First Davidson Lecture

Delivered By
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At the 25th Anniversary Celebration
of the Maryland Hospital Association

June 8, 1995

At the outset I want to express the deep appreciation of the entire Davidson family for the creation of the Davidson Lecture Series.

I will always feel an enormous sense of pride in the achievements of the Maryland Hospital Association and all of the outstanding people associated with that great organization. A Lecture in my name is really a tribute to all of the volunteer members and staff who have participated over the years and pursued the MHA's goals and values. The honor belongs to all of them.

Now, how about a little history and some personal observations of our twenty-fifth anniversary? I trust you'll permit me the use of "our" without further explanation . . .

My entry into this field came in a very unique way—out of a hospital bed. As an assistant high school principal in a Wilmington, Delaware high school, a bad back put me in the hospital for forty days and nights. Coincidentally, the hospital administrator, at that time, was on a search committee for the Maryland-Delaware-D.C. Hospital Association. They were looking for a new education director. Without my knowledge, they already had contacted the dean at the University of Delaware, where I was working toward my doctorate in education administration.

To make a long story short, that administrator appeared at my bedside almost every day, during my extended stay. We discussed the myriad problems in running a hospital. After a long stay and

longer recuperation, I found myself agreeing to take a job in a field I had never even considered. That was the beginning. But I think of those many days in that hospital bed as my roots in health care, because it gave a personal view of how hospital patients are treated. To this day, those early impressions have strongly influenced my perspective on health care delivery.

Converging Paths

After spending the first year in health care in Wilmington, we moved to Maryland in 1966, where my career path would converge with the efforts of Maryland hospitals to build a strong statewide organization. For many years, Maryland hospitals had a tradition of solving problems by working together informally without an association structure. That's why MHA, unlike many state hospital associations, is relatively young—only 25 years old. In fact, structure didn't enter the picture until 1955 when the Baltimore Hospital Council was created. Then in 1959, the Council became a

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statewide organization—The Hospital Council of Maryland. And a progressive group it was! With trustee and physician involvement, shared programs and services, community health education, staff diversity, and minority advancement—Maryland hospitals were way ahead of their time. Political savvy seemed to be the one thing needing more development. But the Council was beginning to learn. Then, 1969 brought a change in leadership. I was honored to be asked to serve as CEO and started that summer.

After accepting the job, the board chairman gave me 90 days to reorganize the place. "Ninety days," he said, "and if you can't do it in ninety, we've got the wrong guy." So, we founded a task force of hospital trustees, physicians, and top executives from across the state, conducted a series of regional hearings and met every other Saturday in order to reach consensus on a new organizational structure within our 90-day deadline. And so it happened that in June 1970, the Hospital Council of Maryland was dissolved, and the Maryland Hospital Association was incorporated.

Association's Founding Values

The vision that group of pioneer hospital leaders shared for their fledgling organization spawned the values, principles, and direction this association adheres to today. We started by asking ourselves the question, "What is a hospital?" Here are some of the characteristics we identified: A hospital has its origin in a sense of community need—often it's a group of community leaders who come together and decide to start one. It is an organization with responsibilities. It encompasses life and death. It seeks to alleviate pain, comfort the injured, and improve the health of the community. It has the power and authority to invade the human body in the name of curing and caring. Hospitals are licensed by the state, and they grant medical franchises of varying economic value to physicians, through privileging and credentialing. The boards of trustees that govern hospitals are responsible for overseeing what they do. Hospitals operate on the public promise that what they do inside their walls is competent, caring, and compassionate, and with an ethic beyond reproach.

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Next, we asked ourselves, "What is a hospital association?" The answer was simple. It is an extension of hospitals—reflecting its members' goals, values, and aspirations. An association's strength lies in its ability to bring institutions together to accomplish what no single hospital can do alone. A hospital association's only power is the power of persuasion and peer accountability. Getting something done is a product of moral suasion. A hospital association is in one sense a form of private government. It has appointed leaders and a taxation system called *dues*. The organization's duty is to provide leadership in developing public policy that aids and better serves the needs of the members' communities. An association is an important resource for education and information. One of the most important things an association provides is protection against those who would like to impede hospitals' ability to serve their communities. When someone labels us a special interest, we should proudly respond, "We are a very special interest." We should never hesitate to be vigorous public advocates for the patients we serve.

Unique Structure

But what made this hospital association unique? As an extension of individual hospitals, the group decided that the association should be governed in the same way as its members—by volunteer community leaders who would serve as its board of trustees. This unique feature has made the dramatic difference in the creative things that the Maryland Hospital Association has accomplished over the years. And so, because we were a small state, we gave the volunteer leaders of *every* member hospital—who were then called "presidents"—a seat on the association's newly created governing body—the Board of Presidents.

We wanted this governing body to build a strong democracy in which the decisions we made together would be binding, even though we had no real power to enforce them. And secondly, we wanted the board to build an organization that would have political strength, especially since the Maryland General Assembly in 1970

was becoming very unhappy about the state's rising health care costs. Not everyone was thrilled with the new MHA governing structure. In fact, we had trouble getting a quorum during its first year. To help motivate our trustees, we asked the hospital CEOs to come with their board chairmen to meetings. Well, it worked and CEOs and trustees are still coming to MHA's board meetings together.

Future Challenges

Enough of our past! Let's look at the future. Our values will face more difficult tests over the next 25 years. We may well look back on this time as the "good old days." As MHA's future membership diversifies and you represent not only hospitals but community health networks, there will be problems. Who do you deal with? Who's in charge? Who sits on the board? What interests do integrated delivery networks have as opposed to individual hospitals?

While nothing happened on the reform front in Washington last year, every single problem that drove national health care reform in 1994 still exists today. Nothing has changed, except the congressional leadership in Washington. More than forty million Americans are without health insurance. Medicare is the fastest-growing part of the federal budget. Medicaid is the fastest-growing part of every state budget. One out of five kids in the United States doesn't have health insurance. We have millions of Americans caught in job lock—afraid of changing their jobs because they or someone in their families have some pre-existing health condition that would prohibit them from getting health insurance in a new job. That's not good for America's productivity. This year hospitals will serve as the safety net for more Americans than ever before. Over 100 million people will come to hospital emergency rooms. Half will not be emergencies—simply people with nowhere else to turn, and many of them will be unable to pay.

Managed Care Environment

As for the political environment, the absence of national governmental initiatives to expand access to care necessitates local solutions, which will be a challenge for all of you. Are we up to the task of service to our community without governmental help? That's what this association must ask itself. Will you continue to be strong advocates for your patients? In a managed competition marketplace, will you be able to keep health care from becoming just another heavily-marketed commodity? As the pressures to contain costs grow and as the regulatory and market forces change, will you be able to maintain Maryland's unique commitment to treat those who are unable to pay?

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As the movement from fee-for-service payment to capitation increases—with new incentives to do less—how will you assure the public that cost cutting won't drive medical decisions? Or will it drive your decisions? As you reengineer the delivery of patient care to become more efficient, and your workforce shrinks, is your responsibility to your employees greater than other employers? Do they deserve to be treated differently? If you become an association of hospitals and competing health networks, how will you get the competing health networks to collaborate on community-wide strategies for improving health status? Or, will they just compete? As for improving community health status, how will you define "community" and get the component parties to work together? That will be an enormous challenge.

In summary, the critical question that you must ask is, "What process will you put in place to identify these issues and others that will test your values in the years ahead?" Or, are you just going to

take them as they come? One of the great strengths of this organization is that it has had a unique ability to anticipate things—to listen to what's on people's minds and translate that into actions before someone else sees the problem and dictates the action to you.

Future Leadership

In closing, it is often said in America that trends and changes start on the west coast and travel east. Sometimes that's true. But for the past 25 years inordinate innovation and leadership in health care has been moving the other way—from this association in Maryland across the nation to the west coast. I have to tell you that in my travels over the past four years, more and more people ask me about the Maryland Hospital Association—the trustee involvement, the Quality Indicator Project, the corporate values and ethics commitment, the collaboration with government, the unique set of regulatory circumstances—and they want to know about it. Why is it so different? I tell them that I think of the Maryland Hospital Association as the *Little Engine That Could.* The association never walks away from an issue, and I suspect that it won't in the future. It has done as much (if not more) as any other state hospital association in America in exhibiting values and courage. The members, employees, and trustees of this association created a unique tradition of quality, innovation, and values . . . a model for others to emulate. As you begin your second 25 years, the only advice I have to offer is to hold on tight to your values, hold on tight to your courage, and hold on tight to each other.