HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Foster G. McGaw

FOSTER G. McGAW

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

Produced in Cooperation with

Library of the American Hospital Association
Asa S. Bacon Memorial

Sponsored by
American Hospital Association
and
Hospital Research and Educational Trust
Chicago, Illinois

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Foster G. McGaw

Credit: Karsh, Ottawa

CHRONOLOGY

1897	Born Hot Springs, NC, March 7
1911	Keokuk (Iowa) High School graduate
1916-1918	Huston Brothers, Chicago, salesman
1918-1919	U. S. Marine Corps
1920-1922	Colonial Hospital Supply Company, salesman
1922-	American Hospital Supply Corporation, founder

MEMBERSHIPS AND AFFILIATIONS

American College of Hospital Administrators
Fellow

Art Institute of Chicago
Member

Chicago Club
Member

Chicago Symphony Society
Life Member

Commercial Club of Chicago
Member

Economic Club of Chicago
Member

Evanston Chamber of Commerce
Life Member

First National Bank & Trust, Evanston
Director

Glen View Club
Member

Institute of Medicine of Chicago
Citizen Fellow

McGaw Medical Center of Northwestern University
Honorary Director

Mid America Club
Member

National College of Education
Life Trustee

Northwestern University
Life Trustee

Onwentsia Club
Member

Presbyterian Club of Chicago
Member

MEMBERSHIPS AND AFFILIATIONS

(continued)

Presbyterian Home of Evanston
Honorary Director

Rotary Club of Chicago
Member

AWARDS and HONORS

American Medical Association
Citation for Distinguished Service, 1981

American Protestant Hospital Association
Trustee Award, 1972

American Statistical Association, Chicago Chapter
Decision Maker of the Year Award, 1969

Chicago Association of Commerce and Industry
Maker of Chicago Award, 1976

Cumberland College
L.H.D. (Honorary), 1980

Greater Chicago Churchman Award, 1968

Illinois St. Anthony Society
Distinguished Citizen Award, 1970

Illinois Wesleyan University
L.H.D. (Honorary), 1953

Lake Forest College
L.H.D. (Honorary), 1980

Laureate, Chicago Hall of Fame, 1983
Junior Achievement of Chicago

Loyola University of Chicago
L.H.D. (Honorary), 1972
Sword of Loyola, 1973

Maryville College
L.H.D. (Honorary), 1981

National College of Education
L.H.D. (Honorary), 1974

National Society of Fund Raising Executives
Outstanding Philanthropist, 1979

Northwestern University
L.H.D. (Honorary), 1973

AWARDS and HONORS

(continued)

Protestant Foundation of Greater Chicago
Distinguished Citizen Citation, 1971

Rotary Club of Chicago
Merit Award, 1974

School of the Ozarks
L.H.D. (Honorary), 1978

Yankton College
L.H.D. (Honorary), 1980

McGAW:

To understand what the author portrays in a biographical sketch, it seems desirable that the reader understands the background of the author.

From the beginning of my life, it seems to me that a Superior Power was influencing my life and making decisions for me so that each step led to the next logical one, making successive steps more productive because of the previous experience.

As a boy between 10 and 12 years of age, I spent summers on an uncle's farm and learned to drive horses and even plow corn when you had a team of horses on a cultivator where you ride with a foot on each side of a row of corn and a horse between each of those rows. You could do this until the corn got more than three feet high.

In high school, I spent one summer working for Stone Webster Company which was building a dam across the Mississippi River which became an electric power plant. I was a "blueprint boy," and made all the blueprints from the tracings the engineers drew that told the workmen exactly where to do what. That was a most interesting experience all in itself.

Halfway through high school, necessity required my going to work, and my job was with the branch office of Standard Oil of Indiana in Keokuk, Iowa, where in two years, I had jobs from stockboy to assistant cashier. In those two years, without knowing it, I was getting the basis of a business school education that young people seek after college.

After two years I thought that I could go to college once I finished high school, so I quit that job and went back to school, finishing the last two years in one year and took an extra course in typewriting. The value of that extra course will be apparent later.

During my last year in high school, a man who had married a cousin of mine was visiting in Keokuk, and asked me what I was going to do after I got out of high school. I said, "Seek some work," as I found I couldn't go to college as the family needed additional income. I accepted his offer of a job.

The night I graduated from high school I got on a train and was in Chicago the next morning, met by Merrick Huston. He took me home with him and put me to work in his office.

Huston Brothers sold surgical instruments to doctors. After a few months in the office, I decided I wanted to be a salesman, and one of the older salesmen urged the boss to let me do it. He said he would start me off with some of his own customers.

George Palmer, that older salesman, gave me the names of his doctors, and I started in Rockford and worked my way west and met Palmer in Dubuque at the end of my first week. We reviewed what I had sold and any spots where I failed to get orders. Selling was my "cup of tea" I knew, so I went on from there on my own into Minnesota and the two Dakotas, and for two years, sold

doctors and clinics. I even sold some instruments to the Mayo Clinic and met Charlie Mayo, a charming, gracious surgeon.

After these two years, I decided that I should enlist in the Marine Corps as the war seemed quite ominous in Europe. I was promised I would be in France in six weeks. I was sent to Philadelphia at the boot camp of the Marine Corps on League Island. After a few days of training on a drill field, the drill sergeant lined us all up and said, "Anyone in this outfit who can operate a typewriter, step three steps forward." I alone stepped three steps forward promptly, and found I had myself the job of company clerk. This enabled me to avoid all KP duty and guard duty. It was true through my two years with the Marine Corps.

Our company, the 158th, which was 300 men strong, was all set to go to Guantanamo Bay. One hundred of those men, including my top sergeant, myself, our commanding officer and one colonel, were left at Guantanamo Bay, and the other two companies went on down to the West Indies at two other locations.

For two years, the Marine Corps gave me an experience that was not entirely my impatient preference, but it was a very interesting and valuable experience.

When the armistice was signed, I thought, "We'll soon get home." The company to which I was attached did go home in September, the following year after the armistice was signed. But because I was the only available sergeant major, they sent me to San Juan Hill where Teddy Roosevelt made his famous ride. This was just outside Santiago, Cuba, a beautiful city. I had another five months there and got to know Cuba because we had freedom to go into the city any night and on weekends. I traveled over much of that part of that

province.

After the war, I went back to my old job but chose not to go back to doctors. I had seen so much in my dealings with the doctors in the two years prior to the war that I thought the hospital field was where the future lay, for me. I saw so many things being done the wrong way. One example was in surgery. Each surgeon had a cabinet with his own surgical instruments. He had to supply his own suture material, his own dressing material, his own gloves. Imagine the poor surgical nurse who had to deal with an operating staff where there were five or six surgeons, and how much trouble she encountered if she placed the wrong instrument in the wrong case after they had been used.

As a salesman for the Colonial Hospital Supply Company, instead of having the whole world as my territory, I said I wanted one state only. I chose the state of Iowa. Because the hospitals were using up material constantly, I felt that this business of buying from New York houses who sent salesmen through twice a year was an absolute waste of their money -- so much was tied up in inventory.

Consequently, I started out selling the people on the idea that I was going to call on them every month, and persuaded them that they didn't need to buy more than a month's supply of anything that they were using. This applied particularly to gloves, suture materials, dressings, and the consumable items they used constantly.

We began to change the buying habits of all those people in Iowa, and all this time I was getting more ideas about what could be done better in the way of providing service to the hospital, and the way the hospital purchased

materials they needed.

About that time, I got acquainted with Harry Drake. We played tennis together on the Northwestern tennis courts. One day after a game, he said, "Mac, you and I ought to go into this hospital supply business you're so enthusiastic about."

I said, "I'm for that if you supply the money."

He said, "Maybe we could buy out Colonial Hospital Supply."

I said, "Let's try."

We tried and we had a deal made with them, but when it came to closing the deal, the owner, Emil Lindholm, said, "I've decided I need $15,000 more. That $15,000 is for my good will."

I replied to him, "You haven't any good will, and we won't give you any more."

He said, "Well, I won't sell then."

So Harry Drake and I decided, "Let's do it ourselves."

That was the genesis of American Hospital Supply Corporation. I chose this name because it meant we didn't have to tell customers what our business was when we introduced ourselves. The name told it all.

It was a very challenging, but a most interesting event in my life, when we started from scratch. We had to sell salesmen on the idea of going to work for us with nothing but a drawing account to live on until they earned more than that through sales. Even finding the right people to work on the inside was critical. And we had to convince suppliers we were worth their credit, goods and services.

The first years were the hardest because we had so much to do and nobody

had ever heard of our company, and very few in the hospital field knew me. But fortunately, by going to the conventions when I was with Colonial, I did meet some of the leaders in the hospital field, and they became staunch friends.

I remember Asa Bacon, superintendent of the Presbyterian Hospital, one of the first men superintendents. Dr. Basil MacLean, another in Rochester, New York; Dr. Robin Buerki, at Wisconsin General Hospital which he headed until the University of Pennsylvania called him to head up their hospitals and medical school. I had met Bob (Robin) Buerki and Rocky (J. Roscoe) Miller at a meeting I went to because of Bob's suggestions.

It was a meeting of American Deans of American Medical Colleges at Sun Valley. It was where I first met Rocky Miller, who was then Dean of the Northwestern Medical School, and later became one of the best presidents they ever had.

Rocky Miller was, without question, my closest personal friend. When he died, I experienced a real personal loss because we did so many things together. He was a superior individual.

His specialty was cardiology, but he understood public relations and handling people better than anybody I have ever known.

During the 1930s and 1940s, a few men were emerging in the hospital field who would have quite an influence on the whole profession. One was a young man named Richard Stull, who I got acquainted with in California, and who impressed me strongly. Dr. Francis Scott Smith (a cousin of mine) was superintendent of California Hospitals in San Francisco, state institutions. He was a doer, an idea man, but he needed a man who knew how to plan systems

and handle details. I put him in touch with Dick Stull, whom he hired instantly and they were an ideal team. Each benefited from the other.

Dick Stull did so well that he became nationally recognized and his last assignment in the hospital field was as President of the American College of Hospital Administrators. It grew and benefited from his leadership until his retirement. I'm sorry Dick didn't live long after his retirement to North Carolina as he deserved to have some years of leisure.

Another man who was coming up in the field was George Bugbee, a product of the Chicago University, and he ended up as the head of the American Hospital Association for several years.

The Association of American Medical Colleges was established in Evanston over 50 years ago. Dr. John A. D. Cooper, who had been associated with the Northwestern Medical School, was made president at a young age.

It wasn't long before he moved the operation to Washington, D. C., which, from the point of view of the Association, was all to the good. He was where the action was and he proved to be a great leader in the medical education field, a role he still plays as this is being written.

One of the great surgeons of my era was Alton Ochsner, who created, built and operated the Ochsner Clinic in New Orleans. He was energetic and a man of vision and dedication.

He was one of my close friends in the profession. I owe him a great debt because he's the first man who insisted that I was practicing a dangerous role in smoking. I quit soon after that and have never smoked since.

I asked him, "What has been your greatest satisfaction in building that tremendous institution, the Oschner Clinic?" His answer surprised me a little

at first when he said, "My greatest reward has been the satisfaction of having taught a lot of fine, young surgeons how to do the best type of surgery they can perform for their patients."

That was typical of the man, an unselfish point of view. He died at 83 years of age after a long, fruitful career.

When you get to mentioning names, you dare not go far as you mention a dozen and you've left out two dozen. So I'll stop with just these few sketches.

The time American started in the hospital field was a time when great changes were inevitable, and we were fortunate that we were on the threshold as our role of a service project to the hospitals when they needed that service the most.

It was my dedicated ambition that American had to become large enough and important enough to set the ethical standards of business conduct between the hospital and the supplier; standards that were so excellent that a competitor who failed to live up to those standards would find difficulty in competing with American.

Before World War I, a great majority of hospitals were operated by women superintendents -- nurses with some administrative ability. The big hospitals in the largest cities had men superintendents, but the women far outnumbered the men. Today, that is all changed. You have difficulty in finding a hospital that has a woman administrator.

A unique bit of Chicago history is that two of today's great medical centers were founded in the same year.

Presbyterian Hospital and the Dental School of Loyola were both founded in

1883. St. Luke's was the oldest, founded in 1864, the last year of the Civil War.

In 1956, Presbyterian and St. Luke's merged, and in 1969, the dormant Rush Medical College was included in that merger to form the great medical center which these three institutions constitute.

Loyola Medical School was founded in 1915. Both it and their Dental School were located on Wolcott Street near Cook County Hospital, which then was one of the finest hospitals in Chicago.

In 1969, both of these schools moved to Maywood where the Foster G. McGaw Hospital was completed to form the great Loyola Medical Center where some of the finest medical and surgical services are provided, as well as taught.

During the 1930s, Dr. Malcolm MacEachern headed the College of Surgeons, and was very active in the hospital field, and was one of the most loved men in that profession. He was largely responsible for the first school teaching hospital administration, which started at Northwestern. Today, the schools of hospital administration are excellent, numerous and needed. I see men from foreign countries who graduate from our schools, some on scholarships which I have furnished.

Today, the operation of the hospital requires superior business management skills, as well as a great deal of professional know-how to cope with the medical profession and the nursing profession, and never loosing track of the patient, which, afterall, is the main purpose of the hospital.

In our business, I have always constantly asked our people to keep in mind daily that the purpose of our business is to supply services and products that will make the life of the patient more comfortable and their stay in the

hospital shorter.

To give you a perspective of the evolution in the health field, one striking example is Wesley Hospital. When American began as a business, Wesley Hospital was located at 24th and South Dearborn in Chicago. Wesley's superintendent was Dr. Gilmore. The hospital bought raw catgut in coils imported from Germany, with which they made their own suture material. They, as all hospitals did, made their own IV solutions also.

A block south of them was the Northwestern Medical School. Today what was a brand-new Wesley Hospital some thirty years ago on East Superior Street is now part of the Northwestern Memorial Hospital, the flagship of the McGaw Medical Center and one of the finest hospitals in the country.

Northwestern Medical School surrounds it in what is known as "Streeterville" in Chicago (the near north side across the river from the Loop and east of Michigan Avenue). Northwestern occupies most of it east of Michigan Avenue. Scarcely a square foot of it does not have a building on it.

In the early 1920s and earlier to that, a hospital was generally thought of, by the public, as a place to go to die. Today a hospital is a place to go to keep alive. Scarcely anyone hasn't an example of it in some part of their own family who has benefited from the knowledge and skill existing in some hospital.

In my judgment, Chicago has always been the health center of the world. This is based on the fact that the American Medical Association, the American College of Surgeons, the American Nursing Association, the American Dental Association, and until a few years ago, the Association of American Medical Colleges were all headquartered in the Chicago area. The latter moved to

Washington where they could be closer to the actions of our federal government. During the ensuing years, many changes were taking place, both in procedure and in demands and in the supplying of those demands. The advent of Medicare and Medicaid had a great influence on the medical profession and the hospitals. There is some evidence that there were occasions when the availability of either of these government subsidies influenced the patient's care, possibly at times, unnecessarily.

One of the most important events in the hospital field each year was the annual convention of the American Hospital Association. The first one I attended was before our company began. I was a salesman for the Colonial Hospital Supply Company. The convention was held in West Baden, Indiana, a resort place.

We had excellent attendance and we almost stole the show because we showed, for the first time, a papier-mache model of the human body, the torso and the head. The principal organs of the body could be removed from the torso so you saw visually the relationship one had to the other, the stomach, the liver, the colon, etc. We had people around our booth two or three deep from morning to night.

Some years later, due to the central location in Chicago of the American Hospital Association, the American Medical Association, the American College of Surgeons, the American Dental Association headquarters, some of the men superintendents thought an organization should be organized which they called the Tri-State Hospital Assembly, made up of hospitals from Indiana, Illinois and Wisconsin. Their first meeting and all their subsequent meetings, as far as I know, were held at the Palmer House in Chicago.

In a few years, this became such an important meeting that Mrs. McGaw and I had a reception for the hospital delegates in one of the many meetings rooms the Palmer House had for groups. We sent our informal invitations, hand-written, to some 150 hospital superintendents I knew.

We served drinks and various hors d'oeuvres. Salesmen of our company, who were there only by my invitation, had to observe a strict rule I had made -- no drinking during the reception. You can have a drink afterwards if you want, but your role is to be a host and not a drinking partner to some superintendent.

This gave a touch to these meetings that became almost part of the program of the meeting, and everybody looked forward to it and everybody came, invited or not.

I think the Tri-State meeting became so important that it almost over-shadowed the AHA, and for that reason, was finally abandoned. But one thing was learned through this Tri-State meeting -- the importance of having it in the same hotel each year. People became accustomed to and familiar with all of the facilities surrounding them and available to them, and you feel more at home when you are in familiar surroundings. I'm sure that's one reason the attendance kept growing. People from other states came because it was such a good meeting.

During those days, no one would have thought of a hospital being run for profit except a few, remaining hospitals which were owned by some doctor who had converted his residence into a combination office/hospital with maybe five, six or seven rooms. Even those, I think, have disappeared.

Yet, today, there are several groups that have purchased hospitals and are

operating them for profit. I believe the groups will find more are joining in this exercise to use health care as a profitable venture.

My own reaction is that if Mr. X can operate the hospital at a profit, certainly the present administration can do it if they get the right administrator and the right policies. And the profit they make reduces the cost to the patient rather than going into the pocket of the shareholders. It distresses me to think that any hospital is operating to make a profit out of the illness of his fellowman. Hospitals should be self-supporting, but not profit-making structures.

With the population increasing and the number of poeple 65 years of age and older increasing, the chances are that the need for charitable health care for older poeple is going to increase. The hospitals that operate for profit don't want to take in such people nor do they want accident cases or patients who can't be screened for their financial responsibilities.

In the 1970s, most hospitals were accepting the fact that they had to be operated like a business, in spite of the fact that they were designed to take care of sick people. Everywhere there was evidence of better management of people, resources, inventory and facilities.

Quite likely, the advent of "hospitals for profit," which showed they could be operated profitably and compete with hospitals that operated without the profit motive, made it obvious that the difference was in management.

Possibly, to a small extent, it was the "hospitals for profit" that had the tendency to discourage the admission of accident cases or those who could not pay for their services. But in my judgment, it was the proof that hospitals could be operated for profit, although, at the same time, I think

hospitals should not be operated for the gain of the owners, but for the gain of the patients. Profits should be plowed back into services or for equipment. If the hospital breaks even, it has made a great contribution to society as they're self-supporting and still taking care of patients properly.

During this period, some hospitals grouped together to form collaborating administration and buying. By this collaboration, they could help each other with a pooling of knowledge and skills, and by pooling their buying power, could reduce the cost of materials needed to run the hospital.

I remember one instance that changed the practices of many hospitals throughout the United States in the location of their X-ray film. The Crile Clinic in Cleveland had a horrible fire which was traced as its origin to the basement next to the room where they stored the X-ray film. The fumes from the burning film filled the whole building and some 250 patients died, most of whom died from smoke inhalation.

I remember this so distinctly because the purchasing agent's office was right next to the storage room of the films, and I was in his office the day before this fire broke out. It struck me with a great deal of horror that such a thing could happen.

At that point, I think hospitals began to look for places on the roof or on upper stories where X-ray film could be stored so that if a fire should occur, the fumes would go up and not damage the patients below.

WEEKS:

That was a terrible tragedy. I talked with Dr. George Crile, Jr. recently. They speak of this event with great sorrow for the loss of colleagues and friends.

McGAW:

You said you wanted to ask a few questions.

WEEKS:

Yes, I would like to ask you a few questions about the American Hospital Supply Corporation. Did Harry Drake, of whom you spoke, stay with the business for some time?

McGAW:

Harry Drake was part of the business until his death in 1946. Arthur L. Towner, who started with me as a Vice President (same title as mine), had a small disagreement with Harry Drake, and, as a result, instead of staying on the inside, Towner went out and became an invaluable salesman living in Iowa City which remained his residence until he died.

WEEKS:

What kind of stock did you carry in the beginning?

McGAW:

We began with a very meager stock and 60% of our sales was shipped directly from the factory to the customer, not an unusual practice in those days. It made our financial statements look good.

WEEKS:

Can you tell me how you went about enlarging your line of products?

McGAW:

It would take a book to tell you how we went about to enlarge our line of products. That progression began in March 1922, and it is still going on in 1984.

WEEKS:

Did you remain a wholesaler? When did you begin to manufacture products, or have products made under your own name?

McGAW:

We really were not a wholesaler when we began. We were a distributor. We didn't begin our own manufacturing in our own facilities until we started a manufacturing plant in Cincinnati known as the three i's -- Industrial Industries, Inc. That is still being used by our company, but under the American name.

WEEKS:

How did you keep your salesmen informed and up to date so they could be helpful to customers in the selection of the best merchandise?

McGAW:

One of the important keys to handling our salesmen was a weekly letter I wrote and distributed. It was called "Weekly Gossip." In this I filled the pages with information about products and prices, and each week there were always new products to add in those first few years.

WEEKS:

What did you do to build good relations with your customers?

McGAW:

From the beginning, I emphasized to the salesmen that as far as the customer was concerned, when he called on them in our name, he was the company. I hoped that he conducted himself on a basis that would make the customer happy to do business with that representative.

I told the salesmen that the best way to sell themselves was to tell him

how enthusiastic they were about this company they were representing in which they had complete confidence.

WEEKS:

What was competition like in your field when you started in 1922?

McGAW:

When we started a completely unknown company, we had, as competition, a surgical dealer in almost every town of 100,000 or more. They were organized in a group known as the American Surgical Trade Association. The manufacturers, at the behest of their dealers throughout the country, were reminded constantly that they should not take on any new company that was in competition to them. This was, of course, an unfair trade practice, but they got away with it for some time.

WEEKS:

What did you do about the situation?

McGAW:

I was persuaded that we should join the ASTA in order to escape this prejudice, and it helped us establish many new lines that had refused to sell to use because we weren't a member of ASTA.

WEEKS:

How did this work out over time?

McGAW:

After being in that organization for some five or six years, I decided it was a stupid arrangement as far as we were concerned. We were in a group who did not compete with each other as they did only local business. They did not compete with each other, but all of them competed with us, and vice versa.

WEEKS:

What was the result of your disillusionment?

McGAW:

I withdrew membership. Within two years, the ASTA was cited by the federal government for unfair trade practices, and the whole organization was required to cease and desist that kind of activity. The citation by the federal government named every one of the surgical dealers and they cited as exclusions to their citation only two names: one was E. I. DuPont and the other was American Hospital Supply. I felt pretty good about that.

WEEKS:

Did your salesmen help customers become more efficient in selection of merchandise, better purchasing methods, etc?

McGAW:

One of the things I emphasized to our salemen was the philosophy of "Give More Than You Get." To do this, an idea that you can leave with them that helps them do something better is worth more than money to them because it keeps working for them constantly.

WEEKS:

How did the salemen come upon these ideas?

McGAW:

I reminded the salesmen that in visiting 50 or 60 hospitals in their territory they were bound to see some hospital doing something better than the others were doing it. They can tell the other hospitals about this hospital that does it better, and leave the customer with the feeling, "that's the man I like doing business with -- he's got good ideas."

Naturally, our salesmen were giving information that was valuable to the hospitals or we couldn't have grown as we have. Our salesmen are constantly reminded that our actual, ultimate customer was the patient himself, and if we thought in those terms, we'd be very alert to anything which would help the patient become more comfortable, give him better care and get him out of the hospital sooner. All that kind of thinking made our organization outstanding.

WEEKS:

Did you help organize buying groups to purchase supplies through your company at a group savings?

McGAW:

We did not directly help hospitals organize buying groups. They did this as a natural evolution, and today the Voluntary Hospitals of America are the largest single buying group in the country. Our chairman and CEO, Karl Bays, as of the end of 1983, signed up this whole group for a three (3) years' contract to buy all their purchases from us through computer to computer which will save them millions of dollars collectively. Their purchases will be something in the area of $650 million.

WEEKS:

Did you help with, or help arrange, financing of large purchases?

McGAW:

Occasionally, we have made special terms for carrying the credit of a hospital, but it is much more likely that carrying them on the books has been an involuntary action on our part and a necessity on their part. But we would give them terms commensurate with their size and credibility when it was to mutual advantage.

WEEKS:

What kind of promotion did you use to build sales?

McGAW:

What kind of promotion did we use to build sales? Over 50 years ago I started a letter that was sent to hospitals every month. It was addressed, "Dear Friend." It was a low-key letter and all that letter ever talked about was some idea that the hospital could put to use right then, if they chose to; an idea that would save them money, would make for better patient care, save them time or be useful to them in some manner. When I would meet hospital superintendents at conventions, they would invariably comment about that letter. Many of them said, "I have a complete file of them."

WEEKS:

That must have been very effective.

McGAW:

A few years after that, I decided that we should send birthday letters to the hospital superintendents. It wasn't hard to get these dates in the general hospitals, but is was a very difficult thing to get the birthday or "feast day" date for the sister superiors of the Catholic Hospitals. But we did get them and today these letters go out as they have for years.

WEEKS:

It is a very personal and warm way to send a greeting.

McGAW:

It has been the strongest force in building a good will for the company of anything we have ever done. With the birthday letters, for some years, we gave them a subscription to <u>The Reader's Digest</u>. We picked that up because it

wasn't of sufficient value to influence or attempt to buy their loyalty. It was just a monthly reminder of the company when they got the publication.

Later we switched from the Reader's Digest to a beautiful etching they could put in their office or in their home, whichever they wished to do. Finally, from the etching we switched to a copy of an original painting. Now we have a man on our staff who is very talented and he goes from place to place in America and picks out a scene that is enticing or beautiful, rugged or early American, and they get a color reproduction of that painting.

WEEKS:

I believe you said earlier that your company rented space at hospital association conventions in order to show your wares. Would you say a few words about that?

McGAW:

In visiting conventions, which have been all over the USA, from Atlantic City to San Francisco and many in between, we always tried to have several new things to show them at the booth. Sometimes they were things that a salesman could have taken with him to show, but usually they were things that were too bulky or too large for salesmen to carry around. This always had an interest and brought people to our booth.

WEEKS:

Did you do much advertising in journals such as Hospitals or The Modern Hospital?

McGAW:

We used to advertis ein Modern Hospital and Hospital Management and Catholic Hospitals, but a talented commercial advertising agency which we

tried to get to act as agents, told me they thought they couldn't help us, and that we were doing a superb job of getting our message to the hospitals, that they didn't think we needed an agency. So we never had one.

WEEKS:

We were speaking of Modern Hospital. Its one-time publisher, Otho Ball, comes to mind. What kind of person was he?

McGAW:

You mention Dr. Otho Ball. He was a very able publisher of Modern Hospital, and I am sure was a help to us because when anyone would ask him about American Hospital Supply he would give them an enthusiastic endorsement.

WEEKS:

Didn't Dr. Ball help develop a hospital supply industry association?

McGAW:

There was a hospital supply industry association and we became a part of it as members to support it, but we never figured we could get anything helpful from them, and the organization gradually dried up and disappeared. I don't think Dr. Ball had anything to do with it. I think it was more an organization started by the manufacturers.

WEEKS:

I believe I have heard of a hospital supply industry catalog for purchasers. If this existed, did you take a listing or an ad in such a publication?

McGAW:

A hospital supply industry catalog? The Sklar Company in Brooklyn was a wholesale instrument dealer and they published a catalog that had a smattering

of hospital supplies and a full line of instruments. In the early years, that was the catalog all the surgical supply dealers used. We used it some, but we began publishing our own catalog, I think, about the fifth year of our existence.

WEEKS:

Going back a bit: Were there any national, "full-line companies" in 1922?

McGAW:

When we started in business, there were the Frank S. Betz Company, A. S. Aloe Company in St. Louis, which was the largest of the national dealers, and an old company in Chicago named Sharp and Smith, a well regarded dealer. But all these people gradually disappeared. Will Ross Company in Milwaukee had been in business for ten years when we started. I think within ten years we passed them, and the last I heard of them, about ten years ago they had been bought by Searle Company, and I think recently Searle divested itself of what was left of them.

WEEKS:

Just as an aside: What happened to the Colonial Hospital Supply Company?

McGAW:

Colonial Hospital Supply Company was the company I sold for for two years before we started American Hospital Supply. That company gradually petered out and disappeared. But some years later, one of our fine salesmen, John McGuire, said he wanted to quit and start a business of his own so that he had something he could leave his boys. John McGuire died last year. He had taken the name Colonial Hospital Supply. His boys have a fine business to carry on because their father was smart enough to protect their future. We had nothing

but good will and warm friendship with John McGuire because he was a fine person, and we wished him well from the first.

WEEKS:

Why did you succeed when many of your competitors didn't? You were a relatively new company when the Depression came. How did you survive?

McGAW:

The reason we succeeded and the competitors did not is because we had an urge and a drive, and we had a notion we could do it better -- and we did it better.

WEEKS:

Will you tell me something about Karl Bays, the present Chairman of the Board and CEO of American Hospital Supply?

McGAW:

In the early 1970s there was a change in the top mangement of American Hospital Supply Corporation. I found a young man coming along rapidly who appeared to be everything desirable in aggressive, knowledgeable ability to manage not only things, but people.

One of his earliest assignments that I gave him was to be President of our International Operations. It was in disarray and needed some better attention than it had had. Karl Bays took this assignment and for a year visited all our agents and customers throughout the world. He came back with such a comprehensive report on the entire operation that I concluded he was the man to follow me in leading American into the promising years ahead. So shortly afterward, he was made President of the company and a year later, was made Chairman of the Board and CEO. This gave him full command under the Board of

Directors.

No one could have found a better man for that job, and we had him in our own organization. He has gone far beyond my expectations in developing the growth, the management, and the sophisticated knowledge of all the devices available to management he put to work.

Karl Bays made a comprehensive statement before the Board of the Lake Forest Hospital just recently, and it carries the material that I think should be in this biography of the hospital field from a businessman's point of view. I'm attaching it verbatim, with his permission and the permission of Lake Forest Hospital. I think you'll find it tells you what we at American think are the coming events in health care. I'm convinced that the farther down the road we go, the more the tendency will be to give more health care in the person's home, and on an increasing basis. People are happier at home and someone at home can take care of a lot of things that the nurses have to do in the hospital. I hope the day will come when the hospitals will need to take care of only surgical cases, and the medical cases that require surgery, therapy from X-ray or physical therapy departments which could not be taken care of at home or on an out-patient basis at the hospital.

WEEKS:

You have said Mr. Bays has given us permission to quote freely from his remarks made before the Board of the Lake Forest Hospital recently. Also, I believe you suggested that Mr. Bays' remarks on the future of health care delivery would be an important contribution to this oral history.

McGAW:

That is correct. Mr. Bays is one of the finest businessmen I know, and I

feel very fortunate in his succession in the management of the company following me.

WEEKS:

Excerpts from Mr. Bays' remarks to the Lake Forest Hospital Board follow.

BAYS:

We shouldn't question this hospital's ability to find the right answers to change. After all, change is something we've dealt with before.

In preparing this presentation, I spent some time looking at changes that have affected health care just in recent years. It was truly remarkable.

I looked first at American Hospital Supply Corporation's own environmental assessment for 1970, and here's what I found:

We were four years into Medicare and Medicaid at that time. The industry was just starting to come to grips with the huge demand being created by those programs, combined with private insurance.

Expansion was still in vogue. National health insurance was considered a possibility, if not a probability. Growing demand was being met in some highly traditional ways. Individual community hospitals and solo medical practitioners were very much the norm.

We also saw a relatively stable economy and low interest rates. The concentration in health-care economics was on continuing growth. And we saw hospitals continuing to be supplied by many "small, domestic" manufacturers and distributors.

Well that was in 1970. In some respecrs, it sounds like ancient history.

Today, our assessment of the hospital environment includes some terms, and concepts, born only in recent years. Rising demand continues. But now it's

matched by concerns about costs. Prospective payment, DRGs, competition and consumer choice are the newest buzzwords.

Look at what's happened to the delivery system. Multihospital groups have evolved. They've prospered. Nationwide, hospitals of all types are sharing services of all sorts. And patients are coming not just from the traditional family clinic but from the independent practice association, the health-maintenance organization, the group practice and beyond. So-called alternative sites are "where it's at" in health care today.

As to the economy, including health economics, our past concentration on growth has been nudged aside. The needs now are for wise management of assets and allocation of limited resources.

What about the companies that are serving hospitals today? A lot of them are anything but small and domestic. They're multi-billion-dollar, diversified firms viewing health care with a global perspective.

So there's no question that we work in a dynamic environment. But we also know that change has always been a characteristic of the health-care industry. Those past ten to twelve years provide ample proof.

Regulations pulled us every which way and pushed the cost of doing business way up. Wage and price controls were laid on hospitals longer than any other segment of the economy. Technology moved ahead faster than ever. We saw floating currency rates, tight money and high inflation. Congress spurned a hospital cost cap, then embraced prospective payment.

I could go on and on. But I won't. I just want to make sure we keep one thing clearly in mind: Hospitals, including this one, not only survived during some stressful recent years they prospered. Of even greater

importance, they provided better health care for more people.

Are there reasons for doubt and concern today? Sure there are. In my twenty-five years in this business, I've never seen more doubt or concern among the providers of health care.

But, as I'm constantly reminding our customers, a calm look at the environment and some true strategic planning present reason for optimism and action as well.

What, after all, are the most basic reasons for strategic planning at this hospital? Why are we here? There are two reasons: first, to provide better health care and, second, to do a better job of managing.

Ideally, of course, you do both. But, for this discussion, I'm going to address only the management side of the equation.

In doing that, I see three key issues that I believe we should be addressing.

The first has to do with the strategic options that Lake Forest Hospital should be considering for success in a much more competitive environment.

In using the term "competitive," I'm not referring only to the latest governmental push toward prospective payment or consumer choice. I'm talking about an environment in which hospitals -- in order to grow or even survive -- will have to view competition as a way of life, regardless of what Washington does.

We'll be competing for patients, employees, capital, income and market share. We'll be competing in an environment in which medicine and management will need to work hand-in-hand in a changing hospital. We'll be competing strategically and operationally.

The second issue falls into the broad area of human resources.

The main question is this: How will Lake Forest Hospital manage to maintain the significant human skills that it will need in carrying out its strategic plans?

In answering that question, I believe we'll find that there's something for everyone. The question, in my view, is one that fully encompasses management, the medical staff and the board as well.

The third issue won't surprise you. It's financial and capital resources. To state it briefly, it's the ability of any hospital to get the margins it will need to finance continuing growth in a volatile economy.

Those are the issues as I see them. Once you cut through the rhetoric and arm-waving, those are the truly key questions we should be addressing:

- How will the hospital survive and produce in a more highly competitive environment?
- How will it manage its most critical resource, the human resource?
- And how will it manage its costs as well as revenue and capital in a way that doesn't mortgage its future?

So let's take the issues in that order, starting with the competitive environment and some options that it offers.

In American Hospital Supply Corporation's strategic planning, we've spent a good deal of time looking at how hospitals might fare in a more highly competitive environment. (How hospitals fare, after all, is crucial to how we fare.)

We studied three factors:

- first, the effects of a more competitive environment on the

economics of the hospital industry,

o second, the organizational effects of increasing competition,

o and third, some of the strategies that hospitals and other providers might follow within the changing environment.

In tackling those issues, one source we drew on was a study of what's happened in five industries that recently encountered increased competition. We then worked to apply their experience to the outlook for hospitals and health care.

The five industries are familiar. They're brokerage, communications equipment, airlines, trucking and railroads. Each of these had, in recent years, become more competitive as a result of changes in their regulatory structure. Regulations hampering competition were either revised or dismantled.

While the five industries vary widely, they all developed similar responses to the changing competitive environment. As one example, deregulation and added competition were generally supported by a few of the largest firms in each industry, and by the smallest. Most often, it was middle-sized firms that kicked and dragged their heels.

That's not to say, however, that a company's initial stance determines whether that company succeeds in a more competitive market.

Delta Airlines, for one example, fought hard against deregulation. Yet it's been among the most successful participants in the newly competitive airline industry.

The study also showed that there was ample time for companies to adjust to their new environment. In each industry, deregulation happened only after a

fairly lengthy period of debate and changing attitudes within both the industry and government.

But the companies that succeeded were limited to those who took that opportunity to do their planning and do it well. Once deregulation was actually put into place, major adjustments within each industry were all but finished in two years' time.

What were some of those adjustments? In the area of industry economics, we found that they took five main forms:

o There was increasing variability in the performance and success of competing companies.

o Prices came under severe pressure.

o There was a proliferation of new products and services. Some that had been offered as a package were "unbundled" and offered separately.

o Next, cost-cutting swept the industries.

o And, finally, higher competition led to higher capital requirements.

Now, we can look at each of those developments in some more detail and consider the lessons that Lake Forest Hospital might take from the experience of the five industries.

In doing so, I should note that "deregulation" really isn't the right term for what's happening among hospitals today. Instead, I refer to prospective payment and related moves as a form of <u>re</u>regulation.

But the net effect is really the same. It's a more competitive environment. And the experiences of the other industries do relate.

Consider the timing as an example. I mentioned a moment ago that major

changes within the deregulated industries were all but finished in two years, and the same will hold true for health care. While prospective payment is to be phased in over a four-year period, I expect the biggest adjustments in our industry to be completed by the end of 1985.

I also noted that performance variability among competitors widened. And it's not just that the strong become stronger, but, rather, that the weak got weaker.

The airlines provide an illustration. In the years after that industry was deregulated, the return on assets of the bottom three carriers dropped sharply, relative to the top three.

What does that indicate for health care? For hospitals, it means that weakness in financial condition will quickly lead to a particularly vulnerable position.

For those providers, the need for effective competitive strategies becomes even greater, and merger or affiliation may be among the most appropriate strategies. But that does not necessarily mean it's a good strategy for the strong to acquire the weak.

I'm a director of Delta Airlines, and I've had the opportunity to observe their strategies firsthand. Delta assiduously avoided acquiring the Braniffs and Continentals. Instead of taking on their week financial structure, obsolete fleets and union problems, we chose to get into their major markets (like Dallas, Houston and Denver) on our own.

I see much the same thing happening in health care today. The large investor-owned hospital companies are much more willing to start from scratch in entering a market if the only alternative is to acquire a financially weak

hospital.

Severe pricing pressure was the next development in the five industries. The pressure affected products and services that had previously been the most profitable. New pricing dynamics also opened opportunities for new competitors in some attractive market segments.

Let's look at some illustrations of the pressure that came into play:

Among airlines, there was tough price competition in the high-load, long-haul routes. Among brokers, commission rates fell rapidly in one highly profitable market segment. And, in trucking, prices fell fastest in the market where it was easiest for new competitors to enter.

Now, in health care, the effects of this trend already are very clear. Prospective payment not only brings pressure on prices, it dictates exactly what they'll be.

The pressure is coming from other quarters as well, In California, it's a bidding arrangement for hospital services. In Lake County, Illinois, pressure is at least beginning to come from a local coalition of businesses, determined to be wise buyers of care for their employees.

I expect to see more of that activity, at the state and local levels. And the implications of this trend are already quite clear.

Hospitals obviously will need to be highly effective in measuring true costs and comparing those costs with revenues. In short, it's a classic question of marketing mix. Which are the DRGs -- the markets -- in which the hospital can work most cost-efficiently and competitively?

The third industry development that I cited was the introduction of some new product and service arrangements. In some cases, products and services

were "unbundled." That is, they were separated into their various components and marketed individually.

Prior to increased competition in the five industries, competitors were working in a fairly narrow range of products and services. Prices were regulated at relatively high levels. Competition was primarily directed toward providing good customer service.

What happened was that trade-offs between price and service expanded greatly as competition increased. And that's exactly what I see happening among hospitals. Restructuring to provide more diversified services, as we've done here, is the most obvious example.

More generally, I believe the experience among hospitals is going to be very similar to the other five industries in this regard.

For many years, prices at Lake Forest and other hospitals have been regulated at a fairly high level. We, therefore, have competed (for both patients and doctors) by emphasizing high levels of service.

Now, with greater competition, I believe the price and service trade-offs will expand greatly. The hospital will need to select and promote specific services in which we can work well. We'll need to price them strategically in order to maintain both competitive and financial strength.

Let's consider the fourth economic development in the other industries. It was cost-cutting.

This was a particularly difficult factor for established firms up against new, low-cost competition. What happened was that inefficient companies had been protected by guaranteed pricing levels. But, as regulations changed, those companies were forced to cut costs rapidly while trying to position

themselves in a more competitive market.

Most often, the cost-cutting took the form of staff reductions. As an example, 15 percent of all U.S. airline pilots are on furlough today, according to the pilots' association. And that's not just a temporary condition, borne by recession. It's as much a factor of competition and cost-cutting.

Again, the implications for hospitals are clear. Close attention to staffing ratios, to productivity and to creativity in personnel management will be vital to competitive success in a time of cost-cutting.

But staffing is certainly not the only area of opportunity. There's work to be done in managing assets, inventories, logistics and the entire range of hospital operations.

The final economic effect of increasing competition in the five industries was the growth in capital requirements. Competing companies needed new capital for everything from equipment to product-development and advertising.

A strong financial base was increasingly crucial as profits were squeezed. But access to capital became more difficult at the same time. Lenders saw higher risks associated with companies in rapidly changing industries.

In short, the experience of the other five industries indicates an even greater need in hospitals for a firm financial base and effective management of capital.

Well, that covers the economic impact. Let's turn to the organizational implications of increasing competition. They're the effects on the structure of the industries, and our study found that they take two main forms: First,

new, low-cost producers entered all five industries. And, second, mergers and acquisitions accelerated.

Clearly, the lesson for hospitals seem to be even more rapid development of some trends that this group has witnessed and talked about already.

For one thing, greater competition will bring added impetus for low-cost providers of many sorts. They're the surgicenters, emergicenters, physician groups and all the rest.

In addition, the pressure of that competition will be heaviest on those hospitals that haven't been working effectively already to cut operating costs. They'll be up against lean, new competitors who aren't tied to built-in overhead.

Now, I hope all of this doesn't sound overly academic. It really isn't. I brought a slide along that seems to prove the point.

This is a picture of just some of the recent brochures that we've received from the newer, low-cost health facilities surrounding Lake Forest Hospital.

It's quite a lineup. And I stress that these aren't the only competitors. There are others. Some are affiliated with hospitals. Some are stand-alones.

One of the brochures is from a new group. It's called the Doctors of Northbrook Court. They're open from 7 in the morning until 9 at night. You don't need an appointment. You don't even need cash. They'll take American Express or MasterCharge.

I really like their slogan. It's straight from their brochure. It says (and I quote) that they want to provide "health care the way you want it."

But what all these brochures <u>really</u> are saying, at least to me, is that

alternative forms of delivery are here to provide health care the way a highly competitive market wants it.

I've noticed in the press that many of the newer organizations (at least those affiliated with hospitals) are now being called "outreach centers." But somebody said last week that what they really are is "outgrab centers."

However you label them, I believe the alternative modes of delivery constitute strong evidence of a market that'll never be the same.

Now, mergers and acquisitions were the other structural effect in the five industries. What we found in our study was that the mergers and realignments came about in several phases.

Consolidation among the weak firms came first. It happened rapidly. Next, there was a wave of acquisitions by the stronger firms. That was followed by some additional acquisitions, outside traditional industry boundaries.

The indication is that consolidation among hospitals is far from over. If anything, it'll speed up, according to the experience of the other industries.

Consolidation is a trend that I've been watching very closely for the last decade.

The current counts show a third of all U.S. hospital beds operating within system arrangements today. I expect to see at least 75 percent within multi-hospital systems, either investor-owned or voluntary, by the end of the 1980s.

So consolidation is here to stay.

Now, there's just one other point that I said I'd cover in this area of increased competition. It brings the whole discussion to a point. It's the

strategic options offered by the new environment.

Within the five industries, we found that there were three main types of successful firms:

The first type included companies that chose to be full-line marketers, often nationwide. They were companies that positioned themselves for expansion before higher competition took effect.

Among those firms were Merrill Lynch, Delta Airlines and Burlington Northern. Sears and American Bell are more recent examples of this strategy.

Among the characteristics of these firms are skillful marketing and integrated operations, as opposed to loosely connected geographical units. In some cases, the firms that chose to be national marketers also offered new, low-cost products and services.

The second type of successful competitor was the new, low-cost producer, targeting price-sensitive market segments and offering no-frills options.

A specific note here: Because of the high costs in labor and other areas that tend to dominate regulated industries, it was difficult for existing companies to pursue this second strategy.

The third type of success was achieved by firms that had previously competed broadly but then changed their direction. They specialized in markets with low price-sensitivity and high customer loyalty. This third strategy seemed to be the best for most firms. The reason is that only a few companies can take on a full-line approach, while low-cost producers are likely to be new on the scene.

So let's bring it home to Lake Forest. What are the options available to us?

To me, it's quite clear that our hospital will be competing with all three types of firms in the years ahead. There'll be more low-cost providers in our market. There could well be competition from the national hospital chains. Neighboring hospitals will probably work to specialize.

The only way for us to become a full-line marketer is to become part of a national voluntary system. From what I know of our operations, we're not likely to become a low-cost provider, at least across the board. But perhaps we could do that in some key markets.

The third option is the one we've been pursuing. It's specialization, marked by high customer loyalty.

My question is simply: What's the right direction for us in the future. I'm only raising the question for discussion.

What I don't think we can question is that Lake Forest Hospital will need to be more competitive, and the time to be doing so is now. That's one lesson from the other five industries that makes this meeting so vitally important.

More generally, I believe the experience of the others tells us that we'd better be keeping our balance in entering this new environment.

Yes, we need to be good and aggressive in selecting among wider options for competitive services. But we need to be careful as well.

Not all the outreach centers, for example, are going to reach far enough to be around two years from now. Not all of the many options presented by a new environment are good options for all hospitals.

The fact is, I've seen and heard some fairly bizarre plans for hospital diversification as I move around the country. So let's move deliberately, with some well thought-out strategies.

Now, the rest of my presentation is quite brief. But it has to do with one resource that I consider, by far, the most important for any hospital and another resource that has to rank near the top. They're the human resource and capital.

We've already seen the difficulty that some companies encountered in one area of human resources as their industries became more competitive: They were harnessed with high, built-in labor costs.

Well, that's a negative statement of the vital importance of human resources in a competitive market. A more positive statement is that poeple, in any environment, are of true strategic importance.

Too often, I see businesses making strategic decisions and personnel decisions as if they had little to do with each other.

I see too many -- even those with sophisticated planning, marketing and financial systems -- that just aren't doing an adequate job of planning around the one resource they can't ever do without.

Here's my point: Strategies and systems are concepts at best without the skills and commitment of people.

I've had a lot of opportunities to discuss this subject with groups of administrators from individual hospitals as well as hospital systems. In those conversations, I've offered a model for human-resource planning. It's the model we use at American to tie our personnel planning to our strategic planning.

I'm not going to do that today because Steve and his staff already have access to that management tool. But there is a point that I want to make in this area, and I alluded to it earlier.

The point is that not one of the groups here today can disown responsibility for human resources. Management, the medical staff and the board all have vital roles to play.

Let's take the three groups in order.

Management's role includes the classical disciplines. There must be clear lines of succession in management itself. The hospitals need a good plan for recruitment in management, in technical positions and others. Compensation systems must be both competitive and effective.

Those are some obvious responsibilities of management. But there are others, made all the more clear by today's competitive environment. Some relate to specific employees -- perhaps most importantly, the nurses.

Are nurses getting the professional growth, the recognition and compensation they deserve? Our company sponsored a national commission on nursing last year. That study reaffirmed something we all know. It's the absolutely essential role of good, well-managed nursing in any hospital.

Other management responsibilities extend to all employee groups. One such responsibility is for productivity.

You know, productivity used to be a buzzword, in hospitals as well as industry. Then it became a goal to be pulled out and dusted off from time to time. But my point here is that it's an absolute necessity in any hospital that intends to be competitive today.

Productivity, as I see it, is something that should pervade the hospital's plans, its supervisory style, compensation and employee-development programs.

So management bears clear responsibility not just for having the human resources but for motivating people behind the stated goals and strategies of

the hospital.

What about the doctors? Can they disown a role in either the strategic or the closely related human-resource elements of the hospital's future?

I don't see how they can. For one thing, they themselves are an essential human resource.

In my travels, I continue to perceive an attitude that hospitals are really two organizations -- one medical and the other managerial. And perhaps that used to be true. But it certainly cannot be true in the future.

The analysis to date has shown that one effect of our new environment will be a changing relationship between hospitals and doctors. My point is simply that it had better be a closer relationship.

Sure, the hospital needs to recognize that it won't benefit greatly -- or for long -- at the expense of the physician. But the doctor needs to recognize that clinical behavior in the future will be directly linked to the economic success of the hospital. And both need to recognize that their behavior always will be linked to the welfare of patients.

There's little time any more for debate about which members of the team hold ultimate sway over the hospital's future or fortunes. The needs transcend any partisan approach in medicine or in management. Professional pride is pale compared to the importance of the work we have to do.

So what about the board? Its role in this area is paramount. It holds the ultimate responsibility for assuring that the hospital is one organization, united for excellence in management as well as medicine.

Historically, hospital trustees often have felt it was their duty to minimize uncertainty and risk. And that's as it should be when it comes to

quality, safety and patient welfare.

But trustees in the future will simply have to assume more risks on behalf of the hospital as it enters a more competitive era. They're the same kind of risks a trustee might take in his or her own business.

The term "hospital" is almost too limiting, as I see it. It's a health-care enterprise that we're talking about. It needs aggressive plans and some real willingness to take responsible risks. Perhaps most importantly, it needs skillful management, backed fully by the board of directors.

I don't deny that there will be some conflict between medicine and management. I'm only saying that it's the board's job to resolve that conflict, quickly and productively.

My third and final topic today has to do with capital and financial resources. This is a topic that has been surrounded by more than a little controversy among voluntary and investor-owned hospitals.

Much of the controvery has been in the area of raising capital. But, again, I want to make a single point. It's that the ability to raise capital isn't the only question that a hospital should be considering in the financial area today, or even the most important.

A deeper look at the financial health of our operation, I believe, should hone in on another factor.

That factor is the quality of our operating margins. I'll discuss why that's true.

Earlier, I said that the reasons for strategic management at a hospital are to provide better patient care, to manage more efficiently or to do both.

And margins provide the clearest possible statement of management effectiveness in doing that job.

I looked at the profit-and-loss statements of investor-owned systems compared to those of half a dozen well-managed, stand-alone hospitals.

I know these figures can vary widely. And, believe me, I'm not trying to start another argument about who does a better job of management. I'm only raising the point for discussion.

Look what's happening. Both types of hospitals, at the net line, are earning on the order of 6 percent. But, at the operating line, the investor-owned hospitals are earning about twice the rate of the not-for-profits.

I could be wrong, but my discussions with managers in both types of hospitals indicate to me that the investor-owned groups are at the top quartile in their pricing and in the bottom quartile in their number of full-time-equivalent employees and labor costs.

Stated another way, the investor-owned hospitals spend 65 cents of every dollar on operating expenses, compared to 75 cents on the voluntary side -- and that 10-percent differential is a major competitive advantage.

My point is simply that health in operating margins is more critical to the sustained growth of any business than the ability to raise capital. It's the area where management and the board should be placing primary attention.

It's all the more important in the environment that I discussed earlier. The financial models we use at American show clearly that the key is in achieving higher operating margins, and better asset utilization, particularly on new or additional business.

A constant rate of return, no matter how comfortable it might have been in the past, is no longer enough. That's something a board of directors today must clearly remember.

So, is capital formation important? Certainly. But a truly rigorous consideration of this hospital's financial health must include an even harder look at the organization's operating performance, including our ability to finance our own growth with higher margins. Better management of our operating expenses and control of our labor costs, in this new environment, is an absolute must.

Well, I've covered a lot of ground. I can summarize quickly.

When a lot of the peripheral debate about the future of health care is stripped away, I believe there are three core issues that the leadership of Lake Forest Hospital or any other should be addressing. The three are:

- o strategic options in a competitive market,
- o human resources in the widest perspective,
- o and, a tough look at improving margins as one necessary step toward increasing financial strength.

They aren't easy issues. Handling them despite a multitude of other concerns is a bracing challenge. In particular, they must be addressed in ways that promote the interests of patients -- of people. That's something we should never forget in meetings like this.

February 9, 1984

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