



RICHARD J. DAVIDSON
In First Person: An Oral History

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RICHARD J. DAVIDSON

In First Person: An Oral History

**Interviewed by Larry Walker
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Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in Lake Oswego, OR

LARRY WALKER: Today is November 23, 2009. My name is Larry Walker and we're at the offices of the Oregon Association of Hospitals and Health Systems for this oral history interview with Dick Davidson, president emeritus of the American Hospital Association. In a health care career that has spanned more than four decades, Dick has been a forward-thinking and thought-provoking executive. The AHA's second-longest serving president, Dick retired in 2007 after 15 years at the helm of the AHA. Dick, good morning and welcome.

DICK DAVIDSON: Good morning.

WALKER: I'd like to begin by taking you back to the late 1930s and the early 1940s. You grew up in Philadelphia. What about your childhood stands out as experiences that helped shape your character and form your direction in life?

DAVIDSON: We lived in a suburb a block away from the city limits. My family lived in a row house until I went off to college, when my folks moved to a little suburban community a bit farther out. I enjoyed the "urban life." We played basketball every Saturday in a crummy parking lot that had a decent basket. Rain, wind or snow, we always played basketball on Saturday. That's kind of a Philadelphia thing, because Philadelphia is a very big basketball town.

We played football in the streets. Not tackle; obviously, it was touch football. There were cars parked on both sides of the street, and a typical play might be: "Go down to the third car, turn right, I'll hit you there." We also played stickball in the street and because the houses on one side were up higher and had steps, we played something called wall ball or step ball.

We were working-class folks and seemed to be happy. Had tough times. Had good times. My father had a job as a china repairman – fine crystal and china, which were very popular and very expensive in those days. He got the job through a family he met during his community work as a Scoutmaster. He had good skills and loved what he was doing. Neither of my parents finished high school because of the Depression. Everybody had to work. My cousin and I were the first to ever graduate high school and go to college.

My father was killed in World War II. I was seven and I was very close to him. I was an only child. My father was the community do-gooder. Before going into the service he was the fire warden, the air raid warden, the tin collection chairman, Sunday school teacher, and as I said, the Scoutmaster. He was the somebody doing almost anything to help lead in the community.

One reason he stepped up was that there weren't that many men around. They were at war. He had been deferred from the Army draft because he was 30 years old and had a seven-year old son. But he became very discouraged by what was happening to the senior Boy Scouts in his troop. They were 17 and 18 years old, and as soon as they graduated from high school, they went into the Army – and they didn't all come back. That troubled my Dad a lot. He decided to join the Army – felt he had to do it. It was a moral obligation and he knew we'd manage at home.

He enlisted; a 30-year-old called "Pops" by all the other soldiers because so many were just teenagers. He was very popular. When it was time to ship out, they were going to exempt him so

that he could stay and train the younger kids. He didn't want to do that – he wanted to confront the war just like everybody else.

Before he left, he told my uncle that he probably wasn't coming back, but didn't want the rest of the family to know he felt that way. He said he didn't want to be brought back. He wanted to be buried wherever he fell. And it happened. He was a month behind the Battle of the Bulge in France and Germany. He was a rifleman and the first day his company actually had an exchange of gunshots, he got hit. He was in a coma and never came out of it and died a month later. He's buried in France.

That experience at that early age, was very significant. I loved my dad. As Scoutmaster, he rode in the Fourth of July parade, and I always got to ride with him. We spent a lot of time together. His death took an enormous toll on both my mother and me. She just couldn't believe what had happened. He went into the Army in June 1944, and he was killed by the end of the year.

WALKER: Your father's view of service and his commitment to service during a difficult time in this country must have had a strong impact on you as a boy.

DAVIDSON: Yes, and that's the power of it. I came to appreciate what he was all about as I got older. That power of service and leadership. I can remember my first interview for the job with the AHA. They said, "Somebody has told us that you are strong on ethics and moral values. Where did you get that?" That question just threw me. Of course, it goes back to what we've been talking about. My dad influenced my sense of values more than anybody could. I didn't realize that at the time. I sure do now.

When my father went into the Army, his employer gave my mother his job. It made me a latchkey kid. It was a learning experience. I'd cook dinner for my mother when she came home from work on the bus. We lived a half a block away from the bus stop. I fixed her some gosh-awful things, but she always said they were great. I knew they weren't! But probably my favorite was a grilled cheese sandwich and tomato soup. That made my mother happy.

After several years, my mother married my father's best friend. I had a stepfather and one who had strong values. He was a 100-percent-disabled Navy veteran. Anyway, our life went on, and it was very, very happy. I learned how to be responsible for myself and take care of things, and I also learned to work. I had a job starting in the third grade. I lugged groceries. I think it might have been at the A&P. I had a little wagon. They didn't have those big carts in the supermarkets then and so I would go inside with my wagon and stand at the checkout place, and say, "Can I help you with your bags?" Some people sneered. Others occasionally would give you a dime and say, "That's okay, I'll handle it." The average tip for hauling a bag of groceries was ten cents. I delivered newspapers, too. I once made a list of the jobs I've had in my life. It's 53 jobs, I think.

But all of that gave me a sense of structure and what values were important. When my father died, so many people reached out and offered their condolences. But there was a point when I kind of said: *Everything's okay. We don't need that.* There aren't many people in a city block who have a loved one killed in the war. On our little block, the community outpouring was amazing. It was overflow. I didn't go back to school for awhile. He was shot in November, died in December. I didn't go back to school until about the middle of January. The healing process meant staying close to my Mom.

So that's a sense of what life was like growing up. By the way, I read Spike Foreman's oral history, and I got a kick out of it because he talked about some of the same things. Every place we lived, it was a row house, and then out back was an alley. You used to hang your clothes across the alley to the next row of houses. The back alley was a big place for action. The iceman came down the alley with a cart. Spike talked about that, and it just reminded me so much of my own childhood. It was important to be friends with the iceman, because if you were – and in the summer time this was really important – he'd knock off a chunk of ice and give it to you.

WALKER: Simple pleasures.

DAVIDSON: Yes. How many people know what an icebox is? We have one in our family room, one I refinished, because it was just like one we had when I was a kid. You know, you put a block of ice in it – it had a drain pan underneath, and it kept everything cold, until the ice melted. One object sure can trigger a lot of fond memories.

WALKER: You met your wife Janet in your late teens, when you were a lifeguard on the New Jersey shore.

DAVIDSON: That's right.

WALKER: How has Janet contributed to your success?

DAVIDSON: To quote the song, she's the wind beneath my wings. And that's probably an understatement. I was a lifeguard in Wildwood, NJ. She and her girlfriends were coming for a weekend there from Delaware. She was camped out behind my lifeguard stand and that's when I noticed her. We struck up a conversation, and that was the beginning. It never ended after that.

We started dating, and I invited her to the lifeguards' ball -- a big annual event in those days in towns all along the Jersey coast. Johnny Ray was a very popular singer at the time. His big hit was "Cry." He was the guest star that year at the Lifeguard's Ball and we got to meet Johnny Ray. That was a big thrill. We had a good old time.

She lived in Wilmington, DE, and I lived in Media, PA – half an hour apart. I was going to West Chester State College, half way in between Wilmington and Philadelphia. We started to see each other on a regular basis and enjoyed each other very much. We decided it would be nicer to be married. That startled people because we were so young.

I mentioned earlier that my mother married my dad's best friend, so by the time Janet and I were getting married, I had a little brother much younger than me. The day we went to get the marriage license at the Wilmington courthouse, my mother had to go with us because I hadn't turned 21. My little brother is there, blonde hair, looks a bit like Janet, and he's yanking on her skirt, saying, "Mommy, Mommy!" And we're pulling on him, saying "Here's your Mommy, over here." We were all hysterical over that.

We got married at a young age. We had a wonderful relationship from the beginning. We have mutual interests. We like music, we like to dance, we like to have fun, and we love the beach. We never met a beach we didn't like. And as a result, we both have skin cancer. So, we got our rewards.

Janet's been a wonderful partner, and she's had a great career in her own right. She worked for 25 years as an administrator for the Maryland state senate, serving several Senate Presidents and she worked for the Maryland Attorney General. When we moved to Maryland in 1966, she knew she wanted to be a good mother to our three sons and at the same time have an exciting career.

She actually went to work for the Maryland legislature before I got my job at the Maryland Hospital Association. Over the years, she was there with all the people we'd be lobbying. A local magazine once published an article about how couples deal with potential conflicts of interest. We were one of the featured couples. Janet had wonderful working relationships with Senate leaders and handled herself professionally so that there was never a question of conflict.

The jobs at the MHA and the AHA were enormously demanding. It was essential to have a strong partner. You couldn't do this kind of work without one – someone to talk with about the issues. I had a knowledgeable, poised partner, all along the way. I always had a strong support system and I learned over time how essential that was.

WALKER: Let's talk about your educational background for a moment. You earned bachelors and masters degrees in education from West Chester State College and Temple University, respectively. You went on to earn your doctorate in education from George Washington University in Washington, DC. How did your educational focus help you in your work as an association executive in Maryland and then with the American Hospital Association?

DAVIDSON: Well first, I never planned to have all that education. I had a little better than average IQ and got along just fine. School was a place to have fun. I never planned to go to college. I had planned to join the Marine Corps, mostly because of my Dad's military service. There was a kid down the alley from our house who was introverted and quiet. He joined the Marines, went to Korea and was one of three survivors in his platoon. When he came home – it may have been around Thanksgiving – my parents invited him over and he shared some of the stories of his experience, which was very unlike him. The experience had been so powerful, he obviously had a real need to talk about it.

I admired this guy and his courage. There was something there that stimulated me. I wanted to join the Marine Corps when I got out of high school. My parents said okay, knowing they weren't going to keep me from doing it if I decided that's what I was going to do.

I played football my senior year in high school and I was pretty good. My best friend was my cousin and, like me, he was an only child. His mom was my mother's sister. He was a terrific athlete – a basketball player. He kept trying to talk me into going to college rather than join the Marines. He was a sophomore then at West Chester State. I said, "For what? If I go to the Marine Corps, I can go to college when I get out." He kept pushing until I finally told him I didn't even know how you get into college. He said, "I'll take care of it."

Sure enough, he went to his basketball coach and told him about his cousin -- the pretty good football player. The basketball coach went to the football coach, who was the dean of students, and told him about me – that my family wasn't poor, but didn't have any extra money. College would be a strain. Somehow the coach made it possible for me to get a football scholarship. Tuition there was about \$200 a semester. I thought all this was kind of hysterical so I asked him about the scholarship and he said: "You get a job as a waiter in the dining hall. We pay you \$50 a

month, and all you can eat. We want our football players beefed up.” So all the waiters in the school were on scholarship.

So, I was off to college to play football. No fancy education. I thought football might lead to something; I didn’t care much about academics the first couple of years. Then I met Janet and my whole world changed, after that I became an honor roll student – which is what I should have been from the beginning.

WALKER: You did eventually join the Marine Corps, as a Marine Corps reservist.

DAVIDSON: That happened while I was at college. There was this other guy on the football team – a big bear of a guy who’d beat the heck out of me – and I asked him what made him so tough. He said he was at Quantico for six weeks just before starting football practice. Well, he really worked on selling me on the Marine Corps and I liked what I heard. So, I joined the Platoon Leaders Corps, which is similar to the ROTC, and served there and was going to be a second lieutenant. Janet and I got married, and I had just ordered my uniforms. We were going to Quantico.

One of my friends who’d graduated from West Chester was on a recruiting trip for a school system in rural southeastern New York. He tried to convince me to forget the Marine Corps and take a job as a social studies teacher and track coach. It sounded good. I visited the community – Goshen, NY, 60 miles outside of New York City. I liked it; I took Janet up there. She liked it and our first two children were born in Goshen. I stayed in the Marine Corps as a reservist and went to graduate school for about 17 years at night. When you have a full-time job and a family and you’re doing that, it’s a killer. I started graduate school in my second year as a schoolteacher in Goshen, teaching social studies and civics. I applied to Columbia University, one of the first-rate teachers’ colleges at that time. My last two years at West Chester were great, but the first two pulled my grade point average down. To make a long story short, I had to negotiate my way in. I told them if they let me in, I would make straight A’s or they could chuck me out.

It worked – and I had straight A’s. Then we moved to Wilmington, DE, when I got a teaching job down there, and I transferred my Columbia credits to Temple University. That’s how I ended up getting my master’s degree at Temple. Then I started studying higher education administration at the University of Delaware. I was going to become the first doctoral student out of the School of Education there.

A Ford Foundation scholarship helped me with the cost of graduate work. I was close to finishing at Delaware when a strange thing happened, a very happy coincidence. At that time, I wanted to be a high school principal or superintendent. Unbeknownst to me, my dean at the University of Delaware gave my name to the Maryland-DC-Delaware Hospital Association. They were searching for someone to manage association education programs. I didn’t know anything about it. I got a call that somebody wanted to talk to me, but I wasn’t home. I was in the hospital having surgery.

WALKER: I understand that you arrived in the hospital to have that surgery in a very unusual way – that you were riding a bicycle off the high dive at a swimming pool, dressed like a clown, and that you hurt your back and ended up as a long-stay patient. That’s where the connection with someone on the search committee for the hospital association was made.

DAVIDSON: Just so you don't think I'm crazy, let me give you the context. When you're a teacher you've got to have another job to pay the bills. I had a job I loved -- running a swimming pool in the summer. It paid well and was great because we had little kids then, and they could go to the swimming pool all the time.

We would close the pool one day every summer and have all the employees and their friends come swim, and we'd have a little show. I was part of the show. I won't talk about all of those details, but I was a swimmer and a diver, and I loved to do crazy things off the high dive. The craziest was to ride the bicycle off and then make it roll over. Well, I injured my back, which led to two surgeries. Needless to say, I stopped riding bicycles off the high dive.

WALKER: I understand that someone who worked at the hospital was on the search committee of the association?

DAVIDSON: Yes, that's right.

WALKER: So things came together for you in an unusual, roundabout way.

DAVIDSON: You couldn't make up this story. So here I am injured and I end up going to the orthopedic surgeon who recommended surgery. Suddenly I'm in this hospital bed and get a message that a Mr. Griffith is looking for me. I didn't know a Mr. Griffith. It turned out Mr. Griffith was a member of the search committee for the hospital association and he was the CEO of the hospital where I was a patient and the one to whom my dean had given my name.

Mr. Griffith called me at home. Janet's dad was babysitting the kids because I was in the hospital, and he asks, "Well, when can I talk to Mr. Davidson?" Janet's father, a wonderful man and a real character, said, "I don't know that you can ever talk to Mr. Davidson. He's lying flat on his back in the Delaware Hospital, in terrible pain." Again, it was the hospital where Mr. Griffith was the administrator. So he hung up the phone and came around to see me in a 6-bed ward. I was in terrible pain. He politely walked in to introduce himself. Janet shook his hand, and he said, "Can I talk to your husband?" She replied, "Certainly. But it won't be for very long because they just gave him a shot of Demerol and he won't know what he's saying."

He explained why he was there. He wanted to see if I had any interest in a job in the hospital field. When I ultimately was able to talk to him, I said, something like: "I don't know anything about hospitals except everything you do here seems stupid, and it just doesn't make any sense." "Oh, I like you," he said. "You're the kind of guy we need."

I really wasn't ready to take a leap like that. I didn't even know there was a job called hospital administrator. I asked for time to think about it. I recovered in about six weeks, and they asked me to come to Baltimore and meet the head of Johns Hopkins. Well, they wheeled me around to meet all these very important people. I didn't know how significant they were until I saw their offices and everything that went along with it.



It was fascinating. I was being courted for a job I didn't know a thing about. I was very uneasy. I really wanted to stop the process, but didn't want to just walk away. So Janet suggested that I ask for a higher salary than they were offering and then they would decline and I would be off the hook. That seemed like a good strategy. I called the chairman of the association's board and told him it was a great job, but the salary was inadequate because of moving expenses, the amount of travel, the need for a new car and on and on – all things that were true. He listened quietly to the list of things and said: "Okay. I'll be back to you."

He was the chairman of the board. He and two other men made up the executive committee, and I guess he talked to them. The next day I got a call saying they'd raised their offer and I had the job. Now I felt honor-bound to accept. I had all these mixed emotions. But it was one of the greatest things that ever happened to me. I would have never known how wonderful hospital people are or had such a great opportunity. All I knew then about hospitals at that time was learned through my back surgery and having my tonsils out as a kid. That was about it.

WALKER: That created the opportunity, then, for you in 1969 to become the first president of the Maryland Hospital Association.

DAVIDSON: I went to work for the Maryland-DC-Delaware Association. They called it Tri-State. I developed education programs centered on some of the problems that existed then. Some of them haven't gone away. For example, we still take all of our best clinical people and promote them to management – something few are prepared for. So I developed, with a consultant, a management education program with certification. Then I guess because I asked a lot of dumb questions about how hospitals are run, they got me involved in trustee education and that got me involved with trustees and CEOs. I was working with all of the hospital CEOs in DC, Virginia, Maryland and Delaware. Then the Maryland Hospital Association Executive position came open (it was called the Hospital Council of Maryland at that time). All of the members knew me and I kind of got drafted into the position.

My first assignment came from the chairman of the board: I had one year to totally reorganize the organization's governance and management. The board chairman was a banker. The Maryland Hospital Association, as far back as the early 1960s, had a blend of people who sat on its governing board: some hospital trustees, some physicians and CEOs. The CEOs never really liked it because they wanted control – a lot like their role in the hospital.

So at the start of the reorganization effort, we put together a task force with a good chairman and they adopted a simple logic: If a hospital association is an extension of hospitals and trustees govern hospitals, then why shouldn't the association be governed by trustees? Up until then, hospital trustees in Maryland didn't play a significant role in the state association. That changed as we developed this trustee-driven model. Maryland was small enough that it was possible

to give every hospital a vote by their board chair on everything we did. It was good democracy, but some of the CEOs found it terribly threatening. It was awkward for the first six months but it ultimately was adopted unanimously by the membership.

It changed the nature of everything the Maryland Hospital Association did because now the trustees were at the top. I tried to get the nervous CEOs to understand the real goal: to get the trustees to be effective and to strengthen CEOs' involvement with them would strengthen the CEOs' and the hospitals' position. With the board chair involved, they know and understand the issues facing the CEO. More often than not, it made the CEO look good. But the point was: we were not abandoning CEOs.

We created a special sub-group of CEOs to insure their strong input. That's how it all played out, moving from one level to another. It was a fascinating experience with all the group and political dynamics that were involved. Some people thought I was the worst thing that ever came along, and others thought I was a genius. I was happy if it came right down the middle.

WALKER: Maryland remains the only state hospital association with that governance model.

DAVIDSON: They've modified it a little bit and increased the CEOs' role. But the chairman still must be a trustee. When someone becomes chairman of MHA, they may have served as many as 12 years on the board. They know what they're talking about. One chairman, Gene Feinblatt,¹ was one of the most knowledgeable trustees in America. He knew more about hospitals than half of our CEOs. So that's how we stumbled into that form of governance.

WALKER: You were one of the first to refer to the health care field as a 'field', not as an 'industry,' as most people referred to it. Why did you think that defining what was done in health care as being part of a field was so critical and why referring to health care as an industry was potentially so damaging?

DAVIDSON: People will judge you by how you seek to be perceived. If you want to be perceived as an 'industry,' with all the corporate connotations, then you're going to be treated as one. Look at Wall Street. If you look at history, there are all kinds of problems. When I started at the Maryland Hospital Association, many hospital boards were riddled with conflicts of interest. We tried to deal with it and it upset a lot of people, but we got rid of some trustees who shouldn't have been there. Leading bankers would make sure their bank had the money from the hospital. Law firms had the account because of a board member.



¹ Eugene M. Feinblatt was a founding partner of Gordon Feinblatt (Baltimore, MD), with a 50-year legal career that featured prominent roles with a number of civic organizations.

A whole string of things began to surface. We supported a kind of ‘let’s have it all out and suffer the consequences’ approach. If that was the perception of what goes on in hospitals, then people really will think it’s an industry, and that some of the people must be greedy.

That’s not the characterization we wanted. Hospitals are magnificent places. If you want to be called an industry, be prepared to get treated like one or change your behavior dramatically so that people will say: “No, hospitals aren’t an industry. They are community-based social institutions.”

I took that on as a theme both in Maryland and at the AHA, trying to get our own hospital CEOs to think about public perception and trust. It was tough because they’re preoccupied with other things. They don’t focus on that. So the whole notion of measuring public perception of hospitals and trust grew out of those things. At the AHA, we did some groundbreaking research led by Rick Wade². The research revealed what the public really thought of hospitals and it wasn’t all encouraging. It sure was encouraging for nurses. One of the things that we learned was those whom people trust, the ones they would turn to for the straight talk, were the nurses. Not the doctors. Not the administrators. Nurses still rank at the top in terms of public trust. My reaction to that was: Get those nurses out in the community. Have them be more visible because they *do* represent what we do. It’s the work we do that is so wonderful, and they do it. The caregivers do it. The business people do the business thing.

WALKER: You’re beginning to talk about that time in your career that you’re best known for, the 15 years that you spent as president of the American Hospital Association. After 22 years as president of the Maryland Hospital Association, you joined the AHA in 1991. One of your first challenges was to do something similar to what you had done in Maryland, and that was to restructure the Association. You had to do some painful things in terms of personnel and in terms of finances. What were some of the challenges that you encountered in 1991 as you joined the AHA, and how do you think it was made stronger as a result?

DAVIDSON: The AHA was always a good organization. It was founded on good values. It had some CEOs over the years who had good values and wanted to promote those values. The principle product of the Association for a number of years was written documents – monographs – around given issues. I don’t know if they still have them in paper or not, but we had warehouses filled with these different monographs around clinical issues, managerial issues and all the rest.

Well, you give me a monograph, and I’ll give you a snooze. Most of the monographs didn’t have impact. It was good information, but no impact. So one of our first major efforts was to look at exactly what was the product of this Association? What’s it all about? Let’s be clear about what members perceive as the greatest value of the association and then let’s structure the organization to play to that. When I went there, the Association had more than 1,100 people on the payroll. Today they have less than half of that. The major changes in personnel took place in the first three years. It was very difficult to do, but we did a hard-line assessment based on addressing the most important priorities. If there were four priorities and we were equipped to do only two of them, the others were discarded. We realigned the plant.

² Richard H. Wade was senior vice president at the American Hospital Association from 1991 to 2009.



In essence, what the AHA really looked like was a learning center for middle managers, not a percolator of ideas for CEOs, board chairmen, and medical directors. The most important function of the Association is advocacy. There are ways to do advocacy effectively, but there are lots of people who are not effective advocates. A lot of our most controversial changes were aimed at effective advocacy.

We restructured around a couple of things. Number one, advocacy is our primary product. We'll provide leadership, education, information, member protection and all the other essentials. To equip the AHA to do advocacy effectively, Davidson's primary office will not be in Chicago, it will be in Washington. Well, that rang a fire bell. Rumors swirled that the entire AHA would be moved to Washington, probably within one or two years, and probably not everybody would survive. We'd get rid of the ones we didn't want or need.

So the day I was named president of the AHA, May 2, 1991, I immediately met with all employees in Chicago. I knew many of them because I worked a whole lot with the AHA in my prior role and knew the organization well. I told them I was thrilled to be there, and that I understood that many of them were nervous about my presence and the fact that the board announced that I would reside in and operate out of Washington. And I said, "My board chairman is sitting right here and I'm going to make a pledge to you right now. As long as I'm the CEO of the AHA, there will always be a Chicago." I turned to the chairman, and he nodded. "So sit back and relax, all right? We do need to restructure some of the things we're doing."

So for advocacy, obviously, you have the foot soldiers, the lobbyists on Capitol Hill, but you also need policy and communications components. You need the political action component, raising money and marshalling support. So we did move some parts of Chicago to Washington and that involved some downsizing. But for the long-termers who were worried about whether it was the death knell, it really wasn't. Our first layoff was around 115 people, and we had employees compliment us on the way in which we did it. We went out of our way to ensure that everybody had counseling. Ultimately their finances were covered. We threw a lot of benefits into the pot and made it as gentle as we could. Those jobs were going to be lost anyway. But even so, it was very difficult.

WALKER: That restructuring and move to Washington, prioritizing advocacy, couldn't have happened at a better time for the AHA because it took place right before the Clinton Administration's health care reform initiative. Early in your tenure as president of the AHA, you were determined that hospitals would be proactive on reform. What were the major issues?

DAVIDSON: There's one phenomenon about hospitals and government – you are always fighting to protect the money. No matter how you spin this, that's the essential thing. It's the department of war protecting the homeland. That's what it's like. That goes on every year. It

doesn't matter whether we're talking about reform or something else, because there are always fiscal problems. Costs keep increasing. So we're always in that struggle.

Second, nobody really had an idea of what reform meant. That's one of the problems we have now. We prepared ourselves by putting together the right mix of staff, and reconfiguring the way we operated. One of the things that I learned (going all the way back to the Maryland Hospital Association) is that hospital CEOs were seldom comfortable sitting in a room talking to a congressman or a senator. That's not what they did. When we told them that part of what they had to do was use their influence – their political power – some of them were uncomfortable. But we got a lot of them to motivate their trustees on some of these issues and, on occasions, their nurses and others.

When I came to the AHA, I found it was even worse nationally than it was in Maryland. Maryland is a small state with fewer than 60 hospitals. We could get people to do some things in that kind of a different environment. I came into the field when the last real health care reform was happening. That was the year Medicare went into place. It was really a significant time. I was convinced that there would be health insurance for all Americans by around 1972. What a prognosticator I am, eh? It's still not there, and it may not be there even after the current debate because it is very complicated. The special interests that we talked about have become so powerful. I don't think that's what the founding fathers had in mind.

Now there are some good special interests. I've always characterized the hospital community as the "good guys." We have so much to be proud of, but we have to have people understand what we do and what we care about. It's an amazing phenomenon. Our hospital leaders are even bashful about talking proudly about what they do. I think they're significantly better at it today.

So the Clintons decided that they're going to take on health care reform. Janet and I met Bill and Hillary Clinton at the Iowa Health Caucuses probably around March 1992. Bill Clinton was really an unknown.

You know, *That governor from where? Arkansas?* We met them and, as it turned out, Hillary knew one of the senate presidents that Janet worked with, so they hit it off real well. I had a brief conversation with Bill Clinton about priorities around reform. But that day he gave a speech in Iowa without a single piece of paper, not a note, and talked about what was wrong with the health care system and how it had to be reformed. He was the most knowledgeable elected official I had ever heard talk about this. I was impressed – you know, whether you like the guy or not. He said the reason he knew about hospital care was that he was in charge of a Medicaid program. He viewed hospitals as great advocates for the poor. And I thought *this guy was singing all the right songs for us*. Clinton had a knowledge base that just startled and impressed me. When I went to the AHA, one of my



President Bill Clinton, Carolyn C. Roberts, and Dick Davidson

objectives was to be a part of the success of passing health care reform legislation. I devoted much of my 15 years there to building frameworks and values that could serve as an approach to reform. When I left, a framework was in place and Rich Umbdenstock³ has picked it up and carried it. What's going to happen? Doggone if I know. But we must keep fighting for it.

WALKER: In 1993, you said that the most difficult aspect of gaining acceptance of a reform plan was the general public. You talked earlier about the need for public trust and public confidence, and I know during your years with the AHA, through the *Reality Check*⁴ and a variety of other initiatives, that was something that was really important. You said back then that the public



Dick Davidson with Senator Daniel Patrick Moynihan

would evaluate the plan, and then the news media would do a lot of interpretation.

DAVIDSON: It sounds as though I knew what I was talking about.

WALKER: Members of Congress would have their say, and then they would listen to the people at home. That sounds like what is happening today. Do you think that Congress will be able to pass health care reform legislation?

DAVIDSON: I'd like to be able to say absolutely that's

what's going to happen. In the political world, it is much easier to kill legislation than to pass it. It's a very simple principle. If you look at the current debate, the threat to people's self-interest is playing out. For example, the most recent one, the recommendations about mammograms – what timing!⁵ Right away the enemies of reform attack it as rationing. A lot of scare tactics are employed. Advocates are called socialists, or worse. “They” are going to take your money, and you're not going to be guaranteed coverage.

Then they scare the elderly by talking about Medicare cuts. The AHA reached an agreement that Medicare could be cut if the number of people with coverage expanded to around 98 percent. It's not difficult to stir things up and frighten people. I think you're seeing that in play now.

³ Richard J. Umbdenstock became the President and CEO of the American Hospital Association in 2007.

⁴ *Reality Check* was a series of focus groups conducted from 1996 to 1999 that tested public opinion about health care and hospitals. Findings of the focus groups were summarized in reports that can be found in the collection of the American Hospital Association Resource Center in Chicago.

⁵ In 2009, there was a controversial recommendation that women should have mammograms to screen for breast cancer beginning at age 50 instead of age 40, as had been suggested previously.

I can't imagine being uninsured in today's world, with all the advances in medicine and technology, and being denied treatment because I didn't have health insurance. We're a much better society than that, and shame on us if that's where we end up.

WALKER: Another of the issues that has come up during this whole health care reform debate has to do with end-of-life care. A decade ago, you pointed to the need to deal with improving quality at the end of life. You said, "There's a better way to leave this world than being hooked up to a lot of machines." One of the factors that has been blamed for creating a lot of turmoil in the current health care reform debate was that House amendment that would have paid physicians for counseling Medicare patients on the choices that they have.

DAVIDSON: Right. What are your options?

WALKER: Do you think that this end-of-life issue is one that is too charged to ever be able to be dealt with effectively in a reform discussion?

DAVIDSON: I think we have to have the conversation. You can't duck the issue. I feel very strongly about all that. On a very personal side, I don't fear death, but I fear dying. Walk through the units in our medical centers. You can see what it's like for the terminally ill. One of the most striking personal experiences that I had was at the Maryland Hospital Association. A CEO from one of our hospitals, an old friend, had lung cancer. He had one lung removed, and now they were down to, "What are we doing about this next one?" He probably wasn't going to make it.

His family asked me to come to the University of Maryland Hospital and see him and, of course, I said yes. He was in the intensive care unit, lying there with an oxygen mask on. He was all connected to monitors, looking like he's smothering under there. His wife, whom I knew very well, and his attending physician were there. He wrote a note to me that said, *They won't let me die*. His wife and physician were hopeful that he could turn the corner. So I said to him: "They say you could turn the corner. And you might. Do me a favor? Stick it out another day, two days at most. If it doesn't happen the way you want, they'll pull the plug." I turned to the doctor and his wife, and obviously they were not going to have an argument in front of the patient. Two days later he was gone.

The man wanted to die. He was suffocating. He had to be anguished. It frightened me to think about it. Claustrophobia, with all of that stuff all over you. But they were holding out. The doctors' instincts are to save lives, not to help people die. His wife – they loved each other very much, a wonderful couple – couldn't face losing him.

Now, go back to the point that you raised about counseling. Many people need counseling. The most sophisticated physicians need counseling on how to deal with this. They don't deal with patients very effectively. My other experience, which was a frustrating situation, was my mother's death. My mother had multiple cancers. Ultimately the pancreas did her in. But she got moved around from specialist to specialist, with no one coordinating any of the conversations or decisions.

So I convened a meeting of her doctors, in her room, and they came, and we talked about her situation. There was the surgeon, the oncologist and the primary care doctor. I asked each what they thought and asked them, "What do you think all that means?" And they agreed. It meant that she wasn't going to make it. She was going to die. It was a matter of time. So what was the best

option? The hospital was not the place to die. There was a great home hospice program in southern New Jersey. They took over her care and she died with dignity. She truly did. We spent a couple of months watching her die. But she never lost her sense of humor. We treasured that time, even had fun. My aunts came to visit and they all sang with her.

But to me, it's the perfect characterization. My friend was smothering under all this equipment, and my mother, just kind of free and knowing the end is going to come, but as she said: "This is pretty nice. I have all my family visiting me." So how do we deal with these issues? Keep pushing forward, for the patients and their families who need some counseling. That's one of the breakdowns in our system. When you talk about reform, that's a piece that really needs to be reformed. Easy to say, hard to do.

WALKER: One of the other things that I know was important to you during your time at the AHA revolves around diversity. You helped establish the Institute for Diversity. How much progress do you think the field has made in the last several years in this important arena?



**Dick Davidson with U.S. Surgeon General David Satcher and
AHA Chair Carolyn Boone Lewis**

DAVIDSON: Marginal, but good. If you talk about being a change agent, change in certain areas is very difficult to bring about. You need a lot of patience. There are many strategies to achieving behavior change – finding the innovators and early adapters for example. It's a lifetime's work. That's a term I use to describe a lot of the things that we work on in the hospital field. Don't expect us to fix that right now, but we're working on it, and it's a high priority.

In some areas, we've really made some progress. One of the things I've done that I'm particularly proud of – and it was a real commitment – was increasing the diversity at the leadership level of hospitals. Not a lot of fanfare and not as many resources as I would have liked, but effective. No one would talk against it because that would be politically incorrect, but the support was not overwhelming at first. We've seen some of it with regard to our new president. No matter what talk you hear, there are a lot of feelings that are different than what people say.

So, we have to keep working on it. Our hospitals, their governance, management and all of the rest should reflect the communities they serve. If you go to most poor, inner-city hospitals, you're not going to find the diversity you might expect. It's change that I think is pretty essential, and we need new strategies. The work that Fred Hobby⁶ has done is very impressive. We must

⁶ In 2005, Frederick D. Hobby became the President and CEO of the Institute for Diversity in Health Management, an affiliate of the American Hospital Association.

keep supporting that, but supporting it with actions on our own. Every hospital CEO ought to have an accountability list around diversity. Every institution ought to hold itself accountable around diversity. It should be part of their self-evaluation. Hospitals are in their communities for the long haul and so we have to keep working on it. We'll get it right.

WALKER: Let me take you back to 1997, when the Balanced Budget Act was enacted. That resulted in severe financial problems for hospitals. What was the focus of the AHA at that time, and how did the field come together to later enact legislation that helped to mitigate some of the damaging effects that happened as a result of the Balanced Budget Act?

DAVIDSON: You can pass onerous legislation like that only if the parties affected aren't strong enough to stop it. I think it was a clear demonstration that our corporate values and ethics and behaviors hadn't served us well. We were vulnerable, and we got beaten up badly. Now, the good part is that it helped us stimulate the members to take seriously the whole question of community health and community benefit. Hospitals exist for one reason: to serve their communities. So it caused us to refocus in a way that I think was pretty effective. It's like anything, if you get beaten up for something that you've done, if it's fair and you deserved it, then maybe you ought to change your behavior.

WALKER: So, to a certain extent, that damaging legislation may have been an important turning point in a lot of hospital and health system executives' views about what it is that they really do, who they really serve, and what they have to do to be able to be considered viable by the people that pass the laws that have to do with reimbursement and regulation.

DAVIDSON: I think you're right. I don't know that there's much else to say about that. I think your description of the circumstance and your summary is accurate.

WALKER: What do you remember most about September 11, 2001, and the way America's hospitals responded?

DAVIDSON: The day is vivid for me. It was the Pearl Harbor of this generation. Coincidentally, on that day the AHA had convened a meeting of all of the state hospital association executives in Washington, at the Mayflower Hotel. We were looking at strategies and tactics for the upcoming Congressional session in January. We always had a lot of communication with the state associations. I was in the office before going over to the Mayflower. As I was on my way out with Steve Ahnen,⁷ one of my associates, the first plane crashed into the World Trade Center. We didn't believe what we saw. We stopped and watched the television for a few minutes and then headed out for the meeting. We had only some sense of what had really happened.

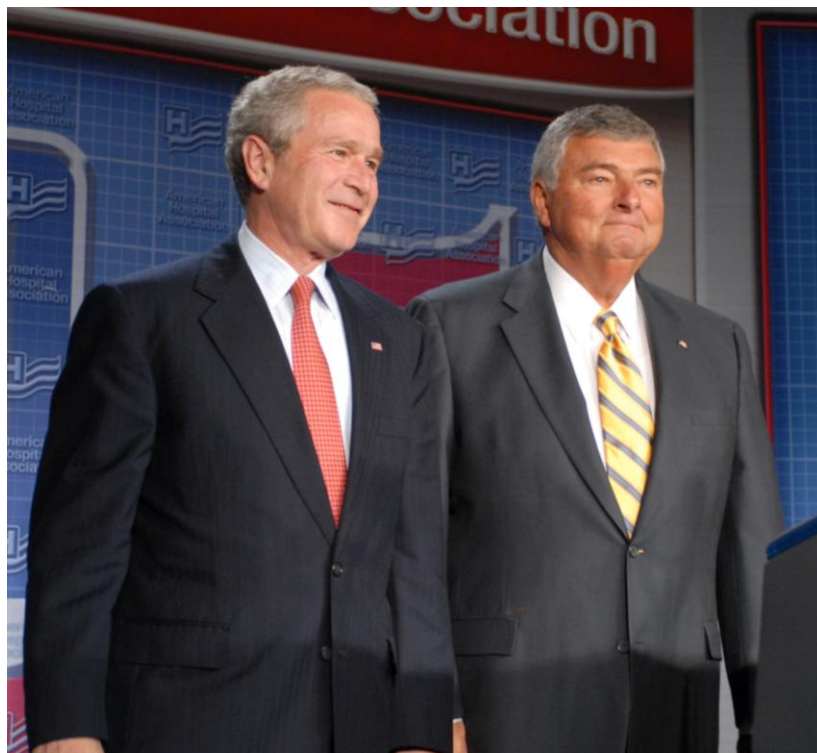
We were in a car going west on Constitution Avenue and up 16th Street on the west side of the White House. Traffic was terrible. We turned onto 16th Street. I was sitting in the back and noticed smoke in the mirror of the car. It was the Pentagon. But we didn't know what it was. So traffic was creeping north on 16th Street, and we were now next to the Old Executive Office – the Eisenhower wing of the White House. All of a sudden, all these people came running, and

⁷ Until 2008, Stephen M. Ahnen was Senior Vice President, Association Development, at the American Hospital Association. He is currently president and CEO of the New Hampshire Hospital Association.

screaming, crying. There we sat and suddenly I had this enormous sense of fear. People were running out of the *White House* because the plane that crashed in Pennsylvania was one that was scheduled to hit the White House. I thought about getting out of the car and walking fast. I didn't. We finally got through traffic and arrived at the hotel.

We had TV screens set up in the meeting room. This was a scheduled workday, but we never did anything except watch the screens in total disbelief. We had group prayer together. Everyone felt threatened. But that horrific event reinforced how important hospitals are to a community's sense of safety and trust. In the midst of all that chaos, people ran to find a hospital. In New York, it was St. Vincent's. The hospitals performed superbly. They didn't have all the casualties they expected. But they were prepared for virtually anything. What it taught us is that first responders are such an essential part of the community infrastructure.

All these state hospital association executives were in Washington to talk about public policy and many of them were stranded there for days. Everything was shut down in Washington. Many roads were blocked. There were guns on the rooftops of every building along Pennsylvania Avenue,



Dick Davidson with President George W. Bush

facing our office. We had a real sense of being under siege. I think what stays with me about it was that there we were, all working together, experiencing together this tragedy that was so important to hospitals. None of us will ever forget that.

to help our members be better prepared and we launched a lot of initiatives to do just that. It was Jim Bentley⁸ who led all of that for us. A great deal of good can come from a horrible event if you know how to learn from it. I think America's hospitals did learn – and communities learned. I think everybody did.

WALKER: It heightened the awareness among hospitals about the importance of being prepared for a disaster which has helped many hospitals to be able to cope with the more traditional disasters.

DAVIDSON: I think you're absolutely right. It's something like our 1997 Balanced Budget Act experience. It triggered behavior change. In this case, it was a signal to AHA

⁸ James D. Bentley, Ph.D. was Senior Vice President, Strategic Policy Planning, at the American Hospital Association until 2009.

WALKER: Let me talk with you about quality. I understand that when you were with the Maryland Hospital Association, one of your chairman, Gene Feinblatt, asked: “How do I know that the care in my hospital is any good?” That fundamental question about quality stunned everybody in the room and led to the establishment of the Maryland Quality Indicators Project. How did you nurture a sense of urgency and importance around quality improvement during the time that you were with the AHA, and how did that early experience in establishing transparent and meaningful quality indicators in Maryland inspire the kind of quality improvement initiatives that you undertook at the AHA, such as the Hospital Quality Alliance?

DAVIDSON: My MHA experience and the expansive activities that we had were perfect preparations for me to try to do many of the same things but on a bigger scale at AHA. It was like going from the sandlots to the big leagues. My game plan was going to be the same: get the leadership to agree on goals and a vision and take small steps first. That’s pretty important. I’m still not finished trying to get some of the things that still go on in Maryland to happen somewhere else.

A major factor was Gene Feinblatt, one of the most knowledgeable trustees I had ever met. He was MHA’s board chairman for three years and vice chairman for three years. He helped to engineer the all-payer system in Maryland, which is a great story all by itself. Gene was frustrated. He was a trustee and a lawyer. He knew what his responsibilities were as a trustee, but he felt he wasn’t meeting them. As he put it: “I don’t know if the care’s any good at my hospital.” He was on the board of Sinai Hospital in Baltimore.

He asked the CEO to help the board understand how the hospital was performing in terms of quality measurement so they would know if the care is any good. He felt they never quite came to grips with that and he was looking for a way to do that. So, we put together a multi-faceted task force of people from Maryland: people from the state medical society, the PSRO⁹ at that time, other key players and came up with a proposal to begin to answer Gene’s quality question. Remember, the mindset at the time was: “Well, The Joint Commission¹⁰ accredited us. We must be good.”

This task force concluded that there should be a new public body focused on measurement of hospital quality performance. That scared everyone to death and ultimately, they backed away from it, but not entirely. A public body might be something to do *down the road*. Their model was Maryland’s Health Services Cost Review Commission. The task force disbanded, but we created another committee led by Dr. Spencer (Spike) Foreman, CEO of Sinai Hospital, to come up with our own new way to do it in lieu of a public body. In essence, they proposed a quality center within the hospital community to define some quality indicators and have all hospitals submit their information by DRGs,¹¹ or other categories. The data would then be analyzed and shared among all participating hospitals so that they could compare performance and improve. It was pretty sophisticated.

⁹ Professional standards review organizations were established in 1972 to monitor the cost and quality of care delivered as part of the Medicare and Medicaid programs.

¹⁰ The Joint Commission, originally known as the Joint Commission on Accreditation of Hospitals, has been accrediting hospitals and other health care organizations since 1953.

¹¹ Diagnosis related groups were developed in the 1960s at Yale University as a way to classify patients by illness or condition. DRGs later became the centerpiece of the methodology used to reimburse hospitals under the Medicare program.

When we did this, we went to the *Baltimore Sun*, met with the editors and told them how hospitals planned to look at their performance and share information with one another. But it wouldn't be made public and we were candid about our reasons: "We're trying to change behavior. We're trying to have physicians and nurses and others be more sensitive to patient safety and more effective outcomes. If you start to name hospitals, then ultimately you can name departments – and everybody will run and hide. They'll bury all this information." We convinced the *Baltimore Sun* not to oppose the notion and just keep silent on it. We even got their praise for developing an educational strategy to improve clinical performance.

We were determined to start small. A few hospitals at first and that would attract others that would be eager to join this new 'quality club.' If you're going to be in the club, you had to demonstrate your commitment to education, to using the clinical indicators, to find the problems and improve. The educational plan in the package was vital.

The program has had as many as 1,100 hospitals participating and it's gone international. The goal was to track quality in a circle – from the patient point of entry into the system (admission) to the exit and tracking all the things along the way with clinical indicators. Even ambulatory and long-term care would be included. That was the vision in 1985, and they're still working on it there.

WALKER: You mentioned that many things at the AHA are a lifetime's work, and this



**Dick Davidson with AHA senior executives
Rick Pollack and Jim Bentley**

quest for quality would have to be counted among one of those. Recently, there was a study published in *Health Affairs* that said that for nearly half of the hospitals surveyed, quality was *not* one of their top two priorities, so this effort that you began back in 1985 continues to be something hospitals across the country have to continue to pay attention to at the board level –

DAVIDSON: Absolutely.

WALKER: – the senior level, throughout the organization. It just doesn't stop.

DAVIDSON: Quality must be the essential thing you look at. If your mission is taking care of people, how are you doing, and how does a board know? As a board member, I'd sure want to know. If I'm the CEO, I want to be the *first* to know. But it's one of those things. You'd expect that everybody would make it a high priority, but it's *one* priority. Do we have to have the government force us to do that? In some cases, the answer may be yes. The Hospital Quality Alliance was an effort to make it a national priority.

The AHA has got a lot on its plate. It can help to get hospitals to be more effective clinically and focus on quality, but there must be other pressure. The Joint Commission will probably be able

to be helpful in all of this. We have to keep the emphasis on the concept of continuous quality improvement for all hospitals.

The Hospital Quality Alliance is a story of the right issues at the right time and place. Every stakeholder claimed a piece of the quality agenda – the Joint Commission, the health insurance plans, Medicare, everyone. Nobody knew what the other group was doing, but everybody was working on quality. They were trying to improve quality. The AHA leadership decided someone should take the lead and it should be us. But, who did we want to align with around quality? The Joint Commission? The government? So we convened a meeting of all the stakeholder organization CEOs to talk about it, because no one seemed to be taking charge.

At the first meeting, 13 to 15 leaders showed up, and in some you could just see there already was resistance to even talking about the issue, much less doing anything. I presided as the convener. We started by going around the room and letting everyone talk about their top priority in quality. Half of them were doing the same thing as the other half. There was overlap; there was duplication. Organizations that by law should be partners didn't tell each other what they were doing. It was fascinating. All of a sudden everybody went, "You're doing that? Well, we were doing *this*." It was almost funny in a way.

So we went as far as we could go that first day. I thanked everyone for coming and noted that we learned a lot about what each of us is doing. Would anybody want to meet again? Every hand went up and that was the beginning of the Quality Alliance. We brought them together and ultimately they forged consensus around quality indicators and what should be released to the public. It's tough sledding because the federal government can be a difficult partner. But you can get a lot of the other partners by persuasion. It's a very interesting exercise, because it demonstrates what you can do around a lot of issues because you're doing the right thing. I'm very proud of what we achieved on that front. But I worry about it long term. When you get new players, you get new attitudes, and the support may not be the same as it has been historically. But I'm the eternal optimist. We can make it work.

WALKER: Your successor as president of the AHA, Rich Umbdenstock, said that you had a simple litmus test for everything the Association worked on. The result had to make things better for patients, for families, for communities. How did you stay focused on ensuring that that ethic of those three things was present in everything that the AHA did?

DAVIDSON: Instinctively, I always asked that question – first of myself. You want to do something new or exciting? Now, how are we going to know if it's effective? We're going to find a way to measure it. Just by asking the question, you keep a sense of importance on these matters. I've always said every organization ought to have somebody that sits in a room like this, looks out the window, and thinks about the challenging questions around all of the work that we do. Maybe we could get rid of some and maybe we discover some brand-new things that we ought to think about. But it's asking the question.

WALKER: What motivated you and kept you focused on working for what's best for hospitals and families and patients and the communities that they serve?

DAVIDSON: What's interesting is you would never hear me say, "Bye, honey, I'm going to work." I've never said I was going to work, because I never found it to be work. I found things to

be challenging and sometimes daunting. You never heard me say ‘the company.’ We never say that. We say ‘the Association’ or ‘our organization.’ It’s all part of how you want to be perceived. I guess it may sound naïve, but I always felt like I was trying to do good. I was happy to have such a nice job and was compensated nicely, but the thrill was having the opportunity to make things better. That’s the excitement.

I like to remind hospital CEOs that they have some of the toughest jobs in America, but they also have the greatest jobs in America. Having a bad day? Well, turn off the electronics, get up out of your chair and walk down the hall to the emergency room. Stand in the corner for a while, and see the diversity of problems that come to your community hospital. There you are, helping these people. Go up to the neonatal intensive care unit and see the miraculous things that are taking place there. Go to the rehab unit and see people walking again that couldn’t walk last week. If you do that, you will feel exhilarated. It’s the reminder of what it is that you do, the work that you do. Not many people have jobs like that. For me, I always felt like that’s what I had as a job. It was wonderful. It wasn’t work.

WALKER: People talk about you as being a leader, as innovative, as a consensus builder, someone who’s dedicated to community service, dedicated to health care. You’ve been called one of those rare executives who listen to individuals with dissenting opinions and who can add value to the discussion. Are those traits simply part of Dick Davidson’s DNA or were those skills that you feel that you learned and honed over your career?

DAVIDSON: I don’t know the answer to that. I do what I do kind of naturally. I don’t know what it is. But I don’t want to be that fuzzy in my description. Let me apply it to a hospital association. If you look at the effective associations, just hospital associations, the most effective are those that have listening posts. When I started in Maryland, we broke the state into little pieces and we met for half a day every third month, to listen to the members, to give them information, but also learn about their educational and informational needs. To listen – here are the issues. We need to know what you think. Where you are? How we could do better?

So listening is obviously a significant skill, but it’s essential to running an effective organization. You think those people on Wall Street were listening? Somebody might have been somewhere, but that’s the whole message to me: They weren’t listening effectively to anybody. Their arrogance was so enormous that they felt they could do whatever they wanted. I think one good thing about what has happened is the public has expressed its anger with greed and self-interest. Government hasn’t found a way to punish them enough. I think it’s a problem.¹²

I probably wasn’t a good listener all the time when I was in school, but when it became really important to know something, to be an integral part of something, then listening was an absolute essential. Then, having the courage to deal with what you hear is a must. You may hear things you don’t want to hear, so you may not really hear them. You strike it out.

WALKER: What was your philosophy in working with your boards?

DAVIDSON: First of all, I believe that if you show me a good organization, I’ll show you a good board of trustees. It’s rare to have one without the other. Good governance moves you

¹² The reference in this paragraph is to the financial collapse that triggered the recession that began in 2007.

toward effectiveness as an organization. I started off in 1969 with a board chairman, and I've had a board chairman all the way up until I retired, in some cases multiple-year chairmen. With every board chairman, the first thing I did was sit down with him or her and ask how we could function together. We were going to be partners, but I worked for the chairman, who was a volunteer. We talked about communication and work style because I wanted to make it convenient for them to serve. Every board chairman appreciated that conversation because they'd been on boards where nobody ever asked them anything. They all had a different style, but one key principle we always agreed on was *no surprises*. This principle is the cornerstone of effective communications and personal relations.

We've talked about Gene Feinblatt, who was a practicing lawyer and a political powerhouse. We met every two weeks, seven o'clock in the morning at his house. He fixed the bagels. That's how we worked. I'd come in with a long list of issues that we needed to talk about, and then we'd work through them. Other board chairmen wanted a once-a-week call and to be alerted if there was an emergency.



Dick Davidson with President George H.W. Bush

They all had a different approach, but the important part was they were asked, and that made them feel that they had a sense of what our relationship was about and a shared vision and agenda. In all those years, I had only one board chairman who kind of didn't make it. He was there, but he wasn't there. I'd meet with him and he'd be engaged, but we didn't work well together. That's pretty good – for I don't know how many chairmen there were – but there were a lot of them. But I was always enthused with the way they received the question: “How do you want to work together?”

WALKER: Your style was said to be one in which you would pull a team together, give them a challenge, have them rip it apart, then come to some kind of a decision that everybody could support and that you could move forward with. Is there a particular situation that you can think of where that kind of an approach yielded the greatest result for the AHA?

DAVIDSON: I think you've just described the Hospital Quality Alliance that we talked about earlier. They shared with each other what they were doing, they discovered what was overlapping and duplicative, the conflicting interests and agendas,

but by the end of the meeting, they started to coalesce. I think that's an illustration of how you can make things happen. The role of the convener is to not be too overpowering or too slick. I hope I haven't been described by too many people as being too slick. I've never felt that way.

There's one other situation that is relevant and fascinating. I can't remember the dates, but I guess it was the very early '90s, when we were at the height of the 'competition versus regulation' era. The investor-owned hospitals thought that tax-exempt hospitals ought to lose their tax exemption. They thought it was an unfair advantage to competitors that did exactly the same things they did. We had all this stuff going on in the 'marketplace,' as some would describe it, fierce competition, name-calling, attack advertising, threatening other institutions. It was a real threat to AHA's effectiveness as an advocate for essential institutions in our society. The AHA Board Chair and I agreed that our approach should be get them all in a room and talk it out, and when we're done, there would be no more name-calling, bad ads or divisiveness.

We convened a meeting of the heads of those groups. Some players were pretty vicious, and they were really making life tough. But they all knew each other. In other words, people in the investor-owned field had all worked for one another at one point. Then we had to turn to the not-for-profit systems, the VHA, Premier, because they were in the middle of this and playing the role of big corporations.

I began by thanking them for coming, but we quickly got down to some candid talk about competition, regulation, and some rules we should have as a field about our conduct toward each other. Then the AHA board chairman picked up the ball. Half the people in the room didn't like one another, but they were all smart enough to know that shutting down all of this negative stuff was essential to hospitals' common goals, such as winning adequate financial resources. There had to be agreement. Everybody made a little finishing statement and then there was a kind of a pledge that caused the turmoil to die down for a long time.

The tax-exempt question didn't come up after that, which was significant. So that's a case where you don't have any rules or bounds. You're in an association and you're supposed to provide leadership to everybody. Some people were dividing the field, so as a leader, what is your responsibility?

Those two things I think are probably pretty good examples. Very different but achieving that kind of change is part of the fun of the work.

WALKER: How did you model work-life balance?

DAVIDSON: I had one-on-one relationships with a lot of people in the organization. I always would know who was over their head in terms of the workload. I pulled them aside and said, "Instead of working this weekend, why don't you take this weekend off? Take your family down to the beach or do something like that." I said to others, who were working themselves to death, "I want you to take a whole week off. And guess what? If I find that you have called this office while you have that week off, look for new work." Then I'd laugh. I was kidding, but the first guy I said that to is a state association executive now. He thought I was kidding, but he wasn't really sure.

I would always try to stress the 'family first' theme. I would talk about it in a big staff meeting with all employees. "Hey, we're working all of you too hard. Turn those damn machines off, will ya? It's okay." Some were fearful of turning them off because they were afraid they'd miss something. I met with all employees in Chicago and Washington several times a year. I would always have some family stories to tell and have them share theirs. I think people had a sense that

there was a real caring for what family life is all about. It's not working all the time. It's just not working all the time. But the workplace is so demanding.

There was no plan to it – just exhibiting concern. I sent some people away with their families just to get them to go. “We’ll be getting you an airline ticket. We’ll do whatever we need to do to have you unload.” We tried nights at the ballgame and things like that. There’s only a small portion of employees who care about that kind of thing, but we wanted to signal that it was okay to shut down, to not always be working, and that your family needs you, and you need to devote time to them.

WALKER: At the end of your career, in 2007, you received the American Hospital Association’s highest honor, the Distinguished Service Award, which recognizes significant lifetime contributions and service to the nation’s health care institutions and associations. What one accomplishment are you most proud of?

DAVIDSON: I can think of several that make me enormously proud. One we didn’t talk about had to do with payment reform. The Maryland Health Services Cost Review Commission has been in existence since 1971. That was my second year on the job there. We had serious payment



Dick Davidson with Senator Edward M. Kennedy

problems in Maryland – hospitals on the verge of bankruptcy. The Association was under pressure to act. Interestingly, we had a couple of utility company executives on the board. Their view of payment reform was to treat hospitals like public utilities. Utilities have to demonstrate what resources they need and demonstrate their performance. If they do all of these things, demonstrate that they’re entitled to a level of payment, then they get it. Public utilities are subject to full and open disclosure, where the public, through the Public Service Commission, can see anything they want. Why couldn’t

we create a system like that for hospitals?

We spent time talking to judges and Gene Feinblatt and some other lawyers. We reached the conclusion that it was a pretty creative strategy. If successful, we wouldn’t have to defend hospital costs as though they were secret. They’d be out in the open. Everyone could see them. To some, that was a scary notion. After a lot of work, a bill was drafted and we went to the governor – who was a friend of Gene Feinblatt’s – and told him what we wanted to do and asked him to sponsor the legislation. He did, and the biggest opponent of it was Blue Cross. They thought it was going to drive their prices up because all payers in the system would share in the burden of uncompensated care.

The debate was vicious at times and pretty exciting. Blue Cross bussed in senior citizens, scaring them with the notion that their Medicare coverage was going to be harmed by this. There would be cuts. The bill passed. In the two houses of the Maryland General Assembly, I think there was one vote against it. It was the governor's bill. He was powerful.

That whole concept of payment reform, an all-payer system, treating hospitals like public utilities, didn't die. It's obviously there and healthy in Maryland today. There were 13 other states that tried some variation of it. I worked with the state hospital associations in many of those states. All of them failed. And the reason they failed was that hospitals didn't want it. If you want to throw mud in the wheels of a regulatory organization, you can, and that can render it ineffective.

The reason this unique payment system works in Maryland is that it was the hospitals' idea. They had ownership and, with the governor, they wanted it to work. Because if it didn't work, how would we deal with these hospitals facing bankruptcy? There was no due process in any payment system anywhere else in America. People saw a real virtue in that.

Now, the Cost Review Commission drove our hospitals crazy over the years, but they were fair. Hospitals in Maryland do just fine. If you're a good performer, you can get double-digit margins. Over all, hospital costs have been significantly contained as a result of this. Maryland costs used to be 25 percent above the national average, and now they're below the national average.



Dick Davidson with Hillary Rodham Clinton

WALKER: It makes you wonder why there aren't more states whose hospitals would want to lead a similar kind of solution.

DAVIDSON: It's very difficult. Talk about a lifetime's work! A lot of energy time and expertise is required to have one of these things work in a state. It's not just hospitals; it's the government too. This is what Hillary Clinton missed. She created this complicated apparatus for every state. We tried to tell her about, how things work in the states and the politics of it all. Policy wonks

can't run it. You're going to have some vested interests that want it to succeed. You've got to really want to do it, and a lot of hospitals aren't hurting bad enough to want to do it.

Now, it's a great form of public accountability. Over the years, most of our state associations spend a good bit of their time defending hospital costs. In Maryland, a public agency tells the public about hospital costs. Here's where they are, and that's where they should be. It changes the dynamic. Could it happen in other places? Maybe. States could opt to do some of these things themselves.

Going back to your question about things to be proud of – it’s all that we worked on in Maryland that was a springboard to my role at the AHA. The American Hospital Association adopted a public policy paper years ago that called for the creation of state-level rate regulatory agencies similar to Maryland. Advocates for it at the time – I was one of them – fought hard. When I went to the AHA, I didn’t try to raise that. It had been rejected. But is there a time for that again in the future? Conceivably. But a lot depends on the outcome of health care reform.

WALKER: You mentioned a time when you were physically threatened. Can you talk a little bit more about that?

DAVIDSON: One threat was generated by our active role in creating a state-level rate regulatory system. One of the vested interests in that outcome made a veiled threat on my life. It’s nothing I ever did anything about. I thought he had kind of gone crazy, but I didn’t realize it was this serious. So, you know, I found my sense of humor then.

The other one was when I started at the Maryland Hospital Association. In 1969, the Service Employees International Union 1199 was organizing Baltimore hospitals. I was 32 or 33 years old at the time. Some people didn’t take me very seriously because of my age. Half a dozen Baltimore hospitals were in the process of being organized. The union was demanding a closed shop – that everybody who worked in the organized unit had to be a union member. The hospitals were trying to fight it but they weren’t having any luck. I called up the head of Johns Hopkins, and I said, “Look, if I jump in the middle of this thing, is it okay with you?” He laughed and said, “Well, our strategies aren’t working on this front right now. Go ahead.”

So the MHA came out with a public statement against the unfairness, at the same time praising the movement of unions to try to improve working conditions. We supported what the unions wanted except that hospitals didn’t necessarily have the money to pay for it – and we didn’t believe in a closed shop or that doctors should go on strike. That was all part of this statement.



There was a public debate in a church between me and the head of the union. The audience was young physicians, residents, interns and front line employees. In the course of this debate, which was covered by the press, the union and I agreed with eight out of ten things the union wanted. But we could never agree to a closed shop or the strike provision. So that got big publicity in the newspaper - big banner headlines. It must have been a slow news day.

Apparently, it had some impact because I got this strange phone call. “Mr. Davidson? There’s no role for you in this discussion over organizing the hospitals. You have no standing in any of this.” I said, “Oh? We’re an extension of our members. I have the right to say anything I want about hospitals and what’s going on there, and this is what I believe.

It's not fair." I got this gravelly comment back, "You just be careful because something might happen that could be very, very unpleasant." It was real clear what that meant. I said, "Okay! Good talkin' to ya." And that was it.

It was a veiled threat, but it was an indication of how high the stakes were because this was big stuff. Outside of New York this was their next big organizing effort. But it was kind of an exciting opportunity. Unions and hospitals get along pretty well, because very often they're fighting for the same things.

Another of the things I'm proud of is that hospitals have become among the most vigorous advocates for the poor that we have in America. When we're fighting for Medicaid money, we're fighting for poor people. We spend a whole lot of our time doing that, and we shouldn't be afraid to say that, and be proud of it. It's preserving the social fabric of the community.

WALKER: You are personally an advocate for the poor with your work with homeless organizations.

DAVIDSON: In Baltimore, there was a very effective program called Health Care for the Homeless. There are other, similar efforts, but the Baltimore group may be one of the most sophisticated. I got involved because we had a problem with our hospitals not wanting the homeless in their emergency rooms. They're a different kind of patient, and require a different kind of management. But aren't these people entitled to some care? So the Health Care for the Homeless program was a way to take the pressure off of the hospital emergency rooms and enhance the way care was delivered to that population.

Over time, that organization has done a tremendously effective job. Jackie Gaines, who's now a respected hospital executive and author, became our executive director of Healthcare for the Homeless in a crisis. We lost our program director suddenly. Jackie was a clinical nurse on loan to the program. I was a vice chairman of the board. I said, "Why don't we just name her the director? She's got great skills. We don't need to look all around." I said, "Look, if you could get her to do it, we'd be lucky." So I was involved with decisions around personnel and all the rest. But it was wonderful to see the change in taking care of people.

WALKER: It's been said that you have optimism for the opportunities that the field has to do more. What are your greatest hopes for what could be accomplished in coming years? What are the things that invigorate you about the potential for better health care in America?

DAVIDSON: I think that as a field, we're going to be in a continuous struggle, decades ahead, no matter how we reshape things, and we have to face that. You can be distracted by that and not focus on doing the right things. The challenge is that there are so *many* challenges that it's easy to miss working on the right things. It's that fundamental, that people stay focused on the right things while they've got a forest fire over here and another problem over there. So how do you keep from being distracted? How do you ensure that you're doing the right things? If I were running a health system, I'd want to hire people to come in and do what I call a "thumb-in-the-ribs." They would make sure we do what we say we stand for. They would give leadership an assessment. Are we doing the right things, and does our community think we're doing the right things? But I'd want to design that listening mechanism as I struggle through the most difficult issues. We may have to shift priorities. The point is, you need a way to listen and I'm optimistic about hospital



(From L to R) Gordon M. Springer, Dick Davidson, Kevin E. Lofton, Gary A. Mecklenburg, and Sister Mary Roch Rocklage

leaders' ability to do that over time. I've seen great progress in some of our institutions that I wouldn't have thought they would have come as far as they have. It's stimulating.

WALKER: What advice would you give to young people who are just beginning their careers?

DAVIDSON: There's something that's really important. Look at the nation's teachers colleges. Many people went to a teachers college, but they never

knew whether they really wanted to be a teacher because they hadn't done it. They'd done practice teaching, but not the real thing. At the *end* of four years and practice teaching, they may think: *Oh, this is awful. I don't like this.*" They've prepared themselves for something they don't want to do.

Start with that. Be sure, before you get yourself invested, that you really find opportunity and gratification in doing the work. What kind of homework can you do to find that out? Do a lot of networking. One thing that has impressed me about hospital CEOs is that every one of them is always willing to help a colleague. As busy as they may be, you can pick up the phone – you don't even have to know the person you're calling – and call a colleague CEO and say, "Hey, this is Joe Smith, the CEO of blank hospital in the next state. I heard you're doing a program we'd like to do..." and so on. And they make something happen. So networking is a terrific way to gain a better understanding of what the work is all about.

I go back to my own experience. I don't recommend it for everybody, but I spent weeks as a hospital patient. My joke about it was '40 days and 40 nights.' But it was several weeks in a hospital, from a 6-bed ward down to a private room. That experience, even though I resisted, – enabled me to say, *Yeah, there's something here. You really could do something that could be helpful.*

So finding opportunities to learn more about what the options are is crucial. I've got a granddaughter right now who's doing a volunteer internship at the local community hospital. She wants to have a health career. My advice to her is, "Look around at everything in the place. Talk to people. Find out what goes on, what makes them happy and then decide what you think is the path for you. Do you want to be a nurse? A doctor? What else might you really enjoy?" It's the hands-on, getting connected experience that guides you. There's no job guarantee in a volatile environment. Find a mentor if you can. A lot of doors open just by asking.

WALKER: What do you hope that your legacy will be? What do you want people to say about Dick Davidson?



DAVIDSON: That he always fought to have hospitals do the right thing. I don't know any other words to add to that that would enhance that meaning. If every CEO every day said, *My job is to be doing the right things for my community, for my patients, for my employees*, then we'd go in the right direction or we'd find ways to make things happen that may not be happening today. But it's the fundamental underpinning that makes all of this go.

Why do people do good deeds? Why do they? This is hospitals' roots. We take you back to the religious movement and hospitals in America, all built around doing good and that was doing the right thing. That's got to be a part of the nomenclature of the way you operate, whether it's 10 years from now or 20 years from now. I'd only add: *Always take the high ground*. I think it's absolutely essential. It's embarrassing to see any hospital organization take anything below the high ground. There's no need for it. We have so much to be proud of. Let's celebrate our accomplishments.

WALKER: Thank you, Dick.

DAVIDSON: Thank you.



**The Davidson Family. Top row (L-R): Mike, Diane, Justin, Tina, Rick, Fraser.
Middle row: Emily, Caroline, Courtney, Margot.
Front row: Sarah, Dick, Janet, Andy.**



In the Rose Garden with President Clinton



Dick and Janet Davidson

CHRONOLOGY

- 1936 Born September 29, Philadelphia, PA
- 1958 State College (West Chester, PA)
Bachelor of Science, Secondary Education
- 1962 Temple University (Philadelphia, PA)
Master of Education, Health Education
- 1965 University of Delaware (Newark, DE)
Educational administration specialist
- 1957 Married September 7 to Janet McCool of Wilmington, DE
Children: Michael (1958), Richard (1960), Andrew (1966)
- 1956-1962 United States Marine Corps Reserves
- 1958-1960 Goshen Central School (Goshen, NY)
Teacher
- 1961-1964 Alfred I. duPont School District (Wilmington, DE)
Teacher
- 1965-1966 University of Delaware (Newark, DE)
Research fellow in urban affairs, Ford Foundation
Administrative Intern
- 1965-1969 Maryland-DC-Delaware Hospital Association, Inc. (Baltimore, MD)
Director of Education
- 1969-1970 The Hospital Council of Maryland (Lutherville, MD)
Executive Vice President & CEO
- 1970-1991 The Maryland Hospital Association, Inc. (Lutherville, MD)
President & CEO
- 1977 The George Washington University (Washington, DC)
Doctor of Education
- 1991-2007 American Hospital Association (Chicago, IL, and Washington, DC)
President and CEO

MEMBERSHIPS AND AFFILIATIONS

American Hospital Association (Chicago, IL, and Washington, DC)

Life member

American Medical Foundation for Peer Review Education (Philadelphia, PA)

Board member

Coalition to Protect America's Health Care (Washington, DC)

Founding Chairman

Health Care for the Homeless (Baltimore, MD)

Board Vice Chairman

Volunteer Leader and Officer

Health Research & Educational Trust (Chicago, IL)

Board Member and Officer

Hospital Quality Alliance (Washington, DC)

Founding Chairman

Institute for Diversity in Healthcare Management (Chicago, IL)

Founding Director

International Hospital Federation (London, England)

Governing Council

State Hospital Executives Forum (Lutherville, MD)

Chairman

AWARDS AND HONORS

Citation for Leadership, U.S. House of Representatives

Commendation on Leadership, Maryland State Senate

Davidson Lecture, Maryland Hospital Association

Distinguished Service Award, American Hospital Association

Distinguished Service Award, Maryland Hospital Association

Distinguished Service Award, Michigan Hospital Association

Diversity Award, Association of Hispanic Healthcare Executives

Good Scout Award, Boy Scouts of America

Leadership Commendation, Catholic Health Association of the United States

Leadership Recognition, Ohio State University Alumni Association

National Leadership Award, National Center for Healthcare Leadership

Outstanding Leadership Award, California Hospital Association

Outstanding Leadership Award and Lecture, University of Iowa

Special Leadership Award, Maryland Healthcare Education Institute

Special Leadership Recognition, Association of American Medical Colleges



The Davidson family celebrating the 100th anniversary of the American Hospital Association.

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