



FRED L. BROWN
In First Person: An Oral History

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FRED L. BROWN

In First Person: An Oral History

**Interviewed by Kim M. Garber
On November 6, 2015**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in Chicago, Illinois

KIM GARBER: Today is Friday, November 6, 2015. My name is Kim Garber, and I will be interviewing Fred Brown, who served as the founding President and CEO of BJC HealthCare, a pioneering health care system in the St. Louis area. Mr. Brown was chairman of the Board of Trustees of the American Hospital Association, as well as holding many other leadership positions in service organizations. Fred, it's great to have this opportunity to speak with you this morning.

FRED BROWN: First of all, let me tell you what a privilege it is to be selected to do the oral interview for the American Hospital Association. I want to say how pleased I am to be sitting here with you today.

GARBER: Your parents were married in the early 1930s and lived in Clarksburg, West Virginia. Did your father have steady work during the Depression?

BROWN: He did. My dad had only an eighth-grade education. He started as a linotype operator for the *Clarksburg Exponent*. He met my mother when she was in nurses' training and they were married in 1931. Except for 1942 to 1944, when he served in the Navy, he continued as a linotype operator until his retirement. When he was in the service, we moved to Charleston, West Virginia, on a temporary basis. In 1946, we relocated to what I call home in growing up – Dunbar, West Virginia.

GARBER: Your father was in his late 30s when he was drafted.

BROWN: He was at the top of the age bracket when he was drafted for those two years, and spent that time in Ireland, in what was then called Londonderry. I did not know much as my dad never talked about that experience. I had the opportunity later on to read some of the letters between my mother and dad. Although he was a fairly quiet individual, he was very expressive.

GARBER: How did living through the Depression and World War II affect your parents' values and your own?

BROWN: It had a definite impact, as it did on a lot of middle class and lower middle class families at that time. My parents were focused on savings and managing money and living within their means. When my dad was working in Clarksburg before he was drafted, he was making around \$35 a week. When he relocated down to Charleston and later to Dunbar, he was working for the *Charleston Daily Mail* where he got a boost to \$50 a week.

We never went without anything. My parents were focused on my brother, my sister and myself, making sure that we were fully clothed and had an education. It created within me the value system to save early and to protect the economic needs of your family.

GARBER: Would you call yourself conservative?

BROWN: I am fiscally conservative and socially liberal.

GARBER: Your mother was trained as a nurse, and she went back to work while you children

were still at home, which was unusual at the time. How did that come about?

BROWN: She started college at West Virginia Wesleyan College in Buckhannon, went there for a year, and then transferred to Clarksburg in nurses' training. It was a three-year diploma program. She practiced as a nurse when we were in Clarksburg. When we relocated to Dunbar, initially she was a housewife but decided to go back and take her refresher training at McMillan Hospital, which is now part of the Charleston Area Medical Center in Charleston, West Virginia.

She worked for a wonderful family practitioner in Dunbar, Dr. Rice, who died suddenly in his forties. Then she continued to work up until '72 with Dr. Joe Smith. When I've gone back to visit my hometown, even as recently as this year, I run into people who remember my parents. My mother saw a couple of generations of families being born and raised. It makes me feel so good to hear that even today, people are still remembering Claude and Anne Brown.

GARBER: Who were your heroes when you were young?

BROWN: When I was young, my life revolved around community activities. My heroes were my parents and my brother and sister. Dad got up every morning at five o'clock and never missed a day of work, was involved with the Typographical Union, but yet was very much involved with the community. He helped start Little League programs, he was on the Toll Bridge Commission, he was Citizen of the Year, and he had perfect attendance in the Lion's Club. My mother and dad were both active in the church. My dad went to night school and got his high school degree in 1958, the same year that I did.

My older brother, Charlie Brown, was athletic, smart and had a wonderful personality. He was someone I looked up to because I was the youngest of three children. He was helpful in giving advice as I went through high school and prepared for college. He was an all-state football player, went to West Virginia University, and then went to Columbia Law School and was president of his class for two years. My sister was in the first class at Duke in the '50s which had a combined five-year program leading right to a master's in nursing. These nurses were almost like clinical specialists. My sister received a Rockefeller grant for that additional fifth year of training.

I made the comment to my parents one time, "Why doesn't much of our furniture match?" It didn't match because their focus was on making sure that we had our education. Through a combination of scholarships and their support, we were the first family from our community which went outside of the state for education. We had a lot of chemical plants nearby – it was known as "Chemical Valley" – and there were a lot of large chemical plants in Charleston along the Kanawha River. A lot of our classmates ended up working at the chemical plants, or some in the coal mines in West Virginia. My mother and dad created a value system and a focus on education. My brother went on to get a law degree from Columbia, my sister at Duke, and I had the opportunity to go to excellent schools. They never said no to that.

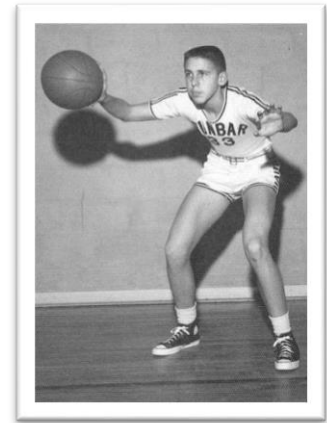
GARBER: That is a remarkable testament to your parents, and to all of you, that you all got advanced degrees.

BROWN: My parents were my heroes because they established a value system. They established the focus on education. They never said no, and the three of us never got into any type of trouble. We had a wonderful life growing up in a small community of West Virginia. They also,

by their activities, created in me the sense that you need to serve others. You need to reach out and make this world a better place. As my career progressed, I followed other people, and read and thought about historical political figures and people who were successful in business or in various occupations.

GARBER: You attended Dunbar High School. Something happened to you in high school that is a testament to your commitment to serving others. Something bad happened that you turned into something positive.

BROWN: Between my junior and senior year in high school, I was a counselor at a camp for crippled children. This was up in the northern part of the state. I was excited about this. Somehow I came down with infectious hepatitis, maybe from the water. There was not much known about infectious hepatitis at that time – patients were put in isolation. It was a freak occurrence at the camp. They had to bring in gamma globulin from around the United States to give to all the kids and counselors and staff. I caused quite a stir.



Ninth grade at Dunbar

My parents were out of town. There I was in this small hospital in Elkins, West Virginia, thinking, “Oh, my gosh, I’m about ready to come back to school and start football season.” This was my senior year, and I was going to be the starting center on the football team and the starting center on the basketball team. I thought about not being able to play all of a sudden. Although I wasn’t able to play, I participated by helping to manage the intramural program during the noon lunch break.

When I tried to come back for basketball season, I had a relapse. That whole year I was thinking about what I was going to do, yet this allowed me to focus on other things. It allowed me to do extracurricular activities that didn’t require physical exertion. When I was accepted at Northwestern University, that first year I was restricted from doing any physical ed because they didn’t really know how to treat that particular disease at that time.

GARBER: Why did you choose Northwestern?

BROWN: Although I was privileged to receive a full academic scholarship to West Virginia, I knew that I did not want to stay in-state because my brother had gone to West Virginia and done well. He had established himself. My sister went to Duke, and that had an excellent reputation. I happened to read an article in *Sports Illustrated* about a Northwestern football player by the name of Robert McKeiver. In the article they talked about this private university in Evanston, Illinois. It was the only private school in the Big Ten. I saw how good a school it was academically.

I had a wonderful high school counselor by the name of Virginia Robson, who helped guide me for several years about colleges. My parents said, “Go ahead and apply, but we might not be able to afford to send you there.” I applied to Duke, West Virginia and Ohio State, too. My parents said, “Wherever you receive a scholarship outside of the state, you can go there.” I was fortunate and received a partial academic scholarship at Northwestern.

When my mother and sister dropped me off up in Evanston, I unloaded into the freshman residence hall, Sargent Hall, and watched the car roll away, thinking, “What is this seventeen-year old

doing in Illinois? Am I going to make it?” It turned out to be one of the most wonderful experiences in the world.

GARBER: I wonder if having been through a year of illness and disappointment had taken a toll on your self-confidence.

BROWN: There is no question. People from West Virginia struggle with insecurity. My late brother had a lot of confidence and was outgoing, but my sister and I both had an inferiority complex and lack of real confidence. I read a book by Jerry West, who is known as one of the greatest ballplayers in the NBA. He played in a school that was in part of our conference in West Virginia. He wrote about his insecurities, and how they drove him to the success he had.

I’ve read about other people from West Virginia who seemed to have that same insecurity. I don’t know if it was because people would say dismissively, “Oh, West Virginia” – thinking of unemployment or lack of education or obesity or coal mines. Over the years I have been able to use that insecurity to help drive the successes that I had. I still have insecurities today at age 75. As I was starting college I said, “Am I good enough? Can I compete with these individuals?” At that time, I was thinking just about getting through the classes, but I think it also helped to drive me.

GARBER: Did you pledge a fraternity?

BROWN: I did pledge a fraternity. My brother had been a member of the Sigma Chi fraternity at West Virginia, so I was a legacy. At that time, there was restriction on who was accepted into fraternities based on race and ethnic background. I looked at several fraternities and did end up pledging the Sigma Chi fraternity, with which I’ve maintained relationships over 50-plus years. It was a valuable experience for me.

GARBER: That’s interesting. I haven’t discussed this topic with anyone before. We are talking about the late ‘50s?

BROWN: This was 1958. Each one of the fraternities had what they would term a “white clause.” Northwestern, with its wonderful academic credentials, finally acknowledged that there was a quota system on the different classes – on the Jewish population, on the African-Americans admitted. This was the beginning stages of civil unrest and appropriately so. Our high school, for example, was not integrated until my junior year, in 1957. Thank goodness we have changed in today’s society. Yet these were restrictions that were applied at that time.

GARBER: How did the integration of your high school go?

BROWN: It went very well. Our community was a suburb of Charleston and adjacent to ours was a community called Institute, which had West Virginia State College, a black college. My father was one of the developers of the Little League and Pony League baseball teams. We played with boys from Institute. We were integrated long before the actual integration of the high school took place. We were friends and we all played baseball together, but then we would go to our separate high schools. Fortunately, in ‘57 there were no incidents. We had integrated within our class, within the athletic teams, within the band, within the activities. That was the beginning stage.

GARBER: Sports and extracurricular activities have an importance in ways that sometimes you don’t even realize.

BROWN: Absolutely.

GARBER: At the time that you were at Northwestern and civil rights activities were starting to come to the fore, did you become involved in any kind of political activism?

BROWN: I was there from '58 to '62, so I was really at college before the activism. It was just the beginning stages of the Vietnam War and civil unrest. We were not impacted as a class or as a university as much as students were later on during the '60s.

GARBER: Northwestern University is located in Evanston, Illinois, which is on Lake Michigan. Is that where you first started sailing?

BROWN: No, that happened after I graduated. My brother was working in Fort Wayne, Indiana, for a manufacturing company. He knew Geoff Gummersall, who had a sailboat at the Chicago Yacht Club. Geoff said, "I'm looking for a dependable crew member." My brother said, "My brother is in Chicago, and he's working now, and he's graduated from Northwestern. He might be interested, but he's never sailed before." Geoff said, "I'll meet him and we'll talk about this."

Here I was, this young graduate. I had just started my job in Chicago. Geoff said, "I'll meet you at the Chicago Yacht Club." I walked in and I met Geoff and his wife Joanie. Geoff said, "I don't care if you know anything about sailing, but you have to be dependable. You have to be there every Saturday and Sunday because we race off of Belmont Harbor every weekend during the season. I expect you to be dependable." I said, "I'm willing to give it a try."

Geoff and Joanie became almost surrogate parents here in Chicago – they had me up on the weekends, and I watched their two boys grow up. I learned, as I did from my dad, that if you commit, you're there and you participate 100 percent. I was there for them every weekend. They taught me how to sail. It became a love of mine. When I came back to Chicago to work at Elmhurst Hospital between 1974 and 1982, we bought a sailboat, and my oldest son learned how to sail.

GARBER: You talked about the values of commitment and dependability. Was there any other way in which sailing developed your character?

BROWN: There was a competitiveness about sailing on the weekends. In college, I had not participated in athletics, but was a supporter of the teams. Here I got an opportunity to compete again. I learned to be humble in winning, as you did in losing. I learned to make quick decisions when the wind would shift or if a storm came up. When I came back to Chicago in '74 to '82, I had the chance to participate in the Chicago to Mackinac race a couple of times and then had the privilege of seeing my oldest son do the same thing.

GARBER: Did participating in competitive sailing change your viewpoint on teamwork? Did that influence any of your later career?

BROWN: It did to a certain extent because you had to realize you were part of a seamless team. If one part of the team broke down, or didn't do their task, that caused potential issues or chaos out on the water, in the same way as you managed within an organization. Teamwork was always a very important characteristic.

GARBER: What's the worst thing that ever happened to you on a sailboat?

BROWN: The worst was on one of the Chicago to Mackinac races. In Northern Michigan the course is shallower, the waves are closer together, and we got into a terrible storm. We didn't make it the first year. We had to pull off in Ludington in Michigan. That was the first time that I was in a major storm on the lake.

GARBER: After you graduated from Northwestern did you go right to grad school?

BROWN: When I graduated, I was draft-eligible. The hepatitis had prevented me from participating in Northwestern's ROTC program. My plan was to go into the Naval Officer's Training Program. Because of being 1-A draft-eligible, companies were less likely to want to hire me. I saw some of my colleagues getting jobs, but I was not getting any offers.

I did get an offer from the Cook County Department of Public Aid as a vocational counselor because my undergraduate degree was in psychology. I knew I wanted to go to graduate school, but I thought at one time I'd be a social service worker. I was living in Rogers Park with some of my fraternity brothers, and I would drive out to West Washington Street to work in a converted, warehouse-like building. We were in an area that was where many homeless were.

My job was to interview those on public aid and try to find employment for them. This job taught me a lot, and I realized the need to help others. I met people who were dedicating their lives to working for the Department of Public Aid and were committed to helping the underserved. It was a wonderful learning experience.

Still, I knew I'd be drafted, so I wanted to apply for the Officers Training Program. At the physical, the doctor asked, "Mr. Brown, have you ever walked in your sleep?" I had never had a habit of walking in my sleep, but it had happened one time after we had won a big basketball tournament. Honest Fred said, "I had this one incident." The doctor looked at me and said, "Son, I'm sorry, I'm going to have to deny your application."

Concerned about being drafted, and wanting to go back to graduate school, I joined a reserve unit on Kedzie Avenue. It was a maintenance unit. I was inducted into the Army Reserves in October 1963 and went to basic training at Fort Leonard Wood, Missouri, from March to August, 1964. Between the time I was accepted and went in to the reserve unit, I applied for graduate school in health care administration.

GARBER: The west side neighborhood where you worked was a rough neighborhood. Did you ever have any fears for your personal safety?

BROWN: I really didn't. I might have had have fears if I had been there at night. Although, we were part of 16-inch softball leagues there that we participated in after work. But although we were right in the middle of the housing projects, I never really thought about my safety. We had security guards at the entrance to the building, and there was a fence around the parking lot, but I never really thought that much about it.

It woke me up to another side of life. Growing up in a small community, I was never exposed to the size and the scope of those on welfare. It was another building block in my own career and my own life – realizing the need out there, and that whether I had a career as a social service worker or in health care administration, it was going to be part of my personal platform to serve others.

GARBER: How successful were you in finding employment for your clients?

BROWN: It was difficult because I would find someone a job in a car wash, or in a service industry, and then several weeks later, he would come back and say, “Mr. Brown, I wasn’t able to go to work,” and would have excuses. I would try to find another place. My job as vocational counselor was to find employment, but that was limited because of drug problems and prison problems and all the issues associated with that clientele.

It was tough because you never felt that you solved things. What you did was achievable over a long period of time. You were never able to follow the individuals over a period of time to see if they were successful, if they sustained employment over an extended period of time, if they got back with their families, that type of thing. You were never able to see that as a caseworker. You were just placing. It was reassuring to get them placed, but at the same time, you were never able to follow the individual all the way through to see if they were successful in sustaining that job or if they were bettering themselves.

GARBER: Part of the reason that you didn’t have that long-term look was because you left.

BROWN: Exactly.

GARBER: It was now time for you to pursue the dream of going to grad school. How did that all come about?

BROWN: The father of one of my good friends in high school, Mary Ann Krisher, was on the board of one of the local hospitals, and we would chat occasionally. He asked, “Did you ever think about hospital administration?” We talked a little bit about it, and he introduced me to the administrator of the hospital where my mother’s boss – a family practitioner – practiced. We talked about how he got into the field, what it involved and that type of thing.

I thought that maybe this would be a good way to combine social responsibility with managing an organization. I wasn’t sure that I wanted to go on and get a master’s in psychology. I began to explore a little bit about the opportunities in hospital administration.

At that time, Northwestern University had a very good program, and subsequently, my first preceptor was a graduate of that program. In my sophomore year, apparently the director of the program had a conflict with the dean, and they shut the program down. It was Dean Barr¹ at the time, and the director was Dr. Letourneau,² who had a law degree. He was board certified as a surgeon. He had a master’s in public health and he had one other degree. He was a very knowledgeable Canadian – very knowledgeable but very arrogant. Apparently, he and the dean got into several conflicts, and they shut the program down.

Most of the Northwestern preceptors migrated to George Washington University. In 1959,

¹ John A. Barr (1908-1979), an attorney and board chair at Montgomery Ward, served as the ninth dean of the School of Business Administration at Northwestern University from 1965 until 1975. [Northwestern University. *Kellogg School History*. http://www.kellogg.northwestern.edu/kellogg_school_history.aspx]

² Charles U. Letourneau, M.D. (1912-1983), served as the director of the Program in Hospital Administration at Northwestern University from 1955 to 1960. [American College of Hospital Administrators. (1970). *1970 directory*. Chicago: ACHA.]

George Washington had just started their program. I began to take a look at the different graduate programs. There were the established programs like the University of Minnesota, University of Michigan, University of Iowa, University of Chicago, Yale and Columbia out east, and Duke had a program as well. There were only about 12 or 14 programs at that time across the country.

George Washington University was starting an MBA program in Hospital Administration with the first graduating class in 1962. I applied in the fall of 1963. The two programs I applied to were GW and the University of Michigan. My GW interview was in December 1963. It was in the terminal at the Chicago North Western Station, and it was just as cold as it could be. I had my interview with Professor Elwood Camp.³ He was full-time at GW but also maintained a home here, and it was during the winter break. He said, “Academically, you aren’t the strongest student, but our program will give you a chance if you’re really committed to doing it. The only problem is that you need an accounting class as a prerequisite.”

I was thinking to myself, “I’m going into the six-month basic training program at Fort Leonard Wood at the beginning of the year. GW is requiring a prerequisite of accounting. Am I going to have to delay a year to be able to get into the program?”

Subsequently, I was accepted at George Washington, and denied at the University of Michigan. That’s why I did not go there. I was in the process of getting engaged – all these things were happening at the same time at the end of 1963. I went into basic training in March of 1964 and got out in August 1964. During my training at Fort Leonard Wood, Missouri, the company commander – a young captain – allowed me to use his office at night. I did my accounting course on a correspondence basis. I finished my pre-requisite.

I got out in August and got married on August 24. My wife was from Arkansas. She had been teaching in Des Plaines, Illinois, and we met after college. We packed up the Chevy Nova, and our honeymoon was spent driving to Washington, D.C. She didn’t have a job at that time, but one of her aunts was a superintendent of a district in Prince George’s County, Maryland, which encompassed Andrews Air Force Base. She was able to get a job, and we lived near Pennsylvania Avenue, right at the District line. The combination of the fact that they were willing to give me a chance, that they had a lot of the preceptors from Northwestern, and that they had a full-time faculty staff – which a lot of the programs did not have – made GW attractive.

GARBER: Do you want to mention any particularly memorable professors or other individuals you encountered?

BROWN: Yes, my high school counselor, Virginia Robson, who was always in my camp and helped me get selected to go to the Boy’s State, which was an honor. Each state had Girl’s State and Boy’s State in which you would duplicate the political process of your state government. I was in a couple contests for the Elks High School Student of the Year, that type of thing, and she helped me prepare the college applications with the support of my brother and sister as well. She was one that I’ll always remember.

³ Elwood W. Camp (1912-1989), an Army major who was instrumental in redeveloping the social work function of the Army after World War II, and had a career in education and health administration, was an associate professor at George Washington University from 1963 to 1967. [American College of Hospital Administrators. (1977). *1977 directory*. Chicago: ACHA.]

I'll always remember my football and basketball coaches, Delmar Good and Bob Young. They were instrumental in helping me. The football coach had gone to the same high school, had been a World War II veteran. No one knew until he passed away several years ago about his distinguished military career. At Northwestern, I admired the President of the university, J. Roscoe Miller,⁴ because he had the vision to create the landfill, to build the beautiful campus along Lake Michigan.

I remember more about my graduate school professors, Elwood Camp, and of course, the founder of the program, Professor Gibbs.⁵ He was a retired colonel who had run the Baylor program, which was a program for the members of the United States Army. Professor Gibbs was stern, a disciplinarian, and he taught us how to be professional. We had classes in decorum that our wives were expected to attend. We learned how to present ourselves at meetings and how to present ourselves in groups, which were the consequence of our responsibilities as health care executives. The discipline from his military career carried over. We wore coats and ties, and we had to be at class. If you weren't in class ten minutes before the starting time, you weren't allowed in the classroom. He taught us to be responsible. He taught us to be timely.

The associate director, Leon Gintzig,⁶ had a nursing career, and he was a Ph.D. The American College of Healthcare Executives has a luncheon in recognition of Dr. Gintzig every year during the Congress on Healthcare Leadership. He taught classes about health administration. The interesting thing about the George Washington program was that while it focused on health care management, we also had classes in planning, finance, and public health. Rosemary Capusan⁷ was another professor who was important to me in helping to guide me in my career. Professor Cook was another individual who was also my residency advisor. He would visit when I was in my residency and helped coordinate my master's thesis around the topic that I had selected.

GARBER: The GW program was structured like many other hospital administration master's programs at the time so there was one year of academic study, and then you went out on a residency?

BROWN: You spent a year academically, and then you spent a year in residency. Most of the programs at that time were structured in that manner. Now the interesting thing about this program, when I went there, was that it was part of the business school. Other programs were part of their schools of public health. Subsequently, the program was shifted from the business school to

⁴ J. Roscoe Miller, M.D. (1905-1977), was dean of the medical school at Northwestern University and later served as president of the university from 1949 until 1974. Among his achievements was reclamation of 84 acres of Lake Michigan shoreline at the Evanston, Illinois, campus and construction of 35 buildings. [Dr. J. Roscoe Miller of N.U. (1977, Oct. 18). *Chicago Tribune*. <http://archives.chicagotribune.com/1977/10/18/page/32/article/dr-j-roscoe-miller-of-n-u>

⁵ Frederick H. Gibbs (1902-1985), retired as a full colonel in the Army after 32 years, during which time he served as director of the Baylor-Army Program in Health Care Administration. He then became the first chair of the George Washington University Department of Health Care Administration. [Forty years of health care administration 1959-1999. *The GW and Foggy Bottom historical encyclopedia*. (2010). George Washington University.

⁶ Leon I. Gintzig, Ph.D. (1916-1984), was a professor in the George Washington University Department of Health Care Administration and became the second chair of the department in 1967. [Forty years of health care administration 1959-1999. *The GW and Foggy Bottom historical encyclopedia*. (2010). George Washington University.

⁷ Rosemary Capusan was the first executive director of the American College of Nursing Home Administrators. [Becker, C.A. (Ed.). (1982, p. 17). *History and handbook of the American College of Nursing Home Administrators*. <http://www.ctachca.org/documents/History/HistoryAndHandbookACNHA.pdf>]

the Milken Institute School of Public Health at GW. When I was there, it was an MBA; now they're getting their master's in health administration. I liked the idea of receiving an MBA.

GARBER: Do you know whether that model is still used today in training students?

BROWN: Not in many of the university programs. Fortunately, George Washington University still requires that so now it's almost a three-year commitment – two years academically, and then a year of residency. I was sorry to see residencies go away in many of the programs. For me, I really didn't have any experience in health care. This residency program was the piece that took the theory and gave us a chance to make mistakes and gave us a chance to learn and gave us a chance to observe. That carried through to my own philosophy. It was important to me to have residents and, as we got larger, to expand that residency base to give more opportunity to residents coming out of their programs.

GARBER: Why do you think the schools walked away from that model?

BROWN: I think it was a combination of requiring more academic courses and, at the same time, considering the tuition costs for students. I think that probably drove some of it, as they were trying to be competitive, with students looking at it not in the long-term, but the short-term, saying, "Three years versus two years? I'm going to take the two-year opportunity."

GARBER: That's an interesting observation. Let's talk about your residency. You went to the famous Methodist Hospital in Indianapolis, and the CEO there was Jack Hahn.⁸

BROWN: Right.

GARBER: Would you talk a little bit about that experience? What did you do there?

BROWN: To get there was an interesting process. We listed some areas of the country where we'd like to do a residency. I was familiar with Chicago. You had Wesley and Passavant⁹ as two hospitals before the development of Northwestern Memorial Hospital under Gary Mecklenburg's¹⁰ leadership. Wesley had a Methodist history here in Chicago. So, I put down Chicago. Columbus, Ohio, had Riverside Hospital, which was a Methodist hospital. As a lark, I also put down a hospital in Florida, because we hadn't been to Florida.

On a Saturday morning, we walked in and Professor Gibbs looked at me and said, "Fred,

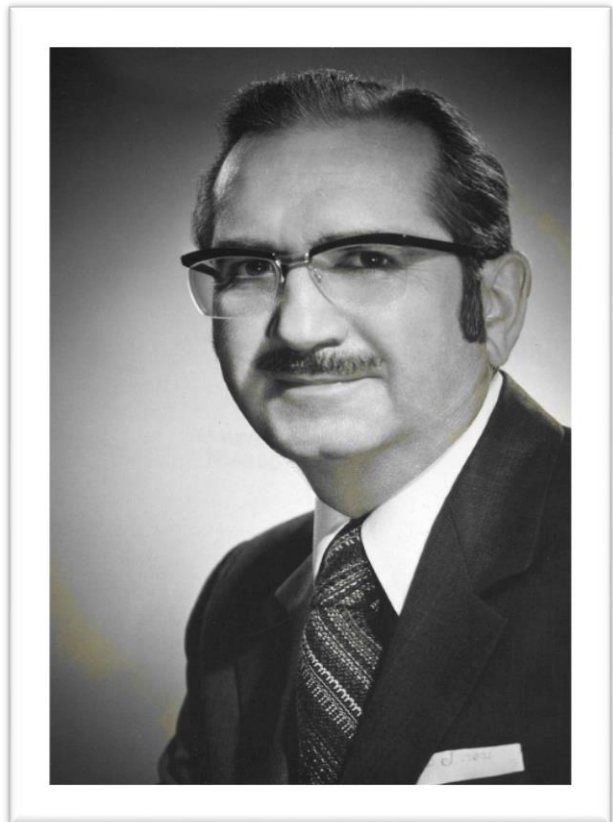
⁸ Jack A.L. Hahn (1922-1998), was president of Methodist Hospital of Indiana from 1954 until his retirement in 1981. His oral history, Newkirk, D.R. (Ed.). (1993). *Jack A.L. Hahn in first person: An oral history*. Chicago: American Hospital Association can be found in the collection of the American Hospital Association Resource Center.

⁹ Northwestern Memorial Hospital (Chicago) was formed in 1972 through the consolidation of two faith-based hospitals – Wesley Memorial and Passavant Memorial. With 1,000 beds, the consolidated hospital became one of the largest hospitals in the Midwest. [Northwestern Medicine. *History timeline*. <https://www.nm.org/location/northwestern-memorial-hospital/about-us-nmh/our-mission-and-core-values-nmh/history-nmh/history-timeline-nmh>]

¹⁰ Gary A. Mecklenburg was CEO of Northwestern Memorial Hospital (Chicago) from 1985 to 2001 when he became president and CEO of Northwestern Memorial HealthCare, the parent corporation. He retired after two decades with Northwestern Memorial in 2006. [Japsen, B. (2006, Jan. 10). Downtown hospital changes leadership: Northwestern healthy for Mecklenburg split. *Chicago Tribune*. http://articles.chicagotribune.com/2006-01-10/business/0601100246_1_teaching-hospital-gary-mecklenburg-northwestern-memorial-hospital]

you're Methodist, aren't you?" I said, "Yes. I've always been associated with the Methodist Church and I grew up in the Methodist Church." He said, "You're going to Indianapolis to the Methodist Hospital of Indiana." I didn't know a thing about the Methodist Hospital of Indiana, or about Indianapolis. I thought, "Okay, he said that's where I'm going." I didn't realize that there was an interview process. I made contact with the preceptor, Mr. Hahn. (I've never referred to him as Jack A. L. Hahn – Jack Albert Louis Hahn. Because of my respect for him, even to the day he passed away and I had the privilege of speaking at his funeral, I always referred to him as Mr. Hahn.)

I called Mr. Hahn up and said, "This is Fred Brown. I'm in Washington, D.C. I'm a student at George Washington University, and I understand that I have an opportunity to do a residency with you." His comment was, "You better get out here, because we've already interviewed six candidates from different universities, and we're about ready to make a decision." I thought, "Oh, my God, what's going to happen if I don't get a residency? All the other residencies are already allocated out to my classmates."



Jack A.L. Hahn in the mid-1970s.
Photo credit
Noble Bretzman Photography

Over Christmas my wife and I borrowed my parents' car and drove out to Indiana and interviewed with Mr. Hahn and Bryan Rogers,¹¹ his executive vice president, and John Mote,¹² the vice president of personnel. I left there not knowing if, at the end of my academic year, I would be going to Methodist Hospital of Indiana. Out of the seven candidates, I was selected. Given my track record, I was surprised but pleased. This 1,200-bed facility was one of the largest church-related hospitals in the country. They always would have competition with Baptist Hospital in Memphis on bed size. When the *Guide Issue*¹³ of the American Hospital Association would come out each year, the administrative resident had to immediately look up how many beds Baptist had compared to Methodist.

The experience there formed the basis of my career. Mr. Hahn was a visionary. He was doing things in the '60s that other people didn't do until the '70s and '80s. Others would say, "We've just developed community health centers," but he had already developed community health centers. He had developed a co-op laundry. We condominiumized physician office buildings. He had a restaurant

¹¹ Bryan A. Rogers (1925-2012) was an executive at Methodist Hospital until 1972 when he became administrator and later president of the Toledo Hospital until his retirement in 1992. [Bryan Allen Rogers: Obituary. (2012, July 8). *The Blade*. <http://www.legacy.com/obituaries/toledoblade/obituary.aspx?pid=158423973>]

¹² John R. Mote was appointed director of personnel at Methodist Hospital in 1955. [*The Indianapolis Star*. (1955, Jan. 23). <https://www.newspapers.com/newspage/105586154/>]

¹³ The *AHA guide to the health care field* is a national hospital directory published each year by the American Hospital Association. Among the data included about each hospital is the bed size.

in the physicians office building. We had multi-layered parking connected to the hospital. We had the first demonstration projects for renal dialysis, one of the first open heart surgery programs, and one of the first programs for neonatologists. They were talking about transgender, this was back in the '60s and the early '70s. There was community outreach. He created a helicopter pad on top of the building, which was unheard of at that time. Private suites were donated from the Eli Lilly family, the Krannert family.

Mr. Hahn allowed residents access to everything except the compensation committee. He'd come in at 5:00 or 5:30 every morning, and he was traveling at that time. He was involved at the national level as president of the American Hospital Association. He was involved in the American College for Healthcare Executives. Every morning he'd come in and write thank you notes. I carried that on in my own career – writing personal notes. He always had time for people. If you said, "Mr. Hahn, do you have a couple minutes?" He'd say, "Come on in! Come on in!" I learned later on that it is a 24/7 job as a health care executive, but he'd still say, "Oh, come on in! I've got a few minutes."

Mr. Hahn loved to play basketball. We'd go out to his house and have pickup games. Mr. Hahn was not that tall – I remember one time that I hit him with my elbow, and I thought, "Oh, my gosh, my career is over! I just knocked over the president of the hospital!"

He would take time to explain why decisions were made and how they were made. He would get out and walk around. This was a 1,200-bed institution, and there weren't many 1,200-bed hospitals around the country. Methodist had a teaching program of 500 residents even though it was not an academic center. The program had a small research function. Frank Lloyd,¹⁴ who ultimately stepped in for Mr. Hahn, headed up medical research. He ultimately became the president of Blue Cross/Blue Shield of Indiana, which today is WellPoint.

I had the privilege of staying there nine years and progressed from the residency to administrative assistant to assistant administrator to vice president of operations. Mr. Hahn gave me continually increasing responsibilities. Here I was, a 26-year-old, managing dietary services and housekeeping. We had our own in-house construction crew, which was unheard of at that time.

That taught me that Mr. Hahn was willing to have confidence in Fred Brown and my young colleagues – James R. May, Charles B. Van Vorst and Steve Abbott¹⁵ – and give us responsibility. That was another lesson that I learned. I was never hung up about giving responsibility to younger executives, because that is how you learn. As I talk with some of my colleagues, we look back and say, "Wow, 25 or 26 years old and we were managing employees who had been in their positions for 10, 15, 20 years." It taught me how to interact, how to relate, how to listen, how to respond, how to bring people together.

¹⁴ Frank P. Lloyd, M.D. served as president and CEO of Methodist Hospital of Indiana from 1981 to 1987. [American Hospital Association. (1988). *Guide to the health care field*. Chicago: AHA, and earlier editions.]

¹⁵ Like Fred Brown, James R. May, Charles B. Van Vorst, and Stephen L. Abbott all served as administrative residents at Methodist Hospital of Indiana and all received their master's degrees from the George Washington University. [American College of Healthcare Executives. (2000 and earlier years). *2000 directory* (and earlier years). Chicago: ACHE.]

Methodist was a faith-based hospital, and Bishop Raines,¹⁶ the Methodist bishop of Indiana, played a very important role. As we developed the professional office building across the street, we wanted to put a high-end restaurant in. We wanted to serve alcohol in the restaurant, but the bishop was absolutely opposed. Dan Evans,¹⁷ chairman of the board, and Mr. Hahn met with the bishop. The agreement was that the bishop would not be at the board meeting when they were going to vote on this. They approved the use of alcohol as was prearranged. These were the things that I began to understand – the important role that the board has in relationship with the administration in trying to work through all of these issues. I learned so much there.

I thought that I was going to spend my career at Methodist Hospital. Mr. Hahn was always gracious, saying that if an opportunity came up, we'd sit and discuss whether this would be the right move for me. At that time, Elton TeKolste,¹⁸ president of the Indiana Hospital Association, and his colleague, the executive vice president, were trying to convince me that I needed to go manage one of the small rural hospitals in Indiana. I focused on staying at Methodist Hospital because I was gaining tremendous experience, learning more of what my strengths and weaknesses were, learning how to manage. I decided I would be there for a long time.

Bob Hampton, who was with the executive recruiting firm Witt & Dolan, sat down with me. The Witt agency has been around for years. Bob was the third member, along with the founders Witt and Dolan,¹⁹ who I think both worked for the American Hospital Association. Bob Hampton said, "Fred, you've got to be able to control your own destiny. What happens if something happens to Mr. Hahn? That's not going to assure you of your own job." I had never thought about that, but subsequently, that did happen. Mr. Hahn left and they brought Frank Lloyd in. That was after I had left, but it played out. Bob Hampton said, "You've got to be in control of your destiny. You've had a wonderful experience at a 1,200-bed hospital, but there are not that many 1,200-bed hospitals around the country. You need to have a good experience at a community hospital." That led to an interview that I had with Bob Magnuson and the board at Elmhurst Memorial Hospital.²⁰ In August 1974, I relocated to Elmhurst, Illinois, as the executive vice president of Elmhurst Memorial Hospital.

GARBER: Could you talk more about faith-based hospitals? At about the time that you were at Methodist Hospital, the Medicare and Medicaid programs were established. Is there as much

¹⁶ Richard C. Raines (1898-1981) served as the head of the Indiana Area United Methodist Church for five terms from 1948 to 1968. [Bishop Raines memorial rite here Saturday. (1981, Sept. 23). *Indianapolis Star*. <http://iagenweb.org/boards/buchanan/obituaries/index.cgi?read=123225>]

¹⁷ Daniel Evans was president of L.S. Ayres Department Store from 1965 to 1977. ['That Ayres look' returns to Indy. (2015, Mar. 13). *IndyStar*. <http://www.indystar.com/story/entertainment/2015/03/06/ayres-look-returns-indy/24511949/>]

¹⁸ Elton TeKolste (1922-1983) became the first salaried president of the Indiana Hospital Association in 1960 and served until his death in 1983. [Indiana Hospital Association. (2015). *IHA's history through the decades*. <https://www.ihconnect.org/About-IHA/Documents/IHA90yearhistory.pdf>]

¹⁹ John Witt founded the firm Witt Associates, specializing in executive searches in the health care field, in 1969. With the addition of Richard C. Dolan, the firm became Witt & Dolan Associates, and later Witt/Kieffer. [Witt/Kieffer (2013). *Serving health care and higher education for 45 years*. <http://wittkieffer.com/about/great-leadership/history.aspx>]

²⁰ Robert M. Magnuson (1927-2012) was president and CEO of Elmhurst Memorial Hospital (Elmhurst, Ill.) for 26 years beginning in 1966. [Robert M. Magnuson 1927-2012: Longtime CEO of Elmhurst Memorial Hospital. (2012, Dec. 3). *Chicago Tribune*. http://articles.chicagotribune.com/2012-12-03/news/ct-met-magnuson-obit-20121203_1_lung-cancer-cancer-treatment-center-leo-fronza]

of a role for the faith-based hospital today with the government taking an increasing role in paying for care?

BROWN: I grew up in the Methodist Church. Mr. Hahn was active in the American Protestant Health Association. At that time, APHA was a very active association. You had the American Hospital Association; you had the professional society – the American College of Healthcare Executives; you had the Catholic Health Association; and you had the American Protestant Health Association.

What excited me was that hospitals were mission-based. That's why we got into health care administration – to reach out and to serve others. Being a faith-based organization created that environment. If you take a look at the history of hospitals, they started out as faith-based organizations that took care of people in need. There was a strong presence by the Methodists and the Baptists and the Catholics. Jewish hospitals were created because students couldn't receive training at other institutions because of discrimination issues, and the Jewish hospitals were located to serve the Jewish populations.

That was a piece of what was important and what helped create my own sense of responsibility and commitment. Until the Darling case in Southern Illinois,²¹ you had charitable immunity. That was an emergency room case in which there was malpractice against the institution. Before the full-time practice of emergency medicine, physicians would donate a lot of their time in the emergency rooms and even in their own offices. They would donate for those that were in need. Some of the uncompensated care was taken care of in that manner.

A fascinating thing about being in Washington, D.C., as a student in '64 was that we had the opportunity to sit in on the Medicare and Medicaid hearings. All these years later, when I went in and signed up for Social Security and Medicare, I thought about that. Franklin Delano Roosevelt and Truman had tried to offer programs, and at that time, the AMA and the others said, "This is socialized medicine. We can't do this." Even up until today with Obamacare, it was the first time that the federal government provided over 50 percent of the care for this country. What Medicare and Medicaid did was begin to rationalize that which had been provided on a voluntary basis.

There were a lot of hospitals with accounting systems that weren't the best in the world in terms of accounting, in terms of setting up a chart of accounts, in terms of being able to manage the financial and fiscal responsibilities created. They were pushed into this with the development of these government programs. To me, the important part of that was that this country finally began to focus on a health policy. It was on a limited basis because it was for people over 65, or those that were uninsured. Yet, it began to create that element of responsibility which was inherent in Europe and other places.

GARBER: In 1974, you moved back to the Chicago area to Elmhurst Memorial. What did you find when you arrived in Elmhurst?

BROWN: It was nice to come back to Illinois. I had wanted a sound, suburban community hospital to take the next step in my career. I felt that it was a natural progression. My goal was to

²¹ Darling v. Charleston Memorial Hospital, 211 N.E.2d 253 (Ill. 1965). [Wiet, M.J. (2005, Summer). Darling v. Charleston Community Memorial Hospital and its legacy. *Annals of Health Law*, 14(2), 399-408.]

become a president of a hospital by age 40.

Bob Magnuson was the president of Elmhurst Memorial Hospital. Bob did not come up in the traditional way. He was a Lake Forest College graduate and then got his MBA from Harvard. He was a chief financial officer who then became CEO of the hospital. He was a wonderful gentleman. I was privileged to work with three outstanding individuals – Mr. Hahn, Bob Magnuson and later Paul Detrick²² at Christian.

Bob was different from Mr. Hahn in the sense that he wasn't a visionary. He was a sound financial person who was respected and well thought of in the community as well as with the employees. He had a gentle air about him and he was precise and logical. He gave me the opportunity to blossom as the executive vice president. I had several people who had been with the organization for many years who were in associate administrator positions – Tony Damiani,²³ Dorothy Gioielli,²⁴ John Freeman, who headed up HR.

Bob allowed me to do innovative things. One was that we created a chaplaincy program. Elmhurst was a community hospital with no religious affiliation. When we developed this program, we got pushback from the Catholic Diocese in Joliet, but we continued to go through and worked very closely with the College of Chaplains. At Methodist we had a large chaplaincy program because that was a faith-based hospital. I wanted to create that, and we were successful in doing that. I remember when we put the chapel in – the hospital didn't even have a chapel originally.

GARBER: I don't understand why there was pushback about creating a chaplaincy program.

BROWN: There was pushback because of concern about establishing a Protestant chaplaincy in a Catholic community.

GARBER: Maybe my lack of understanding is that I don't understand what a chaplaincy program is. Is it solely Protestant?

BROWN: Not necessarily, there were chaplaincy programs in Catholic hospitals, but normally these were administered to by priests or by nuns. In Protestant hospitals, the College of Chaplains got started. The chaplaincy programs were beginning to develop along the same lines as hospital administration programs. They had a process to go through to be certified to be able to administer to all faiths and be certified as a chaplain in a hospital.

²² Paul F. Detrick (1923-1999) served as president of Christian Hospital (St. Louis, Mo.), and later as CEO of Christian Health Services, from 1960 until his retirement in 1985. [Paul Detrick Sr., former president of hospitals. (1999, Sept. 2). *St. Louis Post-Dispatch*. <https://business.highbeam.com/435553/article-1G1-55645740/paul-detrick-sr-former-president-hospitals>]

²³ Anthony D. Damiani was hired as an assistant personnel director at Elmhurst Memorial Hospital in 1960, where he served until his retirement in 1985. [Strouse, L. (2010, June 23). Tony Damiani honored on 90th birthday by Elmhurst Rotary and mayors proclamation. *Trib Local*. <http://www.triblocal.com/elmhurst/community/stories/2010/06/tony-damiani-honored-on-90th-birthday-by-elmhurst-rotary-and-mayors-proclamation/>]

²⁴ Dorothy M. Gioielli, R.N. (1918-1992) was hired as an administrative assistant at Elmhurst Memorial Hospital in 1959 and stayed with the hospital in leadership positions until 1974. [American College of Hospital Administrators. (1984). *1984 directory*. Chicago: ACHA.]

GARBER: A chaplaincy program is a training program?

BROWN: A training program, absolutely. We were not starting a chaplaincy training program at Elmhurst as we had at Methodist. We just wanted to have a chaplain full time on staff at the hospital who would administer to the needs of all patients. We had some pushback, but we accomplished that.

We were involved in several construction programs. We were building an addition to the existing facility. Elmhurst Memorial was in an established community, surrounded by residences. At that time, there were Comprehensive Health Planning (CHP) agencies in each state. The CHP in Illinois had a difficult process. I'll never forget going through the planning stages just to get external signs at the hospital entrances, showing where the emergency department was and the main entrance, and so on. We fought the neighbors for over a year.

We'd start in the early evening, and we were doing this sign project along with getting other construction projects approved. We'd finish up at one or two o'clock in the morning. Bob and I spent a lot of time together during these hearings. After we finally got the signs approved and installed, the residents complained that they couldn't read the signs because they were too small. That was one of the normal things you found out in working with communities, just like airports have to deal with airport noise. The residents who were concerned did build their homes after the hospital was established.

Bob was excellent from a financial standpoint. I learned a lot from Bob. Shortly after I joined – probably about a year and a half later – Bob suffered a serious heart attack. For a period of time he was not allowed to get involved in any of the decisions or any of the activities of the hospital. Later on, after I had left Elmhurst and moved on as president of Christian Hospital Northeast-Northwest, he said, “Fred, I never worried that you would try to usurp my responsibility or my position.” I said, “No, my role as the chief operating officer was to make sure that things were running – that the trains were on time – and that when you came back that there would be no change from your position as president and CEO of the institution.” I'll never forget him saying, “I never once worried that you would try to usurp my position and take advantage while I was ill and couldn't be in communication.” It had been difficult, because I had to say, “Bob, I'm sorry, we can't talk about these things. I know that you'd like to know what's happening and what the issues are, but your doctors have said absolutely not!”

The chief operating officer's role, whether it's in a hospital or any organization, is difficult because you have to balance running the day-to-day operation with the needs of the CEO and the board and the staff. I had total responsibility for operations. There is always a balancing point. I always told my own chief operating officers that it is a difficult position because ultimately you want to be in the CEO's chair, and I want you to want to be in my chair, but you've got to focus on this piece of it, and you're caught in-between.

It worked out. It was a nice experience at Elmhurst, and we enjoyed coming back to the Chicagoland area. Elmhurst was a traditional hospital in which the patients came to the hospital for services. We began to branch out into Villa Park and Addison and establish physician office buildings. There was the large Elmhurst Clinic, which was a good group of physicians who worked at Elmhurst, LaGrange, Good Samaritan and other hospitals, but their primary focus was Elmhurst. We had several physician members on the board from that group, and I began to learn of the need to have physicians

as board members, like Ralph Ryan²⁵, who was an OBGYN, and Paul Wochos²⁶ and Charles Gutzmer,²⁷ who was chairman for a number of years.

The only downside to that board was that there were no term limits. Individuals could continue to serve for many years. I remember coming back when they relocated and built the new hospital in Elmhurst. Bob Magnuson was in failing health, on oxygen, but he wanted me to come back and meet the new administrator and tour the new facility. I walked down the hallway and I saw some of the board members, and I said, “Wow, Bob, this is how many years later, and the board members are still there. They were a solid part of the community – Bob Soukup,²⁸ who was chairman following Dr. Gutzmer, and Joel Herter,²⁹ was an accountant. Bob Soukup and his family had the hardware store in Elmhurst. These individuals were very supportive, and Bob had their respect.

We had this at Methodist, so I wanted to start a credit union with the employees. We had two bankers on our board – they were somewhat averse. Bob let me carry it through, and we developed the Elmhurst Credit Union for the employees. Once Bob understood what you were trying to do and committed, he never veered from the support that he gave. Like Mr. Hahn, Bob said to me, “I know that you want to become president of a hospital, and I want to support that.” Some people in our profession get very concerned if an employee is looking for another position, but every boss that I had realized that to progress in the health care field, you normally had to go look for another position in another institution. Bob was just like Mr. Hahn in being supportive of that and saying, “Let’s talk about it and see what the opportunity is and see if that’s the right opportunity for you.”

GARBER: That is a credit to those leaders willing to take that position. Was Elmhurst Memorial a standalone hospital, or were they affiliated with someone?

BROWN: Elmhurst was a standalone community hospital. We attempted to bring about a merger with Central DuPage Hospital in Winfield, which was the other dominant hospital in the area. The discussions never went anywhere. We were thinking about it and trying to stretch. At that time, we were thinking about the major institutions – Northwestern and Rush Presbyterian and the University of Chicago – and the smaller hospitals. Ultimately, there was the merger that created Advocate and built Good Samaritan in Downers Grove and built Good Shepherd in Barrington. The territory was beginning to shrink a little bit. We had some discussions, but they never went very far.

²⁵ R. G. Ryan, M.D. was medical staff president at Elmhurst Memorial Hospital 1974 to 1975. [Verbal communication with the hospital medical librarian on Feb. 4, 2016.]

²⁶ P.E. Wochos, M.D. was medical staff president at Elmhurst Memorial Hospital 1975 to 1976. [Verbal communication with the hospital medical librarian on Feb. 4, 2016.]

²⁷ Charles A. Gutzmer, M.D. (1904-1984), a surgeon, was head of the Elmhurst Memorial Hospital (Elmhurst, Ill.) for 25 years. Dr. Gutzmer was also chair of the hospital’s corporate parent for the last three years of his life. [Dr. Charles A. Gutzmer, 80. (1984, Nov. 6). *Chicago Tribune* <http://archives.chicagotribune.com/1984/11/06/page/27/article/dr-charles-a-gutzmer-80>

²⁸ Robert E. Soukup was chairman of the Elmhurst Memorial Healthcare board of trustees at the time the new replacement hospital was being built. [Kalousdian, A. (2009, July). State-of-the-art healthcare facility under construction. *Construction Digest*. <http://www.site-kconstructionzone.com/?p=1795>]

²⁹ Joel G. Herter, a CPA, founded Wolf & Company in 1978 and became a founding trustee of the Elmhurst Memorial Hospital Foundation (Elmhurst, Ill.) in 1980, and later became chairman of the board of trustees at the hospital in 1996. [Elmhurst College. *Joel G. Herter*. <http://www.elmhurst.edu/president/16389621.html?popup=true>]

GARBER: You mentioned that there was a total replacement hospital that was a relocation.

BROWN: The relocation hospital came recently – over the last five to six years – under the leadership of Leo Fronza.³⁰ He was also a George Washington University grad, and I brought him in as one of the associate administrators. When I left in August of '82, Leo was named in my position. Ultimately, when Bob retired, Leo became the president.

In the last two years that I was at Elmhurst, we created a holding company. We were trying to position ourselves to have a parent corporation, with the hospital and a couple of other ambulatory functions underneath that. We were beginning to expand the organization. Basically it was the same structure – Bob was president and I was the executive vice president of that.

GARBER: Was that more of an integrated delivery system?

BROWN: It was an attempt at that, but it was a limited attempt. There was the organization framework, but Elmhurst Memorial basically stayed as a standalone community hospital during all the mergers that took place in the Chicago metropolitan area. Elmhurst maintained a standalone basis; so when they built the replacement facility, it was a financial stretch in terms of the amount of money they had to borrow. At the time there was talk about being part of the Northwestern Memorial system, but Northwestern walked away from that.

GARBER: Is there anything else you'd like to say about your time at Elmhurst?

BROWN: It was an important time because I was able to use what I had learned at Methodist, and this reinforced my confidence that I could run a hospital, that I could become the president of a hospital. It reinforced that I did have the skill set, that my ability to relate to people, that my style of management would be acceptable. I interviewed for several jobs at that time. I remember interviewing at Children's Hospital in Seattle. A classmate of mine who had been at Cedars of Sinai got the job and served that hospital well for many years.

I realized that opportunity would come eventually. I had the goal of age 40, but I didn't make that. I think I was 41 when I went to St. Louis. During this time, I served as president of our alumni association for George Washington University. I got involved with the Chicago Hospital Council so I got to know other executives in the Chicagoland area. We had a western suburb group that would meet periodically, and Bob had me coordinate that with the other administrators. He had served a term as chairman of the Chicago Hospital Council, when Howard Cook was president. He allowed me to begin to get my feet on the ground as a potential CEO, and that was a wonderful experience.

GARBER: What was the health care market like in St. Louis when you arrived in the '80s?

BROWN: It was a fragmented market with perhaps 39 different institutions. St. Louis was an interesting area. It had been a trading post in the early 1700s, and it was known as the "Gateway to the West." People said that St. Louis always looked east and Kansas City, on the other side of the state, always looked west. St. Louis was said to have a river mentality or a southern mentality.

Like Baltimore, St. Louis is an independent city – these are two cities that are basically counties.

³⁰ Leo F. Fronza was president & CEO of Elmhurst Memorial Healthcare from 1992 to 2011. [*LinkedIn*. <https://www.linkedin.com/in/leo-f-fronza-09555793>]

That was well when it was prosperous, but as business moved out away from the downtown area, as the demographics shifted, then it became less desirable in the core of the city. All the growth was out in the suburbs.

I came in 1982 as president of Christian Hospital Northeast-Northwest. My predecessor had been Paul F. Detrick, who was president of Christian Hospital at the time it migrated north. The Catholic hospital was downtown; it migrated out to the west and became Mercy Hospital. Sister Roch³¹ headed up that system. On the south side was St. Anthony's Hospital. There was not really a system. SSM³² had the largest number of hospitals. Within St. Louis they had Cardinal Glennon – the children's hospital. They had Saint Mary's, and they had one other hospital. They also had hospitals in Wisconsin and South Carolina. Mercy³³ had a large hospital in West County, but they also had hospitals in Oklahoma and in other parts of Missouri. Then you had the academic centers – Barnes and Jewish Hospital and St. Louis University Hospital.



Paul Detrick photograph from the 1960s

There were two children's hospitals – St. Louis Children's and Cardinal Glennon. It was somewhat fragmented at that time, but they all were prosperous. It was interesting, even though it was fragmented, how the hospitals were located in terms of the patient base. If you placed them on a map, they were appropriately located, but they all operated on a fairly independent basis.

At the time, managed care was just beginning to get established. You had the traditional insurance, Blue Cross/Blue Shield, PruCare and Cigna and Coventry, and the company which ultimately became United. You had two academic centers. You had two medical schools that were in competition with each other.

GARBER: Could you tell a little more about Christian Hospital?

BROWN: Paul Detrick was looking for a president because he was going to retire. He was at a meeting at George Washington University for some reason and made the comment, "I'm looking for a CEO." I was contacted by GW, "Here's an opportunity, Fred." I had stayed in close contact with GW by being past president of the alumni association.

³¹ Sister Mary Roch Rocklage was administrator/president of St. John's Mercy Medical Center (St. Louis, Mo.) from 1969 to 1979. Her oral history: *Sister Mary Roch Rocklage in first person: An oral history*. (2011). Chicago: American Hospital Association, can be retrieved here: <http://www.aha.org/research/rc/chhah/Rocklage--FINAL--092611.pdf>

³² SSM Health was founded in 1986 as a health system to bring together the facilities and services sponsored by the Sisters of St. Mary, now known as the Franciscan Sisters of Mary. [SSM Health. (2016). *Our history*. <http://www.ssmhealth.com/sluhospital/history/>]

³³ Mercy, the health system, was founded in 1986 by the Sisters of Mercy and has its headquarters in Chesterfield, Mo.). [Mercy. (2016). *Transforming the health of our communities*. <https://www.mercy.net/about/transforming-the-health-of-our-communities>]

I gave Paul a call, and he said, “Come on down for an interview.” My wife and I came down, and we hit it off with Paul and Mary, and then he had me interview with the board. They offered me the job as president of Christian Hospital Northeast-Northwest. Paul was going to retire as president, but he was going to stay on to focus on the framework of Christian Health Services. At that time, they had one management contract. He was going to oversee the initial stages, then he wanted to step down altogether in a couple years.

Christian had been founded by the Christian Woman’s Benevolent Association just north of downtown St. Louis.³⁴ The hospital barely had enough money, but one of the major banks, Commerce Bank – which was started out of Kansas City by the Kemper family – agreed to provide the financing, and Paul talked to the founders of Holiday Inns in Memphis. They built Northwest in Florissant, which was a thriving North County city. The hospital could only be three stories high, because it was in the flight pattern for planes coming in to Lambert airport.

In 1976, I believe, they built Christian Hospital Northeast further to the east, right off the interstate almost on the border between Illinois and Missouri. It thrived. It was a 682-bed facility, the two hospitals. Even though there were two sites, it was operated as one organization – one medical staff, one board.

Paul had migrated from an all-women’s board to including leaders of the North County community. There was always representation from the Christian Woman’s Benevolent Association, but like the Catholic orders, the number of those women began to be fewer as the years went on. It was a wonderful board. They were solid individuals within North County who were committed to having health care in North County. There were committed, industrious people: Ed Givens, Max Shelton, Bruce Woodruff, Mel Moellering, Paul Kohnen, Gene Netherton, Art Seewoester, Mildred Volkman, and Gerry Komenko. Paul McKee³⁵ was a wonderful mentor as well as a very good friend and supporter through the entire merger process. He served a five-year term as chairman of BJC HealthCare after I retired from BJC. The five individuals who represented Christian on the merged board included: Paul McKee, Bruce Woodruff, Bill Sullins, Ken Elkins, and Blanche Touhill, Ph.D., who was chancellor of the University of Missouri-St. Louis at the time.



Christian Health System board seminar in 1986

³⁴ Christian Hospital Northwest, a 254-bed facility, was opened in 1968. Christian Hospital Northeast, located seven miles away, opened in 1975. [Christian Hospital. (2016). *History*. <http://www.christianhospital.org/AboutUs/History.aspx>]

³⁵ Paul J. McKee, Jr., is an entrepreneur involved in property development in the St. Louis area. He served as chairman of BJC HealthCare for five years. [Paul M. McKee, Jr.: *Chairman and CEO*. Urban Land Institute. http://stlouis.uli.org/wp-content/uploads/sites/51/2013/10/Bio_Paul_McKee.pdf]

That was the framework I came into. I was successor to a person who took me under his wing but didn't interfere with running the hospital. We traveled together – my wife at the time – and Mary and Paul. We had a wonderful relationship. He was hands-off, but if there was an issue or a problem, I could go over and chat with him. During the two years that he transitioned he had an office in the medical office building.

The organizational framework was developed which included two management contracts of hospitals. One was in Cairo, Ill., and they had a small management contract with another hospital in Illinois. That was the framework that we're talking about.

What was started right after I joined was the construction of Village North. This was the life care concept. I give Paul the credit for initiating the idea. We created what are now retirement villages. We found that people in that environment lived longer than what the actuaries were talking about. We had to transition over time to more of a rental type of a situation rather than total life care, but we had the combination at that time. We had apartments, we had assisted living, we had the nursing home. It was adjacent to Christian Hospital Northeast. I brought my parents from West Virginia up to Village North, and they spent their remaining years there. This was after I had stepped down from BJC and Christian.

We were the first community hospital to have an open heart surgery program in the St. Louis metropolitan area and the first community hospital to have an MRI installed. We were the first to aggressively go after the managed care contracts that were just beginning. I think it was 1983 or 1984 – I remember one of the doctors, an OBGYN, saying at a medical staff meeting, "You're going to destroy this hospital! You're going to destroy this community! This managed care is going to destroy us!" I walked out of there saying, "Whoa!"

I could see that we had to be on the cutting edge because we were not the major player in St. Louis. Barnes was ranked as one of the top ten hospitals in the country. There were the academic medical centers. Mercy had the largest OB service in the metropolitan area in the West County area, that affluent population. St. Luke's was in an affluent population.

We had to be creative. My ability as a manager included having vision and I was never the type to sit and process through a lot of things. I could start a day and see where we were at sea. Sometimes I would short circuit things and people would shake their heads and say, "Why?" That was one of the abilities I had. I realized that managed care was going to be here.

None of this happened in a vacuum. We created a wonderful management team and we'll talk about that. Everything happened because of the management team, not because of Fred Brown. I just happened to be in the chair at the time that we undertook the merger that created BJC. I knew that Christian had to be aggressive. We had to be on the cutting edge because we didn't have the same clout when we sat down with insurance companies that Barnes did or that St. Louis University did or that Mercy in West County did. Even though we were the fourth largest hospital in terms of discharges at the time – about 21,000 – we never had that clout as a single institution. One of my skill sets was to develop relationships with these other institutions, and that ultimately then paid off with the merger.

We knew that the demographics were going to change a little bit over a period of time. When I started, I think our revenue base was \$62 million, and that was probably before deductions for Medicare. When we merged, we were \$528 million in net revenues. Very early, about '83 or '84, I

said to my team, by 1995, we're going to be a billion dollar organization. They looked at me and wondered what was I smoking or where did I come from? When we created BJC in 1993, I came back to the team and I said, "We're now a billion-five, and that's net revenues. That's not gross, that's net. We achieved our goal together."

Two years later, Paul stepped down as president of Christian Health Services, and I stepped in as president of that as well as the hospital. We built up the number of institutions, including nursing homes and home care. We began to go after relationships aggressively. One of the principles was that we would never pay a dime to acquire or merge an institution. These were not-for-profit institutions, community-based assets. I said, "We have to really work on the relationships." We did. We brought Alton (Ill.) Memorial Hospital in. We brought Boone Hospital Center in Columbia, Mo., in. We brought the hospital in Vandalia, Ill., into our system, and in Farmington, Mo., and in Bonne Terre, Mo. We had a hospital on a management contract over in Chillicothe, Mo.

We built up to seven or eight hospitals and four nursing homes because I was thinking that we needed to focus on the continuity of care. We started a home care agency and a durable medical equipment, DME, company. We worked with a couple of the other institutions in our DME – St. Luke's and Mercy Hospital were participants. Later, with the merger, our home health agency became the largest in the state. I wanted to focus on continuity of care, not just inpatient acute. We developed immediate care centers. It's ironic that I currently serve on the board of an urgent care company funded by a private equity group. Back in the '80s we were developing these as sites in ambulatory surgery centers.

The other thing that I did at Christian was that I hired traditionally from those in the health administration program in the operations areas, but I brought in to our marketing department someone from the banking industry. I brought someone outside the health care industry for HR and strategic planning because I felt like we sometimes become too inbred.

The other thing that I'm proud of is that we had diversity in our management team. We had women on our senior management team in the '80s. We had African-Americans on our management team. It was important to me to have the diversity to begin to represent the communities that we served in North County. I feel good about that.

I carried on, too, as a result of my experience at Methodist, a strong health care administration residency program. I carried on that tradition, not only through the residency program but also through mentoring, which was strong with Mr. Hahn and others of his generation. Our generation wanted to do the same thing.

GARBER: In the '80s, there was a trend towards the kind of horizontal diversification that you described. You'd created a system of hospitals and were ready to make a major consolidation.

BROWN: Before discussing that, I want to mention that we were founders of a PPO that became very successful – HealthLink.³⁶ We did that in association with a couple of the other facilities. With the merger, HealthLink was acquired by Blue Cross/Blue Shield of St. Louis and became part of what we know today as WellPoint/Anthem. You want to talk a little bit about the merger?

³⁶ HealthLink was established in 1985 by a group of St. Louis hospitals and provides preferred provider organization (PPO) and case management services. [HealthLink. https://www.healthlink.com/home_visitor.asp]

GARBER: Yes. However, I'd like to note that the merger has been described in great detail in at least one book that I know of – *Anatomy of a Merger* – so I don't think we really need to reiterate the details.³⁷

BROWN: It's interesting how the merger came about though, which isn't in *Anatomy of a Merger*. It was a true merger, number one. Number two, it was the first time that there was a combination of academic, community and rural hospitals. Number three, it was the largest merger of any hospitals.

GARBER: What do you mean by a true merger?

BROWN: It means consolidation of the assets. A lot of the so-called mergers that were taking place were basically affiliation agreements in which all retained their own asset base. We merged all of the assets. The five component parts of that merger – Christian, Barnes, Jewish (ultimately, Barnes-Jewish were merged as a single entity), Missouri Baptist and their system, and St. Louis Children's – all came in as equal partners. We had a consolidated balance sheet and consolidated P&L. A lot of the groups coming together were affiliations. For example, Unity Health – Mercy Hospital and St. Luke's and St. Anthony's – which was a reaction to our merger.

How it happened is an interesting story. I talk about that in the *Modern Healthcare* article.³⁸ Just for the record – back in the fall of 1992, I had had ongoing discussions with the CEOs of the hospitals – Paul Wunderlich at St. Luke's Hospital, Tim Farrell at Mercy Hospital, Norm McCann and his successor Fred Mills at Missouri Baptist Hospital and Rich Grisham at St. Anthony's Hospital.³⁹ We were all in what was called the Beltway area – Christian was in North County, Mercy and St. Luke's and Missouri Baptist were in West County, and St. Anthony's was in South County.

GARBER: These were all institutions that were outside of the urban core.

BROWN: Yes, outside of the urban core in the suburban areas. For many meetings we talked about the possibility of an affiliation. This would have been an affiliation of these institutions because of the ownership issues of the different institutions, but we were serious about bringing that together. We had had discussions for a year and a half or two years.

From August 13-16, 1992, the PGA Championship was going on at Bellerive Country Club, and I was volunteering. At that time, Barnes and Jewish announced an affiliation. They were two academic institutions which were part of, but not owned by, the Washington University School of Medicine. They talked about an affiliation model and felt that they needed to come up with a corporate board. They came up with five members per organization. They were going to go out and do a national search for a CEO. At that time, Chuck Knight⁴⁰ was chairman of the board of Barnes, and

³⁷ [Lerner, W.O. (Ed.). (1997). *Anatomy of a merger: BJC Health System*. Chicago: Health Administration Press.]

³⁸ [Johnson, S.R. (2014, Mar. 22). An early system visionary. *Modern Healthcare*.

<http://www.modernhealthcare.com/article/20140322/MAGAZINE/303229981>]

³⁹ The executives mentioned include Paul H. Wunderlich of St. Luke's Hospital (Chesterfield, Mo.), John T. Farrell of St. John's Mercy Medical Center (St. Louis), Norman E. McCann and Fred R. Mills of Missouri Baptist Medical Center (St. Louis, Mo.), and Richard Grisham of St. Anthony's Medical Center (St. Louis). [American Hospital Association (1993). *Guide to the health care field* (1993 ed.). Chicago: American Hospital Association.]

⁴⁰ Charles F. Knight was CEO of the Emerson Electric Company from 1973 until his retirement in 2000, during which time the company showed a consistent record of earnings and dividend growth. [Emerson. (2016). *Company history*. <http://www.emerson.com/en-us/aboutus/Pages/history.aspx>]

John Dubinsky⁴¹ was chairman of the board of Jewish Hospital.

I was approached by search consultants about my interest in interviewing for the CEO position. I said, “I really can’t interview. It’s not right. I’m under contract to Christian. We’re in the same community. It would not be right to interview.” They said, “Why don’t you think about it? We’d really like you to interview for this position.”

It was August in 1992. I met with Chuck Knight and John Dubinsky. I said, “I’m under contract and I can’t leave Christian, but you know what we need to do? You all need to be aware that there have been a lot of discussions going on among the hospitals along the Beltway about getting together for managed care and for contracting and doing a lot of different things. The other participants couldn’t care less whether Barnes Hospital is part of this or not, because you as academics are high cost, your service is focused on research and teaching, and sometimes your service isn’t the best in the world. What we need to do is think about a merger. We’re about ready to move on this, and I have my board’s full support.”

Chuck Knight, who was out of the Jack Welch model at GE, said, “We’re national in scope. We’re going to get a CEO and move ahead on our search.” I said, “I appreciate that, but if you want to come back and talk about that, that’ll be fine” – not thinking it would happen. I said, “You know, we’ll go on with life.”

During the ACHE Congress in February, 1993, I got a call from Chuck Knight’s executive assistant. She said, “Mr. Brown, Mr. Knight would like to have a meeting with you.” I said, “I’m up in Chicago. I’m at the Congress on Administration.” There was a bit of a pause, and she came back and said, “He’ll fly up to meet with you.” The next morning was foggy in Chicago. You couldn’t see a thing. He landed at Meigs Field, and we met at the Union League Club. He said, “We thought about what you said last fall, and we’re ready to make this happen. Are you ready to make this happen? Do you have your board’s support?” I said, “Absolutely.” He said, “Okay, let’s get it done.” It was February, and we went through all the due diligence and closed it in June of ’93. Subsequently, there were consulting firms who claimed that they were responsible for bringing this huge undertaking together, but that’s the actual facts of how it took place.

Our management team was meeting at the Marriott, and a consultant was talking with us about what to think about in terms of the due diligence and representations and all this. He said, “This is going to change everybody’s life, because you might not be in the position you’re in now under the merger. What will happen is that you’re going to have to re-interview for each position.” An interesting thing about the merger was that Barnes had the national reputation; Jewish was a wonderful institution in research and education and patient care; but Christian had the framework. We had the organization in place to manage a system. This was viewed as David and Goliath.

GARBER: Which one was David?

BROWN: We were obviously David, and they were Goliath.

⁴¹ John Dubinsky, who served as the CEO of Mercantile Bancorp, Inc., was part of the leadership team that created BJC HealthCare and later headed the group that developed a biotech corridor in St. Louis. [Health-care heroes: John Dubinsky. (2005, Nov. 13). *St. Louis Business Journal*. <http://www.bizjournals.com/stlouis/stories/2005/11/14/focus4.html>]

GARBER: Did Barnes view themselves as Goliath?

BROWN: Yes, they always viewed themselves as Goliath!

We had a wonderful management team including Rick Van Bokkelen,⁴² who was president of Christian Hospital Northeast-Northwest; Ron Milligan, who was the chief financial officer; and, Marc Smith, Ph.D., who was the vice president for strategic planning. He ultimately became president of the Missouri Hospital Association. We had John O’Shaughnessy,⁴³ who had been the president of Boone Hospital Center. We had Jay Justice⁴⁴ as our HR director; we had Mary Paspalas Lazare⁴⁵ as our senior vice president for long term care; Ruth Castellano⁴⁶ headed up our home health care; Carl Martinson, vice president for marketing and communication; Robert Hartley, M.D., chief medical officer. James Francis,⁴⁷ who came to Christian as an administrative resident later became vice president for BJC supply chain management activities. Jay Eckersley⁴⁸ was vice president for systems development. Donald Wojtkowski⁴⁹ was vice president for facilities and contracting management – assuming responsibility for all construction and facilities management for the system. Steve Brawley⁵⁰ was communications director. Barry Silver headed up our for-profit activities – because we had a bio-medical engineering program that extended to a four-state area. Wendy Hemmen⁵¹ became my administrative assistant at BJC. Don Klusmeier,⁵² who had been my administrative assistant at Christian moved over to supply chain management at BJC. I would be remiss without acknowledging the 4 exec secretaries who served during my tenure at Christian and BJC: Carol Poelker, Sue Poehlein,

⁴² William R. Van Bokkelen served as president of Christian Hospital Northeast-Northwest, senior executive officer, BJC North Region until 1998. [LinkedIn. <https://www.linkedin.com/in/rick-van-bokkelen-fache-28330618>]

⁴³ John W. O’Shaughnessy served in various leadership positions with Missouri hospitals, retiring as administrator of the Shriners Hospital for Children, St. Louis, in 2010. [Shriners International. (2010, June 8). John Gloss named administrator at Shriners Hospital for Children – St. Louis. *Press Release*. <http://www.shrinersinternational.org/Press/JohnGlossNamedAdministrator.aspx>]

⁴⁴ Jay Justice was senior vice president human resources at BJC HealthCare from 1991-1995. [LinkedIn. <https://www.linkedin.com/in/jay-justice-521705b8>]

⁴⁵ Mary Paspalas Lazare was vice president senior services and long term care at BJC HealthCare from 1992 until 2002. [LinkedIn. <https://www.linkedin.com/in/mary-paspalas-lazare-64b62934>]

⁴⁶ Ruth N. Castellano (1958-2012) was hired as a staff nurse at Christian Hospital, St. Louis, in 1982 but soon became interested in home health, ultimately becoming vice president home care services with BJC HealthCare. [Obituary. (2012, June 8). *St. Louis Post-Dispatch*. <http://www.legacy.com/obituaries/stltoday/obituary.aspx?pid=157964285>]

⁴⁷ James R. Francis was vice president, supply chain at BJC HealthCare from 1993 to 1999 and then became chair, supply chain management at the Mayo Clinic. [LinkedIn. <https://www.linkedin.com/in/james-r-jim-francis-8533ab26>]

⁴⁸ Jay Eckersley served for eight years as president & senior executive officer of BJC Affiliates. [LinkedIn. <https://www.linkedin.com/in/jay-eckersley-82aa9418>]

⁴⁹ Donald E. Wojtkowski started as director of engineering at Christian Hospitals in 1973 and later became vice president facilities, real estate, clinical engineering, design and construction at BJC HealthCare. [LinkedIn. <https://www.linkedin.com/in/donald-wojtkowski-38340657>]

⁵⁰ Steven L. Brawley held a number of marketing and communications positions with BJC HealthCare in the 1990s. [LinkedIn <https://www.linkedin.com/in/brawleys>]

⁵¹ Wendy Hemmen was assistant to the president at BJC from 1994 to 1998 and later became a vice president at McKesson. [LinkedIn. <https://www.linkedin.com/in/wendyhemmen>]

⁵² Donald Klusmeier was director, materiel services at BJC HealthCare for 10 years in the 1990s. [LinkedIn. <https://www.linkedin.com/in/donald-klusmeier-a3a13220>]

Rhonda Miles,⁵³ and Leslie Renz.

I said to the management team, “It’s your choice to say if this is the right thing to do.” They said, “It’s going to change our lives, but it’s the right thing to do for the community.” Today, that has played out because the demographics have changed. Christian Hospitals would not be there today. It did change their lives. They had the sense of what was right for the community versus what was right for them personally.

GARBER: People at the executive level needed to re-interview for positions. I presume that there was consolidation in the management structure. Where there had been several chief nursing officers, now there would be one, and so on.

BROWN: The chief nursing officer positions stayed the same within each of the institutions. Rick Van Bokkelen stayed as president of Christian Hospital Northeast-Northwest. John Finan⁵⁴ stayed as president of Barnes until we merged Barnes and Jewish in 1996, then there was one position. Wayne Lerner⁵⁵ and John Finan recruited Peter Slavin⁵⁶ from Harvard and Mass General who stepped into that position. When we brought Peter Slavin in, Wayne Lerner migrated from his position as president of Jewish to head up the Rehabilitation Institute of Chicago for many years. John Finan left and still heads up a Catholic system in Baton Rouge, Louisiana. Fred Mills ultimately left for a CEO opportunity in San Antonio, Texas.

We had to consolidate strategic planning. We centralized those types of activities. We had to open that up, so individuals shifted. Marc Smith, who was our vice president of strategic planning became vice president for research, and then he subsequently headed up the transplant group in New Jersey and came back as president of the Missouri Hospital Association.

We had to interview for a chief financial officer because we were going to consolidate the financials. Even though we had a financial officer in each of the institutions, we needed a chief financial officer for the system. Edward Case,⁵⁷ who was the chief financial officer for Barnes Hospital became the chief financial officer for BJC HealthCare. Alan Brass,⁵⁸ who was president & CEO of

⁵³ Rhonda Miles is a senior executive assistant at BJC HealthCare, where she has served since 1986. [*LinkedIn*. <https://www.linkedin.com/in/rhondamiles>]

⁵⁴ John J. Finan, Jr., served as president of Barnes Hospital from 1992 to 1996. He later became president and CEO of the Franciscan Missionaries of Our Lady Health System in Baton Rouge, La. [*American College of Healthcare Executives*. (2000). *2000 directory*. Chicago: ACHE.]

⁵⁵ Wayne M. Lerner, Dr.P.H., served as president of The Jewish Hospital of St. Louis from 1990 to 1996. He later became president and CEO of the Rehabilitation Institute of Chicago and of Holy Cross Hospital in Chicago. [*Griffith Leadership Center*. (2015). *Wayne M. Lerner, MHA, DrPH*. <https://sph.umich.edu/glc/about/bios/waynelerner.html>]

⁵⁶ Peter L. Slavin, M.D., served as president of Barnes-Jewish Hospital from 1997 to 1999. He later went on to become president of the Massachusetts General Hospital. [*Massachusetts General Hospital*. (2016). *Peter L. Slavin, MD: President, Massachusetts General Hospital*. <http://www.massgeneral.org/about/slavin.aspx>]

⁵⁷ Edward B. Case held leadership positions at BJC HealthCare and later went on to become chief financial officer at the Rehabilitation Institute of Chicago. [*Rehabilitation Institute of Chicago*. *RIC executive leadership team*. <http://www.ric.org/about/people/executives/#case>]

⁵⁸ Alan W. Brass served as executive vice president of operations at BJC HealthCare until 1998, when he moved to Toledo to head up ProMedica until his retirement in 2009. [*McKinnon, J.M.* (2008, Jan. 24). Leader of ProMedica to leave post next year. *The Blade*. <http://www.toledoblade.com/Medical/2008/01/24/Leader-of-ProMedica-to-leave-post-next-year.html>]

St. Louis Children's Hospital, became the chief operating officer of BJC HealthCare when Children's joined the system in 1994. Alan left the system after several years to become president and CEO of Promedica Health System in Toledo. Ed Case became the chief operating officer for the system.

We had to create a single position for the chief information officer, for human resources, for materials management. David Weiss⁵⁹ from Barnes Hospital became the chief information officer for the system. Jay Justice became the chief human relations officer. Bill Behrendt became the chief benefit officer. Another person who was instrumental in the formation of BJC was Debra Denham,⁶⁰ vice president for diversity.

We had three medical directors. We started out with the executive vice president for clinical affairs for the medical school serving half time as representing the medical school and half time as chief medical officer, but we found that really didn't work. We then recruited Sam Nussbaum⁶¹ from Harvard, who now is the chief medical officer for Anthem WellPoint.

As you read in the book, *Anatomy of a Merger*, the cultural issues and the issues with the board changed. I saw my successor last night, as a matter of fact. We talked about the fact that I had established the organization knowing that my time would be somewhat limited. It was limited more by rolling into the position as chairman of the American Hospital Association and the demands that was going to make. In following me, he had a different type of environment because it was more stable.

GARBER: What were the biggest problems in working through merging the organizations?

BROWN: There were the cultural issues. We had a very large board. There were five representatives from each of the different organizations – so fifteen originally, and then myself as the sixteenth. There was a representative from the dean's office which made seventeen members – and then you added an additional ten. We had 27 members, and then added the Chancellor of Washington University as a member.

We had board members who had been representatives of their boards for years – Missouri Baptist had never had term limits, and some of their board members were in their 70s and early 80s. Barnes had a corporate board. Jewish represented the Jewish community. Christian represented North County. A major issue was getting them to think as a corporate board looking at the entire system. They could never pull themselves entirely away from their individual institutions and what they represented.

They say culture can kill any merger. We tried to create a BJC brand. The name BJC came about kind of ironically as a system. We looked at different names. We had a name that everybody finally liked of the three groups – we named the system before Missouri Baptist came in and before

⁵⁹ David A. Weiss serves as a senior vice president and chief information officer at BJC HealthCare. [BJC HealthCare. (2016). *David A. Weiss*. <http://www.bjc.org/About-Us/Leadership/Profile/ArtMID/695/ArticleID/18/David-A-Weiss>]

⁶⁰ Debra Denham was vice president community affairs at BJC HealthCare from 1994 to 2013. [*LinkedIn*. <https://www.linkedin.com/in/debra-denham-5827559>]

⁶¹ Samuel R. Nussbaum, M.D., served as executive vice president, medical affairs and system integration at BJC HealthCare before becoming executive vice president for clinical health policy and chief medical officer at WellPoint, Inc. [National Health Policy Forum. (2016). *Resources*. http://www.nhpf.org/speakerbio_samuelnussbaum]

St. Louis Children's. We did the copyright search and found that the system in Greenville, S.C. had the same name for one of their benefit products. I knew the CEO in Greenville, and I gave him a call and said, "We'd like to buy this name, if we could, and use it in our system," but they refused to sell it to us.

We came back and said, "Okay, we've got Barnes, Jewish and Christian." We knew that Barnes, because of their stature, would be B first, but then would it be B-C-J, because Christian was larger than Jewish, or B-J-C? We argued over the J or the C. We ended up with BJC and that stuck. It was BJC Health System, and then ultimately it became BJC HealthCare.

One of the mistakes I made at the beginning was that we didn't bring enough physician representation through the five members of each of the constituent organizations. We ultimately changed that and have their participation and have nursing's participation as well.

We combined employee benefits quickly. A lot of systems spend years trying to combine their benefit programs and their wage and salary administration programs. We created a centralized purchasing and materials management program. Jim Francis, my executive assistant said, "Fred, I was trained as a health care executive. Materials management?" I said, "Jim, try this awhile for me." He later migrated to Mayo and heads up all of their materials management and purchasing for not only Mayo hospitals, but also 28 other hospitals.

The same problems with computer operations exist today, 20 or 30 years later, with none of the systems talking with each other. Everyone had different systems. We put David Weiss, who is still the chief information officer at BJC, in charge. He's one of the three remaining out of the original corporate staff. My executive assistant, Rhonda Miles, David Weiss, and Michael DeHaven,⁶² were the three that are still remaining years later.

We brought in strategic planners from Baxter and from Abbott, because they did that very well, brought them into this not-for-profit health care environment, and saw them begin to grow in those positions. Scott Nordlund,⁶³ the head of strategic planning, is now executive vice president for Trinity Health in Michigan, and he heads up all of their business development and strategic planning activity. There were town-gown issues, too. You had the fear of the academic medical center.

GARBER: Could you describe what is meant when you refer to "town-gown issues?"

BROWN: Town-gown is between the academic centers and the physicians in private practice. We had a good example because the academic physicians were all full-time. They had individual physicians practicing that were part of the staffs of Barnes and Jewish, but basically, the staff at Barnes were all full-time. They represented the chairmen of each of the departments. At Jewish, there was a combination of full-time and private practicing physicians. There were private practicing physicians

⁶² Michael A. DeHaven serves as senior vice president and general counsel at BJC HealthCare. [BJC HealthCare. (2016). *Michael A. DeHaven*. <http://www.bjc.org/About-Us/Leadership/Profile/ArtMID/695/ArticleID/14/Michael-A-DeHaven>]

⁶³ Scott Nordlund serves as executive vice president, growth, strategy and innovation for Trinity Health, Livonia, Mich. [Trinity Health. (2016). *Executive leadership team*. <http://www.trinity-health.org/scott-nordlund>]

at Missouri Baptist and at Christian, and you had full-time at St. Louis Children's.

We knew that when we created this system, when we brought Missouri Baptist in, we were represented out in the affluent western suburbs. We had Christian in the north. We had Barnes and Jewish in the center part of the city, and of course, their national reputation. We had a void, however, in the southern part of the city. I tried continually talking with the dean and the chairmen of the medical school departments. There was the whole area of the south that they wanted to refocus. As they reached out from being Barnes-Jewish, they wanted to begin to place some of their activities out in West County. I said, "You're competing against yourselves, in a sense. Also, with your training programs, you're turning out open-heart surgeons that are practicing in all the hospitals. These are ones you trained. Not everything is going to come to Barnes, and ultimately, Barnes-Jewish.

Those are the issues that you had between town and gown. As you read in *Anatomy of a Merger*, we created a clinical service line in women's health and children's health. It was natural that St. Louis Children's wanted to extend, so we expanded our maternal health out into a system approach. But consolidation of pathology or radiology never happened simply because of the issues between town and gown and the power bases that had been established at the institutions.

GARBER: Do you have anything else that you'd like to say about the learnings from the merger process before moving on to talking about AHA?

BROWN: Yes. We learned that you need to move quickly in decisions that employees want to know. They were uncertain about the merger – what did it mean for them? What did it mean for their physicians? Were they going to lose their jobs? We had to learn about the communications process and how we brought everybody in. That was a learning process. We learned that you had to do it fairly quickly, and that it was not a democratic vote on a lot of things, like with the medical staffs. When Missouri Baptist came in, because the merger was already done, they brought that to a vote of their physician groups, and they were actually number three in that marketplace out there. Now they're almost number one, if you take a look at it years later, because of the support structure from BJC.

Those were learnings. We learned how culture can destroy everything. I remember that we wanted to have the identity of BJC. We still wanted that to be the overall, but we didn't want to lose the name of the different institutions. We put "BJC" on scrubs, except Children's just went bonkers because they had to have "St. Louis Children's" on their scrubs – there were small things like that.

We learned that you had to respect the historical cultures. It was interesting, as you read in *Anatomy of a Merger*, about the chaplaincy. I brought all the chaplains together. We had the chaplains at Christian, the Jewish rabbi at Jewish Hospital, chaplains at Barnes Hospital, and Baptist chaplains at Missouri Baptist. I said, "I'm going to let you all talk about this. We need to make each one of the chapels so that it accommodates all religions. The Jewish rabbi said, "We can't do that. We need to have the symbols for the Jewish faith." I said, "That's fine, but we can have them in each of the chapels. Let's make them truly inter-denominational. You all need to deal with this." I received a call later from the chaplain at Missouri Baptist. He said, "Fred, you'll never believe it. We had our first bar mitzvah in the chapel." I said, "This is truly a capstone event. It brings to fruition everything that we wanted to happen."

We were focused on clinical outcomes. Somebody said, "What can we learn from a little hospital out in Vandalia about clinical outcomes? We're Barnes Hospital." I said, "Sometimes in

some of these institutions, they're doing things very well, and we can all learn from each other." Over a period of time, we began to bring all these different groups together in a way that they could interact and realize that, "Wow, maybe they're only 100 beds, but they're doing some things out there that we can learn from."

Andrew Carnegie talked about one of the greatest skills of leadership is development of your employees. It was always important to me that development was ongoing. I said, "We cannot guarantee a job, but we have a responsibility to guarantee those in a job the opportunity to develop within their jobs and to advance. We created a BJC Leadership Program for physicians. We said we would pay their tuition to go get their MBAs. We created opportunities for tuition waiver programs for the employees. We had strong continuing education programs. We began to be able to take an employee out of one role and give them another role. An example was Ruth Castellano, who started out as a nurse on the floor. We put her into the home care program at Christian. She was so good that she ultimately managed all of the consolidated home care programs.

We learned from our board chairman. One of the things he did was to have a room with a magnetic board that had profiles of all 800 managers showing their education and their job – and you could move these around. We used to go in there as a management team and talk about the different managers. That gave you the opportunity to create new roles. We also had the traditional residency programs. We expanded that and had BJC residents that rotated among the different institutions.

The management team selected one individual each year who we would bring up to the management suite and give special project assignments so they would develop as managers. They might have training in physical therapy or nursing. We created that as separate, apart from the residency program, so that people could grow and develop.

I was trained as a single hospital administrator, not as a health system administrator, so I had to learn. At the hospital, I had made a practice every day of going through the hallways and talking with the nurses or talking with the doctors or talking with the physical therapists or talking with the housekeeping employees, and asking, "How's your day?" One of my strengths was that I could say, "How about your daughter? How is she doing?" and that type of thing. As the system CEO, I continued this by going twice a year to all the facilities – the hospitals and the long-term care facilities and the home health and our occupational medicine and our ambulatory facilities – and I would meet with all the employees and have a walk-through. That was a tough thing to continue, as we got bigger and bigger and we had all these different sites, and then I was trying to manage a board, trying to work with the management team.

GARBER: Fred, I'd like to ask you about board chair Chuck Knight and his management style and your relationship.

BROWN: We had a very contentious relationship, and I knew that we probably would have. Chuck Knight had a reputation as being a hard driver out of the Jack Welch mold. He was on the board of IBM, was on the board of BP in England and had managed Emerson for a number of years. He was focused on the bottom line and only the bottom line. He didn't understand the sense of community or the sense of how you related to physicians. His philosophy was: if they don't do what you tell them, you just fire them. I said, "In this community in health care, that's not how it's done. In managing supplies, for example, the nurses, the doctors, the physical therapists, the allied health, everyone's geared to putting all the resources in to save a person's life. It's not to say, 'You can't use

this supply or you can't use this medication,' or whatever.”

I proposed creating a foundation because we had a billion dollars in reserve within the organization and that was fairly significant back in the '90s. I said, “We ought to take some of those dollars, or the excess of our income over expenses going forward, to create a foundation to give back to the community. We were asked by various community functions. For example, we built one of the public schools in the Barnes and Jewish neighborhood because the St. Louis school system had issues with funding.

Those were the type of things I focused on while he focused on the bottom line, so we had a contentious relationship. Ultimately, his style was recognized by the executive committee of the board, and he was asked to step down as the chairman. We managed to operate together. It was difficult at times, but I realized that my mission was to represent those 23,000 employees and the medical staff and the community.

GARBER: This was about the time that you entered into the three-year relationship with the American Hospital Association as far as the chair-elect, the chair and past chair.

BROWN: That is correct, yes.

GARBER: Although that was preceded by years of service to AHA on the board.

BROWN: Right, in the early '90s.

GARBER: How does a person become chair-elect at AHA?

BROWN: You needed to be well known in terms of your contributions. You had to seek recommendation from the president of your state association. I was fortunate because of my activities with the College⁶⁴ and having been on the board of the AHA during the early '90s. Leaders like Gail Warden, Larry Mathis, John King, Gordon Sprenger, Carolyn Roberts, and Ann Davis (“Moanie”) McMahon were supportive of my recommendation.⁶⁵ Some of the key executives from St. Louis and Missouri – like Charles Bowman, president of the Missouri Hospital Association – were very supportive. Duane Dauner – a mentor and very good friend – as president of the California Hospital Association was very supportive.

They would have the hearings in Washington concurrent with the AHA annual meeting. You didn't go in. They made the presentation, and then you'd appear before the nominating committee, which was made up of past chairmen, but then you also had outside representation. You had to present your mission, what you expected to accomplish, how you would help lead and work with the president and the staff of AHA. Then the nominating committee would make that decision, and then you were confirmed by the board of trustees.

⁶⁴ The “College” refers to the American College of Healthcare Executives.

⁶⁵ Gail L. Warden (1995), Larry L. Mathis (1993), John G. King (1998), Gordon M. Sprenger (1996) and Carolyn C. Roberts (1994) served as chairmen of the board of trustees of the American Hospital Association in the years indicated. Ann Hall Davis McMahon, known as Moanie, was the wife of AHA President J. Alexander McMahon. [American Hospital Association. (2015). *AHA Guide to the Health Care Field*. (2016 ed.). Chicago: American Hospital Association.]

GARBER: I've heard that the chair-elect spends the year working on a project.

BROWN: The chair-elect heads up the Long-Range Planning Committee. That's your activity in terms of helping develop, adapt, reinforce or change the long-range plan.

GARBER: Was there any particular issue that you were focused on?

BROWN: One of the main focuses was whether the American Hospital Association should become the American Hospital and Health Systems Association. I remember the deliberations and debates we had to go through with that, ending up with staying with the name – the American Hospital Association. Some of the state associations were changing their names to the "Hospital and Health Systems Association." I remember that we also had issues of government funding that were ongoing.



**Fred and Shirley Brown at the dinner celebrating his investiture as Chairman of the American Hospital Association in 1999.
Photo credit Jowdy Photographers**

GARBER: Which did you enjoy more – your chair-elect year or your chair year?

BROWN: I enjoyed all three years. I had made the decision at the end of '98 to step down at BJC. They agreed that I would continue on as vice chairman for two years. Earlier, in '96, I had gone through a divorce and then remarried in '97. I felt like I had taken the organization to the point that I could. I could have stayed on, but I just felt like you needed to have a fresh look to come in.

It happened that I could spend a little more time with the management team during that year. That was the year of the millennium. I chaired as a representative of President Clinton on the Y2K Committee and represented the hospitals across the country on Y2K. Those were exciting times. We also had some changes in the senior administration. All of those things took place during my term as chairman.

GARBER: Was your service with the Joint Commission earlier?

BROWN: No, that was after. It was interesting because I had almost a parallel course with Mr. Hahn. He had been chairman of the Joint Commission and was president of the American Hospital Association and was very active in the College. I was interested in the Joint Commission, so I spent seven years serving on that board, ultimately serving as chairman. When I was in my last year, I served as chairman of the search committee when Dennis O’Leary retired, and we brought in Mark Chassin.⁶⁶

There was some acrimony between Dick Davidson (and the AHA) and Dennis O’Leary (and the Joint Commission). It had been announced that Rich Umbdenstock was coming in as the chief operating officer who would become president of the AHA upon Dick’s retirement.⁶⁷ Through the efforts of Rich and myself, we were able to get Dennis and Dick and I in the same room and work out some of these acrimonious issues. Rich was supportive of the Joint Commission and that relationship shifted. It went from poking at each other to being partners. I felt good about being the mediator who brought everybody together in the same place, because the American Hospital Association was one of the founding members of the Joint Commission.

GARBER: Could you talk about your work at your alma mater, George Washington University?

BROWN: I served a two-year period from 2000 until 2002 as a visiting professor and executive-in-residence. They had not had that program before. I was transitioning out of BJC and wanted to give back. I talked with Dean Richard Southby,⁶⁸ who had been chairman of the program and then became the dean of the School of Public Health. I spent two years in which I would go out each month and spend time and co-teach as well as have an opportunity to counsel the students. It was a wonderful experience.

The department had always been the Department of Health Services and Policy. George Washington University has a wonderful policy sector, and Sara Rosenbaum,⁶⁹ who headed that up, is a strong individual. She began to push Southby. When he was chairman of the department, it had included policy and management. He moved up as the interim dean and then began to talk about separation of the two. That was an issue that I felt very strongly about because I felt that was the strength of the program – having both policy and management, because the managers in health care are also policy advocates and vice-versa – those in policy need to understand how the systems work. But it was split. I felt that this was a mistake that weakened the program of health services. Policy

⁶⁶ Mark R. Chassin, M.D., became president of the Joint Commission in 2008, succeeding Dennis S. O’Leary, M.D., who had served in that position for 21 years. [Robeznieks, A. (2007, Aug. 6). *Modern Healthcare*, 37(31), 6-7. <http://www.modernhealthcare.com/article/20070806/NEWS/70803019>]

⁶⁷ Richard J. Davidson served as president and CEO of the American Hospital Association from 1991 to 2007 when he was succeeded by Richard J. Umbdenstock from 2007 to 2015. The oral history: *Richard J. Davidson in first person: An oral history*. (2010). Chicago: American Hospital Association, can be retrieved here: <http://www.aha.org/research/rc/chhah/Davidson--090310--FINALFINAL.pdf>

⁶⁸ Richard Southby, Ph.D., was a founder of the School of Public Health and Health Services at George Washington University and was appointed dean of the school. [Richard Southby ’67. (2009, Spring). *Sloan Profile*. <http://www.human.cornell.edu/alumni/saa/upload/Richard-Southby-67.pdf>]

⁶⁹ Sara Rosenbaum, J.D., is a professor at George Washington University and the founding chair of the Department of Health Policy at the Milken Institute School of Public Health. [Sara Rosenbaum, JD. *GW*. <http://publichealth.gwu.edu/departments/health-policy-and-management/sara-rosenbaum>]

went on and policy grew in terms of the numbers.

Now the interesting thing about that is last year, the dean of the Milken Institute School of Public Health, Lynn Goldman,⁷⁰ brought the two back together again. Now it's the Department of Policy and Management, so we've come full circle on that.

I've stayed in contact. I'm on the Dean's Council for the Milken Institute School of Public Health. I am co-chair of the Major Gifts Campaign for the school, and I co-chaired the 50th anniversary of the program. I've stayed closely involved with Northwestern as well. I chair the Council of Regents and serve on the University Board of Governors for the Northwestern Libraries, and am an active supporter. I've also had the privilege to endow a scholarship, along with Peter Fine, for the students at George Washington University.⁷¹

GARBER: You have touched on governance during the course of this morning's conversation. I wonder if we could explore that. What's a good size for a community hospital governing board?

BROWN: In the past, governing boards were made up of donors and friends of the community. You usually had much larger boards. People are finding that a size from 7 to 11 is a reasonable size to manage. At BJC, we had talked earlier about the five organizations and the agreement that had five representatives from each one – 25, plus myself, plus the dean. After I left BJC, they added the chancellor of the university. You manage that type of a board through an executive committee. There was always a balance between the executive committee having one representative from each of the five founding organizations versus a larger board. That was always difficult. It was always important to me that the CEO be part of the board, which didn't happen in a lot of the hospital boards. That was always one requirement that I had – that I be a voting member ex officio, because of the position,

GARBER: What does ex officio mean?

BROWN: Ex officio means by virtue of your office. As president, you're automatically on, but if you leave the organization you are not obligated to continue on the board. You're off of the board because you're no longer in that position.

GARBER: What limits do you think there should be on board service?

BROWN: There should be limits. Now there are pros and cons because sometimes people say you destroy the history of the organization. Particularly in community boards, three three-year terms are sufficient. You have continuity because you don't have everybody going off at the same time. You regenerate the board through a third off every year, or every two years.

There's a point when you lose your effectiveness or you become stale in that particular

⁷⁰ Lynn R. Goldman, M.D., is dean of the Milken Institute School of Public Health and a professor at George Washington University. [George Washington University. *Leadership*. <http://publichealth.gwu.edu/about/leadership>]

⁷¹ Peter S. Fine has served as president and CEO of Banner Health, Phoenix, since 2000. Together with Fred Brown, he established the Fred Brown & Peter Fine HSML Scholarship at George Washington University. [Banner Health. *Peter S. Fine, FACHE, President & CEO*. https://www.bannerhealth.com/About+Us/Banner+Leadership/_Peter+S+Fine.htm]

position. As a CEO, I felt that ten years was an adequate time in one organization. Now I had the ten years at Christian but, of course, we morphed into BJC HealthCare. That was an entirely new organization. Sometimes you get into bad habits and you lose some of that energy level that you should have.

GARBER: Do you think that there should be age limits?

BROWN: That's an interesting question. Even though I retired from BJC at 59 years of age, here I am at 75 and active on six or seven health care boards, private equity-funded. We're all focused on age 65, but 65 today is different than 65 when Medicare was passed. People can be very productive when they're 65 to 75. If you're working with your hands as a surgeon or you're in a situation where you have to make decisions, maybe that's a different story. As long as you're active and healthy, 75 should be probably a max.

GARBER: What are the characteristics of a good board chair?

BROWN: A good board chair should really have an understanding of what the role of the board is. A board of trustees, or a board of directors in a for-profit setting, has three basic responsibilities. Number one is to be good stewards of the organization and ensure financial success. Number two is to assist and support and be a part of the strategic plan. Number three is that you hire and fire the chief executive officer. Those are the three critical elements. When you begin to try to micromanage and you try to oversee areas that the management team should be doing, you take away the credibility of that management team. You take away the support of that management team.

The chairman should be able to lead and guide the board through activities that focus on those three areas. There should be a good relationship between the chairman and the president of the organization. There should be a comfort level. I always used the concept of the kitchen cabinet. That was to bring the board together – it was a much smaller board when we were at Christian – maybe for an evening for dinner and conversation. If you were talking about a project or you were talking about a concept or you were talking about a direction, to get them involved and understanding a little bit about what you were thinking as the president of the organization or where you wanted to try to move the organization. That was not meant to usurp the committee structure of the board, because if you've got a committee structure, you've got to support that committee structure. I used it not as effectively with the executive committee at BJC. Trying to get that group together in an informal setting was more difficult because these were Fortune 100 individuals who did a lot of traveling with their own companies.

GARBER: I'm not sure I understand the concept of the kitchen cabinet compared with the executive committee. Who would typically serve on the executive committee?

BROWN: In the case of BJC, we had one representative from each of the five founding organizations. Along with myself, that constituted the executive committee.

GARBER: Who was on the kitchen cabinet?

BROWN: At Christian, we invited the entire board. This was an informal dinner meeting to discuss things. The board of BJC was so large and unwieldy, I had more one-on-one meetings with the board members, or verbal discussions over the phone or face-to-face, and didn't use the kitchen cabinet concept as much, because we had the executive committee, a much smaller group.

GARBER: Did the kitchen cabinet get together informally at a separate time?

BROWN: Yes. This would be completely separate from the board meeting or the normal meetings of the board. You would just bring everybody together for a dinner meeting on an informal basis. It wasn't done every month or routinely, but you would call it periodically to bring everybody up to speed.

GARBER: For a typical community hospital, how frequently does the board meet?

BROWN: Some meet on a monthly basis. My philosophy was that if you had a committee structure and you had a board, you should meet on a quarterly basis. What you want to do is balance the needs with the time of the board members who have their own businesses and their own activities. At the same time, you had committees that would meet. For example, the finance committee met on a monthly basis. The nominating committee met as needed. The long range planning committee met maybe three or four times a year. The clinical committee that reviewed clinical outcomes would meet maybe six times a year. It varied, depending upon the committee structure, but the board met on a quarterly basis.

GARBER: You just enumerated a number of committees. Was that all of them? You mentioned finance, nominating, long range planning, clinical outcomes.

BROWN: It was always the board's responsibility to approve any appointments, but that was normally handled through a medical staff credentialing process, and then that was brought up to the board. We had a clinical review committee. We had the strategic planning committee. We had the finance committee, which dealt with ongoing operations as well as investments. In other organizations, that's a separate committee. In ours it was combined – the investment and finance committee. The audit committee meets to review the audits and the outcomes of the audits. On some boards, that's the executive committee and sometimes it's a whole separate committee. Then the compensation committee – on the BJC board that was the executive committee. Those are normally the type of committees that you had.

GARBER: What's the relationship between the different committees? Does the governing board chair attend all those committee meetings?

BROWN: No. The governing board chair normally would not attend all those meetings. The president of the organization or a designee would attend the different committee meetings.

GARBER: The president or a designee would be staff to the committee, providing information.

BROWN: Exactly.

GARBER: Over the course of your career, did you find that the way you interacted with board chairs changed?

BROWN: It depends on the personality of the individuals. Some board chairs wanted a lot of data, a lot of information. Others required less information. I operated under the basic rule, don't surprise your chairman and don't surprise your board. That meant that you had to have the preparation. You had to have the communication. When you went into the board meeting, you really

wanted to have the expectation that you had touched all the bases to get approval of the particular project or items that you wanted to have approved. You didn't want to get into a debate or disagreement at a board meeting unnecessarily because someone hadn't been brought up to speed. You wanted to have that pretty well paved.

GARBER: I interviewed John King⁷² recently and we were talking about the way that Carl Platou⁷³ ran the Fairview organization and Carl's relationship with his board. It was exactly as you described – carefully prepared and controlled and structured in the formal board settings. However, John said that staff meetings at Fairview were wild and creative – the exact opposite of board meetings. Did you find that to be the case in your staff meetings?

BROWN: To a certain extent, because there you wanted input. You wanted feedback. You wanted criticisms or positive comments. When you began to take a look at whatever the project was, you absolutely needed to have that input. My philosophy was that you bring good people around you, because you're not making that decision yourself. You're making it as a composite, but ultimately you make the decision to bring forward to the board.

My strengths were in relationship and allowing people to operate within their particular area of expertise. It wasn't so much the financial piece. I knew the financial piece to be able to be safe, but I didn't know all the intricacies of the financial operations, so I always made sure of two things. Number one was that the chief financial officer always reported to me, and also that the chief of human resources always reported to me, because those were two critical pieces in a people organization.

I remember Sister Irene Kraus,⁷⁴ a former chairman of AHA, who made the comment one time, without the margin, you don't have the mission. Even though we were classified as a 501(c)(3), we still had to operate with an operating profit so that we could give back and purchase additional equipment and provide for the raises and support of the organization.

Staff knew that to come in and make a presentation, they needed to be fairly crisp with the top line. I wasn't going to go into a lot of the internal details, but I wanted to have an understanding and know what the bottom line was. I also wanted to know, number one, how did it impact our patients? Number two, was it legal? Number three, was it moral and ethical? We were saying: we

⁷² John G. King served as President/CEO of Legacy Health System (Portland, Ore.) from 1991 to 1996. Earlier he had been in leadership at Evangelical Health Systems (Oak Brook, Ill.), Holy Cross Health Systems Corporation (South Bend, Ind.), and Fairview Hospital (Minneapolis). His oral history: Garber, K.M. (Ed.). (2015). *John G. King in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <http://www.aha.org/research/rc/chhah/King%20-%20Transcript%20-%20FINAL%20for%20WEB%20-%20121815%20-%20Rev.%201.pdf>

⁷³ Carl N. Platou (1923-2012), attended the graduate hospital administration program at the University of Minnesota, earning his degree in 1951. Platou went on to a leadership role in creating Fairview Health Services (Minneapolis). His oral history: *Carl N. Platou in first person: An oral history*. (1993). Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center. [Obituary: hospital visionary Carl Platou transformed Fairview. (2012, May 31). *Minneapolis StarTribune*. Retrieved from <http://www.startribune.com/local/155858835.html>]

⁷⁴ Sister Irene Kraus (1924-1998), Daughters of Charity, served as the American Hospital Association chairman of the board in 1980, at which time she was president of Providence Hospital (Washington, D.C.). Her oral history: Weeks, L.E., (Ed.). (1988). *Sister Irene Kraus in first person: An oral history*. Chicago, IL: American Hospital Association, is in the collection of the American Hospital Association Resource Center.

want to be creative, we want to be forward thinking, we want to run an organization that's going to be responsive to change, but how does that impact the patient? What does that mean in terms of service to the patients? That was always the question I asked. Also, are we adding bureaucracy to the organization? Are we making a truly cutting-edge decision that's going to move the organization forward?

GARBER: The last thing that I'd like to ask about governance has to do with something that Ed Eckenhoff⁷⁵ told me in an interview. He was the founding CEO of National Rehabilitation Hospital in Washington, D.C. I asked him what he considered to be the characteristics of good board members. He said that they have to be so committed to the organization that they're willing to reach into their pockets when needed and make significant contributions to the organization.

BROWN: Within the Christian organization, we were not a big fundraising organization. Once BJC came together, the Jewish hospital raised a lot of money among the Jewish community, and Barnes, by virtue of its reputation, did also. When we created BJC, with the affiliation of Washington University, there was a concern about the leadership of Washington University. Bill Danforth, a physician, was chancellor – his grandfather was one of the founders of Ralston-Purina.⁷⁶

Bill Danforth and Lee Liberman,⁷⁷ who were the co-chairmen and were on my executive committee as a result of the relationship with Barnes-Jewish, were concerned about the money that we were raising under BJC's banner. We had full development staffs in the organizations, primarily in St. Louis Children's, Barnes-Jewish and Missouri Baptist, not so much at Christian. There was concern about this being in conflict with Washington University trying to raise money for the university.

During my experience at Methodist and Elmhurst Memorial Hospital, that wasn't the sole criterion for board members. The National Rehabilitation Hospital in D.C. was focused on a fundraising base, probably no different than the Rehabilitation Institute in Chicago. Some hospitals did select big donors, but you had a mix. You knew that there were certain ones who would be givers to the organization. Others had other interests. The criteria to select those individuals were not solely on their ability to give money.

That's different from a trustee-based organization like Northwestern University, which is going through a \$3.5 billion campaign. Most of those trustees are expected to give a certain amount when they are brought on the board. They bring on the CEO of IBM or the founding CEO of Crate

⁷⁵ Edward A. Eckenhoff was the founding president & CEO of the National Rehabilitation Hospital (Washington, D.C.) from 1982 to 2009. Before that, he held leadership positions at the Rehabilitation Institute of Chicago. His oral history: *Edward A. Eckenhoff in first person: An oral history*. (2015). Chicago: American Hospital Association, can be retrieved from <http://www.aha.org/research/rc/chhah/Eckenhoff%20-%20Transcript%20-%20FINAL%20-%20ONLINE%20-%2020050115.pdf>

⁷⁶ William H. Danforth II, M.D. served as chancellor of Washington University (St. Louis) from 1971 to 1995. [Weiss, R. (2013, Jan. 8). William Danforth, man of grace and accomplishment, accepts St. Louis award. *St. Louis Beacon*. https://www.stlbeacon.org/#!/content/28768/william_danforth_receives_award]

⁷⁷ Lee M. Liberman (1921-2012) served as a trustee of Washington University for 40 years. He was CEO of Laclede Gas for over 20 years, until his retirement in 1994. [Givens, S. (2012, Sept. 4). Obituary: Lee M. Liberman, life trustee, 91. *The Source* (Washington University). <https://source.wustl.edu/2012/09/obituary-lee-m-liberman-life-trustee-91/>]

and Barrel or Pat Ryan,⁷⁸ who was a fraternity brother of mine and who started out selling car insurance and built this into the huge insurance company Aon. He has now given back over \$200 million to the university. University trustees may be focused on that piece. They have outstanding leaders, but there is also an expectation of giving.

GARBER: What is your leadership style?

BROWN: Leadership style is a composite of experiences, both academic training and practical experiences. It is also what your mission and objectives are and what you as an individual are trying to accomplish, both in terms of your own abilities as well as reaching out to others. That always guided me. I always carry in my pocket a copy of my mission statement. It says three things basically: I will serve my fellow man, I will make my part of the world a better place for having been there, and I will bring out the best in others. I developed that when I was at the beginning of my career as president of Christian Hospitals. I wanted to exemplify Christian values. I wanted to be a coach. I wanted to appreciate the differences in people. I wanted to celebrate the success of others, and I wanted to give more than I took from society. I wanted to continually learn about the work and the world around me. The only thing that I didn't do a good job of was balancing between the quest to serve others and taking time for my own renewal. My mission statement is tattered, but I've always carried it around with me, and it's always guided me.

In terms of translating that to my leadership style, clearly it was one of recognizing that I was not an expert in probably anything, but I had an understanding of the operations within the hospital or health care system. I wanted to bring on people who were skilled and had expertise they could add.

Everybody talks about having the best and the brightest. That was important, but you also wanted to have the chemistry of the team. The management team that we created at Christian really drove the development of the Christian Health System. If you asked every one of the members of that management team, they would say those were the best years of their life in the health care field, because we were truly a family. We were truly a team. We truly appreciated what everyone did, and we recognized and celebrated our successes. That was very important to me, to have the right chemistry.

I could be mercurial at times. I could be volatile. Some of it was probably programmed. They knew not to come in with a long list of slides, but I listened. I wanted to develop people because my philosophy was that I wanted every one of them to have the opportunity to sit in my seat. I wanted people who were knowledgeable. Part of my leadership style was to reach outside the health care industry. As health care executives, we were trained to manage the operation, but we were not experts in HR. We were not experts in finance. We were not experts in IT. We were not experts in marketing/public relations. We were not experts in how to manage a for-profit business. We had to bring in that expertise to support the basic framework of those who were trained in health care administration – to round out the team.

That characterized how I viewed things. Did I expect results? Yes, I expected results, but did I kill somebody because they didn't meet that expectation? No. Did I give them opportunities to

⁷⁸ Patrick G. Ryan is an entrepreneur who translated an insurance agency that he opened after graduating from Northwestern University into Aon, a global insurance and reinsurance broker. After retiring from Aon, Ryan founded another start-up business, Ryan Specialty Group, in 2010. [Ryan Specialty Group. (2016). *Patrick G. Ryan, Chairman and CEO, Ryan Specialty Group*. http://www.ryansg.com/ourteam_ryan.php]

improve? Yes. Was it difficult for me at times to terminate people? Yes, it was, because I thought about the individuals, their families, their children. Sometimes it had to be done and you had to make those decisions. I prided myself on individuals who improved themselves and were able to move into CEO jobs or management jobs at other places.

I wanted to bring in that expertise. Our team meetings were a cross-section of all these individuals. I didn't limit it to two or three people in top-down decisions. Now that was counter at times to the chairman of BJC, but that was the way we operated because we felt that we accomplished more from a team approach than we could accomplish individually.

GARBER: When you're talking about creating a team approach you're talking about going all the way to the front-line caregivers?

BROWN: Absolutely.

GARBER: How does a leader go about creating a sense of family throughout the whole organization?

BROWN: Number one is visibility. Number two is commitment on your word. Number three is employee recognition activities. When I came to Christian, these were fairly routine. We'd recognize service anniversaries. They'd walk up, get their pins, shake hands, and they would move on. We created skits done by the administrative staff. One time, it was *Back to the Future* and the chief operating officer and I were the characters in *Back to the Future*. Another time he was Johnny Carson and I was Ed McMahon. Another time I was Elvis.

At one of our board retreats, we had the management team, medical staff leadership, the board, and their spouses. Everyone was required to attend all the meetings, including the spouses, so they learned a little bit. We had that interaction. I would make visits – when I was CEO of a single hospital, I was walking the halls. When I was CEO of a system, I would go to all these institutions and visit the employees so they would see that I cared.

I learned a lesson early when I came to Christian. The night shift had an extra week of vacation. It was a recruiting technique. We decided to take away that week and replace it with some other benefits. I never heard the end of that. I learned that once you give something, you can't take away.

As we became BJC, we would have all management staff meetings together. We'd have the meeting and then we'd go out and celebrate with an activity for 800 members where we would bring them all together. We would have sessions with different cross-sections so people would get to know each other. These were the type of things that you want to try to create. It was the old concept of managing by walking around. That was very important because, as we all know, we're a people industry. Care is based upon the caregivers.

I was as friendly to the lowest employee on the payroll as I was to a Ph.D. They knew that I cared. One time when I was at Christian, our HR Director said, "We've got this situation of an employee who's going to require special treatment that's going to cost like \$100,000. She's been with the lab for eight years, but we can't afford that." I said, "We can afford that. We can, and we're going to. She's been a loyal employee for years, so we're going to pay for that for her family." Those types of actions resonate down through the organization so people see that you really do care. That was my

trademark. If you asked somebody about Fred Brown, they would say he was very principled, he was very honest, he was very ethical, and he cared about us. He genuinely cared about us.

GARBER: Those are beautiful things to have anybody say about you.

BROWN: Thank you.

GARBER: Were there physicians who have been particularly helpful or champions of one thing or another that have been helpful to you?

BROWN: Several come to mind. It was fun for me to give a practicing physician the opportunity to do something on the management side.

I think of a fellow who recently passed away, John Headrick.⁷⁹ When I came to Christian, he was the chief medical officer, and just as bright as they come. The staff trusted him.

When he retired, I brought in a gentleman from Colorado who had a different management style – Bob Hartley. Bob was a little bit more aggressive, and it was during the time of managed care. It was during the time of physician acquisitions.

Sam Nussbaum was our chief medical officer with BJC. As we evolved, I gave him more and more responsibility in the managed care area. He developed a leadership series for physicians to learn more about operations and more about integrated delivery systems. He began to focus more and more on the managed care piece. He went on to become the chief medical officer for WellPoint.

Bill Peck⁸⁰ was the dean of the medical school at Washington University, which is ranked number three in the nation in terms of research grants. We had our moments, but each was protecting the turf of their organization. We worked through our issues and remain good friends. He was an excellent administrator – and an excellent politician – because he had to manage all the full-time chairmen.

Ron Evens⁸¹ comes to mind, the youngest chairman ever appointed at Washington University. He chaired the Department of Radiology. He came from a small town in southern Missouri.

When I think about Elmhurst, I think about the physicians who managed the Elmhurst Clinic,

⁷⁹ John A. Headrick, M.D. (1931-2015) was an internist who practiced at Christian Northeast Hospital, becoming the first vice president for medical affairs in 1976. [Dr. John A. Headrick: Obituary. (2015, July 27). *St. Louis Post-Dispatch*. <http://www.legacy.com/obituaries/stltoday/obituary.aspx?pid=175373257>; and, *Christian Hospital: The story of Christian Health System*. (1998). BJC Health System.]

⁸⁰ William A. Peck, M.D., served for 14 years as dean of the Washington University School of Medicine until 2003, when he became director of the Center for Health Policy at Washington University. [Dr. William Peck provides leadership as dean, doctor, researcher. (2004, Oct. 24). *St. Louis Business Journal*. <http://www.bizjournals.com/stlouis/stories/2004/10/25/focus5.html>]

⁸¹ Ronald G. Evens, M.D., was selected to become director of the Mallinckrodt Institute of Radiology at the Washington University School of Medicine in 1971, when he was 31 years old, and remained in leadership there for 28 years. [Washington University. (2016). *Commencement: Ronald G. Evens, MD*. <https://commencement.wustl.edu/people/ronald-g-evens-md/>]

and the leadership they provided. Don Hoffman,⁸² who was an excellent pediatrician and an excellent manager. Charles Gutzmer, who was the chairman at the time, as I had mentioned, with Bob Magnuson, and Ralph Ryan.

There was an iconic individual – Sam Wells⁸³ – who had been the chairman of the Department of Surgery for many years at Wash U, ruling that with an iron fist. There were individuals that we encouraged to go back for their MBA, and now one of them is the medical director at Texas Health Resources.

Clay Dunagan⁸⁴ still heads up the clinical activities at BJC. We approached him as a young faculty member and physician in internal medicine, and said, “We’d like you to focus on clinical outcomes.” He’s become one of the knowledgeable people in the field of clinical outcomes. I remember sitting across from him at dinner, and he said, “I’m not sure I can do this. I don’t know that much about how you do the methodology.” I said, “You’re a brilliant individual, and we’ll help you learn.” Now he’s one of the leaders in terms of quality outcomes.

John Rice,⁸⁵ who was one of the physicians I brought on the board of BJC, who was a good friend, and at the forefront of a physician group. They didn’t only practice at Christian. They practiced at other facilities. But it was a large group. He was an internist, and just a wonderful individual.

GARBER: What does a hospital mean today?

BROWN: The hospital was always the foundation piece in each community. When I started back in the ‘60s, public health and hospitals were more linked together. As I mentioned, Medicare and Medicaid were really the first attempts of the government to create a health policy. We migrated away from that with our public health agencies and the hospitals. Yet the hospital was still the foundation. As we attempted in the ‘80s and the ‘90s to create what we thought were going to be the integrated delivery systems, we didn’t have the ability to create a defined population base. People were going in and out of our system to other systems. We had a certain number that were at risk, but it was a small number in terms of our total patient base.

We went through the process, as others did, of hiring physicians. We had difficulty managing that piece of it because of issues of incentives and issues of physicians wanting more time off and that type of thing. We lost some of the entrepreneurship of physicians. We developed the insurance piece, but ultimately sold that back to the insurance companies.

⁸² Don Hoffman, M.D., practiced as a pediatrician for 36 years, retiring in 2008. He served as CEO of the Elmhurst Clinic and on the board of Elmhurst Memorial Health Care. [IC Catholic Prep. *Chairman of the board.*

<http://www.iccatholicprep.org/about-iccp/board-of-directors/dr-don-hoffman-m-d/>

⁸³ Samuel A. Wells, M.D., a surgeon, served as chair of the department of surgery at the Washington University School of Medicine from 1981 to 1998. He later became director of the Thyroid Clinical Research Program within the National Cancer Institute. [IThyCa: Thyroid Cancer Survivors Association. *ThyCa medical advisors.*

<http://www.thyca.org/medical-professionals/thyca-medical-advisors/>

⁸⁴ William Claiborne Dunagan, M.D., an internist, is senior vice president and chief clinical officer at BJC HealthCare. [BJC HealthCare. *Wm. Claiborne Dunagan, MD, MS.* <http://www.bjc.org/About-Us/Leadership/Profile/ArtMID/695/ArticleID/19/Wm-Claiborne-Dunagan-MD-MS>]

⁸⁵ John H. Rice, M.D., an internist, is executive vice president and chief medical officer at Esse Health, a physician group with various locations in the greater St. Louis area. [Esse Health. *John H. Rice, M.D.* <http://www.essehealth.com/provider/john-h-rice-md/>]

The three components – the hospitals, the physicians and the insurers – were not in balance. One was trying to get ahead of the other. The physicians didn't trust the hospitals. The physicians didn't trust the insurers. The insurers didn't trust anybody, because costs were continually rising. Hospitals were banding together and creating systems to offset the power of the insurance companies.

I used to say that the happiest day of my life would be if I drove into the hospital parking lot and there weren't any cars there. Why? Because we would have pushed everybody out to the outpatient setting. However, we still continued to build these huge buildings and expected everybody to come to us.

With the Affordable Care Act, number one was, we all wanted care for all. When I started with Methodist, when you asked the question – is health care a right or a privilege? – more people said it was a privilege. Over time, as we migrated more to “it's a right,” we had an opportunity under Clinton, a one-time opportunity, to come up with a health care system that covered all. Unfortunately, because of the way that that was structured and because of political issues, it never went anywhere. We had a possibility with Obamacare, but unfortunately, it became polarized between the political parties, and the Obama Administration did not want to offend the insurers. Basically, it was created as an insurance act.

Now we're going through the same process again, trying to develop – again – organizations that can handle risk, organizations that will be able to operate under bundle payments. But what's happening is, you've got the same players. Everybody is vying for a seat at the table and everyone is vying to become the dominant player. Again, it's that concept of imbalance between the three groups.

This time there is more of a blending. Insurers are working with providers. Physicians want to be purchased and be part of that organization. The question really is, do you have in the community the ability to attract physicians, to build and have the best and latest equipment? That hasn't changed over the years. That hasn't changed at all. We have movement into the outpatient area, but not to the extent that we should.

All of a sudden, you have walk-in clinics, the Take Cares of the world, or the program that CVS has. It was amazing how short a time that it took for brand awareness of these clinics to occur. When Take Care was only a concept, I was on the board of that. When CVS bought MinuteClinic, then Walgreens had to play in the game. All of a sudden, it was in multiple Walgreens around the country, and CVS, Wal-Mart, Target. The insurers are playing more of a role of not only being the insurer, but also having their own groups of physicians, their own urgent clinics and this type of thing. There is a growing trend of that.

Hospitals are at a crossroads as to what they will represent. In this country, health care is the second largest sector after defense. It drives a lot of the economy. Yet we're still on an increased cost curve that's going back up. Premiums are going back up. As the federal government withdraws some of the subsidy and states are reacting, we're beginning to see a push to eliminate some of the Medicaid activities. We should be moving in the other direction.

As I talk with my generation of colleagues, we say that maybe we should have a single payer system, which was unheard of us saying previously. We are realizing that we still have some of the same basic issues. Groups that have been competitive with each other are trying to be organizationally together. More hospitals are getting back into the health plans. Health plans are joint venturing with

hospitals and health systems. Hospitals are continuing to consolidate. Yet, our mortality data are still not as good as other countries. All those forces are working, and on top of it, you have all the federal regulations and all the state regulations that hospitals have to manage.

The jury is out. The hospital will continue to be a foundation for most communities going forward. We will have to operate in a different manner, and will move to a true risk-based model, and a sharing model based on value. Hospitals have had issues in not making change until it came down from either federal government regulations or policy or what have you.

I applaud the Affordable Care Act because we did increase coverage limits and we should have. It was a quick political fix because when you take a look at the Medicaid program by itself, or the Medicare program by itself, or the CHIP program – the Children’s Health Insurance Program – those work very well. Why didn’t we just expand Medicare to a larger population base? Why didn’t we just expand that, a program that works? There are issues about going from Medicare Advantage plans to traditional Medicare, but that’s okay. You can migrate more people into a Medicare Advantage plan. I think we’re still going to be in some turmoil. Unfortunately, there’s polarization in Congress.

GARBER: How did you manage work / life balance?

BROWN: I had difficulty with that. When I thought about taking a vacation, I’d think, “Oh, my gosh, if I leave, what’s going to happen?” Part of that might be the insecurities that have been with me all my life. I was married, the first time, for 32 years. We went to Washington, D.C., and she worked while I went to graduate school. We had two wonderful kids who are both very successful today, who have wonderful families and children.

The pressure of going from Christian, which was like a family environment, to a major system that had all of eastern Missouri and southern Illinois, was a factor in us growing apart. Her interests were different than my interests; I was focused on the organization. I tried to be there for all the children’s activities, but she had to take the primary burden of raising the kids. Once the children graduated from college, we decided that maybe it was better to part, even after 32 years.

When I remarried a couple years later, it was a different situation. My wife’s daughter, who passed away in May 2015, battled kidney disease. I remarried towards the end of my career at BJC when I was moving into the chairmanship of AHA, and then the Joint Commission. My wife was active in the National Kidney Foundation and I served as chairman – we had a common interest there.

I didn’t do a good job of balancing that. There’s no question about it. If you ask my regrets, it was that. Do you toss away 32 years of a partnership? That was the result of the pressures and trying to balance between your family and your organization. It was a tough one to manage.

GARBER: In a job like yours is it always going to be true that the spouse is going to have to bear the principal burden of child care and is going to have to subordinate his or her career?

BROWN: I think that’s a possibility. In health care, our meetings were not scheduled only at three in the afternoon or ten in the morning. They have to be scheduled to accommodate physicians at six or seven in the morning or at seven or eight at night. Hospitals never shut down. Hospitals never have a holiday. They operate 24/7.

GARBER: Is there anyone else you'd like to mention before we close?

BROWN: Yes, I don't want to forget my lifelong friend, Dave Woodrum.⁸⁶ We grew up together, competed against each other in sports, went to grad school together. He later became the executive vice president and COO at the American Hospital Association. I will probably get emotional here. I never thought I'd have the opportunity to make change and create opportunities for others that I did. I wouldn't have traded a minute. My only regret is that when I retired as vice chairman and walked away from that interaction of the family of the hospitals and communities, there was a void in my life. Not because I was a president and had executive assistants and all that. It was because I missed the interaction with the people. They are the heroes. They're there every day taking care of people. Those are the real heroes. I don't regret a day. I was blessed. I was absolutely blessed.



American Hospital Association Board leadership in 1999, on the occasion of Fred Brown's investiture as Chairman. Left to right: Dick Davidson (President & CEO), John G. King (Past Chairman), Jane King, Shirley Brown, Fred Brown (Chairman), Carolyn Boone Lewis (Chairman Elect), Raymond Apollon

⁸⁶ David L. Woodrum was executive vice president / COO at the American Hospital Association from 1987 to 1991. [American College of Healthcare Executives. (2000). *2000 directory*. Chicago: ACHE.]

CHRONOLOGY

- 1940 Born October 22 in Clarksburg, W. Va.
- 1962 Northwestern University, Evanston, Ill.
Bachelor of Arts, Psychology (major)
- 1962-1964 Cook County Department of Public Aid, Chicago
Vocational counselor
- 1964 Married August 24 to Mary Ruth Price of Dumas, Arkansas
Children: Gregory, Michael
- 1965-1974 Methodist Hospital of Indiana, Inc., Indianapolis, Ind.
1965-1966 Administrative Resident
1966 Administrative Assistant
1966-1971 Assistant Administrator
1971-1972 Associate Administrator
1972-1974 Vice President for Operations
- 1966 The George Washington University, Washington, D.C.
Master's in Business Administration, Health Care Administration (major)
- 1974-1982 Memorial Hospital of DuPage County, Elmhurst, Ill.
Executive Vice President and Chief Operating Officer
- 1980-1982 Memorial Health Services, Elmhurst, Ill.
Executive Vice President and Chief Operating Officer
- 1982-1993 Christian Hospital Northeast-Northwest, St. Louis, Mo.
1982-1993 Board of directors
1982-1989 President and Chief Executive Officer
1991-1992 Vice Chairman
1992-1993 Chairman and CEO
- 1983-1993 CH Allied Services, St. Louis, Mo.
1983-1985 President and Chief Executive Officer
1988-1991 President and Chief Executive Officer
1991-1993 Chairman, President and CEO
- 1983-1993 CH Health Technologies, Inc., St. Louis, Mo.
1983-1991 President and Chief Executive Officer
1991-1993 Chairman, President and CEO
- 1986-1993 Village North, Inc., St. Louis, Mo.
1986-1991 President and Chief Executive Officer
1991-1993 Chairman, President and CEO

1986-2003 Christian Health Services, St. Louis, Mo.
 1986-1993 President and Chief Executive Officer
 1986-2003 Board of directors

1993-2000 BJC HealthCare, St. Louis, Mo.
 1993-1998 President and Chief Executive Officer
 1993-2000 Board of directors
 1999-2000 Vice Chairman

1997 Married June 27 to Shirley Jean Fiille of Cincinnati, Ohio, on June 27
 Stepchildren: Kyle and Kathryn

2002-present The George Washington University, Milken Institute School of Public Health
 2001-2002 Visiting Scholar and Executive-in-Residence
 2002-present Professorial Lecturer

2005-present Fred L. Brown & Associates, LLC, Scottsdale, Ariz.
 Chairman

SELECTED MEMBERSHIPS AND AFFILIATIONS

1-800 Doctors, Inc.
 Member, Advisory Board

Abundant Ventures, Inc.
 Member, Advisory Board

Advertising Club of St. Louis
 Member

Alpha Home Extended Care Facility, Indianapolis
 Chair, Finance Committee
 Member, Advisory Committee
 Member, Executive Committee
 Treasurer

Alton Memorial Hospital (Alton, Illinois)
 Member, Board of Directors
 Member, Compensation Committee
 Member, Finance Committee

American Academy of Medical Administrators
 Lifetime Fellow
 Member, Diplomat Committee
 Member, Long Range Planning Committee
 Member, Strategic Planning Committee
 State Director

American Cancer Society, Indiana Division
Chair, Allied Health Sub-Committee

American College of Healthcare Executives
Chair, Awards & Testimonials Committee
Chair, Committee on Credentials
Chair, Task Force on Governance and Constituencies
Governor, District 5
Life fellow
Member, Committee on Ethics
Member, Committee on Gold Medal Award
Member, Editorial Board for the Management Series
Member, Finance Committee
Membership Examiner
Membership Section
Regent for Missouri

American Excess Insurance, Ltd.
Member, Board of Directors

American Healthcare Systems
Chair, Communications Council
Chair, Nominating Committee
Chair, Shareholder Communications
Member, Ad Hoc Succession Committee
Member, Board of Directors
Member, Executive Committee
Member, Finance Committee
Vice Chairman

American Hospital Association
Chairman, Board
Chair, Ad Hoc Committee on Future of Health Services Libraries & Information
Chair, Committee of Commissioners
Chair, Finance Committee
Chair, Nominating Committee
Chair, Political Action Committee
Delegate, House of Delegates – Systems Section
Delegate, RPB 6
Judge, Great Comebacks Contest
Member, Ad Hoc Committee on Data Disclosure on Quality
Member, Board of Trustees
Member, Council on Management
Member, Environmental Leadership Council
Member, Executive Committee
Member, Governing Council on Healthcare Systems Section
Member, Nova Award Selection Committee
Member, Regional Policy Board Nominating Committee

Member, Tools for Change Committee

American Protestant Health Association

Chair, Board of Directors

Member, Executive Committee

Member, Hospital and Human Services Ministries Council

Vice Chair, Council for Professional Growth/Education

American Public Health Association

Member

Annie Malone Children's Home

Chair, Honorary Soiree

Applied Pathways

Member, Board

Barnes-Jewish Hospital (St. Louis, Missouri)

Member, Board of Directors

Blue Cross Blue Shield of Missouri

Member, Corporate Assembly

Camden Partners Holdings, LLC

Member, Board

Central Eastern Missouri Professional Review Organization

Member, Board of Directors

Member, DATA Committee

Member, Medical Advisory Committee

Member, Monitoring Committee

Member, Nominating Committee

Chi Systems, Inc.

Charter Member, Advisory Board

Chicago Hospital Council

Member, Committee on Administrative and Professional Practices

Member, Committee on Insurance

Member, Committee on Personnel Practices

Member, Task Force on Physician Compensation

Chicago Hospital Risk Pooling Program

Chairman

Community Nursing Service of DuPage County, Illinois

Member, Board of Directors

Member, Finance Committee

The Emergency Medical Services Commission of Metropolitan Chicago
Member

First United Methodist Church, Elmhurst, Illinois
Member, Administrative Board

Florissant, Missouri, Fine Arts Council
Member

From All Walks of Life – St. Louis AIDS Walk
Member, Board of Directors

Future of School System, Elmhurst, Illinois
Member, Task Force

George Washington University
Co- Chairman, Milken Institute School of Public Health Major Gifts Campaign
Co-Chairman, 50th Anniversary Gala Celebration for the Milken Institute
Member, Dean's Council for the School of Public Health and Health Services

Governor of the State of Missouri
Member, Honorary Inaugural Committee

Greater Indianapolis District of the Indiana Hospital Association
Member, Task Force Understanding

Healthcare Executives Study Society
Member

HealthLink, Inc.
Chair, Board of Directors
Chair, Nominating Committee
Chair, Search Committee
Member, Executive Committee

Hospital Association of Metropolitan St. Louis
Chair, Board
Chair, Council on Public Affairs and Communication
Chair, HIDI Special Data Task Force
Member, Ad Hoc Utilization Committee
Member, Cost Effectiveness Committee
Member, Council on Management Services
Member, Executive Committee
Member, Hospital Physicians Relations Committee
Member, Medicaid Committee
Member, Public Policy and Issues Committee
Member, Shared Resource Enterprises, Inc., Board

Secretary, Board
Treasurer, Board

Hospital Presidents Association
Member

Illinois Hospital Association
Member, Council on Nursing
Member, Regional 2B Organization

Indiana Hospital Association
Member, Legal and Legislative Council
Member, Planning Committee Tomorrow's Administrative Conference

Inter-Hospital Planning Association of the Western Chicago Suburbs
Chair, ER Medical Committee
President

The Joint Commission
Chairman, Board of Commissioners

Jump
Member, Advisory Board

The Kammergild Chamber Orchestra of St. Louis
Member, Board of Directors
Vice President

Kiwanis Club, Elmhurst, Illinois
Chair, Citizenship Services Committee
Chair, Major Emphasis Committee
Member, Board of Directors

Medical Scribe Systems, Inc.
Member, Board

Missouri Baptist Medical Center (St. Louis, Missouri)
Member, Board of Directors

Missouri Department of Social Service
Member, Medicaid Budget Task Force

Missouri Heart Institute
Member, Board of Directors

Missouri Hospital Association
Chair, Annual Meeting Committee
Chair, Board

Chair, Committee on Multi-Hospital Systems
Chair, MHA Management services Corporation
Chair, Nominating Committee
Member, Council on Research & Policy
Member, District Council Presidents
Member, Special Task Force on Health Reform
Member, Task Force on a Vision for Quality Health Care in Missouri

Missouri Hospital Assurance Association
Member, Board of Directors

National Kidney Foundation of Eastern Missouri and Metro East
Co-Chair, Physicians' Pheast fund raiser

Next Care Holdings, Inc.
Member, Board

Nexus Health Capital
Member, Board

Northwestern University
Chairman, Alumni Board of Regents
Member, Board of Governors of Northwestern University Libraries

President Clinton's Council on Year 2000 Conversion
Senior Advisors Group

RestorixHealth, Inc.
Member, Board

Rotary Club, Florissant, Missouri
Member

Sandlot Solutions, Inc.
Member, Board

Santa Rosa Holdings
Chair, Advisory Board

Scott Air Force Base Air Mobility
Member, Commander's Consultation Committee

Sentient Medical Systems, Inc.
Member, Board

Sold on St. Louis Campaign of the RCGA
Member, Board of Directors

St. Louis American Heart Association
Chair, Honorary Ball

St. Louis Area Council of the Boy Scouts of American Hospital Association
Chair, Activities Council
Chair, Annual Meeting
Chair, Friends of Scouting
Chair, North Star District
Chair, Strategic Plan Committee
Member, Executive Board

St. Louis Children's Hospital
Member, Board of Directors

St. Louis City and County Health Care
Member, Task Force

St. Louis Metropolitan Medical Society
Lay Advisor

St. Louis Multiple Sclerosis Society
Honorary Chair, Annual Fund Drive

St. Louis Regional Commerce and Growth Association
Chair, Campaign for a Greater St. Louis
Member, Board of Directors
Member, Executive Committee
Member, Nominating Committee

St. Louis Regional Medical Center
Chairman, ER Services Task Force

St. Louis Senior Assist, Inc.
Member, Board of Directors

Supplemental Health Care
Member, Board

United Fund of Greater Indianapolis, Inc.
Member, Allocations Committee

United Hospital Services, Inc., of Indianapolis
Member, Shared Laundry Services Board

United Methodist Church, Wentzville, Missouri
Member, Board

United Way of Greater St. Louis

Chair, Audit Committee
Chair, Board of Directors
Chair, Contractual Agencies Committee
Chair, Health Services Division
Chair, Hospital Division
Member, Administrative Budget Committee
Member, Board of Directors
Member, Compensation Committee
Member, Executive Committee
Vice Chairman, Region

Webster Hills United Methodist Church, Webster Groves, Missouri
Member, Board of Trustees

AWARDS AND HONORS

- 1974 *Outstanding Young Men of America*
- 1984 Gold Award for Communications, United Way of Greater St. Louis
- 1981 Alumnus of the Year Award, The George Washington University Alumni Association for Health Services Administration
- 1984 [and subsequent years] *Who's Who*
- 1990 Healthcare Executive of the Year Award, American Academy of Medical Administrators
- 1992 Chapter Honoree of Beta Gamma Sigma, National Honor Society in Business Administration
- 1992 Special Recognition Award, North County, Inc.
- 1992 Statesman in Healthcare Administration Award, American Academy of Medical Administrators
- 1993 Flame of Leadership, National Council on Youth Leadership
- 1993 Frederick H. Gibbs Award for Excellence in Graduate Education, The George Washington University Alumni Association for Health Services and Policy
- 1994 Distinguished Volunteer Service Award, University of Missouri-St. Louis
- 1995 Alumni Recognition Award, The George Washington University General Alumni Association
- 1995 Distinguished Service Award, Missouri Hospital Association
- 1995 Doctor of Humane Letters, hon. caus., from the University of Missouri, St. Louis
- 1995 Participant, White House Ceremony, U.S. Latvia Health Initiative

- 1997 Distinguished Lecturer – 26th Annual Wendell G. Scott Lecture, Washington University School of Medicine, Mallinckrodt Institute of Radiology
- 1997 Distinguished Service Award, American College of Chaplains
- 1998 Better Business Award for Customer Service
- 1998 Senior Level Healthcare Executive Regent Award, American College of Healthcare Executives
- 1999 Alumni Recognition Award, The George Washington University School of Public Health and Health Services Management & Policy
- 1999 Appointment, President Clinton's Senior Advisors Group on Y2K
- 1999 National Quality Health Care Award, National Committee for Quality Health Care
- 1999 Second most integrated health care system recognition, SMG Marketing & *Modern Healthcare*
- 1999 Significant Sig Award, National Sigma Chi Fraternity
- 2000 Gold Medal Award, American College of Healthcare Executives
- 2000 National Healthcare Award, B'nai B'rith International
- 2001 Distinguished Alumni Achievement Award, The George Washington University
- 2005 Martin Wagner Memorial Award, National Kidney Foundation
- 2008 Distinguished Lecturer – Eighteenth Annual Gibbs Oration, The George Washington University School of Public Health and Health Services
- 2008 Distinguished Service Award, American Hospital Association
- 2014 *Modern Healthcare* Hall of Fame

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- Brown, F.L., and Lerner, W.M. (1997). On governance and governing. In *Integrated delivery systems: Creation, management, and governance* (269-277). Chicago: Health Administration Press.
- Lerner, W.M., and Brown, F.L. (1997). Negotiating the merger; and, On governance and governing. In Lerner, W.M. (Ed.), *Anatomy of a merger* (pp. 19-28, 43-51). Chicago: Health Administration Press.

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