



SCOTT S. PARKER
In First Person: An Oral History

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SCOTT S. PARKER

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**Interviewed by Kim M. Garber
On May 9, 2013**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in Bountiful, Utah

KIM GARBER: Today is Thursday, May 9, 2013. My name is Kim Garber, and I will be interviewing Scott Parker, president emeritus of Intermountain Healthcare, an integrated health system serving residents of Utah and Idaho. We're delighted to be including Scott's wife, Sydne, in this interview as well. Scott was chosen to be the first president of Intermountain Healthcare in 1975 and served there for nearly a quarter of a century until he retired in 1998. He has also served in leadership positions with many other organizations, including terms as board chair of the American Hospital Association, and as president of the International Hospital Federation, among many others. Scott and Sydne, it's great to have this opportunity to speak with you this morning.

SCOTT PARKER: Welcome to our home, Kim. Thank you for coming here.

GARBER: Scott, you were born in 1935 in Salt Lake City, the older of the two children of Albert Parker and Emily Smith Parker. Your parents had grown up in rural areas of Utah and came to Salt Lake City during the Depression looking for work. Could you talk about the values you learned from your father?

SCOTT PARKER: My dad was a quiet person, but very deep. He accepted challenges, like not being able to find work or not being able to afford education, with determination and optimism. That was a strong lesson for me. He was committed to his family roots and had a dear relationship with his mother. That was a wonderful example for me, and she became a second mother for me, given the circumstances in our family. When my sister, who is seven years younger, was born, she had serious medical challenges that required a lot of hands-on nursing at home. Grandmother Parker came to the rescue. I was raised by two moms and a wonderful dad and I was benefitted by the experience.



**Albert N. Parker with
son Scott in 1938**

Dad worked hard to find a job. He walked through town and knocked on every door. The Salt Lake Hardware Company had an opening for a warehouse man. Dad offered to work a full day but be paid for only a half day. I think that he felt if he offered to do that, he might be considered for the job. They agreed to that. He worked there the rest of his life with a modest income but a position that was noble, that he was proud of, and that we were proud of. We had a dad who was a businessman. He sustained us in a modest way and set a wonderful example of stability.

Dad had a generous heart, even with a modest income. I remember cousins coming to our home who had come to Salt Lake for school or to find work. Our house was not a boarding house, but it was a constant rolling open house for my older cousins, and they were dear and good examples to me as well. I was the beneficiary of the environment, the times, and the way my folks opened their home to others. We've tried to follow that example as well, and it's given us a lot of joy and pleasure over the years to pay it back.

GARBER: What was your mother's influence on your values?

SCOTT PARKER: Mother was equally shy, but had that same rock-solid, stable attitude

toward life, deeply grateful for her heritage, a religious heritage within our own Mormon Church. Mother's grandfather, Jesse N. Smith,¹ was one of the early pioneers. He was a hero in our family. Jesse Smith's father had passed away in Illinois. He and his brother, who were young teenagers at the time, brought their mother across the plains in a covered wagon. That's a pretty heroic history to read. At about age 18, he was asked by Brigham Young² to go to southern Utah, start a community, and become the leader—both religious and civic—of that little community named Parowan. He built it up successfully over time with a lot of sacrifice. Then Brigham Young, without hesitation because he trusted my great-grandfather, asked him to do it again. He sent him to northern Arizona to found the little town up there called Snowflake. Those were years of total dedication, hard work, and satisfaction. My grandmother was born in Snowflake, Arizona. My mother revered her mother, her grandmother, and grandfather. I was told those stories as a youngster. I've read that history and it's very meaningful to me.

GARBER: How did your family's experience of living through the Depression and World War II affect your values?

SCOTT PARKER: As a youngster, I didn't know there was a Depression. We just thought that was the way it was. We lived through that rather comfortably as youngsters. It was much different for our parents, but as children, we thought rationing of food, gasoline, tires, and many other consumer goods was just a way of life. We didn't have a car during that time. We just used public transportation. It seemed very natural to me.

Looking back, I realized that those were very tenuous and difficult times, followed by World War II. I was six years old when the war started. I really did get into that in terms of understanding the sacrifices that were going on around us, our family, and our neighborhood. There were flags in the windows and stars indicating that a family had military people off to war. Then there were the tragedies—the gold stars that meant they had lost a family member. That was all through our neighborhood and all neighborhoods across the country. I remember the compassion my family felt for that and the worry about their own brothers and relatives who were in the war. I had a favorite uncle who was an artillery officer in Italy and Germany. Every day there was worry and prayer about his safety.

GARBER: Did he make it home?

SCOTT PARKER: He did.

SYDNE PARKER: He never ever wanted to talk about it. I'm sure it impacted his mind heavily. That wasn't a topic to be discussed.

GARBER: You mentioned several family members who were influential in your early

¹ Jesse Nathaniel Smith (1834-1906) was a cousin of the Mormon prophet Joseph Smith. He crossed the Great Plains in a covered wagon in 1847 at age 11. Besides colonizing Parowan, UT, and Snowflake, AZ, he served on missions in Scandinavia. [Source: Brigham Young University. *Register of the Jesse N. Smith Collection, 1845-1970*. Provo, UT: BYU, May 1974. (<http://files.lib.byu.edu/ead/XML/MSS503.xml>) (accessed Aug. 30, 2013).]

² Brigham Young (1801-1877) became leader of the Church of Jesus Christ of Latter-day Saints after the death of Joseph Smith in 1844. He led Mormon pioneers out of Illinois to the Great Salt Lake Valley and oversaw settlement there, later becoming the first territorial governor of Utah. [Source: Bringham, N.G. *Utah History Encyclopedia*. <http://historytogo.utah.gov/people/brighamyoung.html> (accessed Aug. 30, 2013).]

childhood. Was there anyone else you wanted to mention who made an impression at that time?

SCOTT PARKER: Church leaders were very important in our lives. In the LDS Church, there is no paid ministry at the local level. The local congregations are called wards, which would be similar to a Catholic parish. Bishops, the ward leaders, were men who made a living in their own line of work. I had a series of bishops when I was growing up who were very different in their professions—a lawyer, a plumber, salesmen, and businessmen. What they had in common was a love and compassion for those that they were responsible to lead and to guide. They were forthcoming about their guidance with youngsters. I learned many great principles from what they said in the confines of the Church, but I learned a lot more from watching their lives. Each one of them had a significant impact on how I wanted to pattern my life. I watched them do things that strengthened the community as a whole and their families as well.

GARBER: The power of the role model.

SCOTT PARKER: Exactly.

GARBER: Who were your heroes as a child?

SCOTT PARKER: My soldier uncles and cousins were heroes during the war; my father, from the very beginning, through his whole life; and Mother. In the context of the earliest years growing up, those bishops that I mentioned were all heroes. Athletes were heroes, too. My father was an avid basketball fan. I became an avid basketball fan. He would take me out of grade school during the week of the state high school basketball tournament. We would go to dozens of games during that week together. It was very bonding, very fun. Later on, we'd go to the University of Utah basketball games. An unprecedented time for our community was when the University of Utah won the National Basketball Association championship—I still remember it, 1947. I was 12 years old. Those players became heroes.



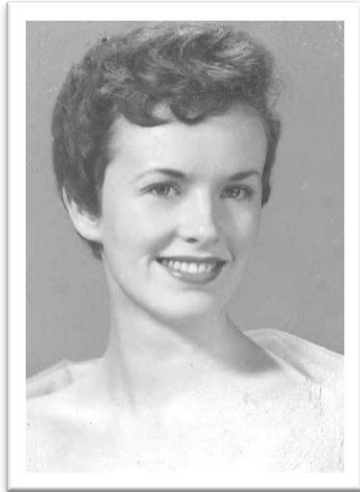
Scott Parker, center, before his junior year at the University of Utah

GARBER: In your high school years, you were a player.

SCOTT PARKER: I loved that game so much that my dad put up a basketball hoop. Because of the confines of the home, it couldn't be put up on the garage. It had to be on the house, right next to my mother's kitchen. I don't think a day went by, winter or summer, that I wasn't out there shooting baskets with the dream of becoming a player for East High School. But that poor, wonderful woman—thump! thump! thump!

SYDNE PARKER: Every day she listened to that! All the thump, thump, thump!

SCOTT PARKER: She never complained. That was my dream. My lifetime goal was to put on that red uniform and play for East High, because I went to so many of their games and their players were my heroes. That had a sobering conclusion to it. When we got to our senior year, I was the last man cut and didn't get to play on that team during my senior year. It was devastating for a young guy. Looking back on it, I think I went into a real depression.



Sydne Lemon Parker

This girl right here came to the rescue. We were dating when we were juniors and seniors. She was a great strength to me, as was one of those church leaders I was talking about before. He was a physician, and an advisor to my age group. Without ever talking to me about that incident—which he knew about—he asked me to come by and see him at the church after one of the meetings, in one of the classrooms.

He was a man of few words. Without any introduction, he said, “Scott, I want to ask you three questions. What period of time would you rather live than now? What other country would you rather live in than the United States of America? What other family would you rather be a part of than your own?” He didn’t ask for an answer. He just said, “I’d like you to just think about that. Thanks for the time.” He left. Those were powerful questions—perspective questions. That took the edge off the disappointment. I’ve asked myself those three questions more than once during hard times.

GARBER: Have you also had the opportunity to put those questions to other people?

SCOTT PARKER: Hundreds of times!

GARBER: Why did you choose the University of Utah for college?

SCOTT PARKER: There were no means to go away to school, and the University had a wonderful reputation. The tuition was within reach, and it was very accessible—just a few miles from where we lived. I could commute.

GARBER: Would you talk about the positive influence of your fraternity brothers?

SCOTT PARKER: They had a strong impact on my getting serious about life and about a career. The fraternity wasn’t as you might see in a comedy movie. There were not a lot of hijinks going on. They were a pretty serious group of guys, like Jake Garn,³ the astronaut/senator, who was a senior when I was a freshman. To see their example, and to see what they were aspiring to do and preparing to do, was impressive to me because I was insecure and undecided about the future. I fell in with good company.

We had a class of 21 who joined the fraternity at the same time. We had a very good student advisor, a couple of years older, whose responsibility was to guide this group of 21. He gathered us in the fraternity house one night after the chapter meeting. We sat around in order, ranked by how serious we were about the fraternity and its principles, and so forth. Out of the 21 students, I was ranked number 21. That’s not high!

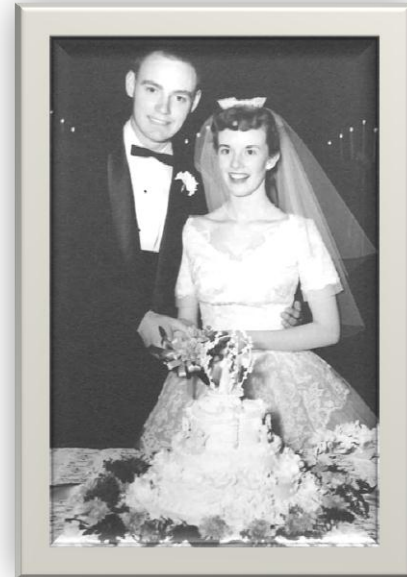
He posed this question, “I want each of you to tell me where you are in your studies, and

³ Senator Edwin Jacob Garn (b. 1932), Republican, was a Navy pilot, retiring as Brigadier General. He served 19 years in the Senate and was a payload specialist on the space shuttle Discovery in 1985. [Source: *Biographical Directory of the United States Congress*. <http://bioguide.congress.gov/scripts/biodisplay.pl?index=g000072> (accessed Aug 30, 2013).]

where those studies are going to take you. What is your career goal?” He started around. The number one guy said, “I’m going to be a neurosurgeon.” He became a neurosurgeon. The number two guy said, “I’m going to be an attorney.” He became an attorney. This was going around the room and coming to me. I didn’t have a clue what I was doing, why I was studying. I hadn’t declared a major and was hanging on in school, not doing too poorly, but certainly not knocking down A’s a lot. It came around to me, and I didn’t have an answer. He didn’t say anything. Nobody said anything. I was sobered by that perspective experience and said to myself, *I’ve got to get serious*; and, as a result of that, I did. I give a lot of thanks to that leader and to that culture for growing me up.

GARBER: After you had been there some time, you decided it was time to get married. Sydne, would you tell how your wedding came about?

SYDNE PARKER: The Korean War was on. We wanted to get married, but we also wanted Scott to be able to serve a mission for our Church. During the war, the government put a limitation on how many missionaries could go. Only one missionary per year from a ward—that’s the parish that we talked about before—could go. Scott was not chosen. We decided we would just go ahead with our marriage plans, which we did. Abruptly, the Korean War ended, and all of the young men could go on missions. We were in a dilemma. We still wanted to get married, but we also wanted him to serve a mission. We felt duty-bound for him to do the two-year service for the Lord in the Church and go out as a missionary.

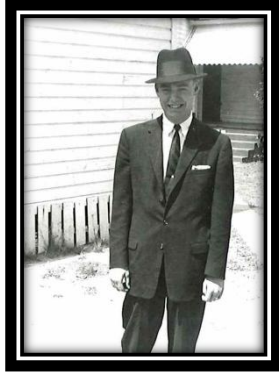


**Mr. & Mrs. Scott S. Parker
October 1955**

We asked our bishops, the local leaders. They shook their heads and said, “I don’t think I can make that decision.” Then we went to see our stake presidents, who were men over about nine different congregations. They shook their heads and said, “I don’t know. This isn’t done any more in the Church. We don’t know how we feel about that.”

I said, “Well, I know Elder Harold B. Lee.”⁴ He was one of the twelve apostles, and we lived in the same neighborhood. I called him on the phone—talk about brassy! He was kind and invited us to his home. We told our story. I can still see him in his big wing chair. He was a handsome older man—younger than we are now. He sat there and closed his eyes and put his head back. It seemed like hours. He opened his eyes and he said, “Yes, I think you should do that. I think that’s what the Lord would like you to do.” He performed our marriage in the Salt Lake Temple at the end of October 1955. In January, Scott left for the Southern States for two years on his mission. We were probably the very last of the “get-married-first, go-on-a-mission-second” group. It just wasn’t done any more.

⁴ Harold B. Lee (1899-1973) became a Council of Twelve member in 1941 and later served as the 11th president of the Church of Jesus Christ of Latter-day Saints. [Source: The Church of Jesus Christ of Latter-Day Saints. <http://www.lds.org/ensign/1976/11/harold-b-lee?lang=eng> (accessed Aug. 30, 2013).]



Easter 1956

GARBER: What was the issue that required all this consideration? Was it because the mission model was changing?

SYDNE PARKER: Yes, it had changed. I only knew one other girl at the University of Utah who was married, and her husband was serving in a mission. It was single young men who went out.

GARBER: Why was this change made?

SCOTT PARKER: It evolved over the years as the Church recognized the heavy sacrifice that it would require. In rural communities, men could leave, and others would help sustain their families. That wouldn't be the case in the modern era. If you left, you were leaving a job, and you were leaving your family in a difficult situation. I think it was a natural economic transition. Also, as the Church grew, there were sufficient single young men to meet the needs.

GARBER: Were young women going on mission as well?

SCOTT PARKER: There were young women going at the time, but not to the degree they do now.

SYDNE PARKER: Now there's an explosion of young women. The missionary numbers have increased dramatically even in the last few months.

GARBER: Where did you go?

SCOTT PARKER: I was assigned to what was called the Southern States mission which included Georgia, Alabama, South Carolina, and Florida, with headquarters in Atlanta. I had assignments in Georgia, in Columbus, and then over on the other side of the state in Augusta.

My mission president, Berkeley L. Bunker of Las Vegas,⁵ asked me to come and work with him as his secretary in Atlanta. I did that for nearly a year, living at the mission home. After that, he assigned me to go to Florida. I traveled from one side of Florida to the other in the middle section, from Daytona Beach over to St. Petersburg, supervising missionaries younger than I was. Then I did the same thing up in southern Georgia for the last part of my mission.

I saw a lot of territory, had a lot of experiences, and became very respectful of my leader. He was an undertaker by profession and a politician. He had served his district of Nevada in the U.S. House of Representatives. He was a moxie guy, strong-minded, firm. I learned a lot about firm hands-on management from him. Interestingly enough, I didn't follow that particular style, but not because I had any disrespect for him or his style. It just didn't seem comfortable, given my personality. You learn from others about leadership, and he was an example of someone totally dedicated and very effective.

⁵ Senator Berkeley L. Bunker (1906-1999), Democrat, served as a mission president in the late '50s. His political career included the Nevada Assembly, the U.S. Senate, and the U.S. House of Representatives. [Source: *Biographical Directory of the United States Congress*. <http://bioguide.congress.gov/scripts/biodisplay.pl?index=B001061> (accessed Aug. 30, 2013).]

SYDNE PARKER: Can I interject that we only spoke to each other on the phone twice a year, on Mother’s Day and Christmas. Many, many letters went back and forth. I went to meet him when his mission was over. I flew to Atlanta, and we drove home.

GARBER: The limited telephone contact that you mention was not by your choice?

SYDNE PARKER: No, that was the rule. Oh, I would have talked to him every day!

SCOTT PARKER: That’s why there was a rule! It was also a financial reality. Long-distance calls were expensive.

GARBER: You had been married only a couple of months. Who do you think the mission experience was harder on?

SYDNE PARKER: I think it was hard for both of us.

SCOTT PARKER: It was mutual.

SYDNE PARKER: I cried myself to sleep many nights.

SCOTT PARKER: As did I.

GARBER: But, Scott, you had this new exciting thing that you were doing.

SCOTT PARKER: It was wonderful. However, Sydne did have college.

SYDNE PARKER: I was going to the University of Utah in Elementary Education, and I had almost a full-time job in a travel agency. I was busy all the time. That worked for us both.

GARBER: I’d like to move on now to your early work experience. Tell us about ZCMI.

SCOTT PARKER: Zion’s Cooperative Mercantile Institution, or ZCMI, was a Church-owned retail operation—the dominant retailer in the region. It had a lovely store that went back to the pioneer days. ZCMI was a pioneer co-op where the members of the Church could trade farming goods for hard goods and clothes. Later, it evolved into a typical retail department store.⁶

Once we decided to do both the mission and the marriage, there was a three-month period before I left, and we needed funds. The Church doesn’t fund missions. Families or individuals fund missions through their own savings. We needed to create any kind of income we could. I went to ZCMI, and they hired me to be in charge of the men’s sock department. If you want to know anything about Gold Toe socks, I claim to be an expert. They were good to me. I got the hours, and I was able to bring a little bit of money home during that time.

SYDNE PARKER: Grandpa Parker really funded the mission. I sent a few dollars here and there, but it was Grandpa that funded the mission.

⁶ ZCMI, which has been called the “People’s Store” and “America’s First Department Store,” was founded by Brigham Young and other leaders in 1868. [Source: *Utah History Encyclopedia*. http://historytogo.utah.gov/utah_chapters/pioneers_and_cowboys/zcmi.html (accessed Aug. 30, 2013).]

SCOTT PARKER: After my mission was over, I went back to ZCMI and worked nearly full time selling men's suits right through graduation from the University. Without that job, we couldn't have made it through because we were a family of modest means. That really did help to get us through.

GARBER: You were modeling men's clothes, too, I understand.

SCOTT PARKER: My boss was good to me. He knew we were right on the edge financially and could use every dollar we could get, especially with a new baby. He said, "I've got something for you. We're going to do TV advertising on the ten o'clock news and we're going to need somebody to show off the clothes. We need a model."

I said, "What do I have to do?" He said, "All you have to do is wear one of our suits and just stand there. Anybody can do that." I said, "How much will it pay?" He said, "Five dollars a broadcast." I said, "Done." It was honest work. Five dollars made all the difference for us every week. Every Monday night, I was there in front of that TV camera, and it was excruciatingly embarrassing. I got a lot of heat from my friends, of course, because I looked like a human dummy. I didn't move. I was just staring into the camera wearing these suits, but it worked.

GARBER: You had a good job at ZCMI, but something made you decide that you wanted to go on to grad school.

SCOTT PARKER: I was focused on retailing and was getting a degree in marketing at the University of Utah. I liked the company. I actually asked for time with Harold Bennett,⁷ the president of ZCMI, and had the audacity to ask him if there might be a chance that I could aspire to be the President of ZCMI someday. I had these great dreams. He was very patient with me. He didn't break out laughing. He didn't criticize. He was very gracious about my presumptuous question. I liked him, and I liked the environment, but there was something missing. I was offered a position to be an assistant manager in one of the departments after I graduated. It was comforting to know there was a job waiting. Still, it didn't quite fit.

A couple of things happened. In one of my classes, I was doing research on a project, and it took me into the health care management literature. I think I was in *Hospitals* magazine. That was new to me—that there is a profession of people who are responsible for the management of these organizations. One of the leaders of the store, who had taken a personal interest in me, came by one day and said, "My brother-in-law just graduated in hospital administration from the University of California. Have you ever heard about that field?" I said, "I read a little bit about it not long ago." He got me a brochure from Berkeley. All of that came together, and I thought, *Wow, I would really like to do something that improves the human condition, more than just tallying up the proceeds for the day in comparison to last year and to budget.* That's important—don't get me wrong. I felt it was important, but I felt there might be more satisfaction in getting involved in something that really had an impact on humanity.

I think that went back to my early roots and to the experiences of my little sister's

⁷ Harold H. Bennett (1900-1999) began his 47-year career with ZCMI as an accountant in 1926, becoming president in 1958. [Source: Harold Harper Bennett, ex-ZCMI president, dies. *Deseret News*, Dec. 2, 1999. <http://www.deseretnews.com/article/print/730970/Harold-Harper-Bennett-ex-ZCMI-president-dies.html> (accessed Aug. 30, 2013).]

hospitalizations—both in Salt Lake and Chicago. I was deeply touched by the compassion of the doctors and nurses who cared for her. This was subconscious, not in the front of my mind, but I think that it all came together at the same time and validated that this was something I could take satisfaction in doing the rest of my life. That was the genesis of the hospital administration interest.

GARBER: You ended up at the University of Minnesota. Tell us about Professor James A. Hamilton.

SCOTT PARKER: Professor James A. Hamilton⁸ was a force to be reckoned with. He was a dynamic, powerful, influential leader within the health care system—past president of the American Hospital Association—and a pioneer in the training of hospital administrators at the graduate level. He started the program at Minnesota. My mentor, Stan Nelson,⁹ who was ten years older, was in one of the first classes at Minnesota. By the time I was admitted in 1960, the program had built a reputation of being one of the very best places to go for this kind of training. One of the strengths of the program was that James A. Hamilton was not only a former hospital administrator, but was also the head of the hospital consulting firm, James A. Hamilton Associates. The faculty he recruited had been experienced hospital leaders themselves.



Professor James A. Hamilton
Photography courtesy of Cristof Studio

Hamilton taught by the case method. He had been taught that way in his own training. He *wrote* the case book—they were all his cases from his experience as a consultant. There was a heavy emphasis on problem-solving, using real life examples in the classroom. It was helpful, instructive, and challenging because he was such a tough-minded guy. He would brook no casual answer. He had no reservations about embarrassing you. In fact, I think he enjoyed it because he wanted to make it as tough as he possibly could. He admitted to us that he wanted it harder in the classroom than it would ever be in the boardroom. That turned out to be true.

I was hopeful to get good grades in the program and was doing reasonably well. But there was a tough boot-camp tradition that they would wash out up to 20 percent of the class after the first semester. I was worried. I needed good grades. In our speech class, when the professor said that we would be graded by our classmates, I thought, *Wow! Here's a chance to get an A. I'm going to give a great speech, because I really need that A.*

I worked hard on it. The grades came in and my classmates were good to me. I received an A from them. Then Professor Hamilton said, “No, he’s not going to get an A. I know about his

⁸ James A. Hamilton (1899-1985) was director of the Program in Hospital Administration at the University of Minnesota from 1946 to 1966. His oral history: Weeks, L.E., editor. *James A. Hamilton in First Person: An Oral History*. Chicago: American Hospital Association, 1983, can be found in the collection of the AHA Resource Center.

⁹ Stanley R. Nelson (1926-2012) was CEO of Parkview Hospital (Fort Wayne, IN), Abbott Northwestern Hospital (Minneapolis) and Henry Ford Hospital (Detroit). His oral history: Weeks, L.E., editor. *Stanley R. Nelson in First Person: An Oral History*. Chicago: American Hospital Association, 1987, can be found in the collection of the AHA Resource Center.

upbringing.” He had been a consultant to the LDS Church health care system, and he knew the culture well. He said, “I know in the LDS Church, they have their children start to give talks in their congregations when they’re age five. I don’t know how many talks he’s given, but probably dozens of talks along the way. He’s had that advantage. He was also an LDS missionary. All he did was teach and give talks for two years. He’s had such an advantage over all the rest of you here.” He said, “Given his experience and background, he really should have done a lot better. Therefore, he’s going to get a C+.”

There was more to that story. He was also trying to teach me that life in the health care administration field is not always fair. You have to live with adversity and see how you deal with it. Is it going to break you down? Or is it just going to bolster you up to try to do better the next time and take your lumps and move on? That was my first real experience doing that. There were many more experiences in my career where I had to do that. But that was an early-on experience.

The other story was in Professor Hamilton’s problem-solving class. Each night we were all given the same case to read out of his book. We could be called on the next day to role-play with him. When my day came, after about 15 minutes, I was done. He had me pinned in a corner. I didn’t have an answer to his questions or his comments. All I did was smile and literally put my hands up and said, “Professor, I’m done. I’m sorry, I don’t have any more to say.” I began to sit down in my seat. Then he verbally attacked me. He said, “That smile might have worked when you were a Mormon missionary in Atlanta, but it’s not going to work in this class. Now get the blank up out of that chair, and let’s go at it.” That was the longest 45 minutes of my life! But, again, that tutorial was very important and very valuable in sharpening my ability to respond, and my determination not to give up easily, and to stay the course during hard experiences. It was painful at the time, but very helpful.

GARBER: Did you find that when you became a professor that you used the same teaching methods?

SCOTT PARKER: I can’t help it. Now I write the cases from my own experiences, which is fun.

GARBER: Do you take the approach of putting students through the wringer?

SCOTT PARKER: Yes, I do. We use the didactic approach. We really try to make them think on their feet.

SYDNE PARKER: I don’t think you’re as mean as James A. Hamilton.

SCOTT PARKER: No, no, I don’t make them cry. I go to a point, and then I try to lighten it up and never really embarrass them. But, I do try to make them think on their feet.

GARBER: If you were tasked with founding a graduate health care administration program today, how would you structure it?

SCOTT PARKER: That’s a timely question because I am involved, as an adjunct

professor, with working closely with Professor Debra Scammon,¹⁰ the head of the department, who started the program in health care administration at the University of Utah. We've worked together for three years now in structuring this program, with her taking the initial lead and doing a wonderful job. We've gone through the process of getting the program accredited and worked through the curriculum together. I've been able to add a few pragmatic things. We've made a good team because she is a gifted academic and dedicated to health care.

The program is molded much after Minnesota, with a heavy emphasis on problem solving. It's a two-year program. It's not a stand-alone MHA program—there are dual degrees. You can choose to have a master's degree in Hospital Administration and Public Health, or Hospital Administration and an MBA combined, or Hospital Administration and Public Administration. We are able to offer a variety of options to students who have interests in several different areas, but a strong interest in health care. Most of the students select the MBA/MHA dual degrees.

GARBER: Is there a residency?

SCOTT PARKER: We do not require an official residency, but we do place students in internships, and we're working hard on the residency or fellowship idea as well. We're brand new at it. We've just been accredited, so we're in our beginning stages.



**Donald C. Wegmiller
in 1967**

GARBER: Going back to your time at Minnesota, I understand that's when you met Don Wegmiller and perhaps others who you remained friends with for a lifetime.

SCOTT PARKER: Yes, but no one like Don Wegmiller.¹¹ But then, there's no one like Don Wegmiller! You're laughing, and I'm laughing, because we know about his wonderful sense of humor.

GARBER: I had the pleasure of speaking with him on the phone as preparation for this interview. Do you have any good Don Wegmiller stories?

SCOTT PARKER: We could spend the whole rest of our time telling Don Wegmiller stories. I don't know why opposites attract, but they do sometimes, and we did. He was younger, with a much different personality.

SYDNE PARKER: Brash.

SCOTT PARKER: Bright. Funny. By far, the smartest guy in the class. He received the award for being the Most Outstanding Student. He aced every test with ease. We did make good friends, and our wives made good friends very quickly.

SYDNE PARKER: We're still dearest friends in all the world. Can you tell about going to

¹⁰ Debra Scammon, Ph.D., is the Emma Eccles Jones Professor of Marketing in the David Eccles School of Business at the University of Utah. http://faculty.utah.edu/u0035503-Debra_Scammon/biography/index.html (accessed Aug. 30, 2013)

¹¹ Donald C. Wegmiller was CEO of Allina Health System (Minneapolis) and is chairman of the Scottsdale Institute. [Source: Former Allina CEO Wegmiller named Scottsdale Institute chairman. *Minneapolis/St. Paul Business Journal*, Nov. 14, 2012. <http://www.bizjournals.com/twincities/news/2012/11/14/wegmiller-allina-scottsdale-institute.html> (accessed Aug. 30, 2013).]

study with him?

SCOTT PARKER: The chemistry was just there between us, so we decided to study together. We'd go through cases the night before class. About the third time we were doing this, I was searching for something. I thought I had read it in the MacEachern textbook we used at the time.¹² He said, "I think it's on page 485." I said, "You've got to be kidding." He said, "No, I think that's where it is." I turned to that page and there it was! I closed the book and said, "You're out of my league, pal." That guy had a photographic memory. I mean, what's fair about that? We were graded on the curve. I said, "You don't need any help." We brought that to a fun close.

SYDNE PARKER: Instead we had weekends as couples together.

SCOTT PARKER: We found a way to have a lot of fun without spending any money. We'd play cards and eat potato chips and drink Cokes—a bond of friendship. We still do today when we get together. A couple of times a year, we still go back to the soda pop and playing cards.

We've had a lot of fun over the years and have played a lot of pranks on each other like when he had just become the chairman of the American Hospital Association. (I had been chairman the year before him.)¹³ He called me up and said, "I'm coming through Utah to give a talk to the Idaho Hospital Association at Sun Valley. We've got to come through Salt Lake and we're going to stay with you..." (He would never ask, he would just announce.)

SYDNE PARKER: "And I'd like my hamburger medium rare."

SCOTT PARKER: Then he said, "...AND I'd like to be treated with respect for the office I hold. I am now the president of the American Hospital Association, and I'd like to have that kind of deference and respect and recognition when I come!"

SYDNE PARKER: Scott arranged for a limousine. He arranged for one of the local newscasters to be there to interview Don. He got the band from one of the local high schools to come. He got off-duty sheriff officers to go on board the plane and escort Don and Janet off. As soon as they walked down the ramp, the reporter had a microphone in their faces and kept asking questions. In the background, the kids were chanting "Wegmiller for President! Wegmiller for President!"

SCOTT PARKER: They had signs.

SYDNE PARKER: Big posters.

SCOTT PARKER: It was the primary election season nationally, so people were gathering because they thought he was a candidate.

SYDNE PARKER: They were taking photos. It's the only time I've ever seen Don Wegmiller sweat. We walked out to the curb. He thought it was all over, but we walked to the limousine and here were all these high school kids who had been inside. They beat us out and they were at the limousine shouting "Wegmiller! Wegmiller! Wegmiller!" We got in the limousine. We

¹² MacEachern, M.T. *Hospital Organization and Management*, 3rd ed. Chicago: Physicians Record Co., 1957.

¹³ Donald Wegmiller was chairman of the American Hospital Association in 1987; Scott Parker in 1986.

closed the door. These girls were kissing the windows.

SCOTT PARKER: They had been primed well. They knew exactly what to do. It's the only time that we ever really "got" him.

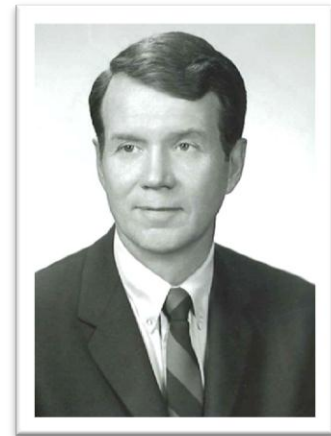
SYDNE PARKER: The wives decided that maybe it had better stop right there. There had been so many pranks over the years, and we thought, *If anything gets worse than this, we may end up not being friends.* That was the end of that.

GARBER: Sydne, could you talk about your influence in cementing Scott's confidence in staying in grad school?

SYDNE PARKER: After a few weeks in school, he felt overwhelmed. I can remember sitting at our kitchen table, and he said, "I think maybe we better go home. I just am not feeling that I can do this." I said, "No, we're not going home." My showing a little toughness helped change his feelings. We made great friends there. He did well in his studies. We had a good church group there. I was happy in Minnesota. We were there for six years.

GARBER: Scott, after you earned your degree, you got a job at Northwestern Hospital in Minneapolis?

SCOTT PARKER: That was a result of the fact that I had been assigned there as an administrative resident. The second year in graduate school, students were assigned to a hospital by the professor. I had identified some places I might want to go from the approved list, but the three that I wanted to be considered for weren't available. There I was, the only student not assigned, and I was worried.



Stanley R. Nelson in 1971

Fortunately, Stan Nelson arrived in town, coming back to Northwestern Hospital to be the CEO. He was interested in having a resident. He had been a resident there. That was a fabulous year learning from a wonderful man. I found great joy in his presence and his friendship and his tutoring. Unexpectedly and joyfully, he invited me to stay and be his assistant. That was before Medicare, so it wasn't all that complicated—there were just two of us on the administrative staff of this significant hospital in Minneapolis. Because there were only two of us, he was very generous by giving me many different departments to worry over. This gave me a chance to grow and learn on the job.

GARBER: How would you describe Stan Nelson's management style?

SCOTT PARKER: Stan Nelson was a master at the subtle. He was bright, but never enjoyed trying to be the smartest guy in the room, although I always thought he was. He was a master of bringing other people out, getting their opinions, respecting their opinions. He was a strategist—could look in the crystal ball and see where things were going. He liked to collaborate. He regularly met with a group of hospital CEO friends across the country. They had a little organization called, "The Group." They would get together at the AHA annual meeting and spend an afternoon sharing their experiences. The rules were: You had to admit something that you'd failed at during the past six months, and something that was successful. From that dynamic, he'd

bring a lot of things home, ideas good and bad, about what to do, and what not to do. I was privy to all of that and I was tutored as a result of his experiences. Later on, he invited me into that group. It was a very valuable source of information over the years. It was called HRDI—Hospital Research and Development Institute.

Being tutored by him was a great joy. One story I'd like to tell happened right at the beginning. I was an assistant administrator and had been there a couple months. I heard from his secretary that Stan was going on vacation. I expected that he'd invite me into his office to give me a briefing on the current issues and what I needed to look out for and be aware of while he was gone. I kept thinking, *He's going to do that. Obviously, he'll do that.*

On the last day before his vacation, I stayed close to my office all day, waiting for his phone call. I looked out my window and there he was, walking out the front door of the hospital with his pipe in his mouth and his *Wall Street Journal* under his arm, which I knew were signals that he was going home. I panicked. I jumped out of my seat and ran out to the parking lot where he was getting into his car. I blurted out, "Stan, I understand you're going on vacation for a couple weeks." He said, "Yep." I said, "Well, do you have any advice?" He said, "Yes, don't do anything dumb." He got into his car and drove away. That was it.

I talked to him about it when he came back. He said, "Look, I know you're young. I know you don't have a lot of experience, but I think you've got some common sense." I always felt he also had a lot of common sense. He was a street-smart guy. He said, "I knew if you felt you needed me, you could find a way to find me. I didn't have to give you chapter-and-verse on that. I also knew you'd probably make a mistake or two. I understand that. I will cut you a lot of slack while you're with me. BUT... [it was an important 'but']... never make the same mistake twice." That always weighed on me as a stewardship responsibility.

GARBER: That is an interesting story on several levels. Would you, as a manager, have done that your subordinates—gone away without letting them know?

SCOTT PARKER: No. No, I would not. I would be inclined the other way around! We would have had at least a little chat. At least I would have said goodbye.

Stan and I became dear friends, well beyond a boss/underling relationship. He passed away last fall. I was invited by the family to come to Minneapolis and speak at his memorial service. A few weeks ago, I spoke at the Scottsdale Institute, a think tank on hospital IT which he organized. They were paying tribute to the founder, so I had the chance to speak about him again. Each time I do, I'm reminded of what a great friend and mentor he was. No one could have had a better beginning than I did.

SYDNE PARKER: Not just professionally. He and his wife became dear friends over the years—a joy to be with.



Scott Parker and Stan Nelson (in hat) serving coffee and cake to nurses at Northwestern Hospital

GARBER: Something happened, though, to take you out of Minnesota. Could you talk a little bit about the move to Mesa, Arizona?

SCOTT PARKER: That was another example of the influence of Stan Nelson. He really cared about everyone who worked for him. I knew he cared about me. After I had been there about five years, we had a chat. He said, “We need to do a little strategic planning about the future management here. I plan to stay for a while longer. I’m happy and this work is challenging. You could stay with me. This is working out really well. Your taking on more responsibility gives me time to play a little more golf [which he loved to do, his passion]. We can just go on like this for as many years as you want to stay, but that’s maybe not the best for you. You’ve got to be thinking about what you want to do long-term.” We talked a lot more about that and concluded that it was time for a transition. That’s what triggered the idea of leaving the cocoon. We did, and it was wrenching.

GARBER: You went to Southside Hospital in Mesa. Could you tell a little bit about that hospital?

SCOTT PARKER: All the small towns around Phoenix, including Mesa, were booming with population growth. Mesa desperately needed a replacement hospital. The idea was that I would go down, become the CEO, and facilitate the construction of a new hospital. They also had some other operational problems; the quality of care was medium; the morale was low; and had a land-locked, worn out facility. There were management challenges—the board had finally given up and fired the CEO, the director of nursing, and the chief financial officer on the same day!

I had just turned 30 and come into my first position as a CEO. It was a wonderful opportunity to turn a hospital around. Being able to put that on your resume was a real gift. The question was, would I be able to turn it around? There were some daunting tasks that made that problematic and which caused me a lot of sleepless nights.

GARBER: Do you recall what you tackled first?

SCOTT PARKER: The major problem was building staff—to find a CFO and a director of nursing and try to increase morale and improve quality. At the same time, I had to focus on the political campaign for the referendum to build the new hospital. The financing would be based on acquiring tax-exempt bonds to borrow the money to build the new hospital. The hospital didn’t have a lot of reserves itself.

In Arizona and several other Western states, you could follow the pattern of school districts, irrigation districts and improvement districts and form a hospital district. This is where the property owners in the defined district would vote, through a referendum, if they were willing to have their collective property used as collateral to finance the bonds. It was done quite frequently in California, Oregon, Washington, and this was an attempt to do it in Arizona.

I’d never been involved in politics, but I was thrown into this political campaign to persuade the people in Mesa and Tempe, Arizona—that was the boundary that was selected—to support the proposition. It failed. It failed because there was a Nebraska rancher, who had retired to Mesa, who had hated taxing districts all his life. It was his passion to oppose them. He took this one on himself. He walked every street in Mesa, knocked on every door warning home owners that their

property taxes could go up if this hospital failed, and there was no guarantee it would be successful. He was successful in making his argument.

Losing left me in a position of desperation. I was young, inexperienced, naïve, and had assumed that we would win. The board was convinced we were going to win it. That's one of the reasons I went, because they were so confident. I didn't have a Plan B. I didn't have a backup position to immediately announce. That was a moment of truth in my career. That moment was literally the nexus of: was my career going to continue to move along, with continued growth and opportunity, or was it going to come to a screeching halt in failure? That was a crucial time in our career and lives.

GARBER: It seems like you felt that the onus was on you to solve the problem. Did you not have guidance from your board?

SCOTT PARKER: No. They didn't have a backup plan either. We were in a crucial moment of decision. What happened the next morning was chaotic because, of course, the press was all over it, the medical staff was all over it, the employees and the board members were all calling me. When I got to the office, there was a stack of messages. I asked my secretary, "Just hold everything. I'll speak to the press. I'll speak publicly, in two hours." I went in my office and went through a deep, personal, reflective period of time trying to decide what to do short-term, which was to come out and say something to keep the idea of a new hospital alive—with some confidence. What was the answer going to be? How was I going to do that?

What came to me in those two hours was based on thinking about: *What do I know? Who do I know? What have I seen?* Two things came to me, both from my time in the Twin Cities. The first was Stan Nelson's experience in merging with a neighboring hospital, which was to my knowledge one of the first not-for-profit, non-religious merger in the country. It had been very successful. This was between Northwestern Hospital and Abbott Hospital, which became Abbott-Northwestern. Abbott had no space to grow. Northwestern did. They were very compatible boards. The medical staff was basically overlapped. It was a very compatible kind of a merger. It happened rapidly. Expansion took place on the campus of Northwestern Hospital. It became very successful over the years.

The second model was Northwestern Hospital's major competitor—Fairview Hospital, a Lutheran hospital run by Carl Platou.¹⁴ He was the one who conceived of building a suburban hospital as part of a downtown hospital—the satellite hospital concept—which was the first in the country. Don Wegmiller was part of the development of that satellite hospital and became the assistant administrator of that hospital in the suburbs of Minneapolis.¹⁵ There was a solid rationale for doing it because they could avoid unnecessary duplication at every level of management. They

¹⁴ Carl N. Platou (1923-2012) attended the graduate hospital administration program at the University of Minnesota, earning his degree in 1951, the year after Stanley Nelson earned his MHA at Minnesota. Platou went on to a leadership role in creating Fairview Health Services (Minneapolis). His oral history: *Carl N. Platou in First Person: An Oral History*. Chicago: American Hospital Association, 1993, can be found in the collection of the AHA Resource Center. [Source: Obituary: hospital visionary Carl Platou transformed Fairview. *Minneapolis StarTribune*, May 31, 2012. <http://www.startribune.com/local/155858835.html> (accessed June 13, 2013).]

¹⁵ Fairview Southdale Hospital (Edina, MN), a new hospital built on a greenfield site donated by the Dayton Corporation, was completed in 1965. [Source: Sullivan, J. A tale of two hospitals: Fairview story began in 1906. *About Town* [City of Edina], Winter 2008. http://edinamn.gov/edinfiles/files/News_Publications/About_Town/L4-91_AboutTown_2008Winter.pdf (accessed June 13, 2013).]

could share many services. They could get it off to a very fast start. The medical staff was thrilled to be able to have a hospital near their offices in the suburbs. It was beautifully thought out and a very successful venture.

GARBER: How would you define a satellite hospital?

SCOTT PARKER: A satellite hospital is a hospital that has the same board, the same management team. It shares services between the two institutions and does not have to duplicate all of the services. It can lean upon the mother hospital, if you will, for a lot of the services they would otherwise have to duplicate. It's a much less costly operation. It gets off to a very fast start because you've got a very successful mother ship, if you will.

In Mesa, these two concepts came to me and I said to myself, *Wow! What would happen if we could find our mothership in Phoenix? The largest, best, most respected, financially strong hospital—we could merge with them if they were interested. Then we could build this hospital in Mesa as a satellite of their hospital, following the Platou model.* That's what came to mind and gave me some hope that at least there was some direction that I could pursue.

Now, I couldn't say that when I came out of my office because I hadn't talked to anyone else about it! So, I said what you have to say, "We will have a plan, and we'll have an announcement to make in a month." I chose one month so we'd have some time to work this all out or at least give it a try. I talked to my board about it immediately, and they gave me permission to enter into discussions with Steve Morris,¹⁶ who was the leader of the Good Samaritan Hospital in Phoenix. and a national figure. He was on the board of AHA, going to become the chair of the AHA, and was a candidate to be the chief executive officer of the AHA at the time—before Alex McMahon.¹⁷ He had a very high profile, was very well-respected, and had a powerful personality. We hadn't met yet. I called him up cold and said, "I'm new in town. I'd like to come over and visit with you about our hospital." He was gracious, and I went over and talked to him.



Stephen M. Morris

I had read something he said at one of the AHA meetings—that hospitals have to be more proactive in working together. I picked up on that theme when I sat down with him. I said, "I've got an idea for you regarding your idea." We had that merger completed in six months. That gave us his balance sheet to leverage our construction financing. We didn't have to use public district bonds. We didn't have to have another election. The Good Samaritan balance sheet was strong enough to get bonds sold in the marketplace, and we used that capital creation source to build a new hospital. I had the chance to lead the planning and design of it. It was a great experience.

¹⁶ Stephen M. Morris (1928-2011) became president and CEO of Good Samaritan Hospital (Phoenix) in 1966 and was later CEO of SamCor (Phoenix), which operated Samaritan Health Service. [Source: <http://www.legacy.com/obituaries/azcentral/obituary.aspx?pid=147980394#fbLoggedOut> (accessed June 13, 2013).]

¹⁷ J. Alexander McMahon (1921-2008) was president of the American Hospital Association from 1972 to 1986. His oral history: Weeks, L.E. (ed.) *John Alexander McMahon in First Person: An Oral History*. Chicago: American Hospital Association, 1987, can be found in the collection of the AHA Resource Center.

GARBER: It's pretty clear why you wanted and needed to do this deal. But why was Good Samaritan interested?

SCOTT PARKER: Steve Morris' perception was that hospitals needed to be more aggressive and proactive. Also, he realized that the suburbs were growing so fast that if he didn't have a part of those suburbs within his system, he could be blocked from a lot of future referrals.

GARBER: This was about building referral relationships.

SCOTT PARKER: That's what it was about, as well as his desire to be a pioneer, and to create a new approach, and to follow the Platou model.

GARBER: Would this also be correctly described as a hub-and-spokes model, or is that something a little different?

SCOTT PARKER: No, it's the same thing, but hub-and-spoke I think commonly is used in reference to clinics—a number of clinics surrounding the hospital. At this point, it was one satellite hospital as part of a beginning of a hub-and-spoke concept.

SYDNE PARKER: One spoke.

SCOTT PARKER: Yes, one spoke—good phrase. Thank you, dear.

GARBER: What was the outcome? What happened to Southside later?

SCOTT PARKER: We closed it. We sold it off because it was outmoded. One of the not-for-profit agencies took it over and used it for their facility. We built the new hospital. I was really anxious to get a lot of property because I had seen how hard it was in Minneapolis to expand Northwestern, having to buy one house at a time and one square foot at a time at very high prices. The board was thinking about 40 acres. Fortunately, they agreed that we should acquire 80 acres, although I couldn't tell them what we were going to do with 80 acres. My point was: we don't know what we're going to do with 80 acres, but those who follow us 30 years from now will know what to do with it, and they'll be grateful to us. I appealed to the stewardship responsibility. What do we owe those who will come after us? Fortunately, we were able to acquire an 80-acre plot, beautifully positioned, exactly halfway between Mesa and Tempe, which was the perfect place, adjacent to a new freeway that was coming out from Phoenix. At the hospital now, all 80 acres are full. It's a validation of that original thought.

GARBER: The hospital is now Banner Desert Medical Center?

SCOTT PARKER: Yes.



GARBER: It must have been a thrilling experience for you as a young administrator to have the opportunity to build a total replacement hospital.

SCOTT PARKER: It was so exciting! I'd loved the planning and construction experience at Northwestern, which had had a major expansion after the merger. I had a chance to see that happen and watch my boss manage that. I learned a lot from him about how to do it, which paid a lot of dividends because I wasn't inexperienced to the process of planning and construction. The fun of the planning, involving the department heads, involving the community in putting that plan together, was a wonderful experience.

GARBER: You wrote an article later about the concept of fast-tracking construction.¹⁸ Could you discuss that concept?

SCOTT PARKER: That was a new and popular approach during a time of very high annual inflation increases in the cost of construction. Construction workers were scarce, prices of everything were going up, and a few months could make a huge difference because the rate was going up so rapidly. The idea was to try to limit the typical period of construction, which was two to three years, and get it down to well under two years. You would first plan the foundation, the form of the facility, and get into the excavation, the pouring of the footings, the concrete structure, before refining what was going to happen within that structure. You're building and planning at the same time. You're shaking your head, and I can see why. The risks are immense, and if you make mistakes, you pay the price on the other end with change orders which neutralize every saving you make by shortening the time. It was a very hot approach at the time. It helped in this situation because we had a strong construction manager who represented, if you will, me as the CEO, in keeping the architects and the builders coordinated in this process.

GARBER: There were other interesting things with that new hospital. It was designed with all private rooms.

SCOTT PARKER: I never did understand multi-bed rooms. When you're the sickest, you're going to be thrown in with a stranger, to suffer your problems as well as the other person's problems? Be disrupted by two sets of nurses, if you will? The noise, the visitors, the distractions – if there is ever a time in a person's life when there is a benefit of privacy, for every good reason, and the most important reason in this setting—healing—that's it. It's in the hospital. We wouldn't ever do that in a hotel. What if you went into a hotel to register and they said, "You're going to be sharing a room with Miss Jones." You'd say, "Pardon me?!" Why do we tolerate that in a hospital? That was what was behind it. I was not to be the only one who felt that way, obviously. There was a beginning of a trend in new construction for single beds. It wasn't a hard concept to sell.

GARBER: The other thing I thought was fascinating about that new hospital was that the plan was for a medium-sized community hospital. But there was some thought that in 15 years, it would be an 1,100-bed hospital.

¹⁸ Falick, J., and Parker, S.S. Coordination of merged facilities: the first phase of an 1100-bed regional health facility takes shape in the Arizona desert. *Hospitals, J.A.H.A.*;45(3):89-92, Feb. 1, 1971.

SCOTT PARKER: Right.

GARBER: Which is a pretty big hospital.

SCOTT PARKER: A very big hospital.

GARBER: At the time that it was being planned, as you mentioned, there was a huge population growth in the Phoenix suburbs. But I think the planning took place before the shift to outpatient care became a clear trend?

SCOTT PARKER: That's exactly what happened. We were planning on the old model—that everything would be done within the four walls of the hospital. It was just after that that the whole outpatient explosion happened. Those numbers were tempered very rapidly. The good news is that that campus is now filled with a lot of outpatient facilities, more than just the hospital.

GARBER: You were in leadership at the time that the Medicare program was enacted in 1965. How did things change when Medicare came in?

SCOTT PARKER: The paperwork changed considerably. There were new documents to be filled out, new requirements of eligibility, new forms to receive reimbursement from the federal government. The federal government was wise enough to use third-party payers, so they didn't have to set up their own payment system. They selected Blue Cross plans for the most part. We had a whole new relationship with Blue Cross, the third-party payer, and we had to have a cooperative relationship with them to make the paperwork flow and the cash flow coming shortly after giving the services.

Those were minor irritations compared to the great benefit to society. It was such a relief for me to know that my own parents would, in time, have that, because I knew they didn't have a health plan at their work. It was the best thing that could have happened to them in their senior years, to have the peace of mind and the security to know that, no matter what happened with their health, the majority of the costs would be taken care of by this insurance plan.

I don't recall any hospital administrator who felt opposed to Medicare. There was a strong segment in Congress opposed to it on a philosophical basis—the same arguments as we're having now—that it would lead to federally-owned hospitals. That hasn't happened. There was a big fight in Congress that took place when we were in school, so we were able to follow that blow-by-blow battle between the conservatives and liberals over Medicare—it was very instructive. I'm grateful that Medicare was passed. It was the right thing to do and it gave peace of mind to millions of people.

Similarly, the new law¹⁹ is a great relief to me from a social point of view. I have a lot of criticisms about the process that's in play now and how ill-thought out some of it is, how impractical, how it's going to have to change considerably. It was a rush job, and now comes the reality of implementation. That aside, the idea that those who have not been able to have insurance through their employment or by being able to afford it personally now had a chance to obtain it was a relief.

¹⁹ The Patient Protection and Affordable Care Act, PL 111-148, was enacted in 2010. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html> (accessed June 13, 2013)

GARBER: That has been a key issue for you, making sure that all Americans have access to health insurance coverage. Did you want to elaborate any more about the new law or the way that we're going right now?

SCOTT PARKER: It will all be worked out. It'll change. What we see now is probably like Windows 2. We're going to have Windows 3, 4, 5 and 6. This will evolve because it's not clearly delineated in the law. There are a lot of generalizations in the law. It's been said that the most commonly-used phrase in the law is, "The Secretary shall," which means: this has got to be worked out later. That's now just starting. Fundamentally, it's a huge shift in a sense of stewardship responsibility of our government for those who are disadvantaged, and long, long overdue.

This really came to my mind in a very vivid nature when I was representing the AHA at the Canadian Hospital Association annual meeting in Edmonton. There are very close relationships, as you know, between the Canadian hospitals and the U.S. hospitals. I was invited to the annual meeting to give a little greeting on behalf of the AHA. I was seated at the luncheon between the president of the Canadian Medical Association and the president of the Canadian Hospital Association. The physician was a very acerbic guy, direct questions, a no-nonsense kind of person.

After we'd chatted a little bit about the fact that the United States was not providing health care to everyone like they do in Canada, he looked at me right in the eye and said, "I sense you're a man of values and have concern for your fellowman. How do you sleep at night, knowing that *you* have health care insurance and not everybody else does in your country?" That was a potent question. Of course, I answered with the standard, "Well, we voluntarily take care of it. We have charity in the hospitals and accept everybody regardless of their ability to pay," and so forth. He knew and I knew that that was not a very good answer, because that's the worst way to take care of patients who are in need of fundamental primary care. I came away from that experience deepened in my sense that we need to do a lot better in the United States. It's taken a couple of decades for that all to play out, but it's played out, and I'm happy about it.

GARBER: Let's go back to the early '70s. You were in Mesa and the opportunity came about to become the CEO of the flagship.

SCOTT PARKER: That was a quantum leap. It was unexpected, and I felt I was unprepared for it. I went from a 100-bed rural hospital—which had no teaching, no research, and no sophisticated facilities—to a tertiary care facility with teaching programs, with research programs. I was going from 100+ beds to 500+ beds—it was a huge difference.

It came about because Steve Morris, after our merger, was suddenly faced with two unexpected opportunities for other hospitals to join in to this merger concept. They were on the other end of the valley, on the west end of the Greater Phoenix suburban area. They were in the same boat we were at Southside. They had limited funds and needed funding for expansion. They came to Good Samaritan Hospital and were accepted as affiliates of Good Samaritan, which then became a system as a result of the three mergers. The flagship and the three suburban hospitals became Samaritan Health Service, a not-for-profit, multi-hospital system in Phoenix.

Steve Morris moved into a central office to be the CEO of the new system. His board became the single board for those hospitals, there were advisory boards in the other hospitals, and he set up a staff. He vacated the CEO position at his hospital where he had trained as a young man

and spent had all of his career up until then, and asked me to come in from Mesa, from this new construction project, to take his place. It shocked me at the time, because I still was very young.

GARBER: How long had you been on board?

SCOTT PARKER: We went to Mesa in 1967 and this would have been 1969 or '70.

GARBER: Just a few years.

SCOTT PARKER: Yes, a few years. I said yes. It was too big an opportunity to turn down. But literally, I was stunned by it.

SYDNE PARKER: How many times did you drive around the block the morning that you had to take over?



In the early '70s

SCOTT PARKER: That's true, I did drive around three times, my hands trembling on the wheel, trying to get up enough courage to walk into the building and sit down in that chair. Because it was so big and so challenging I always had a little bit of a chill, of stress, every day for the two years I was there. But boy, did I have a great opportunity to grow under accelerated circumstances.

SYDNE PARKER: I don't think anybody knew that you felt that way because you had such a good front.

SCOTT PARKER: You knew because you listened to my laments every night. But I inherited a wonderful staff of departments heads, all the best in the state, all experienced. It was kind of a good news/bad news thing. The good news was that the hospital would carry itself whether I was effective or not, because they were just so good. The bad news was that they weren't too happy about having anybody there but Steve Morris. He was the soul and the history of the hospital. He took it from its very beginnings to where it was. It was recognized as the best hospital in the state, if not in the region. To have him leave was a shock to them. There had been another person who came for a while. One of the assistants took the position, but that hadn't worked out. I was brought in as the emergency Minuteman kind of guy, and I was very intimidated by those department heads and by the whole environment of that hospital.

GARBER: How did you resolve that?

SCOTT PARKER: We have an old song in our Church about the pioneers going across the Plains and facing daunting circumstances. One of the phrases is, "Gird up your loins, fresh courage take." That was the approach. Just get in and do it, and do your very best. That's all you can do. You've got the assignment. You better make the most of it. I received a lot of encouragement from Sydne, from Stan Nelson, my mentor, and Don Wegmiller, my best friend, who I called quite frequently for reassurance.

GARBER: In the early '70s, when you were CEO at Good Sam, the Economic Stabilization Program was in effect as a means to control the high inflation that you had mentioned

previously. Do you recall how that affected the hospital?

SCOTT PARKER: Not seriously, interestingly enough. I was very worried about trying to implement the wage and price controls. The fact is that all hospitals were in the same boat, all had to put a hold on salary increases and had to put a control on their prices. I think we all adapted to that on a very short-term basis. The law proved to be impractical. It was only around for a couple of years. It was, I think, clear to everybody that this was just a stopgap, maybe even a political measure, because you can't hold back inflation. Therefore, you can't hold back salary increases. Inevitably, it's going to catch up with you.

I was much more worried about what happens when the wage and price controls comes to a close and you have got that bubble building of expectation on salaries, because they had been limited for so long. You were going to have to make them up fast. How were you going to do that financially? That turned out to be the biggest challenge of all. We had to phase it in over time. We couldn't do it all at once. The fact that the employees knew that it was our goal to make it up over time made it feasible.

GARBER: You were poised to make another career move.

SCOTT PARKER: I loved the Good Samaritan job. After the initial shock, I had worked through the relationships and had become more comfortable with the department heads. Improvements were being made at the hospital. I was enjoying the culture of a system—which was all new and exciting—and learning from it was all great. But, I ran into some philosophical differences with Steve Morris. I've always been grateful to him. He made the merger possible. He opened the door at Good Samaritan Hospital and let me be the CEO well before my time of maturity and experience. But we were not all that compatible in terms of our management styles.

It was time to move on, and the word got out quietly. The alumni network of the Minnesota program became involved. Independent of that, I received a contact from a headhunter about my interest in the CEO position of the St. Luke's Children's and Heart Hospital in Houston. Dr. Denton Cooley²⁰ was in his prime at the Heart Hospital. St. Luke's was a fine tertiary care hospital. There was one parent board over all the three facilities, with local boards for each hospital. I was interviewed by a selection committee and became very excited about the position.

The committee invited Sydne and me to go back to Houston for further interviews. She was always, I think, the one who got the jobs. I get the title, she got the job. She's just so wonderful, natural, good and bright that the members of the committee were intrigued with her. The chairman of the search committee offered me the position, and we were planning to take accept. It was a nice answer to our little dilemma.

I was literally drafting out my resignation letter from my position at Good Samaritan when I received a phone call. It was the chairman of the search committee. He was hemming and hawing, so I said, "Is there a problem now with the offer that has been made?" He said, "Yes." I said, "Would you like me to rescind my application for the position?" He said, "Could you?" I said,

²⁰ Denton A. Cooley, M.D., a world-renowned cardiothoracic surgeon, is the founder and president emeritus of the Texas Heart Institute. In 1968, he performed the first successful heart transplant in the United States, followed by the first artificial heart implantation the following year. <http://texasheart.org/AboutUs/History/cooley.cfm> (accessed June 14, 2013)

“Yes, of course. This is your job to fill, and if I’m not the right person, you shouldn’t force the issue.”

The change was related to my religion. I won’t be specific about it except to say that the religious leader of the hospital, who was on the board had second thoughts. I had talked to him about the fact that I might be asked by my Church to have some kind of a profile religious leadership position in our church in Houston. I asked him how comfortable he would be if that happened. He stated at the time that he would be all right with it. I sensed that he wasn’t quite convinced. That’s what played out later.

I said to the chairman of the search committee, “Is it [that person]’s concern?” He said, “How did you know?” I said, “I was just putting two and two together—it makes sense. Don’t worry about it. We’ll just depart friendly and in a gracious way.” He sent me a thank you letter every Christmas for a number of years after that, because he was in such a difficult position himself.

It all turned out for the best, because right after that, Willard Voit,²¹ President of the Voit Rubber Company, was in his backyard talking over the fence with his neighbor, who was chief of the medical staff at Long Beach Memorial Hospital, the most respected hospital in Southern California. Voit was head of the selection committee at Hoag Memorial Presbyterian Hospital in Newport Beach. They were talking about the challenge of finding a new CEO at Hoag. The doctor said, “Well, my CEO knows all the hospital administrators in the country.” He was talking about Don Carner,²² who was the mentor of my mentor, Stan Nelson. He said, “I’ll talk to him, if you’d like.” That happened and they came back to Willard Voit with my name. That’s how I got into play. Don Carner became a great mentor to me when we moved to Newport Beach, and I became the CEO of Hoag Memorial Presbyterian Hospital.

SYDNE PARKER: We thought we’d be there quite a while. As it turned out, we weren’t.

GARBER: Something momentous happened next in your lives. Could you please talk about the LDS Church and the Church’s involvement in health care right around this time in the mid ‘70s?

SCOTT PARKER: The LDS Church was involved, like other religions across the country, in the founding of health care in the United States, in terms of building hospitals. The Catholic Church set the precedent, with the Catholic immigrants coming, the nuns following, and building those wonderful hospitals. Wherever the Catholics migrated, the nuns were there to build the

²¹ Willard D. Voit (1910-1980) grew a small rubber company founded by his father into a multimillion dollar sporting goods manufacturer.

<http://news.google.com/newspapers?nid=1338&dat=19800226&id=MK0SAAAAIBAJ&sjid=KfkDAAAAIBAJ&pg=3794,2554135> (accessed June 14, 2013)

²² Donald C. Carner (1917-2007) served at Memorial Medical Center (Long Beach) as executive vice president and then from 1978-1982 as president. Previously, he had been administrator at Parkview Memorial Hospital (Fort Wayne, IN) at the time that Stanley Nelson was assistant administrator there. When Carner left Parkview to take the position in Long Beach, Nelson succeeded him as administrator at Parkview. [Source: *1992 Directory*. American College of Healthcare Executives, 1992; and, <http://www.legacy.com/obituaries/pasadenastarnews/obituary.aspx?page=lifestory&pid=93941884#fbLoggedOut> (accessed June 14, 2013)]

facilities. They set a high standard and a great example to all the other religions, including the LDS Church.

In the pioneer days here, there was no other entity that had the resources or the ability to build hospitals. The LDS Church stepped into that void and built hospitals which were open to everyone. Over the years, that pattern continued and LDS hospitals were built in Utah and Idaho. The hospitals were part of a hospital system, with some qualifications about the term “system.” There were very few central services. It was more like an “association” of LDS hospitals. Each hospital had its own board. Each hospital had its own medical staff, planned its own strategy, figured out its own finances, defined its own services, and so forth. About five years prior to the big decision of the Church to divest their hospitals, there began to be a little more centralization, but it was not significant.

The reason for the Church’s decision to move away from operating hospitals came as a result of the fact that the senior leadership group of the Church responsible for hospitals was also responsible for all the other non-religious entities of the Church. This included the Church’s quite extensive “welfare program”—including farms, ranches, and other ways to produce goods and materials and food, to assist with helping our poor within the Church, and to respond to emergencies across the world. They were also responsible for all of the other businesses owned by the Church including ZCMI, which we talked about earlier.

The three-man leadership group was named the “Presiding Bishopric of the Church.” In addition to all of the temporal responsibilities for the Church they were responsible for the 15 hospitals. Each was serving as the chairmen of the board of five hospitals. These hospitals were spread up and down Utah, Idaho, and Wyoming. It was a daunting demand on their time, the travel and so forth. Because they had so much more to do than they had time to do, they invited Cresap, McCormick and Paget, a consulting firm, to help them try to determine how they might better manage their time.

The consultants’ lead man, Earl Frederick,²³ who had been a hospital administrator himself at the children’s hospital in Chicago, asked them, “You are spending a great deal of time overseeing your 15 hospitals. Is the operation of hospitals central to the mission of your Church? You need to ponder that.” They began to ponder it and concluded, no, it wasn’t part of the doctrine. It had happened because of the circumstances that I mentioned earlier—they’d stepped into a void that needed to be filled—but now these communities were strong, able, and probably willing to assume responsibility for the hospitals.

They also faced the reality at the time that there was a debate in the U.S. Congress about whether hospitals that accepted federal money, e.g. Medicare, should be required to perform abortions on demand. That issue was being highly focused on in the news. That, of course, caught the Church leader’s attention because the Church, along with some other religions, would not perform abortions on demand in their hospitals.

In addition, when the Church looked at their budget for the capital improvements that were necessary in the hospitals, which they thought would be \$100 million (but which turned out to be

²³ Earl J. Frederick was the president of Children Memorial Hospital (Chicago) from 1975 to 1991. [Source: *Guide to the Health Care Field*, 1976 ed. Chicago: American Hospital Association, 1976, and later editions.]

ten times that much), the questions were raised—*Is it right for us to spend \$100 million in this center part of the West when our Church is worldwide, and we have demands from all over for new buildings, new temples, new schools and so forth? What about the balance and priority of our resources?* They concluded that the hospitals were not central to the mission of the Church, and that they could be divested.

“Divested” is the key word. They didn’t say “sold.” They could have sold the hospitals. I know how much they could have received, because even before the Church was talking publicly about their interest in divesting, I was approached by Hospital Corporation of America to represent them to the Church. HCA thought the Church might be interested in selling if the price was right; and, I knew the price was that HCA was willing to pay.

It didn’t matter. I told HCA at the time, “I don’t think they’ll sell their hospitals. If they want to be out of that work and that responsibility, I don’t think they’ll sell because they understand that if they were to sell the purchasers would need to recoup their investment, which would mean incremental costs.”

That turned out to be true. When the Church decided to divest their system they turned it over to a new organization that they helped form by selecting the first board of trustees. The Board was beautifully put together, diverse from every angle, including religion, gender, background, profession, and geography. Then they said to the new board, “It’s yours. We’re giving this to you as a gift. Here are the resources. Here are the hospital assets. Here are all the personnel. Take this if you’re willing to be of service without pay, because it will be a not-for-profit organization. Are you willing to validate our decision to do this by committing yourselves to be stewards to create a model health care system?”

I’m sure there were some long pauses. That was a very high standard for a rural state to become a model for the rest of the country. But the members of the board who said yes were deeply committed to that goal. When I was interviewed for the CEO position that was the first question they asked me, “Are you willing to take this stewardship upon yourself?”

That was the hardest professional question I was ever asked. Am I really willing to do that? Do I think I can do that? Do I have the ability to do that? Do I have a desire to do that? I had a very comfortable position in Newport Beach, California—arguably one of the most beautiful places in California, probably in the country—a beautiful hospital looking out over the Newport Beach harbor. There was a compatible medical staff, a very reputable board, and many good things going on. Should I leave that comfort zone and take on this new entity and try to make it a model health care system?

I accepted, soberly. The challenge to become a model health care system was the most valuable asset I had as the leader over all the years I was the CEO of Intermountain Healthcare—and continues to be for my successors. There have only been three of us to serve as CEO in the nearly 40 year history of the organization. But each of us, when we came into our position, made that commitment. It wasn’t formal—we didn’t stand up and make a pledge. It was understood that you were going to continue this tradition of moving Intermountain Healthcare always forward in becoming a model health care system.

That was a powerful tool. I never gave a talk to our employees, never wrote a newsletter, never made a community presentation about Intermountain Healthcare anywhere in the world

without mentioning those beginnings and that imperative. When I recruited our management team, I passed that challenge on to them. Were they willing to assume the same sense of stewardship? Happily, they all said yes. We were together as a team, five of us, for nearly 20 years, working diligently to try to fulfill that expectation.

GARBER: It was a remarkable gift of the Church. Was there a precedent for this?

SCOTT PARKER: No. It was unprecedented at the time and to my knowledge unduplicated since.

SYDNE PARKER: The Church truly did walk away. They didn't try to micromanage anything. They just said, "Bon voyage—do a good job."

GARBER: There was no attempt to remain influential by placing certain people on the board? Rather, they hoped and prayed that because there were good people who accepted this stewardship challenge that it would work out.

SCOTT PARKER: You have it just right. There were no Church leaders on the board. I kind of expected and wanted them to check in once in a while so we could at least tell them what we were doing. They had the discipline not to do that.

After five years, I couldn't stand it any longer and my board chair felt the same way. We said, "Five years! We've done quite a bit. We think we're at least working hard on the challenge they gave us. We'd like them to know!" We invited ourselves to give a presentation to the presiding leaders of the Church—it's called the First Presidency—the President and two Counselors. They accepted our request.

We were briefed by their staff. I said, "What kind of presentation would they like? Do you want us to stay within 20 minutes?" This was back when you did slide shows—long before PowerPoint. The staff said, "They'd like to see visuals." We worked hard on our presentation. They were very gracious, but all were elderly men. As soon as the lights went down, they all nodded off. When the lights went up, the Senior Leader opened his eyes and said, "Wonderful presentation." We said, "Thank you," and left, but we at least had our moment. That was the degree of our return report stewardship. But they were very happy. We learned subsequently that they wanted us to know that they really were aware of our progress and were pleased.

GARBER: All right, back to the model health care system. I know that you looked at Mayo Clinic, Cleveland Clinic, and others. How did you begin to figure out what a model system looked like?

SCOTT PARKER: Those were helpful models and we found a lot of compatibility in them; Kaiser²⁴ was included. These systems all served with a passion and with a sense of stewardship responsibility for defined programs or geographies. We loved the Mayo²⁵ story—the rural

²⁴ Kaiser Permanente was founded in 1945 by Henry J. Kaiser and is composed of the Kaiser Foundation Hospitals, the Kaiser Foundation Health Plan, and The Permanente Medical Groups. <http://xnet.kp.org/newscenter/aboutkp/fastfacts.html> (accessed June 27, 2013).

²⁵ At the time of the Civil War, Dr. William W. Mayo settled in Rochester, Minnesota, where he later took his two sons, William J. and Charles, into his practice. These innovative physicians, who believed in a teamwork approach,

beginnings in Rochester, Minnesota; two very bright physicians who thought there was a better way to practice medicine by bringing a group of physicians together who would share stewardship for an individual patient's need. You get all of that expertise focused on one patient—what a beautiful concept that is, and it's been very successful, but seldom duplicated. There are a few mini-Mayo's around, but not very many. Geisinger—I think they come very close to that, probably the best.²⁶ That's why they're mentioned along with Mayo as a model for the future.

Kaiser was a different kind of an organization but similar in that they had a passion. Mr. Kaiser had a problem. He was building ships; he later built cars after the war. The country was dependent on him to build these ships. But because there were threats of Japanese bombing, he had to spread out his locations all along the West Coast. There were industrial accidents and marginal care being given in these small ports. Like Henry Ford did when he built the Henry Ford Hospital,²⁷ Henry Kaiser built Kaiser hospitals. He followed the model of Ford, employed physicians, provided the insurance as a benefit, and set the whole Kaiser model into place.

Now that wasn't our model. We weren't starting out employing physicians. But we were starting out trying to bring together economy of scale from shared services. The whole idea of a "model system" is that it takes serious effort to improve quality by being careful in the approval of physician privileges, and more discipline when things aren't going well in terms of quality.

Our board said to management, "Look, we received a gift. We don't have a lot of debt. Therefore, shouldn't our costs to our patients be lower than other hospitals that have higher debt?" We said yes. They said, "Okay then, what percentage lower than the average should we be?" We came to a conclusion, with some outside help from our auditing firm, Ernst & Ernst, that we should be 10-15 percent lower. That became our standard. We always operated at 15 percent lower than other hospitals in our region.

Those kinds of disciplines are what a system is all about. You cannot accomplish those kinds of things if you are just an "association" of hospitals. You can only bring them about when you have a central board that is dedicated to it and willing to do something about it, such as putting in new, creative management tools and systems in place in order to make it happen. That's a long answer to your question about what a system does.

Strategy is crucially important. When you have got 15 hospitals, and you have a sense of stewardship, you're deeply involved in the role of each of those hospitals, what they should be, how they should be coordinated, and how they should avoid duplication. Basically, there's a culture of

established the first private integrated group practice in the United States. [Source: *Mayo Clinic History*. <http://www.mayoclinic.org/history/> (accessed June 27, 2013).]

²⁶ The Geisinger Health System (Danville, PA) is an integrated health services organization serving a rural region in central and northwestern Pennsylvania. The hospital was founded by Abigail Geisinger in memory of her husband, George, and opened in 1915. A guiding force in development of this leading rural health system was Dr. Harold Leighton Foss, who served a fellowship with the Mayo brothers. <http://www.geisinger.org/about/history.html> (accessed June 27, 2013).

²⁷ In 1911, the Detroit General Hospital Association broke ground on a new hospital located on the outskirts of Detroit. Fundraising and construction lagged until Henry Ford offered to take over financial and organizational responsibility for the hospital. Accordingly, Henry Ford Hospital opened in 1915. Physicians, many of whom came from Johns Hopkins in Baltimore, were organized according to a closed staff model. [Source: *American and Canadian Hospitals*. Minneapolis: Midwest Publishers Co., 1933, p. 569; and, *Henry Ford Hospital History*. http://www.henryford.com/body_nologin.cfm?id=39484 (accessed June 27, 2013).]

hospitals and boards that they want to be “better,” always want to be better, and that’s good. Usually, historically, it is an attempt to be “better than the next town’s hospital.” That old competition between the towns—the high school team competition, all those traditions—that also applies to hospitals. That one-upsmanship game can lead to unnecessary duplication. In a system, you have the ability to try to contain that and define the role of each hospital so you don’t have unnecessary duplications and you can get economy of scale

We moved into disciplined central purchasing very quickly because it was the “low-hanging” fruit. You gained immediate savings by bringing the independent purchasing offices in hospitals together into one. We were buying at a much higher volume, and therefore we were getting a lower price. Then we helped form a national coalition of hospitals called Associated Healthcare Systems.²⁸ We managed it out of Intermountain Healthcare for a few years. There were 15 systems buying together. The prices went down significantly.

We did the same thing when we brought insurance together, banking together, investing our portfolio together, rather than independently. You get more return on your investments and you get less cost on your insurance. You’re able to provide malpractice insurance to your physicians at a much lower cost by setting up your own malpractice insurance company in a co-op, like we did with several other hospitals. I’m trying to give you a sense of what a system can do that a freestanding hospital cannot do. We try to take full advantage of those opportunities that were there to be taken and create a few of our own that were new.

GARBER: It’s a powerful concept and one that’s been replicated all over the country. When you talked about wanting a hospital to be better than the next town’s, I take it that “better than” means, “I’ve got more services than you. I’ve got more high-tech equipment than you. I’ve got more specialty docs than you.”

SCOTT PARKER: Exactly, right. More beds.

GARBER: How does the concept of that kind of competition work in health care?

SCOTT PARKER: Both good and bad. I think that natural competition can bring out the best in people and in services. But, it can bring out the worst behavior because you can get over-engaged in the competitive spirit and make mistakes. There have been many mistakes that have been made where hospitals have tried to expand too fast and have run out of the resources. There can be difficulties created within the organization over fights of who’s going to have priority. It’s always this fine balance that has to be made by the board and by the CEO and the management team, to have all the constituents understand that there have to be priorities.

The art of it is to get all of them involved in helping make those decisions, so they’re not just commands, but they come from a process of participation. We found that to be very important in building our priorities within the system. Just that participation took a real edge off that unnecessary and probably damaging kind of internal competition.

GARBER: You’re speaking of hospitals that are part of the same system.

²⁸ At the time of the 1977 American Hospital Association convention, Scott Parker was chosen to head a committee to examine the feasibility of a shared services group made up of tax-exempt multi-hospital system members. [Source: Tax-exempt chains plan group buy of equipment. *Modern Healthcare*;7(10):16, Oct. 1977.]

SCOTT PARKER: Correct.

GARBER: What if we're talking about non-related hospitals?

SCOTT PARKER: There was a strong effort, and a goodwill effort, during the '70s and '80s to foster cooperation and shared services among hospitals. The federal government encouraged it. They had a process of requiring hospitals to talk to each other before the hospitals could receive approval to make major expansions and expenditures. There were some good things that came out of that—of tempering unnecessary growth and creating cooperative ventures between hospitals to try to lower the cost of capital investments. But like all regulation, the bubble burst on that as well. Then came antitrust issues after that, where you really couldn't sit down with your competitor and talk about doing things together. It was not legal to do it and that brought the cooperative era to a close, unfortunately. That remains in place today.

GARBER: Would you comment on the often-cited statement that “all health care is local?” Do you buy that concept?

SCOTT PARKER: Generally, I do. I think the key decisions are made locally. It's the local volunteers in the not-for-profit systems, serving on those boards that make those decisions. So, yes, it is local. There is no federal plan for hospitals, indicating what hospitals should do or where they should be located. It's a very open economic environment—the free enterprise system at work in health care. Those decisions are made locally, unless you're like an HCA with national ownership and you're a for-profit hospital. There are a lot of nationally set controls there that are not set locally. Those are national strategies of what hospitals will be doing what, where they'll be built, where they'll be closed, and so forth.



William N. Jones

Going back to your question, generally, yes, it's local. The fun comes when you try to define what's “local.” Is “local” your neighborhood? Is “local” your city? Or in our case, is “local” our region? We took the approach that “local” is our region, that health care is local, yes, but our location or service area was the whole Intermountain area. We stayed in the Intermountain area.

When we first received a little visibility, our board chair, Bill Jones²⁹—a thoughtful, experienced man, saw his management team start to get invitations to expand outside of our natural region. California was a strong draw. The Midwest was also a draw. We had invitations from Florida. We had invitations from overseas including some of the Arab countries to build IHC hospitals. We started to ponder that possibility. Frankly, to younger managers like we were, there was a lot of interest and excitement in that prospect. It's complimentary and validating, and it gets your juices going. It's the next new thing—going to get bigger and therefore better.

But that's not necessarily the case. Bigger and better aren't locked together. Bill Jones explained this concept to the management committee with this question—and I give him great credit for it—“Would you rather be smaller and stronger, or larger and weaker?” That was a very

²⁹ William N. Jones, Ph.D., was founding chairman of Intermountain Healthcare and served on the board for over 25 years. http://thementorseries.blogspot.com/2009_04_01_archive.html (accessed June 28, 2013).

good question! It brought us back home to our roots. As far as growing horizontally, everything was pretty well covered in the Intermountain states by then. There was not a great need for new hospitals. We made a strategic decision to grow vertically. We expanded our service within our zone rather than try to keep building hospitals outside of our zone.

That turned out to be a very good decision, and it's paying great dividends now as we look at this new law.³⁰ Those hospitals and systems that have integrated cradle-to-grave services will do well. Being able to show emphasis on quality within all of those parts of the delivery system, being able to control it, and take total financial risk for a defined population will likely be a pattern for future success.

GARBER: Is vertical integration the same as an integrated delivery system?

SCOTT PARKER: Yes, those are synonymous.

GARBER: What does horizontal integration mean?

SCOTT PARKER: I don't think there is a horizontal integration. They are two different concepts. Horizontal means that you just keep doing what you're doing, like running a hospital. You just go get more hospitals or build more hospitals.

GARBER: And horizontal is hospitals that are linked together as opposed to having different types of providers linked together?

SCOTT PARKER: Correct.

GARBER: You mentioned HCA. I had the opportunity to interview Dr. Thomas Frist, Jr., who is a co-founder of HCA. He talked about the importance of owning the hospitals that are part of your system, as opposed to contract-managing them. Would you comment on that?

SCOTT PARKER: I agree with him. When we inherited the LDS Church system, they had a variety of arrangements for management. The majority of the hospitals were owned, but they had some management contract agreements where they were being asked to manage the hospital that still had local ownership. They were also in a couple of situations where they were asked to lease the hospital and be totally responsible for it and just pay a lease payment to the government entity that owned the facility.

We operated those three models for the first five or six years. By evolution, most of those hospitals that were being managed, or that we were operating on a lease basis, saw the advantage of being an official member of the family. This would allow them to get all of the services of Intermountain Healthcare and to have the protection of the balance sheet of Intermountain Healthcare which would guarantee their growth. They were willing to concede local ownership for all of those security advantages. We never pressed the issue. We never put them in an either/or else situation—e.g. “if you don't sell to us, we're going to leave.” We were never inclined to do that.

There were two that decided they wanted to continue to try it on their own and the leases

³⁰ The Patient Protection and Affordable Care Act, PL 111-148, was signed into law in 2010 by President Barack Obama. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html> (accessed June 28, 2013).

were terminated. That was their philosophy, and they had their rights to do that.

SYDNE PARKER: Could I ask, how did they do?

SCOTT PARKER: Well, not well.

SYDNE PARKER: That's what I thought.

SCOTT PARKER: Neither of those hospitals is still operating today. But that's understandable. So, we evolved into all ownership. I think Dr. Frist was right. It just simplifies everything, clarifies everything, brings everybody onto the same song sheet in unity.

GARBER: Your friend and colleague, David Jepson, told me a story about the origins of Intermountain Healthcare's involvement in managed care. It was a story about the discount demand that Blue Cross Blue Shield made of Intermountain, and also ties back to what you were talking about previously about your decision to have lower charges.

SCOTT PARKER: There were two strong entities in the state at that time—Blue Cross and Intermountain Healthcare. There were only one or two other commercial insurance companies, and there was no other Blue Cross plan. We had to come together once a year to negotiate payment. This was non-Medicare—just regular patients with insurance sponsored by employers—which Blue Cross contracted for, and they in turn contracted with us to determine how much they were going to pay us for our services in providing hospital care. It was always a debate.

That dynamic went on and worked quite well until there was a change of direction in our local Blue Cross and there were no longer hospital administrators on the Blue Cross board. That was part of federal regulations to separate the two. We no longer had collegial relationships in place like we had had in previous years. Those relationships went right back to the beginnings of national Blue Cross, with the AHA playing a major role in the founding of Blue Cross.

Now we were in a more businesslike approach. Blue Cross decided to get quite proactive on their negotiations, with the argument that: "You can afford to charge less because you have strong financial reserves." We did have a strong philosophy about being frugal and saving as much as we could every year, within reason, and still keep our rates low. It was a kind of narrow trough with pressures on both sides. One side was to keep your rates lower than the competition. The other side was trying to make as much margin as you could in order to put into the rainy-day fund.

Blue Cross of Utah saw our reserves, and said, "Look, you've got all these reserves. You can afford not to take a rate increase for the next four or five years. We think you should take no rate increase and pass that savings along to the employers through our lower insurance premiums."

We said, "Wait a minute, if we do that, then you're really taking the life blood out of us. We would have no reserves. Therefore, we could not respond to future needs for construction programs, new technology, and new programs. We would be neutered, if you will. And of course, that is not acceptable."

We then learned that Blue Cross was planning to go to the public through the media making their argument about why we did not need a rate increase for several years to come. That was a moment of truth regarding our relationship with Blue Cross. It suddenly turned into a very difficult,

stressful business relationship.

In an important sidebar—the timing was uncanny because it was at that same time that President Clinton had assigned his wife, Hillary, to come forward with a proposed reform for the United States health care system. Her proposal, which was well-known, would be based on the HMO model. Doctors, hospitals and insurance companies would be required to come together in cooperatives and take mutual responsibility and financial risk for a defined population, which would be all of the uninsured. We see echoes of that concept in the new health plan.

We reasoned that if the proposal became law we would have to go to Blue Cross and become partners. We are going to have to go to all of these independent physicians (in the West they are mostly in single- or two- or three-member practices) and make individual deals with all of them about taking risk together?” It seemed an impossibility to do that. That’s when we decided that we needed to form our own insurance company, so that we would be on the same song sheet, under the same leadership, with the same goals.

Ironically, that was also at the time when we were beginning to be more deeply committed to clinical quality improvement. That was the very beginnings of improving clinical processes. How were we going to do that if we were not in harmony together with the physicians, wanting to do it together rather than our trying to impose it on them?

All of that led to two major directional decisions for Intermountain Healthcare. One was to start our own insurance company, which we did. Not too long after that, we started inviting physicians to come into our organization, into leadership positions, memberships on our boards, and involvement as employees of the system, if they were so inclined. We acquired the two major clinics in Salt Lake City, that were anxious to come in because they were facing challenges with capital improvements because they did not have strong balance sheets.

That swirl of external realities and possibilities for the direction of the future resulted in our decision to be more than a system of hospitals, and truly descriptive of our name. We were not Intermountain *Hospital* System. We were Intermountain Healthcare.

GARBER: I’d like to go back to the subject of the appropriate relationship between physicians and health systems, having to do with ownership of physician practices, and the concept of physicians serving on the governing board.

SCOTT PARKER: I’d be glad to. Up until the last twenty years, the tradition and desire of physicians was to be totally independent of the financial matters of the hospital. They were there at the invitation of the hospital, but they had their own medical staff bylaws, elected their own officers, and had only lightly been engaged with the management of the hospital.

That was both good and bad. Good for them in that it didn’t demand a lot of their time. They could focus on what they had been trained to do—provide care—and not get involved with the administrative complications or decisions. On the other hand, it was also frustrating for them. Because they didn’t have a say in the key decisions, they understandably felt separated from the key decisions that impacted them directly. Their careers could be impacted by a decision that they were not part of—for example, are we or are we not going to start a new program or buy new equipment for their specialty?

Hospital administration students in my era were strongly encouraged in the classroom to do everything possible to stay away from physicians' personal finances. Physician relations are complicated enough making it all work on a cooperative basis, let alone trying to get involved with issues over money. I think most hospital administrators of my era have always had that concept in the back of their head, and I had it in the back of mine.

However, integration related to quality improvement was going to require hospitals and physicians to come much closer together, if not be totally engaged, and that was daunting. I had a lot of second thoughts about that, as did my colleagues, but it seemed like it was inevitable. Times had changed so dramatically that we simply had to step forward and do it and at the same time try to minimize as much as we could the stress that comes over issues related to control and money.

When we approached it at Intermountain, we looked at Mayo, we looked at Geisinger, we looked at Kaiser. The team from Intermountain Healthcare that was assigned to visit Mayo came back to report. They said, "Mayo explained to us that they have three compensation plans with their physicians who are part of the system: last year's, this year's and next year's! Which means it's a rolling negotiation that has to be worked out constantly." That's really been the case for Intermountain Healthcare over the years.

As we began our dialog we had the goal to have an objective, open, candid, honest discussion with the physician leaders in our hospitals. We brought them together every Tuesday morning for an entire summer for a two-hour dialog about the environment, the changes in the industry, the changes in the politics, what's coming down the stream, and how we—physicians and hospitals—needed to be together to try to respond to it.

We engaged McKinsey—a fine hospital consulting firm—to be the independent consultant and facilitator. They did a magnificent job and created an environment of openness and trust. We entered into those discussions not knowing where it would take us.

It became clear that our physicians were very interested. They saw how the health care organization was trending. They saw the HMO movement and what it meant. They saw the limits in capital for their own operations. They saw the complications that would come to them with all of the equipment they were going to need just to process business matters. There was an attitude of, *Wow! We all have got the same kind of challenges here—just on a different scale. If we're going to be successful in this new environment of the government and insurance companies compensating on the whole cost of care—the physician side and the hospital side—we need to find a way to bring us together compatibly.*

We came forward spontaneously to our physicians—again, without strategy—and said, "This is going to be a big change for you and for us. If you're going to be a part of us, then we have to make you really a part of us, as much of an equal partner as we can. We have never done this, but we'll open up our board and you can have a physician's division, if you choose. You can elect your leaders, just like you do at your local hospitals. That leader will be automatically a member of our board. Then we're going to have some key new management positions open here, because it's a whole new line of administrative activity that we haven't had before—a physician's division. That should be led by a physician. We will have other positions that we need to open up, in quality particularly. Those of you who are interested in those kinds of positions will be welcome to apply.

These invitations were well received by the physicians. The vast majority of the physicians

on that committee voted in favor of the integration proposal. That gave the imprimatur of approval of the key physician leaders in the organization.

Interestingly enough, the three physicians in that group who were the most participative, interested, and articulate ended up in senior management positions at of Intermountain Healthcare. One of them became the third CEO of Intermountain Healthcare. That never would have happened had we not had that summer of open and honest dialog.

GARBER: That was Dr. Sorenson?

SCOTT PARKER: Yes. Dr. Sorenson.³¹

GARBER: Who were the other two?

SCOTT PARKER: Dr. Linda Leckman,³² who heads our physician division, and Dr. Kent Richards who became the COO of Intermountain.

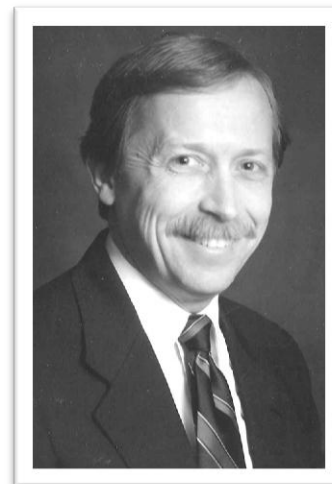
SYDNE PARKER: What about Brent James?³³

SCOTT PARKER: Brent James was not a part of that study group. He came to us later.

GARBER: Brent James is an important part of this story. I wonder maybe if this is a good time to move on to quality.

SCOTT PARKER: Quality was an important part of our original mission statement, which has not changed over the years. We stated that we would provide quality care at the most reasonable cost, also quality had to be measured. We understood that. This was really a nurse-driven process in the beginning like the original quality assurance programs. We had a wonderful nurse leading that effort, supported by a member of our board and a member of our management team. That was Diane Moeller,³⁴ a Catholic sister, who was asked to serve on that original board by the LDS Church. Diane had been a hospital administrator. She was a nurse. She was dedicated to quality. She selected another nurse to head it up. Because of Diane and her team we received national recognition for what was then called a quality assurance programs.

Then came the next iteration, we were talking about what the nurses were doing to improve



Brent C. James, M.D.

³¹ Charles W. Sorenson, M.D., became president and CEO of Intermountain Healthcare in 2008.

<http://intermountainhealthcare.org/about/news/resources/Pages/ceo.aspx> (accessed Aug. 26, 2013)

³² Linda C. Leckman, M.D., became vice president of Intermountain Healthcare and CEO of Intermountain Medical Group in 1996. <http://intermountainhealthcare.org/about/news/resources/Pages/medgroup.aspx> (accessed Aug. 26, 2013)

³³ Brent C. James, M.D., is chief quality officer at Intermountain Healthcare.

<http://www.worldcongress.com/speakerBio.cfm?speakerID=131> (accessed Aug. 26, 2013)

³⁴ A. Diane Moeller became director of quality assurance at Intermountain Healthcare in 1976. She later became CEO of Catholic Health Corporation. [Source: 4 are named to IHC board of trustees. *Deseret News*, July 13, 1995. <http://www.deseretnews.com/article/427853/4-ARE-NAMED-TO-IHC-BOARD-OF-TRUSTEES.html?pg=all> (accessed Aug. 25, 2013).]

quality, then next came what the physicians can do to standardize procedures that are the best practices. Dr. Brent James came to us unannounced and unexpected. He was a surgeon on the staff of the Harvard Medical School. He was enamored by the whole idea of quality improvement and was an advocate of the Deming methodology. Deming³⁵ was the man who advised the Japanese car industry on how to improve the quality of their cars, which had a significant impact on our economy because they were just so darn good at it.

He thought, *if you can do it with cars on an assembly line, why can't you do it on the hospital "assembly line" of a procedure, with the idea that at every segment of it, from admission to discharge, there ought to be a way to improve every piece of it? If you can get everybody who's involved at the same table and talk about "together we can really improve it," why don't we do that?* That was one of his mantras.

The other was: *there has got to be a best clinical way to do any procedure, if we just knew what it was, because there is such variation.* Surgeons do it the way they were taught in residency by their mentor. They are so loyal to their mentor that they wouldn't even think about doing it any other way. But in fact, there may be a better way if they just knew about it. Dr. James' idea was to bring groups of physicians in the same specialty together to discuss various procedures. He made those discussions informal with no pressure, commands or demands. He invited each physician to explain their approach to the procedure under discussion.

When Brent met with our management committee he said, "I can guarantee you that I can increase quality and lower cost."

I said, "Dr. James, that's a worthwhile goal. But I cannot see how that might be possible because I've seen in my whole career that an effort to improve quality always costs money. It is connected to a new piece of equipment, a new procedure, or a new specialist. All of that is added-on cost. I just can't see how you can improve quality and lower cost at the same time."

He said, "Yes, I can do it. Give me a chance."

We did. We were persuaded he could do it. He became the leader of our CQI effort. He came on board and handpicked the first clinical group he wanted to work with. He knew there was a lot of sharing of information among the urologists. He sat down with them said, "All I want you to do—there's no right or wrong here, there's no bad guys coming out of this, and it's all confidential—just tell everybody what you do and why you do it."

SYDNE PARKER: And how you do it.

SCOTT PARKER: And how you do it, thank you. For a series of meetings, they did that. In the beginning, they developed a chart of variation, and they saw how everybody did it. There was wide variation. Then after about six months, without any prodding, they measured it again. That curve tightened considerably. Most were in the center doing the procedure the best way because they'd all learned now from each other. Without having to admit they were doing anything wrong, they started to do everything right and came to that center point of quality improvement.

³⁵ W. Edwards Deming (1900-1993) was a scholar, teacher, author, and consultant whose ideas revolutionized quality improvement efforts in the U.S. and abroad, most notably in the Japanese auto industry. <https://www.deming.org/theman/overview> (accessed Aug. 26, 2013)

That study not only validated the concept, but it cemented it into Intermountain Healthcare's culture. Brent was so smart—he picked other groups, inch by inch, never forced, always cooperative, always letting the natural logical process take place when people have been educated. He understood they would be self-motivated to make the changes that needed to be made.

That's the story of Brent James and Intermountain Healthcare, now taken to the maximum as he's teaching others. He has seminars and schools, with an institute. He has trained thousands of physicians around the world on this simple approach that is magical. It just really, really works.

GARBER: It does sound simple.

SCOTT PARKER: Yes.

GARBER: At least the concept of how you effect a change. After you retired from Intermountain, you didn't exactly hang it all up and go play golf. I wonder if you would talk a little bit about your teaching experience.

SCOTT PARKER: I'd be glad to.

SYDNE PARKER: Could I just interject?

SCOTT PARKER: I was just going to invite you to say what I know you want to say.

SYDNE PARKER: He flunked retirement, in spades.

GARBER: And how did you do? Did you flunk retirement also?

SYDNE PARKER: I think wives and mothers and grandmothers just kind of go on. Die with your boots on.

GARBER: But that's interesting. Initially there was no particular plan. You were just going to relax.

SCOTT PARKER: See what happens. And then stuff happened. A lot of stuff happened.

SYDNE PARKER: He stayed on a number of boards, and then the U of U opportunity came along, and really, he's just about as busy as he's ever been.

SCOTT PARKER: The LDS Church has had a big impact on that. As I said earlier, they depend on volunteers. Sydne and I were asked to go to New York City for a three-year assignment. It turned out to be one year because I became ill on the job and had to go home and have a heart operation.

We were responsible for 200+ of these young missionaries you see on the streets in the white shirts and the black badges, to teach them and to try to motivate them, try to watch over them, try to counsel them on personal matters, try to maintain enthusiasm and compatibility. They're in a whole new world, literally, coming off farms in Idaho or the beaches of Southern California or from foreign countries. Wherever they came from, one of our tasks was to bring them

together in unity.

They have to learn how to be compatible in that kind of a setting, and be responsible for themselves, their work, and work hard. They get up early in the morning and work until late in the evening, constantly focused on their responsibility to teach what they think is valuable religious philosophy about life and eternity, also what brings happiness when you stay within the bounds of trying to be respectful of historic directions and commandments about how to live a worthwhile and moral life.

These teachings are sometimes received well and sometimes not so well. The young missionaries have to learn how to deal with adversity and disappointment. It's a huge growing up time for them, as it was for me as a young man. We had a lot of responsibility. Sydne was magnificent. I used to say that the missionaries got to know and love the Parkers. That is, they got to know President Parker, and they loved Sister Parker. (These are LDS ecclesiastical leadership titles.)

GARBER: Sydne, what did you do? What was your contribution during that year?

SCOTT PARKER: The one that took the most time was being in charge of their medical care. You know, sometimes we'd get calls at 2 a.m. – "Sister Parker, my companion's on the floor with a stomach ache! What do I do?" Or, "I've been sneezing for a few days. What do you think I should do?" I said, "Elder. Elder. Elder."

SCOTT PARKER: The title is "Elder" for them.

SYDNE PARKER: "Just weather it out. A couple more days, you'll be fine." That took the most time. You have to keep records of medical appointments and medications that they're given. I had a binder by the end of one year that was about that thick with these young boys. They've never been away from mama, and they don't quite know what to do when they get a cold. There was a lot of that. Then we had zone meetings where we both spoke. We had nine zones? Zones consisted of 10 – 16 missionaries working in the same geographic area.

SCOTT PARKER: We did. Nine zone meetings every six weeks.

SYDNE PARKER: Every six weeks, we needed to teach various topics to the missionaries, and I did that. The food was a big responsibility. Every time a new group of missionaries would come to the mission, anywhere from fourteen to twenty of them, I would fix dinner for them, and breakfast the next morning. When they left the mission at the close of their two year assignment, there was a dinner for them, and we had new groups coming in every six weeks.

SCOTT PARKER: You might talk about Missionary Medical and how that worked, your resources in Salt Lake.

SYDNE PARKER: When my personal diagnosis didn't work so well with the boys and girls, I would call church headquarters in Salt Lake City. There's a whole department in the Church—Missionary Medical—and there is always a doctor on call there. You would check with them on the more seriously ill.

SCOTT PARKER: The system works exceptionally well. As a sidebar, it will become

more sophisticated in time as handheld medicine becomes more possible. Anyway, Sydne became Mother Medical, and she did a great job. You were talking about retirement. That was a big part of it. We did that for a year. We came back early because I needed heart repair, and fortunately it turned out well. I'm regaining my strength.

Then I was asked by our Church to be the Church's local representative in the Greater Salt Lake area to all the other churches in what's called an Interfaith Roundtable. We meet monthly and it's kind of a little show-and-tell. Everybody gets to talk about what they're doing within their congregation, or what they're doing collectively in trying to improve the human condition. They've done a marvelous job.

We did that for eight and a half years. We loved every minute of it. I had a chance, and Sydne came along quite often, to worship with Roundtable members in their own worship services. We learned a great deal about other religions and philosophies. We found that there is a common core. These wonderful people were all trying to do the right thing for the right reasons, with a great deal of compassion for one another. It was a growing experience for us, and we loved every part of it. We just finished that assignment after eight and a half years.

SYDNE PARKER: We miss it. Friends of different faiths became great friends and colleagues. You knew you were all working together to better others and have them be closer to their Father in Heaven.

SCOTT PARKER: Bottom line in all of that is, we learned very quickly the difference between tolerating other religions and respecting other religions and individuals within those religions (there's a big difference between the two), and loving individuals of other religions, which happened by the natural process of just getting acquainted with them.

There are a lot of health care related startup companies in Utah being spawned by research at both Brigham Young University and University of Utah. There is a research park at the University where these companies are spawned as part of the Governor's strategy on economic development. It's worked very well. A lot of new companies have been started successfully here and have help grow and build the economy.

Many new companies are led by founders who do not have a lot of management experience. As a result they are vulnerable to making mistakes in their formative stages. The word got around that I was available, that I had some experience in health care management, and that I knew a little about medicine. I was invited to serve on a startup company board, and I enjoyed it. The CEO liked my participation because I became a safe harbor for him to talk to about his management challenges. I could share my experiences with him. We became friends and colleagues, and I thus became a mentor.

This word got around among startup company board members, and as a result other board assignments became available. It's been a great new experience for me working with those small companies and mentoring the CEOs. I have learned a lot about technology.

Unexpectedly, the University of Utah came along with their desire to establish a program in health care administration. I was serving on the University board at the time. I wasn't enamored with the idea, frankly, because I was concerned about the program being able to compete

successfully with established programs in other states. Because of my concern I abstained on the vote.

They were going to vote on it again at the next meeting. The president wanted total support. He requested that I meet with the associate dean of the medical school, the dean of the business school—where the program was located, and the program director. We spent a couple of hours. They were persuasive in making their point that there were potential health care leaders in our community who were not going away to school; therefore, they were being deprived of their careers and the industry was being deprived of their talents. They said we should give these students equal opportunity and train them at home.

That was a persuasive argument because health care has changed and broadened so much. The programs have evolved from hospital administration to *health care* administration. I was willing not only to be supportive but also participate as an adjunct professor in the new program. I'm delighted to be engaged with some gifted students and have an opportunity to teach and mentor.

GARBER: I realize that we skipped over your time serving as the board chair of the American Hospital Association. This would have been in the mid '80s?

SCOTT PARKER: 1986. That was a fabulous experience but not without its stress and sense of stewardship responsibility. I had strong support from Alex McMahon³⁶ and Gail Warden,³⁷ who were the senior leaders at the time. Support and help also came from other board members who preceded me as board chairs, particularly Sister Irene Kraus,³⁸ who was the CEO of Daughters of Charity in St. Louis at the time. She was the first person to suggest the possibility of my serving as chair.

I was reluctant. I had no thoughts whatsoever about seeking the position. However Sister Irene convinced me that I could add some value if I'd be willing. She took me under her wing and prepared me for that assignment, and was a very strong advocate of it happening. I was able to lean on her. Stan Nelson, my mentor, who had served as chairman himself, was also helpful.



Serving as the Chairman of the Board of Trustees of the American Hospital Association in 1986

³⁶ J. Alexander McMahon (1921-2008) was president of the American Hospital Association from 1972 to 1986. His oral history, Weeks, L.E., editor. *John Alexander McMahon in First Person: An Oral History*. Chicago: American Hospital Association and Hospital Research and Educational Trust, 1987, is in the collection of the American Hospital Association Resource Center.

³⁷ Gail L. Warden was executive vice president at the American Hospital Association and later became president and CEO of Group Health Cooperative of Puget Sound and then President and CEO of Henry Ford Health System. His oral history, Garber, K.M., editor. *Gail L. Warden in First Person: An Oral History*. Chicago: American Hospital Association and Health Research and Educational Trust, 2010, can be found here: www.aha.org/chhah.

³⁸ Sister Irene Kraus (1924-1998), Daughters of Charity, served as the AHA chairman of the board in 1980, at which time she was president of Providence Hospital (Washington, DC). Her oral history, Weeks, L.E., editor. *Sister Irene Kraus in First Person: An Oral History*. Chicago, IL: American Hospital Association and Hospital Research and Educational Trust, 1988, is in the collection of the American Hospital Association Resource Center.

SYDNE PARKER: I had all the fun.

SCOTT PARKER: You were great.

SYDNE PARKER: That was a fun time for me.

SCOTT PARKER: It took a lot of time. My board was supportive of giving me a recess, if you will, for a year to do all the travel and visit nearly every state, followed by my becoming a member of the board of the International Hospital Federation, representing the American Hospital Association. The international group is an association of individual national or country hospital associations. There were about 30+ national members. Sydne and I were invited to visit many different countries and meet a lot of outstanding leaders.

Much to my surprise and pleasure I was eventually asked to chair the IHF Board, and that really intensified the travel. We visited over 30 countries and spoke at the Korean, German and Australian Hospital Association annual meetings. We visited hospitals in all those countries, met the government health care leaders, and learned about how other people do it differently than we do it, but do it very well.

I also learned that America does not have a corner on all the best ideas related to health care management and financing. I became respectful of what others do and why they do it. We can learn much from them, particularly the countries that make health care available to all.

GARBER: As we wrap up, I wonder if you'd like to take the opportunity, Scott, of speaking a little more about your wife, Sydne.

SCOTT PARKER: I would be so pleased to recognize her essential role in my professional career. You have gained a sense over the past three hours of what kind of a person she is, but more importantly, what kind of spirit she has. She is without guile. Her total focus is to make life as right as she can for her husband and children and to represent the values that she believes in. She is the example within the family for that, to guide us, and keep us safe from any kind of harm. When we stumble, she binds our wounds and builds us up. She is a safe harbor for all of us, including our grandchildren and great grandchildren, who can't wait to come here, to be in her presence, and to feel her strength.

In professional matters, I'm convinced, and sincerely so, that for several of the key jobs that came to us over the years—particularly Intermountain Healthcare—much of the credit can go to this woman, because she was so well received by those boards. They saw the kind of strength she was for me. They realized that this was going to be a partnership, and that she was going to be front-and-center in almost all of the activities that were social. As a representative of Intermountain Healthcare she did extremely well. From the beginning our board saw that I had an asset that perhaps others didn't have. They knew Sydne would keep things stable at home.

We're sitting here in our home, which we love. We've been in it since just about the time I retired. I was very busy during those



Sydne Lemon Parker

last years. She planned this house. She met with the architects and contractors. She did all the detail work. I floated through that and kept my focus on my profession.

We've been able to maintain a balance in our marriage. We decided that from the beginning—never to let profession, or outside interests, or anybody else, including children, divide us. We would be totally supportive of each other, back-to-back. Our children learned that if you were dealing with one, you were also dealing with the other. I think that helped our family, our children, and us.

She has made “family first” a priority. She was always here. I was here as much as I could be. David O. McKay,³⁹ who was leader of our Church when we were in our formative married years, said, “No other success can compensate for failure in the home.” That has been our mantra. That has been our goal. Obviously, we haven't been 100 percent successful, but a lot more successful than we would have been without that imprimatur which we believe in, and now see our children trying to implement in their own families.

It also made it possible for me to feel like I was involved through my work with something that Sydne believes in strongly that is the opportunity to improve the human condition. That's why we had a mission services division of Intermountain Healthcare, where we funded enough money so that we had the ability to go out and assist other not-for-profit organizations involved with helping the disadvantaged.

One of our friends was the head of a major corporation, the largest banking company in the Intermountain region, and I was on his board for many years. He said to a graduating class at Brigham Young University, where his son was receiving an MBA, that, “If you're not careful, the corporation will suck the very soul out of you—and when it does, it will always attack the family first.” That's been strongly on my mind over the years. I never let that happen.

We tried hard, as a team, to keep this home a safe harbor where important principles of life can be taught—honesty, integrity, and so forth—and where our children could come safely to share their burdens without any recrimination. Where we could be objective, loving and supportive, no matter what course they took, whether it's a course we found comfortable or a different kind of course. That didn't matter as much as the fact that they were our children and we loved them unconditionally. We worked hard on that—which was sometimes a challenge. But overall, we've seen them grow and mature and now lead their own families. That gives us great satisfaction and would not have happened without this lady by my side.

SYDNE PARKER: You're so kind. I have always been a Mama Bear with my cubs.

SCOTT PARKER: Or your husband.

SYDNE PARKER: Or my husband, that's true.

GARBER: Thank you for your comments. Was there anything else you wish to add?

³⁹ David O. McKay (1873-1970) began his 19-year service as the 9th president of The Church of Jesus Christ of Latter-Day Saints in 1951. [Source: The Church of Jesus Christ of Latter Day Saints. (<http://www.lds.org/churchhistory/presidents/controllers/potcController.jsp?topic=facts&leader=9>) (accessed Aug. 30, 2013).]

SCOTT PARKER: There's one more story I'd like to share. It was one of those crossroads kind of experiences. I explained the transition and the decision by the LDS Church to divest their hospitals, which was not an easy one to make, and not without debate at the highest levels of the Church.

The strongest advocate for divestiture was the Presiding Bishop. His name was Victor Brown.⁴⁰ Previous to this full-time church calling he was a senior airline executive. He understood business very well. Now he was in full-time service and part of his responsibilities included fifteen hospitals. His recommendation to the President of the Church was accepted and the divestiture took place.

As the newly-appointed CEO of the independent system, Bishop Brown was most gracious to me. He offered me a temporary office at church headquarters on the same floor where he was located. He was available for any questions I had about the system and I had many.

About a month before my official start on the job, I spent a week in Salt Lake City interviewing board chairs, administrators and medical staff chiefs of the 15 hospitals. During that week of interviews the leaders of every hospital explained their urgent priorities and matters that required immediate attention. The Church had placed a moratorium on capital expenditures while they were making the divestiture. All of the hospitals were in need of significant capital improvement. The majority of them needed to be expanded and several of them needed to be replaced. There were many problems that hadn't been addressed. You can imagine! Each of those hospitals came to me with problems that needed—from their point of view—immediate attention.

SYDNE PARKER: Just dumped them all on his desk.

SCOTT PARKER: By the end of that week, that stack of problems was overwhelming. I looked at the situation and said to myself, *Wait, what am I doing here?! This is an impossible situation. I've just turned 40. I mean, I've got some experience, but I'm not a senior veteran here.* I was thinking back to Newport Beach --- a very compatible, comfortable situation and a place where I could probably spend the rest of my career. I thought again, *What am I doing?* I was overwhelmed by it. I was scheduled to leave in about an hour to catch a plane, and I had my head down on my desk feeling the weight of heavy responsibility pushing me down and not knowing how I was going to accomplish the task. I was not inheriting a strong management team. I felt very alone with what seemed like an impossible task.

Just then, this large man came in my door. He had seen me with my head down as he just happened to be walking by my office. It was Bishop Brown. He was so perceptive; he figured out immediately what was going on with me. He approached my desk. I looked up, and he said, "Sit down." (He knew I would stand out of respect for his position.) He said, "Scott, I just want to tell you two things. First, I would give anything to be your age. And second, I would give anything if I could have your job."

SYDNE PARKER: Changed the perspective rapidly, didn't it?

⁴⁰ Victor L. Brown (1914-1996) served for 13 years as the 10th presiding bishop of The Church of Jesus Christ of Latter-Day Saints. [Source: Elder Victor L. Brown dies at age 81. *Deseret News*, Mar. 26, 1996. <http://www.deseretnews.com/article/479793/ELDER-VICTOR-L-BROWN-DIES-AT-AGE-81.html?pg=all> (accessed Aug. 30, 2013).]

SCOTT PARKER: The lights went on! I thought, “What is management for if not to solve problems?” I had been trained and mentored on how to do it. I had some experience in tough decision making. Now I had the opportunity to apply to my knowledge and experience at a level much higher and much more daunting than ever. I thanked Bishop Brown for the perspective he had given me. His words had energized me and reminded me again of this great assignment that had been given to me to create a model health care system.

I’ll close with this statement from an anonymous author: “We’ve all been warmed by fires we didn’t build.” Victor Brown was one of those fire builders for me. I was warmed by his courage to pursue this idea of divestiture. I was warmed by his encouragement and by his mentoring. It validated something I’d always believed in—go out and build a lot of fires.

GARBER: Thank you very much. Thank you both.



The Parker family

APPENDIX
PROVENA HEALTH SYSTEM
CONVOCAATION
A LETTER TO MY SON TOM
April 26, 2001

By Scott S. Parker

I come to this microphone this morning mindful of the great trust that has been placed in me by your program committee. I am sincerely honored to have been asked to participate in this conference and I am grateful for the warm welcome I have received today.

I have been asked to address the theme of professional morals and ethics and I will use, as the format, a personal letter that I wrote to my 38-year-old son, Tom. Tom is married to a wonderful young woman and they are the parents of four children. They live in Gresham, Oregon. Tom is a hospital administrator at Mt. Hood Hospital, which is part of the Legacy System in Oregon and, with Tom's permission; I will share the letter with you.

A year ago last November, Tom brought his family to Salt Lake City. He, along with our three other children, participated in my Intermountain Healthcare retirement dinner. Their words were most touching and it was a memorable evening for me.

Later, at home as the evening quieted, Tom and I sat at our kitchen table, and we enjoyed wonderful conversation about the work we have shared in common. At the end of our chat, it was so thoughtful of Tom to suggest that it would be helpful to him if I could just put some of my experiences and observations about health care leadership in writing and I agreed to do so.

At about that same time, I received an invitation from the American Hospital Association to give the annual lecture honoring Roger Larson at the AHA's annual meeting. Roger Larson was a respected hospital CEO as well as an outstanding human being. When he died prematurely in the 1980's, his friends contributed funds in order to create an endowment for an annual lecture that was established to remember Roger's contribution to the field of health care, his example of successful leadership and his warm-heartedness to his hundreds of friends in the field.

Roger had been a dear friend of mine and he and I frequently discussed common lessons learned along the way in our careers. We both did our graduate training in Minneapolis and we both served our administrative residency years at the Northwestern Hospital. I felt most fortunate to be numbered among his friends and also honored to give the 1999 lecture in his name.

As I thought about what I felt I should share with my son that might be of value to him and, at the same time, thought about what theme Roger Larson might have wished me to address, I concluded that what might be of interest to Tom could also have some broader interest to others in health care leadership as well.

As a result, the letter became my theme for the Larson Lecture as it is for this presentation this morning.

To make this work, I am going to ask the permission of those of you who are in the age range of say, 30 to 45 or younger (the age of my own children), to please let me “adopt” you as my sons and daughters for a half hour as I address you like I addressed Tom. For those few of you who are in an older age bracket, I hope that you will be willing to track along with me and nod a little, if you are in agreement, or just bear with me if your thoughts do not exactly reflect my own.

I am hopeful, however, that there might be at least a concept or two or some observation addressed today that might find broad interest to most of you who are here. That is my goal.

In my comments, I will reference some thoughts written by my friend, from our growing up days, Dr. Stephen R. Covey, who has written and lectured extensively on the subject of leadership. I will also mention some principles taught by a tough-minded professor and program director at the University of Minnesota, Jim Hamilton, and there will be a few other references that I will note along the way as well and because the letter touches some tender chords, please forgive me if I find it necessary to take a quick emotional “time out” along the way.

And so – to the letter:

Dear Tom,

Thank you for inviting me to share some thoughts with you regarding leadership in the profession we share. You have honored me by your request.

I would like to begin with a principle taught to me by my preceptor, mentor and first boss, Stan Nelson. It is an overarching concept that condenses all other wisdom on successful health care leadership into one sentence. I still remember the setting and the situation that triggered his comment.

I had been on the job at Northwestern Hospital in Minneapolis as the new assistant administrator in the early 1960s for about a month when I heard a rumor that Stan was going to leave that day on vacation. He had not told me he was going on vacation and I said to myself, “Who’s going to run this place while he’s gone?” And then I realized it was going to be me – fresh out of school with approximately 30 days of hospital administration experience. I was frightened and numbed at the prospect. I had just assumed that Stan would call me to his office and give me a full briefing with detailed instructions before his departure, so I stayed close to my office, next to my phone all morning waiting for the call that never came. Late in the afternoon, I just happened to look out my office window and I saw Stan leaving the hospital with his pipe in his mouth and his Wall Street Journal under his arm, the signals that I had learned meant, “I’m leaving for the day.” I could not contain myself. I was desperate. I jumped out of my chair and I raced out into the parking lot and met him just as he got into his car. I said, “Rumor has it that you’re leaving on vacation.” And he said, “Yup. I’m going to be gone for about a week.” I was stunned because there obviously was not going to be a briefing session and all I could think of to say was, “Well, Stan, do you have any instructions before you go?” He said with a wry smile, “Yes, just don’t do anything dumb.” Then he got into his car and drove away.

When Stan Nelson said, “Just don’t do anything dumb”, it was his shorthand for, “Just use common sense and you and our hospital will be OK while I am away.”

That response that was so casual and seemed so terse at the time, did, in fact, bore right down to the core of what I have come to know rests at the foundation of every other leadership principle. Simply stated – we must lead with common sense and wisdom.

There is more to the story. When Stan got back from his vacation, we talked some more and he said, “You’re going to make some mistakes. You’re young, you don’t know a lot yet, but that’s OK. Never duck a decision out of fear that you are going to make a mistake, but if you’re going to work with me, over the long run, you should never make the same mistake twice.” This then, Tom, is the first thought I would like to share. When we are given that kind of trust, like Stan gave me, we deserve a little patience when we’re new at it and, later, we should give our young associates that same kind of slack when they are new at it. But we should encourage them not to take advantage of that good will and, therefore, never make the same mistake twice.

Webster states that common sense is the application of practical judgment. The dictionary states that wisdom is the application of good judgment. Both are essential attributes for effective leadership.

The pursuit of wisdom should be a never-ending goal. The pursuit of collegial relationships with persons known for their gifts of common sense and wisdom should be a never-ending quest.

Stan Nelson provided that kind of exposure and example to me in the beginning of my career and it has been enhanced by interaction with other collegial friends ever since. Stan told me that I would not learn much that was really fresh or new, sitting behind my desk. He argued for the importance of getting up and getting out and seeing other organizations and other leaders in action in order to be able to tap into a continuing source of new ideas.

I personally recommend this pattern. Friendships should also be nurtured with some few very close professional friends, men and women of high moral and ethical values, who will give you honest feedback when you seek their counsel. That kind of honest feedback is what Steve Covey labels “the breakfast of champions.” That kind of breakfast might prove to be a little distasteful at the time, but it can be very nourishing over the long run.

As Steve Covey has travel extensively in his consulting work, he has been inside many organizations and inside the heads, if you will, of literally thousands of leaders. This is his observation about successful leaders and I quote: “Successful leaders will have vision. They will know where they want to go. They will have a passion to get there. And they will have the discipline to make the sacrifices necessary to get there.”

Vision, direction, passion about the vision and the discipline to make the sacrifices necessary to get there. According to Steve Covey, these are identified as the core characteristics of a successful leader and a successful organization. I agree.

In one sense, this seems to be elemental and yet, on the other hand, Steve has mentioned to me that he has rarely found an organization that has all of these elements working well together. I have discovered the same thing as an employee or trustee of several different health care delivery organizations, health related associations and, in recent years, as a director of several publicly-held corporations as well as some start-up companies. The basic Covey-defined principles that appear to make so much common sense, are, in fact, not all that commonly or comprehensively applied.

I have some thoughts about the reason why. First, vision can be easily blurred by trends and sudden environmental shifts. Our friend, Boone Powell who is president of the Baylor System in Dallas, has called this “health care vision and strategy du jour inspired by last week’s Modern Healthcare Magazine’s cover story.”

Vision should not be altered by short-term trends, or fads, but rather, it should be rooted in the very core values of the organization and it should be able to withstand the sudden storms of change that will occasionally try to prevail.

Tom, what is your vision for your organization? What is it that you want your organization to become in order to fulfill its highest potential, and what is the mission of your parent organizations? Are the two aligned? Do real mission statements exist, and if so, are they real and are they right?

I would also like to strongly recommend a process that has the potential to bring your vision and mission into powerful application.

First, make certain that your mission statement clearly describes who it is to be served by your organization, where those services will be delivered and what level of quality of services will be rendered. Some very fine health care organizations have floundered or even self-destructed because they were unwilling to tightly focus their efforts to a logical geography and/or to a practical scope of service.

On the question of who will be served and where they will be served, you will be faced with challenging questions of ethics and principles. It is possible, if not probable, that you will find strongly stated opposing positions within your board and within your management staff on these questions:

- Will all who come to you for care be given care – regardless of their ability to pay?
- Will they have to always come to you, or will you take the initiative to also go to them?

This tug of war between the need for strong margin versus the core charitable mission of your organization will always be with you.

Your responsibility will be to find the balance that will sustain your personal values and sense of stewardship responsibility, and then create clarity, unity and support from your board and staff around that essential decision and commitment.

After establishing a clear definition of mission, next create a clear statement of understanding regarding the social, economic, political and competitive environment surrounding your organization. Understanding the environment will have a significant impact on your strategy in pursuing your organization’s mission. Again, wisdom and common sense argue for such data, but in my observations, such data is not all that successfully pursued or utilized by many health care leaders.

The next step in this process is to carefully prepare a strategic plan for the successful pursuit of the mission, accompanied by measurable, long- and short-term goals that will calibrate and measure the organization's progress and also serve as a tool to evaluate its leadership performance. This will help minimize the subjectivity and politics that can serve to undermine objective performance evaluations.

When the organization has this whole process from core values and vision all the way through to short-term measurable goals clearly defined and implemented, there will be a measurable sense of confidence, solidarity, purpose and unity that will permeate the organization and it will also define the positive reputation of the organization's leader. Tom, I strongly recommend this process to you. It will require the Covey-defined leadership traits of vision, direction, passion, discipline and sacrifice. It will also require a clear commitment to your own high personal standards, values and ethics.

Before I make further comments on the principles of passion, discipline and sacrifice, I would like to mention a simple definition of organization that was taught to our graduate class by Professor Jim Hamilton. His definition was divided into four simple steps as follows:

1. Take the job to be done.
2. Divide the job into specific tasks.
3. Assign the tasks to capable individuals, and
4. Follow up.

I have found this simple formula as valuable as any organizational technique I have ever utilized. It has worked well in activities ranging from the simple organization of a church picnic to putting together the complex challenge of organizing an integrated health care system.

On the subject of assigning tasks and, therefore, selecting capable individuals, please remember the wise counsel that I received from my first IHC board chairman, Bill Jones, when he suggested that I should ask myself the following three important questions before making a final selection decision:

1. Is the candidate capable?
2. Is the candidate honest?
3. Is the candidate compatible?

This simple formula works and it helped attract some nationally-known and respected individuals to our IHC organization such as David Jeppson, Diane Moeller, Dr. Brent James, Bill Nelson and many others who have added immense strength to IHC.

Now, Tom, I would like to move on to the next Covey-defined essential leadership characteristic and that is having a sense of "passion." The successful leader must have a passion for the vision and values of the organization. The leader's passion, or lack thereof, will be felt and it will provide a clear signal (one way or another) to those who have been asked to join in the battle. The ancient wisdom of the scriptures describes this need for clear, passionate commitment and clarity of purpose by asking the following question, "For if the trumpet give an uncertain sound, who shall prepare himself for battle?"

You cannot lead with passion if your own passion is lacking or worn dangerously thin.

If, in your assignment, you do not feel aligned and inspired by the mission of your organization or the morals and values of its leadership, please do not linger on in passionless job security. Do not permit yourself to accept that kind of reduced self respect. Even if it is painful to make a change, make it, when necessary, in order to gain the peace of mind that can only come from a full alignment of your values with the values of the organization you are asked to lead.

Further, on the subject of passion. I would encourage you to feel a passionate discontent about a compelling social issue that you feel must be addressed and resolved and then take every appropriate opportunity you can to address it, and help to resolve it.

You know, Tom, that for your dad the issue has been our country's unwillingness to provide access to health care insurance coverage to all U.S. citizens. Ours is the only strong, developed nation left in the world unwilling to do so. Perhaps you remember my telling you of my Canadian experience in 1986 when I served as the elected chairman of the American Hospital Association. I was assigned to represent our association at the annual meeting of the Canadian Hospital Association held in Edmonton. During their banquet, I was placed at a table between the elected chairs of the Canadian Hospital Association and the Canadian Medical Association. In the course of our dinner conversation, the subject naturally turned to a comparison of our health care systems. The physician focused his full attention on me and asked this exact question, "As chairman of your national hospital association and as a citizen of the United States of America, how can you sleep at night knowing that 15million (now 42 million) of your fellow citizens have no guaranteed access to health care, and you do?"

Rather than responding with some comments about some weaknesses in the Canadian health care system, I decided to simply address his question with the expected explanations, noting that there are generous voluntary programs for charity care in the United States and that, in fact, many of the uninsured do receive care through such benevolence. But he knew, and I knew, that there were then 15 and there are now over 42 million Americans who simply do not know how to enter the health care system to receive the charity care that is available, and if they do make it to the E.R., the care is often late in the disease process and wastefully expensive for the ultimate payers.

When my thoughts turn to this subject, I still feel a passionate discontent, and so here I am today expressing my concerns.

Tom, you have a great deal of strength and ability within yourself to work hard to resolve a social issue that troubles you. Take a stand, be an advocate and work to correct the problem.

The last two essential characteristics of leadership mentioned by Steve Covey are discipline and sacrifice. Both are clearly needed in the pursuit of a successful health care career. Our work is not casual or frivolous. Our work is serious and it is essential that we do it well. It is, by definition, compelling and demanding and, therefore, it does require discipline and sacrifice. But there must be defined limits.

Our friend, Spencer Eccles, the chairman of the First Security Bank Corporation, recently gave this caution to a graduating M.B.A. class, born out of his long career of being pulled between the crises of the day at his corporation and the basic needs of his family at home. He said, "If it

goes unchecked, your profession will suck the very life from you, and remember, it always robs the family first.”

Spence also reminded the group that Pope John Paul II made the following observation about the need for balance. He said, “The first and fundamental structure for human ecology is the family, in which we receive our first ideas about truth and goodness and learn what it means to love and be loved, and thus, what it means to be a person.”

And to further make the point, the late president of the Mormon Church, David O. McKay said, “No other success can compensate for failure in the home.” These three wise observations identify the need to maintain balance so that things of higher importance are never sacrificed at the altar of things that are of less importance.

Not long ago, I attended the semi-annual meeting of the Senior National Advisory Board of the University of Utah.

The newly-appointed dean of the school of business was asked to make his first presentation to this influential board in the newly-constructed school of business seminar building. At the beginning of the meeting, the new dean announced that he had delegated his important assignment to one of his most capable faculty colleagues because he had decided that he had a more pressing responsibility during that same hour. He explained that he was going to attend a high school play in which his son had an important role. There was a long, awkward silence following his announcement.

But then the response from that veteran group of CEO’s and professionals, most of them grandparents, was a warm and sustained round of applause, indicating that they were strongly in support of the dean’s decision and in full agreement that the dean had his priorities in order.

At the core of the dean’s own ethical and moral foundation was his understanding that his family would always come first. He not only believed it, he practiced it. Tom, I would hope that you, too, will not only believe it but also practice it.

Now, Tom, with these basic principles of leadership and ethics in place, I must admit to you that their positive application will never permanently immunize you from problems or disappointments. Harsh storms reach every sunny beach in time and those times can be filled with pain, disappointment and discouragement. You have observed your dad go through some of the most difficult periods. They can also drain away self confidence, health and overall happiness. Internal pressures build because you know that your colleagues are looking to you for strength and confidence when, in fact, you could use a little transfusion yourself.

When this happens, the first thing I would recommend is that you quickly separate yourself from the “gloom and doomers.” They can easily pull you down in their own overstated pessimism. Don’t let them.

Next, turn to those you love and respect for reassurance, confirmation and perspective. That core group of collegial professional friends that I have previously referred to will come to your assistance with strength and needed perspective if you will let them. And in time, they may ask the same from you. On occasion, we all need strongly rooted trees to turn to for shelter.

During these difficult times, there will usually be a small group of people eager to place blame and to criticize. They are usually very vocal and they seek out opportunities to voice their criticism widely – often through the media. The resulting public news reports can sting and wound. This is not a new phenomenon. Shakespeare put these words into the mouth of Romeo who said of Mercutio, “He jests at scars that never felt the wound.”

During one of these difficult periods for me, several years ago, a friend sensing my need, sent me these words of wisdom given several centuries ago by Thomas a Kempis, “Thou are none holier if thou are praised, Nor the viler if thou art reproached. Thou are what thou art.”

Fortunately, after the storms pass, the sun always comes out again and we find ourselves back making decisions, organizing work and pressing on with our strategy to reach our goals. And then some opportunity comes along for the organization or for ourselves that is most compelling because it is perceived to have the potential to further the work of the organization or to further our own personal agenda. The only problem is that we are a little uncertain as to whether the opportunity really meets our own defined standard of acceptability on our personal scale of morals and ethics. When you face one of these uncertainties yourself, will this decision stand up under the scrutiny of a tough investigative reporter with a powerful magnifying glass? An even more compelling moral and ethical safety test is this -- Will this decision meet the “Mom Test”? We both know what that means because of the great moms we both have, women who have high values. If you really think the decision will pass the “Mom Values Test” then go for it, because you will always be on safe ground.

Well, Tom, the hour is getting late and it is time for me to close and so I will briefly mention just a few concluding observations about leadership and professional ethics with a condensed sentence or two for each. I hope that some of these ten distilled thoughts, gained through your dad’s experience, might prove to be of some value to you.

1. Always remain teachable. An unfettered ego or sense of infallibility is a passport to self destruction.
2. Never assume that intelligent people will always respond rationally. Try to cut them some slack and remember the virtue of patience and long suffering. The Golden Rule has full application in the field of health care leadership.
3. Helen Keller said, “No pessimist ever discovered the secrets of the stars or sailed an uncharted sea.” Stay optimistic and encouraged so that you will maintain the desire to sail and soar.
4. Remember the power of the pen. It is a wonderful tool for good in your hands if you will use it regularly to write brief, personal notes of appreciation to those who are working so hard to strengthen your organization. The e-mail message is fast and efficient, but it will never replace the warmth of a hand-written note.
5. Stay in good physical condition and stay away from anything that is potentially addictive. Your organization and your family need you over the long run and as a health care leader and as a father, it is important for you to try to set a personal example. Honor the body that was given to you through the providential miracle of creation.

6. Give of yourself to your religion and to other community organizations that are concerned about those who someone identified as being members of the “5-H Club”. They are the homeless, the hungry, the hopeless, the helpless and the hugless.

7. Another thought about the pen and the occasional urge to write an angry letter. I would recommend the following steps when that happens: Draft the letter carefully and say everything that you feel needs to be said to put someone in their place or to set the record straight. Next, put the letter on your desk at the end of the day for editing the next morning. When you get to the office the next morning, review the letter again with care and get it just the way you want it and then take it in your hands, squeeze it hard, squash it into a ball and then “shoot” it into the waste basket. Then, give yourself two points, not only for a slam dunk, but also for having exercised great wisdom and common sense. Later, if necessary, address your concerns personally with the person who has upset you. You will almost always learn something new and important in the exchange and it is highly probable that your anger will be tempered by some increased perspective. By the way, e-mail is an even more dangerous weapon and it can be a self destructive tool in the hands of someone who is inclined to quick emotional responses. Be very careful with this new technology.

8. Find humor in your own frailties. This will send a message of hope to those who model themselves after you – and they do. They will take comfort in knowing that success does not require absolute perfection.

9. No one person can master all of the leadership skills required to successfully manage today’s health care organization. Enjoy the satisfaction that comes from building a great team of leaders rather than personally trying to be the only “All American.”

10. And finally, never forget the sacrifice, effort and pain that went into the creation of the organization you are now a part of. We have all been warmed by the fires that we did not build and we have all quenched our thirst from wells we did not dig. Look for opportunities to make things better for those who will follow. And, always look for opportunities to make things better at home.

I ran across a Beatitude years ago, written by a thoughtful anonymous author. I had the quote framed and it is placed near my work area. The Beatitude has served as a constant reminder over the years of the importance of my responsibilities as a leader and as a father. It states:

“Blessed is the man. . . .
In whom a clean conscience rests.
In whom a faithful woman trusts.
Who finds fulfillment in his work.
Through whom his children see God.
In whom good friends comfortably confide.”

And now, Tom, in closing I would like to add to the Beatitude one additional phrase:

“Blessed is the man
Who has a son who seeks his counsel.”

Love, Dad

And, now, to all of you, may I also add –

“Blessed is the man. . . .
Who has been invited to be with
A group of men and women
Dedicated to high personal values
And who are fully engaged in noble work.”

I am grateful that you have permitted me to do so. Thank you for the opportunity.



Sydne and Scott Parker, 2013

CHRONOLOGY

- 1935 Born March 3, Salt Lake City, UT
- 1955 Married October 28 to Sydne Lemon of Salt Lake City
Children: Jennifer, Thomas, Michael, Sara
- 1956-1957 Missionary service (Atlanta, GA)
- 1960 University of Utah (Salt Lake City)
Bachelor's degree, Business Administration
- 1962 University of Minnesota (Minneapolis)
Master's degree, Health Services Administration
- 1961-1967 Northwestern Hospital (Minneapolis)
1961-1962 Administrative Resident
1962-1967 Assistant Administrator
- 1967-1971 Southside Hospital (Mesa, AZ)
Administrator
- 1971-1973 Samaritan Health Services (Phoenix)
Vice President
Administrator of Good Samaritan Hospital (Phoenix)
- 1973-1975 Hoag Memorial Hospital Presbyterian (Newport Beach, CA)
Administrator
- 1975-present Intermountain Healthcare (Salt Lake City)
1975-1998 President
1998-present President Emeritus
- Currently University of Utah, David Eccles School of Business (Salt Lake City)
Adjunct Professor

MEMBERSHIPS AND AFFILIATIONS

1-800-Doctors
Consultant

American College of Healthcare Executives
Life fellow

American Hospital Association
Chair, Board of Trustees
Chair, Steering Committee for Health Care '94

Amerinet
Consultant

Arizona Hospital Association
President

Ascension Health
Member, Board of Trustees

Associated Hospital Systems
Founding Chairman

BLOXR
Member, Board of Directors

BMW Bank of North America
Member, Board of Directors

Bonneville International Corp.
Member, Board of Directors
Member, Executive Committee

Career Step
Member, Board of Directors

Carefx Corporation
Member, Board of Directors

Church of Jesus Christ of Latter-day Saints
Ambassador
Chair, L.D.S. Public Affairs Council for the Salt Lake City Area
President, Bountiful Central Stake
President, New York, NY North Mission

Comprehensive Health Planning Council of Maricopa County
Trustee

Decipher Genx, Inc.
Member, Board of Directors

First Consulting Group
Member, Board of Directors

First Security Corporation
Member, Board of Directors
Member, Executive Committee

Governor's Mansion Foundation
Vice Chairman

Honorary Canadian Counsel for Utah

Hospital Research and Development Institute
Chairman

Huntsman Cancer Center Foundation
Member, Board of Trustees

Independent Witness, Inc.
Member, Board of Directors

Intelistaf Corporation
Member, Board of Directors

Interfaith Roundtable
Member

Intermountain Healthcare
Member, Board of Trustees

International Hospital Federation
President

Inthinc Corporation
Member, Board of Directors

Invectus Corporation
Member, Board of Directors

Jesse N. Smith Heritage Foundation
Board of Trustees

Judicial Performance Evaluation Committee
Member

King's Fund College
International Fellow

KUED Radio
Member, Board of Trustees

MediConnect
Member, Board of Directors

MMI Insurance Corporation
Member, Board of Directors

National Academy of Sciences, Institute of Medicine
Member

National Committee for Quality Health Care
Trustee

Phoenix Regional Hospital Council
Member, Executive Committee

Questar Corporation
Member, Board of Directors

Salt Lake City Chamber of Commerce
Trustee

Sera Prognostics
Consultant

Sutter Health Care System
Member, Board of Directors

University of Utah
Member, Board of Trustees
Member, David Eccles School of Business National Advisory Board
Member, National Advisory Council

Utah Economic Development Corporation
Member, Board of Trustees

Utah Foundation Board
Member, Board of Trustees

Utah National Guard Honorary Colonels Corps
Member

Utah Symphony
Chairman, Board of Trustees
Lifetime Director

Violin Memory, Inc.
Member, Advisory Board

Westminster College Capital Campaign
Member, Executive Committee

SELECTED PUBLICATIONS

Falick, J., and Parker, S.S. Coordination of merged facilities. *Hospitals, J.A.H.A.*;45(3):89-92, Feb. 1, 1971.

Parker, S.S., and Wardell, K.S. Multihospital systems form a cooperative for sharing services. *Hospitals*;54(12):79-80, 82, 84, June 16, 1980.

Parker, S.S. The underinsured: how much do we care? *Hospitals*;60(7):108, Apr. 5, 1986.

AWARDS AND HONORS

- 1969 Outstanding Young Man of the Year Award, Mesa (AZ) Jaycees
- 1990 National Healthcare Award, B'nai B'rith International
- 1995 Distinguished Alumni Award, University of Utah
- 1995 Distinguished Service Award, American Hospital Association
- 1995 Gift of Life Award, Utah Chapter, National Kidney Foundation
- 1996 Gold Medal Award, American College of Healthcare Executives
- 1996 Significant Sig Award, Sigma Chi National Fraternity
- 1998 Catholic Community Services Award
- 1998 Distinguished Alumni Award, University of Utah's David Eccles School of Business
- 1999 Giant in Our City Award, Salt Lake City Chamber of Commerce
- 1999 Scott S. Parker Administrative Offices [building named], Intermountain Healthcare
- 2002 Gold Caduceus Award, AMICUS, Intermountain Research & Medical Foundation
- 2004 Utah Business Hall of Fame
- 2005 Healthcare Hall of Fame, *Modern Healthcare*
- 2006 One of 30 most influential individuals in health care, *Modern Healthcare*
- 2008 Annual Recognition Award, Salt Lake Interfaith Roundtable
- 2009 Continuum of Caring Award, CHRISTUS St. Joseph Villa (Salt Lake City, UT)



Scott Parker (center) at the awarding of the B'nai B'rith National Healthcare Award in 1990. Don Wegmiller is at the right.

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