @ AGH, then transferred to Shands Jacksonville. AGH still had the "community hospital feel" while I worked there. You got to know a lot of people in a short period of time. I do miss the smaller atmosphere & always will. I learned soooooo much working w/ my Hospitalist Physician Group. They were TREMENDOUS!

Have you ever found a person that remembered EVERYONE'S name they EVER met? That was the Administrator of AGH in the '80's. It didn't matter what you did for work at AGH, he would greet you with his "How in the Health are you?", ask your name, and use it to greet you from then on. He never forgot a name!

One of Gainesville's original Doctors was Dr. McChesney. He rode to the local folks homes on horseback with his medical bags strewn over his horse behind his saddle. He later went on to work at the AGH Emergency Room. In retirement, he would drive his wife to the AGH Beauty Shop every Friday to get her hair done. While waiting for her, he would come to my office and tell me a (usually humorous) story. What a gift it was to know Dr. McChesney.

I was a Surgical/Sterile Processing Tech and "I Loved My Job". I had to stop working due to illness. I was finally diagnosed in 2007 with Waldenstrom's Lymphoma. It's very rare and non curable. All the nurses at the Cancer Care Center at AGH were WONDERFUL!! Dr. Manuel de la Puerta was my doctor. He was the Greatest! That man help save my life several times during chemo,due to the fact that I was allergic to the Rituxin. But I'm sorry to see AGH go. SHANDS was it's downfall from day one. And that's the truth!! But as an employee, what could you do about it? NOTHING!! We all seen the difference. AGH wasn't a family anymore after SHANDS took over. AGH...RIP.

My son was born premature at AGH, and as a dad I was real concerned about his life, if he would make it though this ordeal. A friend of mine from church came by and offered to pray with me in the chapel downstairs. During the prayer in the chapel, a peace came over me and assured me that all was going to be fine. With the help of the nurses and doctors at Shands at UF, my son was sent home with his mom and me 3 months later. He is now married and has a daughter of his own. Thank you for all your care and help so many years ago.
My father was first to practice Urology at A.G.H. He began a surgical unit there. I remember waiting for him in the parking lot while he made hospital rounds.

I fondly remember my spouse telling me she/he came back from break to find his/her supervisor standing in the hall crying. First thought he/she had was, someone has died in the dept. No---only that AGH was closing and everyone would be out of a job come Oct! Phew! and I thought it was something Serious!! Oh wait; he/she CAN have a job (Thanks Benevolent Monolith), but on a DIFFERENT SHIFT, at Shands U/F, so here we go with a "Hunting Permit" a.k.a. : Expensive Parking Decal. Way to go, Goldfarb and Machen.

One day in 2002, in the now empty 5 East nurses station, several of the female employees were talking about how good it makes them feel when they receive flowers from a man. Dr. Bruce Stechmiller was sitting there just taking it all in and being very quiet. During the conversation, I mentioned that I did not remember the last time I received flowers from a man. Later that day a dozen of the most beautiful orange roses were delivered to me at the nurses station on 5 east. The card said from "a secret admirer". After process of elimination and in light of the earlier conversation of the day, I called Dr. Stechmiller's office to ask if he was the "secret admirer". I could hear him in the background saying "Yes, I mean NO". It really made my day and all the other girls were sooo jealous! Thanks, Dr. Stechmiller, you are a gem!

I was born at AGH. My son and daughter were also born there. That hospital has been there for long time I hate to see it close down. There has been alot of people helped at that place.

We have two lovely memories of Shands at AGH. Our very first child was born there and our second child was born there, in the same operating room with most of the same staff. Both were delivered by Dr. George Buchanan's capable hands!

My siblings and I were all born at AGH and two of my three children were born at AGH. Four years ago a nurse came to work on 5 east. We became best friends and later realized we were crazy about each other and fell madly in love. We have been married two years and are still crazy about each other. Great things happened for me at AGH!

I graduated in the first class of Alachua General Hospital. There were 14 of us in the class. I met my husband through an underclass mate. He and I were married in the living room of the nurses' home, between semesters of the U of Florida where my husband was a student. We had a wonderful 50 years of marriage before I lost him to cancer.

My oldest daughter was born at Shands AGH. There is no day in a mother's memory like the day she meets her child for the first time. For these past several years of motherhood, I have looked back on the joyous event of my daughter's birth with such fondness. It was not until giving birth to my son in a different state and hospital that I realized how much of my wonderful experience had to do with the caring doctors and nurses at Shands AGH. I thank you for taking good care of me and my precious child during those first days of her life.

At age 17 I began my nursing career at AGH. For three years, I went to the School of Nursing at AGH, graduated and became an RN with a diploma. The physician and RN staff served as our instructors. AGH was the only hospital in the area until Shands at UF opened in the late 1950's. The education I received at AGH served me well during my nursing career until I retired. I had the privilege to be employed at AGH as an RN with direct patient care and later specialized in OR nursing. The professionalism at AGH during the years has been second to none. Excellent physicians and nurses have always been accessible and caring, giving it a home-like atmosphere. I have been a patient at AGH several times including giving birth to my two children. Many changes have come to Gainesville since AGH opened in 1928 but loosing a main-stay like AGH will be a great loss to this community forever.
I had a unique opportunity Fall 2008 as a contract case manager. I have 29 years of nursing experience, predominately in the inpatient setting. What stood out the most is how the entire staff was extremely happy and friendly. Good Luck

I'm proud to say that a long-awaited first grandchild was born at AGH 8 years ago. I was a bit surprised at how nice everything was in the birthing room. State of the art equipment and extremely caring personnel. What I loved 2nd best were the individual hand-prints and words on the ceiling tiles. What a terrific idea. Hope you all are bringing those tiles over to Shands.

At the age of 18, I entered the AGH School of Nursing. I graduated and took the RN state boards. I was employed by AGH and I received a check for $75 dollars for my first 2 weeks of work. I was employed by AGH for 36 years. Most of the time as a member of the management team. During this employment in 1978, I went to Santa Fe Community College and received an ADN then transferred to the University of Florida and received a RN BSN in then a MSN, all the time still employed by AGH. My memories of AGH are very positive from growing up during nursing school to further my education and being involved in such programs as the development of Hospice and the association with the other hospitals in the Santa Fe Healthcare system. The fondest memory were the people I worked with. Lasting relationships were formed that continue today. AGH was ingrained as part of my identity. Two generations of my family were born at AGH. My 3 daughters who were all born at AGH, worked at AGH. All are RN's and two are employed by Shands at present.

I was born at AGH and will have many memories of this hospital that has been such a lasting part of the Gainesville community. As a teenager in the mid-late Seventies, I was part of the Volunteer program. I remember working my shift one August afternoon when the nurses station was a buzz with the news that Elvis had just died. Back then, I did everything from change bedpans to write letters for the patients. They had to make me go home when my shift ended, I loved being involved in that program so much. I still have my uniform. I watched and waited as many friends and family brought their children (and since then, their children's children) into the world at AGH. I held vigil in the ICU waiting room when we had little hope a beloved schoolmate would survive the night after a terrible automobile accident. Miraculously, she survived, and our vigil turned into a celebration. Even though the building may no longer stand, the memories and the lives that were touched by this hospital will always remain an integral part Gainesville's heart and will truly be missed.

When having my second child right in my room was the birthing room. Once the baby was born it turn right back into my regular room. Oh the dinner was lobster tail and steak. OMG it blew my mine. The service and care was memorable.

My birthplace.

I was born at Alachua General Hospital!

I was born at AGH! I can't believe the hospital is closed.

I was born at Shands AGH (known at Alachua General Hospital at the time) and my mother said I was that biggest baby (10 lbs 5 oz) in the hospital at the time. I know my sister was born there as well. Back in the day it seemed like a huge hospital but compared to the ones I am around today (like INOVA Fairfax) it seems quite small.

I was born at AGH and have lived in Gainesville all my life. It is sad to see the hospital going way.

My parents welcomed the first of their 7 children at AGH (me). Later I was the first employee of the year at AGH and my sister was the second. We welcomed the third generation at AGH with the birth of my nephew and my niece. AGH is such a part of my family.
I had a heart attack. I had just moved back to the area and when the EMT asked where to take me, through shallow breaths, I said, "Shands". I'm so glad I did. Except for a small mistake with my name, everything ran so smoothly. The ER team was professional and on the job. I had to have a stent put in an artery, and when I was taken to my room, my RN was a character, and I love her very much. She helped make a VERY SCARY situation...well not "FUN", but at least bearable for me. We had each other laughing the entire time I was there. My roommate and I enjoyed her so much. When I needed anything, she was there helping. I honestly don't know how she cared for anyone else, she was with us so much. EVERYONE in the nursing staff was kind, gentle, smiling and helpful. I even made a crack, "This is the best heart attack I've ever had." LOL If anyone has to choose a hospital for any reason, even if it's with a ragged, shallow breath, I tell them to speak one word...."SHANDS"

i remember many moments but i did have 4 surgures at shands by a doctor Dr Robert Bright can anyone help me find him or where he went PLEASE.  i lived in sarasota and had to be drivin every year for 6 years to shands i lost my ankle from 18 sheets of drywall when i was 8 and thanks to dr bright i still have my foot i have no ankle but i have my foot. so please try to find him for me please i live in Atlanta now but u can contact me.

My wife was recently in your hospital. The staff was very professional, friendly and always helpful. Thank you for taking care of my wife.

Our special child was diagnosed with dilated cardiomyopathy. We spent 2 weeks in the PICU. As the parents we would like to say, thank you to all the doctors, nurses, and care givers. A special thank you the nurses. Thank you Shands, we needed you and you were there.

I will really miss AGH, which has always been one of the mainstays of my Gainesville memories. I was born at AGH, tonsils removed there, birth of my daughter, various trips to the ER, surgeries and illnesses of my grandparents. Although some of the visits were fairly traumatic, I always appreciated the staff and the facility.

I worked in the MICU. I enjoyed this experience greatly and will never forget the great people and patients that I had the privilage of working with. Thanks for the memories.

I will miss the hospital. I grew up in Shands and it brings tears to my eyes to see it being closed down. I won't forget all the wonderful nurses and doctors I have met. I will always remember this place.