



RON J. ANDERSON, M.D.
In First Person: An Oral History

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In First Person: An Oral History

**Interviewed by Kim M. Garber
On February 28, 2014**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in Dallas, Texas

KIM GARBER: Today is Friday, February 28, 2014. My name is Kim Garber, and I will be interviewing Dr. Ron Anderson, a physician and professor of internal medicine, who has championed care of the medically indigent in many ways, most prominently in his three decades as President/CEO of Parkland Memorial Hospital, which is the safety net hospital for Dallas County, Texas. Dr. Anderson, it's great to have this opportunity to speak with you.

DR. RON ANDERSON: I'm glad to be here, thank you.

GARBER: You were born in Oklahoma in 1946. What was your hometown like?

ANDERSON: Chickasha was an agricultural community, with both ranching and farming, but now oil is big. There were perhaps 16,000 people when I grew up there, and there are still 16,000 today. It's a watershed area for a large agricultural community, with a lot of little towns that feed into it. I appreciate how good the school system was in preparing me for college, but it was also a place where a lot of people drank and fought and behaved badly—one of those typical rural communities where kids get into lots of trouble and sign up for the Marine Corps instead of going to jail.

It was an interesting community. A lot of people lived there all their lives and took over their fathers' businesses. The people were really nice, and I liked it from that point of view. I got a lot of my values from people there who were hard working. There's a large Mennonite community around Chickasha—honest and frugal people. It was a good place to grow up, but not a good place to grow professionally. A lot of us got out when we could.

GARBER: How did your parents end up in Chickasha?

ANDERSON: My grandfather, Charles Harston, came to Oklahoma right around the time of statehood. He had been a foreman on the Four Sixes Ranch in western Texas, in the Panhandle area around Shamrock. He was a cowboy and a rancher. My grandmother was from West Virginia and had come west to find her fortune with her family, the Chapmans. They were pioneers. The man that my grandfather worked for wanted him to stay as a kind of surrogate son, but instead of taking land from him, my grandfather gave that up and moved to Oklahoma to marry my grandmother. They went to a little place by Chickasha called Anadarko, which was where the Plains Indians were relocated. He was a person who had experiences with Indians and had met Geronimo. This fascinated me.

My grandparents had five daughters and a son who survived. My grandfather became a farmer and had a third- or fourth-grade education. He saw the value of education, and all of his children except his son went to college and then into professions. His son went into the military and came back home.

My mother married my father in 1941, right as Pearl Harbor happened. My biological father and all my uncles signed up. In 1946, they had all returned, and I and several cousins were born that year in the fall. That was typical—we were the start of the Baby Boom. My mother raised me as a single parent because my father came back changed by the war, and they divorced while I was still in

utero. It was a difficult time. I depended on my grandparents all through my teenage years. My grandfather was the person who had the greatest influence on me because he was a stable, moral rock of a person that I could always depend on.

My mother, Ruby Alice Anderson, was a supervisor for Southwestern Bell and worked for them for over 30 years. She remarried—a gentleman named Cudd. My stepfather had a restaurant in Chickasha that didn't have any keys to the door because it was open 24 hours a day, 365 days a year. On Christmas and Thanksgiving, they fed their regulars for free. It was the kind of place that everybody knew, next to the courthouse in town.

We were a blended family. My stepfather brought a son with him who was seven years older than me. I later got a half-sister, eight years younger than me, and a half-brother, fourteen years younger. In some ways, I was like an only child; in other ways, I was more like their uncle. My stepfather died young, while I was in pharmacy school, so I became a father figure for my younger brother and sister and helped work with them.

GARBER: Besides your grandfather, who were your heroes when you were a boy?

ANDERSON: I read biographies of Lou Gehrig and Babe Ruth and a lot of the sports figures of the time. Some of them were German and they went through discrimination during the war, but overcame it. I was always interested in their life stories.

One of the people who had a lot of influence on me was John Kennedy. It's ironic that I later came to Parkland.¹ Kennedy was a person who embodied a great deal of hope, and it was during a time when America was pretty dark. I could see what he had dreamed of, and I thought that was worthy of our aspirations. The assassination was awful, but it allowed Johnson to take Kennedy's popularity and accomplish the Civil Rights Act and Medicare, which had been an uphill battle. It inspired me that John Kennedy was interested in social justice, yet the Kennedys were affluent.

I always loved history. I loved Lincoln and Theodore Roosevelt. I admired rugged people who made it in spite of the odds. I always liked the underdog story—maybe I thought I had to be an underdog and bite harder. Those were the people who inspired me as well.

Then there was this other side of me that was looking for reconciliation between science and religion. During the Civil Rights movement, I became interested in a Catholic priest named Chardin,² who had written books about spiritual evolution.

Some of the people I worked with in the Civil Rights era, when we were involved in demonstrations at Oklahoma, were Catholic priests. People looked down on us for participating in demonstrations. I was impressed by these men who were out leading marches and trying to make change happen. There were people like Father Valentine, Father Brousseau—men in the Diocese of

¹ President John F. Kennedy (1917-1963) was treated in Trauma Room 1 at Parkland Memorial Hospital after having been shot in Dallas on November 22, 1963. [Source: The Kennedy connection. *Parkland Health & Hospital System*. <http://www.parklandhospital.com/whoweare/kennedy.html>]

² Pierre Teilhard de Chardin (1881-1955) was a Jesuit priest interested in the natural sciences, particularly paleontology, human origin, evolution, and how these can be reconciled with faith. [Source: *Ignatian Spirituality*. <http://www.ignatianspirituality.com/ignatian-voices/20th-century-ignatian-voices/pierre-teilhard-de-chardin-sj/>]

Chickasha who were putting themselves at risk to do what was right. Those were some of the people who impressed me.

When I was in medical school, I went back to Chickasha and rented a tux and took some of my teachers out to a Ferrante & Teicher concert. This was to say, “Thank you,” to educators like Anna Potts and Mr. Talbert, who would encourage students despite the fact that there might be challenges to overcome. They let you know that you could be whatever you wanted to be if you studied hard and worked hard. Looking back on it, some of the people who really influenced me were a handful of teachers. They gave me a lifelong love of learning. Sometimes those are the folks who go unsung and unheralded. I suspect all of us have had those people in our lives, but we don’t go back and thank them. I didn’t realize that they had scrapbooks of a lot of their students. One teacher brought out her scrapbook. I had no idea that she even knew what was happening to me, but she had kept up with me all those years.

I went to high school in Chickasha, where there were about 170 in my class. It was an excellent school system that prepared us well. In college, there were people who were at the top of their classes in small town high schools, but they’d get there and flunk out the first year. High school was not particularly hard for me. I made good grades, but I didn’t realize how good it was compared to a lot of schools that had grade inflation. It was a place where they were disciplined enough to get you ready to go to college.

Mr. Talbert, who was a biology teacher, took me aside and said, “I wanted to go to medical school, but I didn’t apply myself as hard as I needed to, and now I’m teaching biology. You’ve got to really buckle down and do what you need to do if that’s what your goal is.” Subsequently, he became superintendent of schools, so he did fine. I wish my children could have had as good a public education as I did.

GARBER: Did you also participate in athletics?

ANDERSON: In junior high, I played football. Then I got a job at Humpty Dumpty, a grocery store chain. I remember the guy I worked for. His name was Curtis. He said, “If you quit school because you’re making money to do something now, I’ll fire you. This is only to help you go to college.”

During that time, I was in a little bit of rebellion and did crazy things. The high school football coach, who had been my coach in the ninth grade, said to me, “You didn’t play in your sophomore or your junior year, but you’re a tough guy. You were tough in the ninth grade. Now you’re in street fights, and all kinds of stuff, and you’re in rebellion. Why don’t you come out and show me what you can do in your senior year?” I said, “I’m making some money. I’m not sure I want to do that.” Coach Powell convinced me to come back.

Because of missing those two years, I never was a superstar, but I did make All-State Honorable Mention. I was offered a scholarship to the University of Oklahoma, but I didn’t take it. I saw that if I wanted to go to pharmacy school and then on to medical school, it was going to be difficult to put those kind of hours in on the football field and be academically prepared. Guys who went into athletics at that level were playing against super athletes. I went the academic route in college instead.

I was glad that I played football in high school, though, because I had a close friendship with Coach Powell for a number of years after. It was a proving ground that I could compete. His goal was to get me out of a rebellious period in my life. He made me more disciplined. I appreciate his investment in me to get me out of being a guy who would pick a fight with three other guys. It was always the right issue, but it was something that could have gotten me into a lot of trouble. He saw that and helped steer me into a better direction. In college, I played intramural sports all the time.

I went to several colleges where I could afford to go because I was working. In my first year, I went to Central State University in Edmond, Oklahoma, lived in Oklahoma City, and worked until midnight at a Texaco station. The second place I went was the Oklahoma College of Liberal Arts, which was my mother's alma mater. Previously, it was called Oklahoma College for Women. My mother graduated from there, and all her sisters went there. It changed to coed the first year I went there. Now it's called the University of Science and Arts of Oklahoma. There were maybe 2,000 students at that time, and only 170 of them were men. I still kept my grades up with a 4.0 that year—despite that sort of ratio and my interest in the ladies.

There were two pharmacy schools. I went to Southwestern Oklahoma State University in Weatherford. It was the more rigorous of the two schools at that time. Weatherford was a little town of 5,000 people, and they have 5,000 students or so. The pharmacy school is the strength there. There is nothing between you and the Canadian border except a barbed wire fence and prairie. There is nothing to do out there except study. Weatherford was good for me because there were very few distractions. I got into medical school while I was a senior in pharmacy school and went directly on in the next year.

GARBER: Is it unusual to use pharmacy as a pre-med path?

ANDERSON: Nobody in my family had an advanced degree. Nobody had been a physician. Nobody had been a lawyer. I didn't think that would happen, so I went to pharmacy school because I liked the science. I liked the biology, the physiology—all that was terrific, and it was a really good school. It was the best pre-med I could have had. Although it cost me an extra year, I had a profession to practice if I didn't get into medical school. I was looking ahead and thinking, "What's your Plan B?" Later, when I became a professor of internal medicine, a lot of the teaching I did was in pharmacology, such as trying to get people to understand adverse drug effects. I dealt with overdose research, addiction research, and related areas that have to do with receptor theory. It followed me throughout my career as a physician.

Pharmacy school is not known for grade inflation. If you go the pharmacy route, you better be sure you're going to make good grades, because it's a good way to get grades that won't get you into medical school. I did well in pharmacy school. It also made medical school easy. Medical school was physically more demanding, but intellectually, it wasn't any harder.

Things have come together for me at several points in my life. Understanding of stereochemistry and medicinal chemistry, receptor physiology and pathophysiology, comes together and causes you to start thinking systematically. It came together in pharmacy school, so that when I went into medical school, I aced the first couple of years.

When it came together again, I was a fourth-year medical student and taking elective surgery. I knew I was going to go into internal medicine, but I wanted to do a year of surgery and be as

complete a physician as I could be. All of this came together in a systematic way—I had insights like light bulbs going off. Facts and figures change. The doubling of all knowledge every couple of years will accelerate even more, and we’re going to need artificial intelligence to help us with that. If you think about how to study things logically, how to solve problems you’ve never seen before, what really makes sense, you can see the systems working together and integrating. It comes together as a fourth-year medical student and then again when you’re a senior resident. Pharmacy helped me with that.

It helped me practically, too. When I graduated from medical school, I had been raised by a single parent, was helping to raise my brother and sister, and I had only \$1,000 of debt. This was because I had worked weekends and summers during the first two years of college as a pharmacist and had packed away enough money working 12-hour shifts to pay for my tuition and rent.

I lived in an austere setting in Oklahoma City, where I went to medical school at the University of Oklahoma Health Science Center. I walked three blocks to school from a little apartment located in the heart of a Black Muslim community. This was one of the best things I could have done. I had a good relationship with the community. My apartment was \$95 a month, split three ways. That wasn’t a plush place. I was able to afford it by being frugal and by having a pharmacy income for part of the time I was in school. In the third and fourth year of medical school, you can’t work at an outside job. You’re pretty much in the hospital all the time. In those days, it was every other night or every third night on call.

It’s sad that when young people come out of medical school today, they’re in several hundred thousand dollars’ worth of debt. A lot of times, this dictates what specialty they choose. They might like to go into primary care, but can’t afford to. I was in a situation where I was flexible and didn’t owe anybody. I was independently poor, so to speak. That’s a good place to be as a student.

GARBER: How did you become interested in the Civil Rights movement?

ANDERSON: My grandfather’s father freed his slaves when he came to Texas, but they chose to come with him. After his parents died of cholera, my grandfather was raised by his brother with help from a black woman. My grandfather was involved with a group of farmers who would help black farmers sell their cotton. Black farmers couldn’t sell at the cotton gin in Amber.³ The Ku Klux Klan was active there. My grandfather taught me respect for blacks. The n-word was unacceptable. My grandfather was insistent that people be shown respect.

When I was a little boy, there was a young black man who came to our farm. Klan members in robes arrived in a pick-up truck. My grandfather was tall and lanky, strong, and determined. He went out and said, “What do you want?” They said, “We want that boy.” He said, “No. He’s come here for sanctuary. You can’t have him. I’ll take him to the sheriff if that’s what needs to be done, but you just go on home now.” One of the Klan members said to my grandfather, “Charlie, we can take him. There are enough of us to take him.” My grandfather said, “Well, that would be a sad thing. I know who you are—you were wearing those same shoes this morning at the cotton gin. You’re hiding behind that sheet, and you won’t take him because you’ll be dead. I know I can’t do anything about all of you, but my son there—he has a shotgun aimed at you. My wife has a shotgun

³ Amber is a small town about 10 miles north of Chickasha.

aimed at you, and I have a Colt 45 in my pocket. You'll be dead, and that would be a terrible thing for your wife and two children. That would be sad, but that's what's going to happen."

The Klan members backed away and left angrily. My grandfather took the young man to the sheriff. I don't know what he had done. This was the early '50s. The young man was lynched from that jail. I never will forget that. My grandfather was distraught. He would never join a secret organization. He was asked to become a Mason, but he wouldn't do anything in a secret society because he didn't believe in that.

His brother, Dan Harston, was sheriff of Dallas County.⁴ Dan Harston ran on a Democratic ticket, which meant he was endorsed by the KKK. He was one of the 50 toughest men in Texas history, according to *Texas Monthly*. I have a son named Dan, named him after him. He was 6'7" or so, weighed 315 pounds, had a big handlebar mustache. My grandfather said of him, sadly, "He's hung people from the courthouse steps. My brother and I don't agree on these things." Part of it was the endorsement by the Klan. It was common in Dallas in those days.

My grandfather was a very gentle man. He never used corporal punishment with any of his children. If you did something wrong, he used to look at you and make you melt. He could make you joyful, as well. He helped me throughout life and gave me important life lessons.

GARBER: Did you have any particularly influential teachers in medical school?

ANDERSON: Gordon Deckert⁵ had been an internist at the Mayo Clinic and later went into psychiatry. He was a brilliant lecturer about how to merge medicine and behavioral health, how to interview patients, how to understand patients, how to see your patients walk into the room and get an impression of them. They would film interactions with patients in those days, like we film football games today, to see what you were observing and what you weren't. He helped us develop a keen sense of being an observer and a listener. Patients will tell you what's wrong with them if you listen to them. The problem with medicine today is that, many times, nobody has the time to listen. Dr. Deckert gave a course on human sexuality, which was the most entertaining thing I'd ever been to. I loved it. He was one that stood out.

Another was Ernest Lachman,⁶ affectionately called "Spanky," although not to his face! He had survived the Holocaust and had been friends with Niels Bohr and Anna Freud in Europe. He had used x-ray and had done thousands of autopsies, merging the two together as the science of forensics.

I remember Dr. Lachman working on the case of a young woman who had died of anorexia nervosa. The psychiatrist hadn't wanted to force-feed her for fear of adding to her delusional problem. Dr. Lachman knew that wasn't right. You had to re-feed people carefully. He had been in the concentration camps and knew what killed people from starvation—re-feeding can kill them.

⁴ Daniel S. Harston (1876-1936) was Sheriff of Dallas County from 1918 to 1924. [<http://www.findagrave.com/cgi-bin/fg.cgi?page=gr&GRid=67122153>]

⁵ Gordon H. Deckert, M.D., was the chairman of the Department of Psychiatry and Behavioral Sciences at the Oklahoma University Health Sciences Center from 1969 to 1987. [Source: Everett, M.R. *Medical Education in Oklahoma*, Vol. III. Norman, OK: University of Oklahoma Press, 2000, Vol. III., p. 79.]

⁶ Ernest Lachman (1901-1979) was a professor of anatomy at the University of Oklahoma Medical School from 1934 to 1971. [<http://www.oklahomaheritage.com/Portals/0/PDF%27s/HOF%20bios/Lachman,Ernest.pdf>]

I remember going to the autopsy in one of those tiered rooms. Dr. Lachman knew even before opening this young lady up what would be found. He said, “She is going to have massively enlarged adrenal glands because of the stress of anorexia nervosa, like we saw in the camps.” It was so real to have somebody who had lived through that, who knew what was going on, and who could impart it in such a humble way. He took the psychiatrist to task, saying, “You have no understanding. You don’t know what it’s like.”

We had Dr. Henry Turner,⁷ an endocrinologist who described the Turner Syndrome, which is seen in young women. At the University of Oklahoma, medical students were assigned to senior faculty members, and you got to go to their clinics and see their patients. In his practice, I saw cases that I wouldn’t see again for years and years. While Oklahoma was not the high-powered research institution that UT-Southwestern is, for example, it was a great place to learn clinical medicine because it was the university hospital for the whole state. Although many patients were poor, they were treated with dignity.

I also learned a lot from a couple of private doctors that I was assigned to do rotations with—who demonstrated the value of physician-patient relationships over time. Dr. Gault could see a patient walk down the hallway and, because he’d known that patient for so many years, he’d say, “Get the cardio booth ready.” He was thinking, “If he’s coming here today with chest pain, then he must be really sick because his wife can’t get him here for anything else.” He’d know when somebody just had anxiety. I thought he was a quack when I first got there, but he knew his patients so well that he was right. I learned that over time an internist gets to know a patient as a total person. That’s one reason I liked internal medicine.

The physician who taught me what I *didn’t* want to do was Loyd Williams,⁸ a family practitioner in Wetumka, Oklahoma. I was assigned to him for ten weeks. He was the only doctor in town except for an osteopathic physician named Wenrick,⁹ who was really a great guy, but he was elderly and had an illness that kept him from practicing full time. Dr. Wenrick asked me to come to Wetumka. He offered to give me his practice if I would come help Dr. Williams, who he felt was killing himself working so hard—seeing 40 or 50 patients a day. Dr. Williams did have a heart attack in his early 40s, and then, at age 48, he died in a single car collision going out at four in the morning to deliver a baby. He was worn out. In that little town of Wetumka, Dr. Williams’ death closed the hospital. The town had maybe 3,000 people then but, over the next ten years, dwindled to 1,800 people. Three pharmacies dwindled to one.¹⁰

⁷ Henry H. Turner, M.D. (1892-1970) was a clinical professor at the University of Oklahoma Medical School. His paper describing the Turner Syndrome was published in 1938. [Source: Henry H. Turner, M.D.: the man behind Turner’s Syndrome. *Endocrine Today*, Oct. 2011. <http://www.healio.com/endocrinology/news/print/endocrine-today/%7Be08bfc5c-2429-4f13-be91-535f34bb2309%7D/henry-h-turner-md-the-man-behind-turners-syndrome>]

⁸ Loyd G. Williams, M.D. (1931-1982) practiced in Wetumka, a small town about 90 minutes east of Oklahoma City. Dr. Williams taught medical students in Wetumka for over 20 years. [Source: Hann, R. What does the title “doctor” really mean. *BaldScientist* [blog], Oct. 22, 2013. <http://baldscientist.wordpress.com/2013/10/22/what-does-the-title-doctor-really-mean/>]

⁹ David L. Wenrick, D.O. (1912-1986)

¹⁰ The community struggled to keep Wetumka General Hospital, which opened in 1959, viable after Dr. Williams’ death. The hospital was downsized and continued as a 12-bed critical access hospital, but ultimately closed. [Source: Jackson, R. Wetumka hospital threatened. *Tulsa World*, Aug. 22, 2003. http://www.tulsaworld.com/archives/wetumka-hospital-threatened-with-closing/article_cd72f5ee-916d-5c06-a20c-56f6f82b5003.html]

I had thought it was kind of romantic to be out there working in a little community. I had thought maybe that's what I would want to do, but I realized that I needed to be in a bigger place. One reason I have always had a warm place in my heart for rural medicine is that physicians and hospital administrators in those small places do everything. They have to do it all. There's so vulnerable and so fragile an ecology there. I decided that was not something I could do. Maybe that's a tougher job than I had at Parkland.

GARBER: You did move on to a bigger place—heading to Dallas for your internship and residency. Could you compare your internship and residency experience with what it's like today?

ANDERSON: While still in my fourth year in medical school, I took the position of an intern who had died during the first month of his internship. I had already finished all my requirements. With my pharmacy background, I could pretty much take my fourth year as an elective. I elected surgery. I was on call every other night as a fourth-year medical student, taking calls as a surgery intern.

When I got to Dallas, they had just changed to every third night on call, instead of every other night. These were still 130-hour weeks, so it was very tough. I'm not sure we made bad decisions because we were tired, but when you work that many hours, you get snappy, and you're not as compassionate as you could be or would want to be. Twenty cups of coffee a day don't help you either. I remember another intern saying, though, "It's sad we're switching to every third night on call. If we were on every other night, we've already missed half the medicine, and every third night is further diluting our experience." It was more humane. Internship was easier than my fourth year. I loved it.

Internship was exciting because I was with a terrific peer group. I tell young people that there are several things you look for in an internship and residency—and I got them at Parkland. Don't look for mountains and ski slopes. Don't look for the beach. You're not going to find any of those in Dallas. What you do look for is a peer group of individuals who are as good as you, who will drive you, support you, and take care of your patients when you're not on call. You want to find professors of medicine who have an open-door policy, who don't treat it as a sign of weakness if you ask for help. That is absolutely critical. You want a place that will allow you to exercise some independence under supervision—where you can grow. A place where you get to do things, where you are not just a fifth wheel watching things being done, and where you're needed.

I adored the friends I had in medical school. The friends you develop in a residency when you're on call and you're in the trenches and you're with them back-to-back—making crisis decisions all the time—those are the people you remember for a lifetime. We had a strong peer group. We had available professors.

I always tell people to go to the inner city and to public hospitals—where patients really need help—but they're also harder. Parkland in Dallas and Charity Hospital in New Orleans were the two lowest-paid internships in the country at the time, yet they were two of the most sought-after. You had to want to do this, and you had to be willing to work hard.

When I got here, the whole department of surgery had relocated to Seattle, except for five surgeons. The whole group was recruited out because they didn't have a private hospital to work with. While Parkland gave them trauma, burns, gunshot wounds, and lots of pathology that they

needed to study, it didn't give them the chance to do a lot of private bread-and-butter surgery that would enhance their incomes.

One of my most important mentors early on was Dr. Don Seldin, who was the chairman of medicine here for 35 years.¹¹ Seldin has a 200 IQ, a photographic memory, and is a speed-reader. As a student, I adored him, but he was demanding. He might call an intern an assassin, saying, "Here's a quarter. Call your mother. Tell her you're trying to kill this patient." He was old school, hard. He said to me, "You've done so well as an intern, if you stay, and you're in my program and don't go to surgery, there's a good chance you could be chief resident." He said about my interest in surgery, "Does your mother know you want to cut people for a living? Does she know that?" He doesn't like surgeons. He wants to keep patients from using them. I stayed on and became chief resident.

Two of my professors went on to win Nobel prizes. Seldin's view was, "I want to create the environment where people can win Nobel prizes." Today, there are six Nobel laureates who did their research at UT-Southwestern. Dr. Seldin talked about the Bayer family in Germany who did the same thing that he did. They created the environment where a lot of Nobels were won. That was enough for him. He didn't have to win a prize himself. He wanted to be the mentor and the person who helped create the environment for that.

That was intellectually stimulating to me. When I was chief resident, Dr. Seldin asked me to stay on and join the faculty. He wanted me to run the division of general internal medicine. Interestingly, he was a nephrologist, very specialty-oriented, and not so sure about this whole movement toward generalism in internal medicine. He was suspicious of it. He even gave talks about how it was a flash in the pan and probably shouldn't be done. When I was in Boston for an exchange program, someone asked me, "Why would you work for Don Seldin? He doesn't even believe in general internal medicine, but you're starting that division." I said, "He told me that he's not sure he believes in it, but if we're going to do it, he wants to be the best. That's what I'm going to do for him."

I stayed on in academics because of the intellectual environment, the needs the patients had, and the challenge of having students around who keep pushing and driving you. It's nurturing. Some people said, "You don't want to leave the nest." Actually, you have to work harder and you have many more bosses. You've got to publish. You've got to take care of patients. You've got to do research. You've got to do what, in those days, we would call the "three-legged stool."¹²

Because I ran the ER and the clinic, and was on the wards attending year round, I had so many patients that I could study what I was doing. I did studies on heat stroke because we had several summers where we had heat stroke epidemics. We had lots of overdoses with things like tricyclic antidepressants, which were prescribed ubiquitously. Street drugs were a big problem.

¹¹ Donald W. Seldin, M.D., came to Dallas in 1951 to build the recently-established UT Southwestern Medical School from virtually nothing to the leading institution that it is today. [Source: The Father of Dallas medicine. *D Magazine*, Oct. 2013. <http://www.dmagazine.com/publications/d-magazine/2013/october/dr-donald-seldin-of-ut-southwestern-father-of-dallas-medicine>]

¹² The "three-legged stool" refers to the three missions of academic medicine—teaching, patient care, and research. [Source: Wilson, M.R. Scholarly activity revisited: balancing the three-legged stool. *The Ochsner Journal*;6(1):12-14, Spring 2006. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3127477/pdf/i1524-5012-6-1-12.pdf>]

I tenured by studying the patients I had. I didn't have a laboratory, but I was in a place where people would loan me their laboratories. I had several mentors like Jim Knochel,¹³ who helped me with alcoholic rhabdomyolysis and heat stroke. He was well known for those things.

It was intense and exciting. I left home looking forward to the day; I went home dead tired. It was a good environment to practice in, probably harder than private practice. I had fully intended to go back to Oklahoma and practice in Chickasha. I had been offered a lucrative opportunity there practicing with doctors I respected. It never happened because of the tie to academics. Once you publish your first article, you like it. You want to do it again.

You can make a difference, too. I didn't want to do administrative work, but I did administrative work around the ambulatory care center and the ER. Part of the reason was that it wasn't being done as well by other people. As physicians, you can't keep complaining, you've got to get involved. The administrative people reported to me. In running those areas, I could have an impact upon not just one person at a time, but a thousand people a day, or more.

Later on, when the CEO position came open at the hospital, I was approached and asked if I would consider it. I told them, "No, I want to see patients, and I want to teach." I still was doing research. I wouldn't give those things up. Ralph Rogers,¹⁴ who was chairman of the board, said, "You can do those things. I'm hiring a chief executive officer. If you want to work 80 hours a week instead of 40, and that's what gives you pleasure, do it. That's not a problem."

He asked me again, and when I had turned him down a third time, he said, "As a physician, you were taking care of one patient at a time. You took over the clinic and now have an impact on a thousand patients a day. Think about the impact if you ran the whole system and dealt with hundreds of thousands of people per year. Then, Ron, if you moved into policy and public health, you could impact millions of lives and change things. You know those things, and you can do them and apply them. Wouldn't that be better?" He added, "I understand, because I've watched you on rounds with your patients, that you get immediate feedback and benefit from that. I know you're not going to give that up. You don't have to. I won't make you do that."

That was the condition under which I took the CEO job. I didn't have a contract, but that was it. That later became controversial in my career because people wanted me to focus on administration. One of the things about making rounds, though, wasn't just the immediate gratification, and caring for patients, and the things I love about medicine. It was also my validation that things were working. It was managing by walking around. If you're walking around talking to patients, you get the truth. One reason I never wanted to give it up is that it gave me a real sense of what was going on in the institution. There were practical reasons why I continued to do it, although it was selfish, too. I enjoyed it and still do.

GARBER: What does it mean to be a chief resident?

¹³ James P. Knochel, M.D., was professor of internal medicine at the University of Texas Southwestern Medical School. [*Irving Daily News*, July 15, 1977. <http://www.newspapers.com/newspage/58594006/>]

¹⁴ Ralph B. Rogers (1909-1997) was a Dallas businessman and philanthropist who was instrumental in spurring research into rheumatic fever and is considered to be one of the founders of the Public Broadcasting Service (PBS). [Ralph Rogers, 87, philanthropist who led and defended PBS. *The New York Times*, Nov. 6, 1997. <http://www.nytimes.com/1997/11/06/arts/ralph-rogers-87-philanthropist-who-led-and-defended-pbs.html>]

ANDERSON: The chief resident at UT-Southwestern is one of two out of a class of maybe 40 residents in that given year who are selected to oversee the training program for the chairman of the department—handling conferences and that sort of thing. It's an administrative job, but I also used it as the time to start my academic career and to attend. I was a house staff officer, but I was attending as a senior person with my own interns—attending six months at Parkland and six months at the Dallas VA Hospital.

It was a chance to start teaching, learning how to teach, learning how to prepare talks, and getting involved in research. Today, it's still very much like it was in those days. It's an extra year of time, but the investment usually helps propel you into an academic opportunity.

Dr. Seldin's chiefs form a society, if you will, and you become one of the inner sanctum. You pay a price for that, though. You do a lot of hard work. I handled most of the discipline for the house staff, too. If somebody had a problem, I'd try to help. I took a lot of the burden off of the chairman. That's still true today. The chief residents are the go-to person for the house staff before they get to the chairman.

GARBER: What are the teaching methods used in academic medicine?

ANDERSON: Most of the time—and that's one of the problems in academic medicine—you learn by doing. You see someone else do it, then you do it, and then you teach it. That's going away. More and more, people are using simulation and other things that are much better and put patients at less risk. You don't want to do trial-and-error learning at the patient's risk. That doesn't seem right, but that's how medicine was taught. It's getting better. It's much less likely to be “see one, do one, teach one.”

If there ever was a system of social Darwinism, it would be academic medicine, because if you don't publish, you perish. You'll see good doctors move out into private practice after seven years because they didn't “make it.” I always believed in mentoring and talking to people and helping guide their career path—telling them what was expected of them. No one did that for me much. It was survival of the fittest. I was dealing with people who were amazingly successful, and they let me be successful. Dr. Seldin didn't guide me as much in a mentoring relationship as I've tried to do with the folks I've tried to help, both in administration and in academic medicine.

You need to have periodic checkups, taking people aside to assess them and give feedback. A lot of times during my era, the only feedback was, “You didn't make it. You didn't get tenure.” That's a sad situation. Some of the best doctors I know didn't get tenure and went out into practice, yet they knew the art of medicine far, far better than some of the doctors who made tenure because of their work in the laboratory. What you value and reward may be lab science, research, and publications, whereas the guy at the bedside is working really hard. I've seen guys at the bedside work so many hours that they didn't get around to publishing, yet they were the best role models you could imagine, and they could teach the art of medicine.

A lot of my rounds were about teaching the art—teaching how to give people information, how to give them bad news without devastating them, and things like that, that are not going to change. The facts of medicine change incredibly fast. It's important to teach people how to think, not just the facts. How do you approach problems logically? How do you approach problems systematically? How do you look at the ladder of abstraction, and build the case for what may be

the diagnosis, and look at all the differential, and everything—that’s incredibly important. Look at the whole patient. That won’t go out of style, whereas the facts change rapidly.

The way we educate will change. We’re going to have to depend on artificial intelligence because of the rapid increase in knowledge. There is a saying, “Knowledge leaps forward and wisdom lingers.” It’s going to require us to rethink who we select in medicine. Are we looking for good memorization skills, someone who is smart, and that sort of thing? Or are we looking for somebody who also knows how to use the information systems support they need to be able to assimilate all this information into a sound approach for the individual patient?

We’re going to have standardized care and be held accountable for outcome. In my day, we were not as accountable as we will be in the future. We’ll know more about what the individual doctor does in the future than we did during my training years. That’s better now, and it will be a lot better in the future.

GARBER: Do you see the three-legged stool model in academic medicine going away?

ANDERSON: Few people can do a three-legged stool model in modern academic medicine. Two of the men I worked with when I was a house staff officer, Mike Brown and Joe Goldstein, were Nobel laureates for their research in cholesterol metabolism.¹⁵ They were superb attendings—compassionate, bright, and challenging. Everybody wanted to get them as an attending. However, they became so valuable after they won the Nobel Prize that it was almost as if the school couldn’t afford to have them at the bedside any more. They needed to be at the bench. Subsequently, they helped several other people win various awards and have done some incredible research beyond what they did which won the Nobel Prize. That’s where their greatest value to society and to medicine really is. They almost had to give up their clinical side.

More and more, I see that you’re superb in one thing and pretty good in a couple other things, but you’re not superb in all three. Don Seldin was. Don Seldin was a triple threat. He was amazing. That model is going to lead to a lot of frustration. When we promote faculty, we should promote them along clinical tracks. We should give them the opportunity to be an excellent teacher or an excellent clinician or an excellent researcher. It’s good that they have some crossover and do some of those things, but to expect excellence in all three areas is really not reasonable now.

We’ve had to make changes. As medical schools see more patients at their own hospitals, they have to have a lot of those clinicians they used to give away because they didn’t reach tenure. They gave them to their competition across town. Medical schools are going to have to keep these folks on in an important role in the academic arena, but not expect them to excel at the bench.

GARBER: You’ve mentioned how quickly knowledge is proliferating. How does a medical school professor keep up to date?

ANDERSON: One of the reasons I stayed in an academic situation is that it would force me to continue to read. It would force me to continue to learn. If you go into medicine without the expectation of being a lifelong learner, you’re going to sell yourself short, and you’re going to sell

¹⁵ Michael S. Brown, M.D., and Joseph L. Goldstein, M.D., were awarded the Nobel Prize in Physiology or Medicine in 1985. [Source: *The Nobel Prize in Physiology or Medicine 1985*. http://www.nobelprize.org/nobel_prizes/medicine/laureates/1985/]

medicine short. You're going to be obsolete in five years.

Being around bright students and house staff always gave me encouragement to be ahead of them. I knew John Townsend at Oklahoma.¹⁶ John would pay extra to get his journals, like *The New England Journal of Medicine*, shipped two days early, so that he could read them two days before everyone else. He would quote something that hadn't gotten to you yet. He'd say, "You know, you should really keep up. You should read the literature on this." I didn't realize the trick he used for a long time. It was incredible that people would push that hard to try to keep up.

It's hard to keep up with all the new drugs that come out—the new antibiotics, the new anti-inflammatory agents. Being a pharmacist, that's important to me. A lot of the medications are going to be highly individualized, and cell biologists, not just pharmacologists, are going to be involved in trying to create new treatment plans. It's going to be more difficult to keep up.

We had grand rounds the other day by one of my mentees, Ruben Amarasingham,¹⁷ who is a brilliant doctor who runs the Parkland Center for Clinical Innovation, working on big data analysis and analytics. He said, "In the 2040s, the rate of knowledge accumulation is going to be so great that without artificial intelligence, the average physician will be obsolete before the training is over." If you're in medical school four years and then you're in a residency, you've got to learn how to learn as you go and how to find resources. It's not enough just to be really smart anymore.

I remember reading articles years ago about chloromycin, a dangerous antibiotic not to be prescribed except in very limited circumstances. There were doctors prescribing it for a lot of things they shouldn't have prescribed it for because they had been trained to in their medical school training and, twenty years later, they were still doing it. Even after lawsuits, even after a lot of malpractice claims, they were still doing what they had learned in medical school.

Those guys are dangerous. We can't let medicine do that. To a large degree, we are changing our training to simulation. We're changing to ways to train people on the go and to continue their education. Many of us who stay in academics stay because we want to continue to be students. It's more comfortable than being that doctor isolated in Wetumka, Oklahoma, who has a hard time getting away to go to a conference because of being the only doctor in town. I admire those people for their sacrifice, but it's difficult to get people to do that anymore.

Parkland helped get legislation passed in Texas allowing hospitals to hire physicians. Texas was one of the last states to have a prohibition against the corporate practice of medicine. One of the big drivers was Parkland. We needed doctors to work in clinics in the community and rural areas. They couldn't replace the doctors they had unless those doctors had some connection to continuing education and other things. The doctors couldn't do that as much in solo practice as they could if they were employed and had the benefit of affiliation with a bigger system. It's easier in a group practice where you get some free time for education than in a solo practice.

Medicine is changing and evolving toward feedback. How do we have accountable care

¹⁶ John L. Townsend, M.D. (1932-1990), was an endocrinologist and professor of medicine at Howard University School of Medicine. [Source: John Townsend, Howard U. medical school professor dies. *The Washington Post*, Dec. 30, 1990. <http://www.highbeam.com/doc/1P2-1166391.html>

¹⁷ Ruben Amarasingham, M.D., is the founder, president and CEO of the Parkland Center for Clinical Innovation. [<http://www.pccipieces.org/why-pcci/leadership-and-board/>]

organizations¹⁸ without feedback? We need feedback from analytics. We need to know what we're doing individually as doctors and as a system. We need to adapt and change and constantly educate ourselves about what we're doing. Continuing education is not only about the new article that just came out, but also— are we making a difference by the practice that we're trying to promote?

It's exciting, but a lot of people are so worried about that challenge that they don't want to do this anymore. It's going to be a renaissance. There is going to be so much new knowledge and so many opportunities for treatment in the next decade or so that this is a great time to go into medicine.

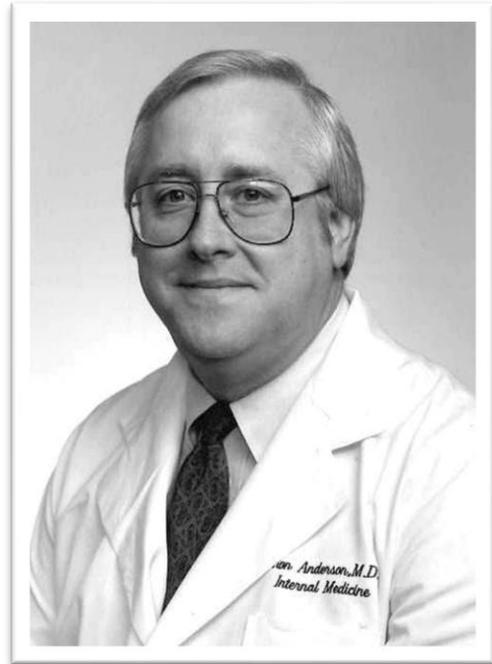
GARBER: Is there any area of your research that you're particularly proud of?

ANDERSON: A lot of the research that I've done was about things we saw a lot of. I could find people to collaborate on things like hyperthyroidism and heart disease because I took care of a lot of patients with Graves' disease, or scleroderma, and heart disease. I didn't have a laboratory, but I had some cardiology friends who allowed me to use their laboratory for the measurements I needed to take. Some of the work we did on alcoholic rhabdomyolysis was precedent-setting. That was early in my career.

I've liked most what I've done in policy, involving social determinants of health, and the things we can do outside the hospital. One of the areas that I want to spend the rest of my practice in is trying to figure out how we can do prevention and health promotion, but also how we can leverage the socioeconomic determinants of health.

For example, we know from European studies that the healthiest thing you can do in your lifetime is to graduate from high school and then from college. If you're gainfully employed, you're more likely to be healthy. There are lots of things that are not related to doctors or hospitals that influence health outcomes. Social disparity in income, and other things like that, have a lot to do with outcomes in health that we have not looked at because it seems to be a little meddlesome. We're changing more than taking care of the individual patient. We're going to have to do that if we're going to get statistics in America up to the level of some of our European colleagues. A lot of the reason our statistics lag way behind them is not because of our medicine. We're excellent in medicine and in sick care. We're not so good at health care. We're also very much a libertarian nation and we don't like to have the "nanny state" tell us what to do.

We've had some gains. It came out this week that there has been a 45 percent reduction in



¹⁸ Developed as part of the implementation of the Patient Protection and Affordable Care Act, accountable care organizations are intended to facilitate the coordinated care of Medicare patients whether in the hospital or in other care settings. [Centers for Medicare & Medicaid Services. *Accountable Care Organizations*, 2013. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>]

childhood obesity. It has taken a decade to do that, but it took several decades to get as bad as it was with overeating and the lack of exercise. These are things that are cheap to fix if we're willing to fix them. They're behaviorally hard. We need to get into that behavioral health aspect and leverage the things that we can leverage.

When I was at Parkland, we wrote about "managing the in-betweens." We were working well in silos—the education system was working well, the public health system was trying to work, police and fire protection, housing. All of these people were working in their silos and giving a good faith effort. However, people don't live in the silos. They live out in the matrix of the community. The cytoplasm of life is the community. How do we get out there and leverage all these things that we're doing in our silos?

We have to do it through collaboration and cooperation—not through competition. If we sat down and strategically determined what we could do to assist one another and find synergies, then there would be huge things that would be accomplished that would be much cheaper. Where we've failed in this country, so far, in health reform is not going that extra step into prevention, health promotion, and the social determinants of health—and trying to find ways to leverage those. The call to do that and the discussion of community-oriented primary care (COPC), and what it could actually accomplish, are the things that I like the most about what I've published.

GARBER: This would be a good time to talk more about Parkland. Could you give us a thumbnail of what the institution is like?

ANDERSON: Parkland is more than bricks and mortar. It's almost a culture—a way of thinking. When I got here, Dr. Seldin taught us first of all the sacred trust we had from our patients. Many of them might not have choices, but we were in partnership with them. They were here to be cared for. They needed us, but they also provided the opportunity for us to be educated, and we owed them a great deal. It was not about seeing patients as subjects, but as somebody's mother or father, daughter or son. We needed to have an appreciation for that. We were privileged to be caring for them, and they could withdraw that privilege.

It was a cultural attitude of service. If you didn't want to work really hard, you shouldn't come. I remember one time during an interview that a young man said, "You guys work longer hours. You work harder. I'm not sure this is the place for me." He was being interviewed by some other house staff officers, and they said, "It's not the place for you if you're not willing to pay the price." It was like the Navy SEALs of house staff officers.

It was also true of the nurses. They could do more with less than anybody I ever saw. My wife was a nurse here in the burn unit and the emergency room and psychiatry. She was a head nurse on neurosurgery when she left to have children. She would always find a way to make things work. That is just true of Parkland people.

If you were trained at Parkland, you could go anywhere. If you were a nurse trained at Parkland and you worked in the ICU, you could go anywhere and be head nurse. They always knew that. We had a real respect for the nurses. They were allowed to do more here than in most other places. They were not the handmaiden for the doctor, not at all. In many ways, they were like the old British nurse—this was their ward, they owned it, and you were rotating through. They let you know that.

The brick-and-mortar Parkland was old—a 1954 chassis. With rooms just 155 square feet, if there were two patients in the room, with extended families, you could hardly turn around. There were very few private rooms, and they were mainly for isolation. It was industrial built, and we got a lot of squeeze out of that orange. We were seeing many, many more patients than the place was intended to see.

That may also have helped in our downfall because we always tried to extend ourselves, no matter what, to take care of the next patient who came in. We felt like we were the safety net. We couldn't turn anybody away because there was no other option for them in the community. When I came here, it was a huge place that everybody came to.

When I got here from the University of Oklahoma, I said, “Why are we seeing three or four diabetic ketoacidosis patients a day?” In Oklahoma, we would see one a month. The reason was that we didn't have a system of care, and people were coming in extremely ill. We were taking care of them as crisis management. People would say, “It's great pathology to learn from.” It was great pathology that should never have happened.

Parkland has changed from that intense inner-city experience to one where we've moved upstream, out into the community, to try to do early access intervention and prevention. We want to be more accessible so people don't have to wait until they are very ill to come in. It's gone beyond safety net to system thinking and integration.

Many of the things that health reform wants to accomplish have been accomplished already by some public hospitals in Texas. Parkland is not unique. Ben Taub,¹⁹ the University Hospital in San Antonio, and some of the bigger public hospitals have integrated clinics into their systems. They're not just clinics—they are community-oriented primary care clinics. This means that they're looking at more comprehensive investment into the community, and getting the community's investment back into them to help solve problems.

Community-oriented primary care is a model that was developed in South Africa during apartheid. It was taken to Israel by the Karks and developed for the kibbutzim.²⁰ Now it's used all over the world and, here in the United States, used in federally qualified health centers. An early example was a community health center in rural Mississippi started by Jack Geiger.²¹ Many of the people he cared for were malnourished. He wrote prescriptions for food because, as he said, “Last time I checked, food was the drug of choice for malnourishment.” They got involved and organized the community so the community could help itself.

¹⁹ Ben Taub General Hospital (Houston) is part of the Harris Health System.

²⁰ Sidney and Emily Kark were South African physicians who developed the concept of community-oriented primary care while working in a Zulu tribal reserve in the 1940s. This model is a population health approach that blends aspects of primary care and public health, as well as epidemiological data collection. [Mullan, F., and Epstein, L. Community-oriented primary care: new relevance in a changing world. *American Journal of Public Health*;92(11):1748-1755, Nov. 2002. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3221479/pdf/0921748.pdf>]

²¹ H. Jack Geiger, M.D., is the Arthur C. Logan Professor of Community Medicine Emeritus at the City University of New York Medical School. He is known as a pioneer in the development of the community health center model. The food prescriptions that Dr. Anderson mentions were for milk, produce, and meat that could be “filled” at local grocery stores; the bills would then be sent back to the community health center for payment. [Bornstein, D. Treating the cause, not the illness. *The New York Times*, July 28, 2011. http://opinionator.blogs.nytimes.com/2011/07/28/treating-the-cause-not-the-illness/?_php=true&_type=blogs&_r=0]

Parkland has been doing some of that. We have a number of clinics out in the community. We share that attitude of, “We can do this when we’re not afraid of the challenge.” We took on the county jail, which is the seventh largest jail in the United States. Sharon Phillips,²² one of my senior vice-presidents who ran our clinic system, volunteered to try to take on the jail with the understanding that if we were going to take it on, we wanted it to be a center of excellence. There is no reason that these men and women who are there an average of less than seven days, when they get discharged, we throw them away. If they have a chronic illness, we’re going to plug them into our clinic system because, ultimately, they will come back to us much more ill and it will be much more expensive. Let’s let them know that we still care, that we’ll try to get them into the system of care. If they’re captive in the jail, we can do TB screening, venereal disease screening, and look for chronic diseases that are going to cause a lot of problems, like renal failure for hypertension. We can try to nip those things in the bud and practice what we preach. Sharon Phillips has turned it around to be a center of excellence.

Parkland can’t be all things to all people, but it has been exemplary among public hospitals in the country. Parkland does trauma and burn level one, and has the largest neonatal intensive care unit west of the Mississippi. At one time, there were 17,000 babies a year delivered at Parkland. Now we’re down to 12,000. We’re the only public hospital in the United States that I know of that’s been able to show a reduction in infant mortality for African Americans that now puts it in parallel with Caucasians. Everywhere else, mortality is two-and-a-half times or more for African Americans. We’ve been able to reduce the rate because we’ve been doing prenatal care in the community for 25 or 30 years and systematically measuring what we do and making interventions that improve it with feedback. It’s a disciplined process, and something to be proud of.

Public hospitals have had a bad rap because it’s a take-it-or-leave-it kind of thing. Patients stand in line forever. Public hospitals have been forced to ration through inconvenience. When I came to Parkland, the place was dingy and dirty. It had four-bed wards. If we had to put a fifth patient in the room, because there was no other place to put him, we couldn’t see him well because there wasn’t a light directly over him. There were renovations to convert to two-bed wards and some single rooms, but the hospital is still compressed into a skin that was built for a different era, when we didn’t have HIV/AIDS or MRSA or some of the hospital-acquired infections that we have to contend with now.

When I came to Parkland, the hospital had just been air-conditioned. It was built without air conditioning. People had been having heat strokes on the ward. The feeling was that the poor should not have air conditioning if Baylor didn’t have air conditioning at that time.²³ The feeling was that, “Patients would never go home if we have too many amenities,” but nobody wants to be in a hospital. They want to go home.

²² Sharon Phillips started her career as a nurse with Parkland in 1985 and is currently executive vice president and chief of population health. Her responsibilities include managing 22 community-based clinics and the Dallas County Jail Health System, serving 100,000 inmates. [Parkland Health & Hospital System. *Senior Executives*. http://www.parklandhospital.com/whoware/leadership/senior_executives.html]

²³ Parkland Memorial Hospital, which had fallen into disrepair during the Great Depression and the war years, was replaced by a new building in 1954. At about the same time, Baylor opened the 436-bed George W. Truett Memorial Hospital, billed as “the hospital of tomorrow,” featuring air conditioning and phones in all patient rooms. [Buntin, J. Lifeline. *Governing the States and Localities*, July 31, 2008. <http://www.governing.com/topics/health-human-services/Lifeline.html>; and, Baylor Health Care System. *Timeline: Baylor Health Care System History*. <http://www.baylorhealth.com/About/Pages/Timeline.aspx>]

We avoided that attitude this time with the building program for the new hospital.²⁴ I'm very proud of the new building program. We'll have about the same number of beds that they had when I came here, but we're seeing half again more patients, having become much more efficient with much lower length of stay. We'll have all private rooms. They'll all be the same handedness. They'll all be standardized. They can be changed in the future—because we don't know where medicine is going and what type of challenges we'll have in the future. We wanted something that could be changed if we needed to change it and not be so constrained. We were landlocked before; now we can grow.

We're putting in amenities that any private hospital would be proud of. We'll have rooms not 155 square feet for two patients, but 300 square feet for one patient with a zone for family, a zone for caregivers, and a zone for the patient. We'll have flat-screen television so the patient and family can be educated at the bedside. It's going to be energy-efficient and nice.

Wayfinding will be easier. The old Parkland wayfinding was lines on the floor—red, green, yellow. They would tell the patient in the emergency room, "Follow the red line." People got lost. The new building will have wayfinding that's thoughtful.

In the new hospital, everybody gets a good view. It's not disorienting as much as it was. The attitude now is that the poor deserve this. Eventually, we don't want to be the hospital just for the poor and a hospital of last resort. We want a social structure in the United States where everybody has access to health care. We want our patients to choose us because we're the hospital that can best care for them—that we're their first option and not a last resort. The ideal thing would be that people would all have a choice, and we'd have to compete for their business.

That's why we put the effort into building the hospital the way it should be built in hope that we would do the right thing at the state level and the right thing at the Congressional level to provide that safety net through insurance. We haven't in Texas. Parkland still will be the safety net, but we would prefer it if our patients would have a choice and could fire us. That's the best assurance of quality—if patients can leave. Many of our patients, we hope, would choose to stay.

We did a survey some years ago. In Dallas, the number one hospital for technology was seen as Parkland. The number one hospital for the quality of doctors and nurses was seen as Parkland. Where do patients go? Parkland was only about third or fourth. The reasons were amenities, because it was an old facility, and that Parkland was stigmatized because it was for the poor.

If the community knows that we already have great doctors and nurses, and soon we will have the amenities, and if we do ever get to social justice in this country where everybody has access to health care, then we will more likely be the hospital of choice. If you don't have the physical plant, it's very difficult. A lot of public hospitals are faced with that situation. On average, and particularly in rural areas, they are many years older than other hospitals. We may need another Hill-Burton²⁵ program because those hospitals are worn out. We need to have equity in infrastructure

²⁴ Construction for the Parkland replacement hospital, a state-of-the-art teaching hospital, began in 2010, with the move in planned for 2015. [Parkland Health & Hospital System. *Less Than Five Months from Completion*, Mar. 26, 2014.]

²⁵ The Hill Burton Program was established by the passage of the Hospital Survey and Construction Act of 1946. This postwar legislation authorized \$3 million to help states survey and determine the need for new facilities and an

for the people that we care for. Hopefully, we'll still do the right thing from the point of view of creating an insurance product for them.

GARBER: What accounted for the shift in attitude from, “We’re not going to put in air conditioning for the poor,” to the new facility where, “We’re going to do something really nice?”

ANDERSON: The other hospitals have been supportive of Parkland taking a lot of the burden off of them. We had a lot of support in the bond program from the other hospitals. I’ve been in communities where the hospitals were against the public hospital being restructured or rebuilt because they saw it as competition. We provide services that the other hospitals didn’t want to provide, trauma, burn, HIV/AIDS care. During epidemics—influenza, polio, tuberculosis—Parkland has never run away from those issues.

When I first came to Parkland, 73 percent of the doctors in Dallas were trained at Parkland. They love Parkland. Now it’s about 50 percent because we’ve had an influx of doctors from other states. This was because we had tort reform in Texas, which brought a lot of doctors here to get away from the litigious environments that they were in. While there has been a dilution of that earlier relationship, we had the support of the medical society. We had support of interfaith groups. We had the support of the clerics in the community. When we first looked at this and talked about it, five years before we did it, we were talking about an increase in taxes that was probably going to be prohibitive. The county commissioners balked. There wasn’t the political will to do it.

I had a very conservative board. We went back and looked at it, and we put together disproportionate share adjustment money, upper payment limit money. We put money into reserve to buy down the obligation of a \$1.3 billion building program, and we only got \$747 million worth of bonds. We won that election by 82 percent. Part of it, I believe, was we agreed to raise \$150 million in philanthropy. We bought down nearly 40 percent of the cost of the project so it wouldn’t be a burden to future taxpayers. If somebody buys a house and makes a huge down payment, the monthly payments are going to be less. We tried to stay within a budget that would not have as much impact upon raising taxes. People agreed that we would raise taxes because our volumes would go up.

We also agreed that we wouldn’t build it too big until we saw what the Obamacare²⁶ impact would be. If we built it without considering that there might be relocation of patients into private sector hospitals, we would be foolish. We might overbuild it. Our clinic was sized to support the central campus with specialty care. In the bond program, we agreed to build five more clinics at our expense, in addition to the 12 we already had, to decompress the central campus and do more of the primary care out in the community.

additional \$75 million each year for five years to fund construction. In exchange for this infusion of capital, hospitals agreed to provide a certain amount of free care or reduced-cost care. [Hoge, V.M. The Hospital Survey and Construction Act. *Social Security Bulletin*;9(10):15-17, Oct. 1946. www.socialsecurity.gov/policy/docs/ssb/v9n10/v9n10p15.pdf; and, U.S. Department of Health and Human Services, Health Resources and Services Administration. *Free or Reduced-Cost Health Care and Participating Hospitals, Nursing Homes, and Other Health Care Facilities*, July 2010. <http://www.hrsa.gov/getthehealthcare/affordable/hillburton/hillburton.pdf>]

²⁶ The Patient Protection and Affordable Care Act, Public Law 111-148, later known as the ACA or Obamacare, was signed by President Barack Obama in 2010. [*The Patient Protection and Affordable Care Act*. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>]

Seeing that we were not going to put all of our eggs in one basket on the central campus, but that we were going to move out into the community, that we were going to do more outreach programs, and that we were going to do this at a cost that would be only 60 percent of the total cost being financed, allowed us to go back to the voter and be successful. It was a very conservative plan, a disciplined plan. Five years before, it wouldn't pass because we were trying to finance the whole project. We put money back and we sacrificed to get it done.

The new Parkland hospital will serve Dallas County for 50 years. It will be flexible and adaptable in the future. It's a statement about Dallas. People don't want the poor to suffer. They want people cared for. They expect the non-profit hospitals to be part of that, and they are. We have good relationships with all the hospitals. It's not just Parkland as a safety net, but other hospitals are also part of the safety net, and we need each other. If Parkland went away, the other hospitals would go down. They couldn't handle the burden. Likewise, if they closed or curtailed services, it would place a burden on Parkland that would not be realistic either.

In a state that has such a poor Medicaid program, we really need each other, and we collaborate. We talk about "coop-tition." For example, we have an injury prevention center here funded by Parkland, but also Baylor, Methodist Hospitals, Texas Health Resources, and Children's Hospital. All of these hospitals came together during the trauma crisis back in the early '90s because we felt like we were going to be using up all of our operating suites on trauma if we didn't do something to curtail the number of injuries.

Many of these were penetrating injuries from gunshot wounds related to cocaine traffic. Interdicting into the cocaine traffic successfully decreased the penetrating injuries. The average trauma we have now is blunt injury. These patients are more likely to be insured, more likely to be something that the other hospitals can handle. We have people now willing to do trauma. We became a trauma 1, as did Baylor; Methodist became a trauma 2. We merged our children's hospital with Children's and included a condition that Children's had to become a trauma 1. We created collaborative opportunities to work together. They told the story with us in the community.

We worked hard to get as little opposition as possible. Eighteen percent of the people are against everything, and that's what we had. Today, in 2014, after our CMS²⁷ issues and other things, I'm not sure we could pass a bond election. It was during Barack Obama's first run for the White House. He carried Dallas. The minority community voted for Parkland. We had great support from every commissioner.

We did our homework. We didn't go out unprepared or think that we'd have an easy road. We were shocked by 82 percent—that was tremendous. The other bond election I was involved with back in 1980, when I was the medical director of the ER and would go out and give talks on it, passed by 63 percent. We knew that Parkland would likely pass. This was a great victory for us to do that. A lot of it was because we re-engineered the way we financed it and did it the most conservative manner we could possibly do it.

The lack of expansion of Medicaid in Texas probably means there are still going to be huge barriers for a lot of our patients. We think Parkland is going to be busier as a consequence, post

²⁷ The Centers for Medicare & Medicaid Services [CMS] is the federal agency that administers the Medicare and Medicaid programs. [<http://www.cms.gov/>]

ACA.²⁸ It's good that we built as big as we did.

GARBER: There is some talk today about the issue of “redefining the hospital.” How will the new Parkland be positioned for the future?

ANDERSON: We will probably always have to have a large central campus because of trauma and burn and neonatal intensive care and some of the specialty services that are not readily available to the poor in our community. Primary care relationships have been developed with the federally qualified health centers (FQHCs), but there are only three FQHCs in Dallas. We provide the majority of the outpatient clinics throughout the community. We call them community-oriented primary care sites. We need to build more. These go beyond direct care. For example, a lot of them provide wraparound services.²⁹ We've integrated behavioral health with primary care, which is incredibly important.

Traditionally, we've not had post-acute care because it wasn't funded by the County, but to be an accountable care organization with integrated systems, we're going to have to be able to control the continuum of care. We may not need to own, but we need to be able to access skilled nursing facilities and home care. We do have home care. We have house call programs for about 400 minority, frail elderly in which we go out into their community and make a huge difference in their lives and keep them out of hospital. We're going to need to do hospice. We're going to need to look at the downstream work as well as the upstream—prevention, health promotion, early access, and early diagnosis and intervention. We need a whole continuum, but post-acute care is something that's been ignored by many public hospitals because they haven't been funded to do it.

I want young people to be exposed to nursing home care that's done well. We have a geriatric residency program. A lot of people don't want to practice in geriatrics because of a memory of going to visit grandmother in a nursing home that smelled bad. It doesn't have to be that way. We need to have teaching nursing homes, and we need to show that it can be done correctly and done well.

If you go out to our clinic sites in Pleasant Grove, we have a three- or four-acre farm so the doctors can do what Jack Geiger did—write a prescription for a “mess of greens.” If you're a diabetic, you can eat all the greens you want. Our African-American patients know what we're talking about, and they will go out and gather their own. We have a little communal farm there, a little garden. With the help of the Urban League, we're also building a tilapia farm out there. They'll sell fish to local restaurants and use the money for social benefit. We have some extra land, why not use it for those kinds of things?

We have a Dallas Area Rapid Transit line running right through our central campus. We oriented our campus around that so we could be a destination point for employees, patients, and others. Twenty years from now, it's going to be incredibly important. We bought enough land not to be landlocked. Eventually, we'll create a community there of housing for nurses, doctors, house staff; medical offices and complexes; restaurants; and other things, which will generate some income

²⁸ Affordable Care Act (ACA), see footnote 26.

²⁹ Wraparound refers to a collaborative process intended to plan services and support for children and youth with complex behavioral health issues, with the goal to avoiding residential or institutional treatment. [National Wraparound Initiative. *Wraparound Basics*. <http://www.nwi.pdx.edu/wraparoundbasics.shtml#>]

to help pay for Parkland, so we can reduce the burden of taxation.

You always think you can tax your way out of anything, but you can't. Ad valorem taxes are very regressive, and they tax the poor. If I'm a poor homeowner who can't afford insurance, I'm paying taxes at Parkland. If we can decrease that burden, then we'll be living up to our obligation as best we can for people who are carrying that burden.

We need to be thinking about the full continuum of care. An example is that we have an injury prevention center that helped Dallas become designated as a Safe Community by the World Health Organization. It's been recertified twice. The center was created during the time of the trauma crisis in Dallas in the early '90s. While a lot of hospitals in Dallas didn't want to do more trauma, they did want to do prevention and they did help fund it.

That could be the platform for people who work in that area to grow from an injury prevention center to a community health institute for prevention, to expand beyond injury prevention to prevention more broadly. A lot of this is about involving the individual patients and their families, giving them the tools they need to do the things they can do even better than we can. It's about trying to find synergies for prevention out in the community.

A good example is the Dallas Independent School District. In the summer, schools with tracks, pools, and basketball courts are all shut down. In some communities, there may not be any safe place for children to play. We wonder why they sit on the couch and play video games. If we could make infrastructure resources available, we could do something about the obesity problem. We do work with the school system in another way—in addition to the clinics we have out in the community, we have 20 school-based clinics.

We've also worked with the Dallas Housing Authority. In studying asthma, for example, we found that in the West Dallas housing projects, 75 percent of children were exposed to cockroach antigens, which are likely to cause asthma. We were able to convince the Dallas Housing Authority to get rid of water coolers—which have mold spores—to get rid of rugs, to get rid of cockroaches, to clean the projects up. The number of patients from that area who had been coming into Children's emergency room and Parkland's emergency room with asthma decreased by two-thirds.

We also asked school nurses what patterns they saw with asthma. They said that children have asthma attacks on Monday and get sent to the emergency room because they've been unsupervised on the weekend. They go out and play and are exposed to lots of things. That helps us to know how to intervene to prevent that. But we wouldn't have known if we had not talked to the school nurses. Our school-based clinics intervened there.

That's what I mean about "managing the in-betweens." How do you find the leverage points in the community? They can be very impactful. There are a lot of non-profit organizations that are working to create jobs in the community. One is HIS BridgeBuilders, a Christian organization. They came to us and said, "We want to create jobs. We train people to make eyeglasses. Last year, we gave 8,000 pairs away. We want to help the patients who get the glasses, but we also want to train people in a new job that will be a living wage." They had found a location in West Dallas. They needed somebody to come in and provide health care at that site. We try to find those kinds of partnerships that make sense, because having a living wage job is also very healthy.

We've got to start thinking that way in the entire country, not just in Dallas. I'd love to see us at the forefront of doing research to show that these things lower health care costs over time, and that they don't cost very much. How when we bring the patient into the equation, we decrease demand for unnecessary services.

We're working on a project with the Dallas Fire Department using data from the Dallas-Fort Worth Hospital Council about ER use. I looked at people who misuse the EMS system to get rides to the hospital. It turns out, we can hotspot and identify individual patients and individual housing units where this is a prevalent practice. One patient might cost a million dollars a year. Care management is the key. If we could care manage that patient for a few thousand dollars a year, we could provide better care, better outcomes, and save that money.

We need to talk about things like housing for inebriates. In studies that have been done in Europe and other places, wet housing³⁰ leads to dry housing leads to sobriety. In our community, we've not had the willingness to pay for wet housing because we don't want to encourage people to drink or to use drugs. What happens to them then? They go to the jail. They go to the Parkland emergency room. They go to the Baylor emergency room. Some of those patients cost an incredible amount of money. Some of them have zero coping skills. We've got people who use the emergency room more than 100 times per year. If we could intervene with the top 200 users and do care management, we could save tens of millions of dollars that could be then reapplied to other health care needs in the community. That's what we've got to start doing.

Back in the '60s, Dallas had an enlightened mayor named Erik Jonsson.³¹ He brought the Dallas-Fort Worth International Airport in even though the bond election for it had failed. He went ahead and got it done, and it's made a huge difference for this community. The airport was part of the mayor's initiative, "Goals for Dallas." In developing the Goals for Dallas, participants candidly sat down and talked about the problems they had. They had dialogues, and they dealt with race relations. They had a Tri-Ethnic Commission. They had all kinds of things that came out of that initiative that made Dallas better.

Parkland could lead a "Goals for *Healthy* Dallas." Hospitals have to get out of that box and move out into the community into health. I'm seeing that happening in a population medicine program at Children's Hospital. That's where I'm working right now in consulting. Baylor has one. Texas Health Resources has one, and Parkland is building on a 20-year tradition of injury prevention and will hopefully go toward a larger prevention institute. There are 33 communities across the country that have created public health institutes to deal with these kinds of issues and hospitals need to align with them.

Hospitals need to align with the FQHCs and the other providers that are out there, instead of seeing them as competition. There is too much work for any of us to do. We're going to have to find new ways to do primary care that's going to be team-approached. We can't afford to have a

³⁰ Wet housing refers to subsidized group housing for alcoholics where drinking is permitted on the premises. It is intended as an alternative to homelessness. [Source: Denizet-Lewis, B. The 'wet house' where alcoholics can keep drinking. *The New York Times*, Apr. 26, 2011. http://www.nytimes.com/2011/05/01/magazine/mag-01YouAreHere-t.html?_r=0]

³¹ J. Erik Jonsson (1901-1995) a cofounder of Texas Instruments, served as Mayor of Dallas from 1964 to 1971. [Jonsson, John Erik. Texas State Historical Association. *The Handbook of Texas*. <http://www.tshaonline.org/handbook/online/articles/fjowh>]

doctor seeing 2,000 patient panels per year. They're going to need to work with nurse practitioners and physician assistants and primary care technicians and all kinds of other people. Like with the Fire Department, after we've identified all of these people who are high users, we're going to make preemptive visits and see if we can't keep them healthy and keep them stabilized. If they have congestive heart failure and start gaining weight, for example, we can intervene.

We're going to get out of our traditional thinking and form partnerships we've not formed before. If we do that, we can be successful. Some people think that the average primary care doctor with a team could actually extend from caring for 2,000 people to caring for 6,000 or 7,000, maybe even more. The physician would care for the sickest, perhaps 1,000 of that group, and the other team members would take care of the rest of them.

There are opportunities with telehealth and the iPhone—all kinds of interventions that we can create with technology. We can monitor blood glucose every day. EKGs and blood pressure can be done with the phone. You can monitor whether somebody who is bedfast at home is in a wet bed or a dry bed. There are all kinds of monitoring tools that we used to call telemedicine. We thought telemedicine was just between one doctor and another. In fact, it can be between a doctor or a health care system and the home. We're going to have to invest in that kind of technology. Google came out recently with a lens for your eye that monitors your glucose.³²

There are going to be new technology breakthroughs, and we're going to need to be adept at using them. One of the biggest areas is the use of "big data" for analytics. Ruben Amarasingham, the physician I mentioned before who does artificial intelligence work here through the Parkland Center for Clinical Innovation, has developed a means of risk stratification to be used when patients are first admitted to the hospital. He can identify the top 20 percent of people most likely to be readmitted within 30 days of the discharge from that admission.

What did we do in response to that? We put social workers, nurse practitioners, dieticians, and everybody to work on those patients with congestive heart failure. At the end of one year, we had decreased readmissions by 27 percent for all patients, but by 40 percent for Medicare patients. This was done by also taking into account socioeconomic determinants. If the patient was a widow or widower, there was a much higher risk of readmission. If the patient lived in the Little Mexico barrio where you have great Mexican food but very high sodium content, the patient was likely to be readmitted. He was able to identify these patients so that we could intervene with them, and it saved a fortune for the Medicare program.

We've put together a registry from our clinics of 29,000 diabetics. Every time they touch the system, we know it. Because of the availability of a unique patient identifier in the database at the Dallas-Fort Worth Hospital Council, we can tell if they were readmitted to Parkland or readmitted to Baylor or someplace else. We know what the success rate is and we can feed that back to the physicians. This really makes a huge difference for them in gauging how their practice is working. For 29,000 maturity-onset diabetics, we can tell if the doctors individually are doing what they should do. System-wise, are the patients getting the services they should get? Are we having outcomes we say we should achieve? The big step in the future is use of big data to prove outcomes

³² Google has announced development of a smart contact lens-like device that monitors the glucose levels in tears. This device, currently in the testing phase, could serve as an alternative for finger pricking for diabetics. [Introducing our smart contact lens project. *Google Official Blog*, Jan. 16, 2014. <http://googleblog.blogspot.com/2014/01/introducing-our-smart-contact-lens.html>]

and be accountable. I see evidence that hospitals are going in that direction.

I've worked with a little company in Chicago called AlertMD. This is an iPhone app where doctors can bill at the bedside in about seven seconds—it codes ICD-10. It codes correctly for the hospital so the hospital gets paid the proper amount. It tells you what the length of stay should be, and if the patient exceeds that length of stay, to go back and see if you got the proper coding. The hospital will be graded on expected outcomes because they'll be more precise, and so their quality numbers may actually improve.

The nicest thing about it is that it notifies the referring doctor. If I'm a primary care doctor and a hospitalist is caring for my patient in the hospital, when there's a transition of care, I'm notified real time. If the patient is discharged, I'm notified real time, and I've got the data. I don't have to wait for a transcription service, and have the patient come back to me for an office visit and because I don't have what happened to them in the hospital, have it be a wasted visit. I know what happened and can make an impact. One of the biggest ways to intervene to prevent readmissions is to get a patient out of the hospital into a clinic and be seen in follow-up. To do that effectively, you need the data.

Managing that data in a new and robust way is going to allow hospitals to get out of the box, so to speak. You'd hope hospitals will get smaller. They'll be more intensive and the patients will be sicker. However, you're also going to see a variety of things there. You're going to see in Dallas a lot of physician-owned hospitals developing that don't take Medicare and don't take Medicaid. They'll just take cash. They're obviously not looking for sick patients, are they? Some of the hospitals that I worry the most about are the safety net institutions, public and private, who are willing to take on everybody and do everything and take on care management and try to really make people better. If they lose the profitable business, if it's siphoned off, then they're less capable of doing that because financially it's more difficult. It's a fragile ecosystem. People are going in the right direction and they're seeing themselves as health systems, not just sick systems.

In the future, many public hospitals are going to have their own HMOs. Then I get paid if I prevent. If I prevent something, I'm making money. Geisinger³³ is a good case in point, because they have their own HMO. They may lose money in the hospital through preventive care—losing revenue because the patient wasn't readmitted—but they make it up on the HMO. That's a good way to think about this. I want to be incentivized to prevent, but if prevention takes revenue out of my pocket, it's kind of an oxymoron to do. It's one of the Achilles heels of American medicine. If we have true integration of the insurance product with the delivery system then, in fact, you can do that. You may see partnerships between insurance companies and hospitals, and gain-sharing. At some point you may see gain-sharing with physicians as well. That may help a lot, particularly in rural hospitals, because it will be either that, or the doctors are going to have to be salaried.

GARBER: Does Parkland have an HMO?

ANDERSON: We have an HMO with over 200,000 Medicaid and CHIP patients.³⁴ I'd

³³ Geisinger Health System, Danville, PA, is a physician-led integrated delivery system with seven hospital campuses and a health plan, which serve a large rural area of central and northeastern Pennsylvania. [Geisinger Health System. *Geisinger History*. <http://www.geisinger.org/about/history.html>]

³⁴ Children in low income families may qualify for Children's Medicaid benefits. Those in families with income that is a little higher than the Medicaid cutoff, may qualify for Children's Health Insurance Program (CHIP). [Texas

had plans to try to morph it into a full insurance product for working poor people so they could participate in the exchanges. I wasn't going after patients that other hospitals have. What I wanted to do was to say, "We have these patients that we've traditionally cared for. If we can get them insurance, and get them into an insurance mindset that they have skin in the game, then they could choose to come to us, and they wouldn't have to leave us because we didn't have a product for them." In the exchanges, we need to be an available option. That hasn't been done yet, but that's one of the things that I hope Parkland will do with the next CEO, that they'll create a product that will be able to interface with the exchanges.

GARBER: Earlier today, before we started recording, you were telling me about the time of the Kennedy assassination.

ANDERSON: Two years before the Kennedy assassination, there was a doctor named Shires, who wrote the textbook *Care of the Trauma Patient*.³⁵ Already, Parkland was becoming a trauma hospital, although there was no trauma designation yet. I got the first designation of a Trauma-1 hospital for Parkland years later in 1987—it was 001. They didn't do that in Texas in the '60s, but Parkland was prepared.

When President Kennedy was brought in, he was mortally wounded. Because of the extent of his injuries, he probably would have died at whatever hospital he would have been taken to. Governor Connally was severely wounded as well, but he survived because he came to a hospital that was prepared to take care of him. He had as many doctors working on him as Kennedy had, because that's what happens in trauma hospitals. Usually patients come in several at a time, and you have to have team after team do this. We had an elevator right to the OR. Mrs. Connally said she was amazed that her husband wasn't lost in the melee of caring for the president.

Today, here in Dallas there is the Southwestern Institute of Forensic Sciences and a coroner system with M.D.s who are terrific. In 1963, there was a coroner who was not a physician. President Kennedy's body was taken away at gunpoint, even though the murder had occurred here in Dallas. The Secret Service agents didn't know what was going on. They didn't know who had done this. Was there a larger plot? With the Lincoln assassination, the whole Cabinet was targeted. They didn't know for sure what else might happen now. They wanted to take Vice President Johnson out as quickly as they could and get him safe. There were a lot of things that could have been done better.

When Jacqueline Kennedy passed away, we got the National Archives to come take the records we had related to the assassination. I saw the handwritten notes. These were doctors I know, and normally you can hardly read their handwriting. These notes were legible. The doctors printed them. They knew this was history. Some of the doctors that were there went on to become world-renowned, but they never talked much about the assassination.

Two who were there are still alive and speaking about this. Even those two, Dr. Ron Jones

Health & Human Services Commission. *How to Get Help: Health Care*, 2014.

<http://yourtexasbenefits.hhsc.state.tx.us/programs/health/>

³⁵ George T. (G. Tom) Shires, M.D. (1925-2007) was chief of surgical services at Parkland at the time of the Kennedy assassination. He operated on Texas Governor John Connally and later on Lee Harvey Oswald. [Dr. G. Tom Shires, 81, surgeon operated on Texas governor shot during JFK assassination. *Los Angeles Times*, Nov. 1, 2007. <http://articles.latimes.com/2007/nov/01/local/me-shires1>]

and Dr. Bob McClellan,³⁶ have different views of whether or not there were two shooters. One believes the Warren Commission report. The other thinks that there had to have been several shooters. It's still a controversy. I wish they would open up what they know about this; because it was pre-Watergate, things were sealed that probably would never be sealed today.

As a consequence of that tragedy, we have a system of hospitals around the United States that are prepared for dignitary travel. Parkland has been involved with the Secret Service ever since. When President Reagan was shot in DC, they took him to the right hospital at the right time and saved his life. He could easily have died from the wound he had.

GARBER: Was President Reagan taken to Walter Reed?

ANDERSON: No, it was George Washington.³⁷ He was taken to the only trauma hospital in Washington, DC, at the time. The Kennedy assassination led to the understanding that trauma hospitals were needed. Sadly, medicine advances during a war. A lot of things we learn about, we learn about through tragedy. That tragedy in 1963 helped us, as a nation, prepare to have trauma centers in key locations around the country. It's a big commitment to be a level 1 trauma hospital. You've got to do research. You've got to do education. You've got to do outreach. You've got to keep your doors open. You've got to take whoever comes, and that means a lot of non-pay patients in Texas.

People don't know that because of international travel, there are many hospitals designated not just for trauma, but for Ebola and things like that. If a quarantine had to occur, who's going to handle that? The nation's hospitals have stepped up and done that. During the Contra conflict in the Reagan Administration, we all agreed to set aside 50 or 100 beds, if we had to—if there was actually a war in our hemisphere. We were needed to help with this because the military hospitals weren't up to the numbers that might be required. Everybody agreed.

Hospitals are an incredible asset. It's not like Israel, where the hospitals can convert to trauma status from civilian status in five minutes. We need to be able to do that in this country. Disaster preparedness is an important issue. Parkland is working on disaster preparedness and various types of scenarios constantly. I've seen two major airline crashes where we took almost all the patients that came. After the Branch Davidian compound fire,³⁸ we were prepared to take whoever came out of that—sadly not as many came out as we had hoped. It's important to have that sort of asset here.

³⁶ Ronald Coy Jones, M.D., and Robert N. McClellan, M.D., were part of the team who operated on President John F. Kennedy and later on Lee Harvey Oswald. [Parkland Foundation. *Ronald C. Jones, M.D.*

<http://www.istandforparkland.org/ronald-jones>; and, Baylor University. *History Through the Eyes of the Medical Arts*, Nov. 26, 2013. http://www.baylor.edu/medical_humanities/news.php?action=story&story=136214

³⁷ President Ronald Reagan was taken to George Washington University Hospital where he underwent emergency surgery after receiving a gunshot wound to the chest on March 30, 1983. White House Press Secretary James Brady, who was even more seriously wounded, was also treated successfully at GW University Medical Center. [President Reagan shooting. *The GW and Foggy Bottom Historical Encyclopedia*, 2010. http://encyclopedia.gwu.edu/index.php?title=President_Reagan_Shooting]

³⁸ In 1993, over 80 people died in a fire near Waco, TX, which ended a 51-day standoff between the Branch Davidian sect and agents of the federal Bureau of Alcohol, Tobacco and Firearms, who had a search warrant to look for illegal weapons in the sect's compound. [Hannaford, A. The standoff in Waco. *The Texas Observer*, Apr. 18, 2013. <http://www.texasobserver.org/the-standoff-in-waco/>]

Eventually, maybe we'll know what happened with the Kennedy situation. It's still on people's minds. We had a chance to do an oral history here about "the day that you remember the most." The surgeons who were here at the time remembered the Kennedy assassination. The nursing staff, on the other hand, remembered the day that Parkland integrated the wards. It was the first hospital in Dallas to become integrated. The nurses had always worked together side-by-side, black and white, but the patients had been segregated, even the children. When the nurses were able to put the patients bed-to-bed and everything else—that was joyful to them. It was a huge victory. Within days, the other hospitals in town did it. The African-American people of my generation remember that, and they appreciate the fact that Parkland did that. In apartheid South Africa, it was the hospitals that first said, "No more," and they opened the door.

Hospitals have a lot that they can do to change the norm. Parkland was noted for that as well, and that's what some people remember the most. The Kennedy assassination was a tragedy. It was imprinted on their brain. Everybody knows where they were that day. It's interesting that the nurses saw the social justice issues of the day being so powerful. They were playing it out, and they got to be a part of that.

GARBER: When did integration occur?

ANDERSON: In 1965, largely because of the implementation of Medicare. Medicare participation required integration. This is something that people may not give the Medicare program credit for. It took a couple of years before real integration occurred in the South, even though Medicare had come out and demanded it. They literally had to have people go by and check and see that integration had occurred before those Medicare checks were written.

One of the first administrators that I hired was an African-American man, Claude McCain.³⁹ He was the first African-American administrator in Dallas, and he had worked at Parkland. When he worked for the Medicare program, his job was to go throughout the South and see that integration had truly occurred.



C. Jack Price

GARBER: Do you mean he would actually go into a hospital and walk the patient care units and see who was in the rooms?

ANDERSON: Yes. Claude McCain worked for Mr. Price,⁴⁰ who was the CEO here during those days. Mr. Price said, "I want a set of black feet and a set of white feet in the room." I brought Claude back when I came on, because I remembered him from when I was in training. He

³⁹ Claude McCain, Jr. (1931-1995) became the first African-American administrator at Parkland when he accepted the position as head of the personnel department; returning to Parkland after working for the U.S. Department of Health, Education and Welfare and earning his master's degree in public administration. He later served as night administrator, and went on to become a vice president at Parkland. [Texas House of Representatives. *House Resolution*;436.

ftp://ftp.legis.state.tx.us/bills/74R/billtext/html/house_resolutions/HR00400_HR00499/HR00436F.HTM

⁴⁰ Charles Jack Price was administrator at Parkland from 1963 to 1979. [1984 *Directory*. Chicago: American College of Hospital Administrators, 1984.]

was the night administrator, back when we had such a thing. That was his job, to go be sure that true integration had occurred.

GARBER: You had told me earlier that Lee Harvey Oswald was also brought to Parkland.

ANDERSON: Everybody in the Kennedy tragedy was brought there—John Connally, then Lee Harvey Oswald—literally within days. The same surgeon, Bob McClellan, worked on both of them. In the movie *Parkland*, one of the things that isn't quite correct is that it shows a huge resuscitation effort down in the emergency room for Lee Harvey Oswald. In fact, he came in bleeding and with stable blood pressure, but he was an elevator case—they took him straight to the OR. When they opened his abdomen to try to get control of the bleeding, the clot on his inferior vena cava blew off. They gave him over 12 units of blood. They tried heroically to save him.

That's the one thing you see in a trauma hospital. On TV, when you see dramas about this, there's always somebody who says, "Well, should we let him live or not?" The surgeons don't do that. They go take care of the patient. They know how to do it technically. They get in there and they try. With Oswald, they tried their best to save him. That was not really portrayed as much in the movie as maybe it should have been—that's the character of trauma hospitals. You just take care of him.

We also took care of Jack Ruby. I had all those records in a vault in my office until the National Archives came. Jack Ruby had lung cancer. He was in the county jail and eventually succumbed to that. He was cared for a number of times at Parkland.

Marina Oswald's child was born at Parkland. There were lots of interactions that people don't know about. They just know about the Kennedy assassination and that's it. A lot of other people in that tragedy were cared for here.

GARBER: Some other interesting things happened related to trauma and the emergency department at Parkland. You were a general internist and became the medical director for the emergency department.

ANDERSON: Yes.

GARBER: It would be unusual today, wouldn't it, for a general internist to be in charge of the ED?

ANDERSON: Frankly, I thought it was less than ideal to have an internist do that. At that time, though, there were very few emergency medicine residencies and there were no boards in emergency medicine. Many of us who were trying to develop that specialty flew to Chicago and met at a hotel out by the airport to help develop the exams for the residency fellowships.

I had been President of the National Trauma Center Association, which is now called Trauma Center Association of America (TCAA). I chaired that because I was involved in trauma as a public health issue, because trauma is preventable. Preparation can help prevent bad outcomes.

The surgeons didn't want to do the administrative work. Surgeons want to operate. They acquiesced to having me do the administrative side of it. Later, when I became CEO at Parkland, I looked into getting a residency program; today, there is an excellent emergency medicine residency

training program. Oddly enough, it's actually in the department of surgery, and they work together collaboratively. Dr. Paul Pepe⁴¹ runs it now, and it's well endowed with grants. He is an internist who later took his boards in emergency medicine, and also has a master's in Public Health. He does a lot of studies in pre-hospital care, resuscitation, and things like that.

I was teaching in the emergency room, and I was running it, but I would also go do internal medicine rounds. My major focus was on a portion of the emergency room—which was medicine. I felt comfortable there. Today, the emergency room is emergency room, period. Except for psychiatry, everything is one big emergency room. Emergency medicine today is a better model than what we did in those days, but we were pre-boards and pre-residency programs. We had one of the first residencies in Texas. There are still way too few residencies in emergency medicine.

GARBER: You were in that administrative position for about five years?

ANDERSON: From 1976 to 1982, when I became CEO on January 1.

GARBER: How did the CEO opportunity come your way?

ANDERSON: As the chief of ambulatory services and emergency medicine, I had the opportunity to work with administration and become an administrator, so to speak. I was approached by the Parkland board, by a man named Ralph Rogers, who was an industrialist—he probably saved National Public Radio during the Nixon years. Although he was a Republican and conservative, he fought Nixon tooth and nail to save NPR. He'd also helped bring back the Arboretum here. He brought back a number of Dallas institutions that got in trouble. He was asked to come run Parkland as the board chair. He got rid of the board, and a new board was appointed. They had a new county judge. His attitude was, "Leave your Republican and Democrat hats outside and come back in here where we're talking about people who all have red blood and who we're going to take care of. That's our job, and politics—out." I admired him for that.

Charles Mullins, the previous CEO, had mentored me for two years. He came in in transition to clean house and take out the remnants of the 17 years when C. Jack Price had run it. I liked C. Jack Price and thought he was a decent guy. The county commissioners rode out from under him and the medical school was against him. I probably was part of the reason that he left, because I documented some Joint Commission⁴² problems here that were not being resolved.

In any event, Charles Mullins⁴³ came in. He was a cardiologist. I had been reporting to him for my academic work. He was the vice-chairman of the department, so we were very close. He encouraged me to take it. On rounds one day, Mr. Rogers said to me, "You're taking care of one patient at a time. What if you could take care of a thousand patients? What if you could take care of

⁴¹ Paul E. Pepe, M.D., is a professor at UT Southwestern Medical Center and also serves as the City of Dallas director of emergency medical services. [UT Southwestern Medical Center. *Doctor & Faculty Profiles*. <http://profiles.utsouthwestern.edu/profile/43741/paul-pepe.html>]

⁴² The Joint Commission was founded in 1951 as a non-profit, independent organization that would develop standards for hospitals and conduct on-site surveys to determine whether hospitals meet those standards and qualify for accreditation. More recently, the Joint Commission has expanded into the accreditation of other types of health care facilities. [<http://www.jointcommission.org/>]

⁴³ Charles B. Mullins, M.D., is executive vice chancellor for health affairs emeritus for the University of Texas (Austin). [Texas Medical Association. Austin physician to lead TMA's 50-year club. *Press Release*, May 13, 2011. <http://www.texmed.org/Template.aspx?id=21604>]

10,000? What if you got involved with policy, and you could still do the things you love to do? I'm willing to do that. We have 100 applicants, and you've seen a lot of them. What do you think?" I said, "Well, we've just gotten out of a pretty bad situation. We've gone through a two-year turnaround. I don't want to go back into the situation where I'm working for somebody that I don't really think has the best interest of the institution at heart. I'll do it, but I'll only do it for five years." He said, "Okay."

That was in 1982. Mr. Rogers lived until 1997, when he called me to his bedside and said, "I'm going to stop taking liquids, and I wanted to see my grandkids, and I know I've just got another couple of days, but I want to talk to you. I think you made a really good decision." He said, "I wanted to ask you, how many years has it been now—that five years?" At the time, it was 17 years or something. He said, "I wanted you to know before I die that I was right." It was very important to him to be right. He teared up a little bit, and he said, "Now go on." He was a sweet man. I actually went to his house and made house calls.

He was right. He said, "Once you start solving problems, once you start working in this area and you start seeing change, and you start being able to rudder the change, you won't want to quit." It's hard to get physicians interested in administrative positions because they see it as taking them away from medicine, when in fact, many times they can influence so much by ruddering the change. It doesn't mean you have to be the engine. It's much more consuming to be the engine of change, but sometimes you can be the rudder of change, and it doesn't take as much energy and you can get going in the right direction.

You've got to recognize then that it takes a whole team. It's not just you. I've always tried to say, any successes we've had were our successes, not my successes. That's a little atypical for physicians, who are of the "captain of the ship" mindset. You find out that that's not so true. You should be the servant of the ship. I found out that my style of leadership was servant leadership, and, if you gave away credit, you never lost it then. It was about promoting other people and replacing yourself over time.

I didn't get a chance to replace myself. A very good guy is going to take my place, it turns out, after a two-year search. I had three or four people beneath me who could actually have been my successor, and that's what I felt like I owed the board. They didn't have to choose who I had prepared. My chief operating officer is now the CEO at Grady in Atlanta. My chief medical officer is now the interim CEO at Cook County [John H. Stroger Jr. Hospital of Cook County, Chicago]. Others are in important positions in their respective areas. They could have done it, and that's all I owed the board. I owed them a succession plan that could have done it, but change was desired.

When I left Parkland, over time they got rid of the top 12 people. There was a desire for real change. I've mentored a lot of young administrators, both physicians and non-physicians. I've told them that, in the public hospital, if you're not prepared to lose your job, you can't do your job. You have to realize that while you probably won't change, the politics will change at some point.

I went from a situation where I had a board that asked me to stay on until the building program was over, instead of retiring, which I had told them I was going to do—to a completely new board that decided they wanted a change. This was driven by one of the county commissioners who wanted more diversity. The irony of it was, I had one chief medical officer who became the CEO of UT-Tyler who was African-American, and another African American chief medical officer

who became the CEO of several Bon Secours hospitals. That was in the last three years of my practice.

My chief operating officer for years was named Mac Day,⁴⁴ and he had done administrative residencies that resulted in populating the hospitals of Dallas with administrators of color. He would take twice as many residents as we really needed in order to create opportunity. As a consequence, both he and I got a lot of credit for creating a whole chapter here, a national chapter. We were criticized for not retaining the residents at Parkland, but they got a chance to go out and earn multiples of what they would have made at Parkland, and got into substantial roles and responsibilities. We feel good about what we did with diversity, but we didn't satisfy one of our county commissioners. That was a part of it.

I had one of the best teams I ever had at the end of my career—people I could trust and who did a good job—who could become really good and get good jobs elsewhere. If everything had fallen apart and they weren't any good, it would have been different. They carry Parkland with them wherever they go because they learned how to behave as a servant leader.

During the 30 years I was there, there were several attempts to take me out—all of them political. This convinced me of one thing: governance is the Achilles heel of public hospitals. A lot of people are appointed—the only requirements are that they're 18 years old and live in the county. If you would want to serve on the board of a non-profit hospital, they'd be looking at your skill sets, expertise, and commitment. They'd want to know, "Why do you want to do this?" You're wouldn't be there to serve the person who appointed you. You'd be there to serve the institution. You'd have a trustee responsibility.

In the last situation, I had a circumstance where people said, "I'm responsible to the people who appointed me." No, by state law, that's not who you're responsible for. You have a separate and fiduciary responsibility under law as an appointed official to vote your conscience and do what's right, and not just do what's politically expedient. I've taken more than one board to task on that. Most of them came back and did the right thing.

Some of the best people I've ever met were on hospital boards—quality people—but it's sad when you have folks who are appointed who don't have an understanding of how you run a \$1.5 billion corporation, and what you're really there for. What is the mission? How can you further that mission? Patients come first. Employees are critical to take care of the patients, so they have to be considered before the politician and the taxpayer, even though you have to pay attention to those things, too, eventually, or they will really cause you problems.

There was a woman I met on the American Hospital Association Board, a nurse named Brenita Crawford.⁴⁵ She was doing her doctoral thesis, and she and I sat next to each other quite a bit at the board meetings. She asked me to be judge of the thesis, which was on the public hospital CEO perspective of hospital governance. I said, "Wow, I'm living through that right now. Okay, I'll do it."

⁴⁴ MacGregor W. Day (1943-2001) served at Parkland for 27 years, the last 12 as executive vice president and chief operating officer. [Parkland Administrator MacGregor Day dies. *The Dallas Morning News*, Mar. 14, 2001.]

⁴⁵ Brenita Crawford, has held a variety of leadership positions including president/CEO of Mercy Hospitals & Health of Detroit. She is currently an assistant professor in the School of Public Health at the University of Memphis. [<http://www.memphis.edu/sph/crawford.php>]

She interviewed 20 or 25 CEOs of big public systems. I could have told you what the result was going to be: when the media starts paying attention to you, you batten down the hatches. I had wanted to be open and transparent with the media—I had been on *60 Minutes*, *20/20*, *Primetime*. I had been open with journalists. They closed in. They were under attack. Don't talk to anybody. It became an armed camp practically.

Board members oftentimes were appointed for the political reasons, not because of expertise, and may or may not have had the skill set that was needed. But mostly, it was the fact that they didn't understand who they were ultimately responsible for and to. Brenita Crawford documented that very well in these interviews. The theme was stated over and over again—purges that occurred with a new mayor or with a new judge, and the problem with patronage.

Luckily in Dallas, we'd avoided patronage. People like Ralph Rogers wouldn't tolerate that. That was something that I appreciated, and that didn't change until toward the end. That's a big issue, though, in public hospitals. The more the CEO can stay out of the purchasing arena, the better, because there are all kinds of friends who want you to work with their cousins and this and that. I never did.

It's important to be open with the community. You can't battle *The Dallas Morning News* without dire consequences. We had a unique situation. As I said, the board became an armed camp. When the medical school had an individual who had sued them four times and lost, but then went the whistleblower route, the plaintiff's attorney was close to investigative reporters. There were probably people who interceded with the regulatory agency to ask them why they hadn't found anything—the Joint Commission didn't find anything, the state didn't find anything. They were kind of told, "You better go back and look, because if you don't, then there is something inept here. Maybe *you* need to be investigated, because we're finding all these things."

All this was about a tenured person who was demoted but couldn't be fired because of his tenure. The medical school felt like this wasn't right and they weren't going to pay him. They were right. They didn't do anything wrong. His allegation was that the house staff were not properly supervised. He alleged that people were operating on patients unsupervised. It turned out that it had happened, and it turned out that it was him. He was the only one that we could find, and we documented it.

There was a death in the ER—a walk-in patient who became nauseated and had a vomiting episode. He had arrhythmia and had to be resuscitated, but passed away. That happened three or four days before the election for the bond campaign. I went down and said, "The data you have from the whistleblower saying that we don't supervise is incorrect. Here are the OR records to prove it." I didn't bully them, although I was told later that I was being a bully because I told them that they shouldn't adversely affect the election when we knew that there was a person trying to harm the institutions—both the school and Parkland.

They saw the data. They saw that they had been incorrect and that he had misled them, so they backed away. We did fine for a while. Then there was a death in the ER again, in psychiatry. In Texas, we're the 50th lowest state in the nation on per capita funding for behavioral health. There is no place to refer people to care manage them. The jail—the seventh biggest in the country—has around 1,700 people a day who are taking psychotropic medications, out of 7,000 or 8,000 inmates. It *is* the mental hospital.

Inmates come to the ER repeatedly. There are violent situations at times, and it is crowded. In this situation, this was a person who had to be taken down and medicated. Everything was done by right protocol. The doctor was standing right over him, giving verbal orders, but didn't write an order for restraint. In that situation, that's a breach. After the second medication, and after they had left the room, he died. I think the coroner first said he died of natural causes—hypertensive heart disease, cardiomyopathy, and an arrhythmia. You can't prove an arrhythmia, so they had to come back and say "death by undisclosed cause." Then there was a lawsuit with that same plaintiff's attorney alleging civil rights violation because the patient was in custody. In fact, it wasn't a civil rights violation. It was a therapeutic misadventure, if anything.

We continued to have those kinds of problems. When CMS came back in that situation, I think the media influenced the regulatory environment. The message to us at Parkland—after we had been down there before and told them that we thought they were incorrect, and we criticized the regulatory people they had sent because they were harsh—was that, "Nobody's too big to fail."

As I saw this coming, it was like looking at when Duke was chastised for research and lost their Medicare participation. You can't survive without Medicare participation. It got everybody's attention in the research world. They thought, "If they'll do this to Duke, they'll do it to anybody." The truth in this situation was, "If they'll do this to Parkland, they'll do it to anybody." The intention was to let hospitals know, "Nobody is too big to fail. The banks may be too big to fail, but hospitals aren't too big to fail. We want you to know that and to be serious about this."

We had always done extremely well on Joint Commission surveys. The conditions of participation for Medicare⁴⁶ are different than Joint Commission, but we thought we'd do just fine as well. We want to do well. It's important. There is almost an industry that's been developed around the CMS Systems Improvement Agreements.⁴⁷ The fee of the company that got our contract to do this was \$7 million initially. It eventually ended up at \$14 million and climbing. We went from 3 deficiencies that were cited by CMS, to 498 deficiencies identified by the consultant selected to administer the Systems Improvement Agreement. There was a clean sweep of things. Some of it was needed, but a lot of it was an incredible amount of industry around something that wasn't necessarily as broken as it was implied in the media.

It left a sour taste in everybody's mouth. You're never too big to fail, and people should know that. It got my attention. We were working very diligently. We would have had it solved. I think that's part of the reason, but the real desire was change anyway. That was a useful thing politically to make the decision at that point because we were well on our way to getting these things fixed, which is okay. You know that those things can happen to you, and you have to be prepared for them. I would caution folks, particularly when they have an event like this.

The day that the first gentleman passed away, 440 patients went through the ER. He had

⁴⁶ The Medicare conditions of participation are minimum standards that hospitals must meet in order to qualify for reimbursement under these federal programs. [Centers for Medicare & Medicaid Services. *Hospitals*. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html>]

⁴⁷ The Systems Improvement Agreement (SIA) is a way for a hospital to obtain an extension on the deadline to make changes in areas that fail to comply with the Medicare conditions of participation. [Fenner, K. The systems improvement agreement. *H&HN Daily*, May 31, 2012. http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Daily/2012/May/fenner053112-7070008304]

been seen the day before in the clinics. He had a complaint that was four years old of a hernia, never had any chest pain or anything like that. It was something that was minor, and it was the wrong place—it was in the ER. We got cited for EMTALA violations, which is really ironic, because I helped to get EMTALA signed into law in Texas when I was chairman of the Board of Health.⁴⁸ They came out with Parkland’s initial policy on stopping patient transfers. We were on *60 Minutes*, on the “Billfold Biopsy,” stopping transfer of people because of financial reasons. Parkland had always been the champion to stop that.

Our breach was sending a patient from the emergency room on the ground floor to the clinic on the first floor and being seen within four hours for a minor illness when she came through the wrong door. Had we escorted her—physically walked her up there—it would have been okay. That was seen as triage without examination. We accommodated the care, but now you come in, you get evaluated, and that’s before we send you upstairs. We’ve actually done the work already.

Everybody was looking at this model. I had even been told by several people in the Medicaid program that they really liked the program because it was getting people out of a high-cost environment to a low-cost environment without threatening them. We were accommodating them. We weren’t “turfig” them off somewhere, and we weren’t transferring them. We were seeing them within the system. The difference is in having a qualified medical person see them first before you triage them instead of a nurse seeing them and triaging. Actually, the nurses were very good at triaging sick from non-sick. We had people come in to study our system while we were implementing it. They were building a clinic across the street from their ER to try to get people over there instead. I can’t tell you how many people stopped all those things because they were scared that they would get an EMTALA violation for that.

We could have done things better. It was a perfect storm of litigants and whistleblowers and investigative reporters wanting to win a Pulitzer and a tenacious plaintiff’s attorney and head-butting with regulatory agencies. I’d fight with everybody else, but I wouldn’t head-butt with regulatory agencies. There is no win there. You’re taking a knife to a gunfight when you do that. There is no way to win that. That was a lesson learned.

GARBER: Parkland never did lose the Medicare certification, right?

ANDERSON: Parkland received the “death letter,” but it said that if you employ the SIA—the Systems Improvement Agreement methodology, and you satisfactorily accomplish that—then you won’t lose Medicare. We never lost Medicare, but it’s like this Sword of Damocles hanging over your head. When they would write an article in the paper about it, they’d talk about the loss of \$400 million, what would it do? It would be devastating. There’s no other option but to comply. Consulting on this has become an industry. We were, I think, the third in the country. Now there have been quite a few more, and there are companies that specialize in these kinds of things. My advice to people is to get a company that specializes in this only, rather than management companies who come in and want to get rid of everybody so they can manage the hospital. It’s a perfect time to get rid of everybody and then bring your people in. People can avoid that by getting companies

⁴⁸ The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed in 1986 to help stop the practice of transferring uninsured patients to public hospitals for financial reasons alone. [Zibulewsky, J. The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians. *Baylor University Medical Center Proceedings*;14(4):339-346, Oct. 2001. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/>]

that do this and do it well, and get in and get out. You have to be very diligent about this—you have to go do it.

Life's a learning experience; sometimes the learning experience is painful. This was hard because I left Parkland with a lot of capital reserves. A lot of them were dissipated during this process. Probably \$75 million was spent in staffing changes. The real question would be, did it improve quality or did it improve compliance? I don't know the answer to that yet. I hope it improved quality and compliance.

The interim people have done a good job in trying to see this happen. They were very competent people, particularly Bob Smith and Dr. Tom Royer,⁴⁹ both with distinguished careers. Tom Royer, who left after nine months, and then Bob Smith, accomplished the nuts and bolts, dotting the I's, crossing the T's, and getting things back into compliance. The new CEO coming in will have a maintenance issue to deal with, but he won't come in to a disaster. He may have to rebuild teams because the interim people will leave. It is a good opportunity for that person to bring in his own team.

We're going to be stronger and we're going to be one of the best hospitals in town from a quality point of view by having gone through this, even though it's like childbirth. We're going to be better off and with higher quality having gone through this pain. Hopefully, that will reassure the community that we're actually living up to our fiduciary responsibility.

GARBER: It was a difficult time for you, too, because this was the time when the board decided not to renew your contract. You were out of your position as CEO. How did you deal with that?

ANDERSON: I knew that I could lose my job for political reasons a number of times, and there were several runs at me by different people, from a governor to a county commissioner. A lot of them were people who were "anti-poor people." I was seen as an advocate. I should have just been a manager and not an advocate. I couldn't do that. I knew I could lose my job.

Somebody gave me sage advice. "You won't change. The board will change." That's what happened. The previous board asked me to stay and extend my time from age 65 on through the end of the building program, even though I was fully vested and, financially, it really wasn't that attractive to continue. The board liked me enough to ask me to stay and not leave during the middle of the building program. A new board came in and there was desire for change about the time I had a fight with a county commissioner over whether or not I was able to get enough diversity in my senior management.

Interestingly enough, that's still his issue, and he's upset that the guy who's going to replace me is not of color. The board went through a laborious process for two years. They had several different candidate pools. I kept telling them, there are some really talented physicians and hospital administrators of color in the community. I know them. Here are 20 names. Ten or twelve of them are African-American or Hispanic or Asian. They're great. They're happy where they are.

⁴⁹ Thomas C. Royer, M.D., formerly CEO of CHRISTUS Health, was replaced as interim CEO of Parkland by Robert L. Smith in September 2012. [Parkland ousts interim CEO, hires for-profit hospital exec. *The Dallas Morning News*, Aug. 15, 2012. <http://www.dallasnews.com/investigations/patient-safety/headlines/20120815-parkland-ousts-interim-ceo-hires-for-profit-hospital-exec.ece>]

You're going to have to recruit them. You're going to have to be nice to them, and you can't treat them as though that's why you're hiring them, because they are competent." You know, it's like Martin Luther King said, "Judge me on the character, but not on the color." That's what they want.

There was one candidate who withdrew from consideration because that's how he felt he was being treated. He had accomplished a great deal and had run several important health systems. He didn't want to be categorized as an affirmative action player. Early in his career, he said, that had helped. It gave him the opportunity. Now, he felt he should be judged by what he was able to do.

That's really sad, in a way, but it's not the end of the world. I'm more interested in somebody who cares about our African-American patients, our Hispanic patients, our Asian patients—whether we're going to be culturally competent to care for them and to create a system of care for them. I don't care what color the CEO is.

We have a great selection now as CEO. He's very interested in diversity, so he may do better. I'm proud of publications that I've written, but I'm also proud of people who worked for me and have gone on to do great things. That's how you extend yourself. They may do more than I'll ever do. They may be more successful than I ever was. It's like training medical students. I've helped train medical students who will save lives in the future that I'll never see or know about. That's one reason you stay in the education field. You want to be able to do that. It's the same way with hospital administrators. I'm real proud of some of them.

I'm working for Cheryl Mayo Williams⁵⁰ here at Children's, along with a guy named Peter Roberts.⁵¹ Cheryl was one of the residents that Mac Day and I took into our program to encourage minority hospital administrators. It's interesting how things come around—now I work for her in Population Health here at Children's.

I'll probably never be able to satisfy that one commissioner, though. I guess that's okay.

GARBER: Has it been announced who the new CEO is?

ANDERSON: Yes, Dr. Fred Cerise.⁵² He went to Notre Dame, LSU, and Harvard, where he got his MPH. He ran the LSU system until he and Bobby Jindal butted heads. Jindal wanted to privatize the public hospitals and wouldn't accept Medicaid expansion.⁵³

⁵⁰ Cheryl Mayo Williams is senior director of community and government relations at Children's Medical Center (Dallas). [Texas House of Representatives. *House Resolution: 1437*. <http://www.legis.state.tx.us/tlodocs/83R/billtext/pdf/HR01437L.pdf>]

⁵¹ Peter Roberts is executive vice president of Population Health and Network Development at Children's Medical Center (Dallas). [Children's Medical Center. *Press Release*, Aug. 29, 2012. <http://www.childrens.com/media/press-releases/2012-archived-press-releases/paul-hain.aspx>]

⁵² Frederick P. Cerise, M.D., became president and CEO at Parkland in March 2014. [Parkland welcomes Frederick Cerise, M.D., as new chief executive officer. *Press Release*, Mar. 24, 2014. <http://www.parklandhospital.com/phhs/senior-executives.aspx>]

⁵³ Piyush "Bobby" Jindal took office as the 55th governor of Louisiana in 2008. Dr. Cerise was replaced in 2012 as head of the ten LSU hospitals after he opposed Governor Jindal's privatization plan for the public hospitals. [Louisiana Office of the Governor. <http://gov.louisiana.gov/index.cfm?md=pagebuilder&tmp=home&navID=38&cpID=1&catID=0>; and, Cerise finds new job in Texas. *The Advocate*, Feb. 4, 2014. <http://theadvocate.com/news/8277725-123/cerise-finds-new-job-in>]

I met him right after Katrina.⁵⁴ We were going down to help with the New Orleans situation. We had 30,000 New Orleanians here. We were down there to help them reconceive their health system if they weren't going to rebuild Charity. He was a bright young guy, and I knew that he had been up to his axilla in water getting patients out of Charity on a gurney. I admired him.

I suggested him two years ago and, ultimately, he rose to the top. We had a very talented second candidate—David Lopez⁵⁵ in Houston. He runs the Harris County Hospital District. He was training as a resident in hospital administration when I was training as a resident in medicine. When I was chief resident, David was a young administrator for C. Jack Price. He's a wonderful guy with a great value system. He's terrific. He's run the Corpus Christi and Nueces County Hospital District. He's run the University of Texas Medical Branch as chief operating officer. He was willing to consider it.

A lot of people would have liked the selection process to have been quicker, but the board came up with a great guy. I was with him yesterday in DC and I told him that I have great expectations of him, that I expect him to do more than I did.

GARBER: A few minutes ago, you mentioned your work that resulted in the passage of EMTALA. Could you talk about the issue of “patient dumping?”

ANDERSON: I was running the Emergency Room, and it was sometimes so egregious to see how people came in. I remember a young woman in labor who was sent to Parkland from another hospital—a religiously-affiliated hospital. When she told them that she was so glad that they would still see her even though her husband had lost his job, they pushed her legs together, started an IV, and sent her to Parkland. She was crowning—the baby was coming any minute. She delivered in the hallway at Parkland. I went over to that hospital and I saw the people there. I think I challenged the doctor to go outside. I was pretty hot-headed about it. It was ridiculous, putting her and the baby at risk like that.

I remember a guy with a stiletto in his back—in his kidney. As he breathed, the knife moved up and down. He was in a taxicab with an IV hanging on the coat hook. The cab driver was saying, “I had nothing to do with this. I had nothing to do with this. I don't know the guy. I don't know what happened. I just drove here as fast as I could.”

We had at that time what was called BioTel,⁵⁶ which allowed the doctors to talk to ambulances in the EMS system. I didn't realize at the time that those call records were public documents. Calls for transfers were subpoenaed by *60 Minutes*. They got them through the courts.

⁵⁴ Hurricane Katrina, which devastated New Orleans in August 2005, resulted in the closing of Charity Hospital. The decision was made not to repair and reopen Big Charity. [New Orleans city hall to occupy historic Charity Hospital building. *Next City*, July 9, 2013. <http://nextcity.org/daily/entry/new-orleans-city-hall-to-occupy-historic-charity-hospital-building>]

⁵⁵ David S. Lopez has been president/CEO of the Harris County Hospital District since 2004. [Head of Harris County public hospital system is candidate to run Parkland. *The Dallas Morning News*, Jan. 2, 2014. <http://www.dallasnews.com/news/metro/20140102-head-of-harris-county-public-hospital-system-is-candidate-to-run-parkland.ece>]

⁵⁶ BioTel, short for Biomedical Telemetry, was begun in 1975 in the emergency department at Parkland. It refers to the radio technology used to communicate with paramedics in the field as well as the resources needed to staff the consultation service. [UT Southwestern Medical Center. *The History of BioTel*. <http://www.biotel.ws/TheBioTelSystem.html>]

They had some statements in there like this one from a doctor who was from Colombia. He said, “This is a capitalist system. I don’t really like it. This guy can’t pay. It’s your job. You’ve got to take care of him, and I’m sending him, whether you want me to or not.” I said, “Is he stable?” He said, “He’s as stable as he’s going to be. I’m sending him right now.”

We set a policy. We had a hotline. We’d take transfers if they were stabilized and they were cared for. If it doesn’t put the patient in jeopardy, we’ll take them. But if you dump them, we’re going after you. We sued three counties for doing this and we won. That led to the passage of indigent health care legislation in Texas, because counties like Dallas County and Tarrant County do a lot, but other counties don’t do anything. We sued them for transferring patients to Dallas instead of being a burden on them.

We had the data. We had the BioTel system. We wrote a policy and we enforced that policy locally. When I became chairman of the Texas Board of Health, I used that policy to create the state law. We drafted it. I took it in. We worked with State Representative Jesse Oliver⁵⁷ to fight the hospitals tooth-and-nail on this because this was huge money to them. They said that’s what public hospitals were for. We said, “No, we have to give care where stabilization is key.”

It was intended to protect the patient. We never presumed that it would be sending an patient who was ambulatory from the ER up to the clinic to be seen on the same day. We never thought of anything like that. That’s a consequence of us making somebody on the regulatory side mad. That was a hard stretch for me to take. I’m glad we passed the bill. I know that EMTALA has become kind of the universal health care substitute, but what was going on was unconscionable, and it stopped.

Now in Dallas, it had stopped already. It had stopped with Parkland’s policy. We had community support and the hospitals worked with us. At one time, I was almost sanctioned by the county medical society because I had brought it up as an issue, but then they backed away. I was told by someone at the Texas Hospital Association, a person who is now deceased, that I would never get a job if I ever left Parkland. Later, I got their highest award. I got the highest award from the county medical society. These were people who were so mad at me initially, but later gave me their highest awards. The three things that I’m proudest of in my career are this change in the care of emergency patients, the creation of the outpatient clinics and the concept of community-oriented primary care, and leaving the legacy of the new hospital, built for the future and to serve the community well. It’s not built “for poor people,” it’s built for patients.

GARBER: Earlier, you had mentioned servant leadership. What does the concept of servant leadership mean to you?

ANDERSON: Servant leadership means that I lead because I first serve. I didn’t necessarily want to lead. From my reading of the books on servant leadership, a lot of times, the people who lead are reluctant to lead, but they lead because they need to. You do it also in a way that brings the other people with you along.

⁵⁷ Jesse D. Oliver (D) represented Texas District 111 in the state legislature for two terms from 1983 to 1987. He was instrumental in passage of HB 1963, which addressed the issue of proper transfer of patients. This legislation was signed into law in 1985. [*Legislative Reference Library*. <http://www.lrl.state.tx.us/legeLeaders/members/lrlhome.cfm>]

To lead, you have to have followers. They have to want to follow you. It's your obligation to make their lives better, to help them grow, help them mature, help them be better than they are today—so at the end of the day, they're better off than they were before.

It's not demand and control. The idea that you can demand and control, and really think that you're in control, is an illusion. You're really not. You still need cooperation, you need collaboration, and you need support. You need to be respectful. A servant leader is available, has an open-door policy, tries to be transparent, and tries to work with everyone in a fair way.

That doesn't mean you have the power. That's, again, an illusion, but you also find that you can create power by giving it away. As a CEO, I can delegate responsibility to people and let them grow and watch them grow. I can expand my power by giving others the authority to go out and do things, to create, to accomplish, and to grow. In many ways, that's how CEOs create power. It's not in and of themselves and their energy, it's that business of ruddering. It's not the engine, but through the rudder. You have to believe in those other people. You have to hold them accountable. You have to evaluate them and talk with them, tell them where they can get better—mentor people.

Mr. Price was a classic demand/control. There was a button at the front which was put in by his secretaries. When he came through the front door, someone would push the red button. "He's in. Straighten up!" They didn't need a button with me. I think that's important. He did control. He had a red carpet. I asked him one time, "Why do you have a red carpet?" He replied, "So you can't see the blood." He meant it. You towed the line. In many ways, he was very successful for 17 years, and in other ways, not so much. A servant leader wouldn't approach things that way. The servant leader asks for opinions and advice and input, realizing that just the fact that he or she demands something doesn't mean that it is right.

The Greenleaf Center in Indianapolis was very helpful to us. We worked with a woman named Ann McGee-Cooper,⁵⁸ who was a disciple of Robert Greenleaf. She helped us develop our own internal network. Instead of it being a program that we rolled out like all our programs—we did it by subterfuge. We started a book club on servant leadership. We invited people we knew to be servant leaders, and many of them were not people who were in senior administration.

One of the servant leaders we picked was Casteen Adams, who ran the laundry. Casteen would go to her church and find people who needed a job. She'd hire them in the laundry, which was hard work. Then she'd go look at the hospital job board and say, "You've done so well here. There's a job opening in dietary," or, "There is a job opening here with more money. I want you to go look at this." She helped people move up, then she'd go hire some more people for the laundry. She helped a lot of people grow into careers that helped put their kids through college. When she was 18 years old, and not yet married, she took in the four children of a woman from her church who was dying and needed to have somebody raise her kids. Later, Casteen got married and had two kids of her own. That woman was a servant leader.

We had rewards for servant leadership, and it wasn't always about what you did in the hospital. It might be what you did in your church, what you did in a non-profit, eleemosynary thing

⁵⁸ Ann McGee-Cooper, head of Ann McGee-Cooper & Associates, is an author, speaker, and consultant in the area of servant leadership and creativity in business. [Ann McGee-Cooper & Associates. *About Us*. <http://amca.com/about/meet-our-team/ann-mcgee-cooper/>]

out in the community, how you served others.

I had a guy who was African-American say to me, “Just about the time that we become senior managers, now you want us to be servant leaders. Do you know our history?” I said, “I’m going to take you out to Dallas Baptist University.” We went out there, and there is a statue of Christ washing the feet of the apostles. We pulled up and sat in front of it for a while. I said, “What do you see?” He happened to be Baptist like me, and he said, “Oh, okay. I get it.”

You can’t always put it in a religious context, particularly in a secular institution. It really is: are you willing to sacrificially serve others in order to lead? If you look at the Marine Corps, you’ll have these tough Marines. If the leader in that unit gets killed, what happens? The next guy picks up, and he goes. Everybody is trained to know what the others need to do. The next guy up is going to be the leader. He may be a reluctant leader, but he’s going to have to do it. In a fashion, that’s what it is—step up to the plate when you need to. If you do it with humility, and you give credit away, and you talk about “we” instead of “me,” that’s the key.

GARBER: As we close today, I’d like to give you the opportunity to speak about your wife and her support for your career.

ANDERSON: My wife came to Parkland before I did. She came to John Peter Smith⁵⁹ even before that. She was going to be a missionary nurse to Africa, but she got to these two public hospitals and found out she could do about what she could do in Africa here.

She’s a Baptist. She’s from Madill, Oklahoma, and Borger, Texas. She had worked in the ER and in psychiatry. She did the equivalent of a nurse practitioner program with Dr. DeLoach,⁶⁰ who was the chairman of psychiatry. He took her under his wing. She also went on to a head nurse position in neurosurgery when we had our first child.

She was a stern nurse. There were no decubitus ulcers on her ward. There had been a real problem there. She wouldn’t tolerate it. She went out on the ward with the nurse’s aides and the LPNs, and she did the same work they did. They admired her for that. They can be recalcitrant to nurses who tell them what to do. When she rolled up her sleeves and did the same thing they did, she showed them that she wasn’t afraid of the work. That’s how she had worked her way through nursing school. They admired her and liked her and would do anything for her.

We’ve been married 38 years. She left Parkland when our first child came along and being the CEO of our home became her fulltime job. She knew as well as anyone what I was going through. She knows what Parkland was like and then what it evolved to. When she was at Parkland, they had to swap sheets from another nursing unit to get their patients the sheets they needed. It was an underfunded place and then, all of a sudden, we changed it remarkably. She was appreciative of that. She was supportive of that.

⁵⁹ John Peter Smith, a resident of Fort Worth, donated land in 1877 for construction of a hospital. The City-County Hospital was built on this land about 60 years later. It was renamed the John Peter Smith Hospital in 1954. [JPS Health Network. *History*. <http://www.jpshealthnet.org/About-JPS/History.aspx>]

⁶⁰ Asa William DeLoach, M.D. (1922-1979) was named interim chairman of the Department of Psychiatry at UT Southwestern Medical School in 1971. [Dean names Asa William DeLoach interim chairman of psychiatry. *Newsletter: The University of Texas Southwestern Medical School at Dallas*, July 1971. <https://repositories.tdl.org/utswmed-ir/bitstream/handle/2152.5/1170/Newsletter197107.pdf?sequence=1>]

She never liked the politics of it. She never understood why they had to be as mean as they were. But, she understood the hours and tolerated the work situations. There were few times that we had a vacation that I didn't get called back or something. I don't know if I could have found anybody else who would have tolerated the work conditions.

My children were very angry. None of them went into medicine, very much because of the attacks I had from one of the county commissioners. When my daughter was 13, I saw her taking a page out of the phone book and tearing it up. I said, "Why?" She said, "That's Commissioner So-and-So. It's somehow symbolic. I just needed to tear it up." It was very personal. In public life, that happens.

My wife got me back in church. That's what I'm doing a lot now—some work with Ambassador International Ministries, and Christians in Public Service, Inc., which is a group of people who have been through the wringer trying to live their values in a secular system. She's been there when I was a deacon in three different churches and has always been supportive in that regard. I would credit her with praying for me and getting me back involved and getting our kids involved. When I became so enamored of medicine, I became a closet Christian instead of the person who's practicing. She helped get me back in touch with values that my grandfather gave me. She can humble me pretty easily. She knows how to tell me I'm really not who I want to be and think I am.

GARBER: Is there anything else you'd like to talk about?

ANDERSON: No, I appreciate the time and thoroughness. Thank you for that. I hope it helps mentor somebody someday.

GARBER: I hope so, too. Thank you very much for your time this afternoon.

ANDERSON: Thank you.

CHRONOLOGY

- 1946 Born September 6, 1946, in Chickasha, Oklahoma
- 1969 Southwestern Oklahoma State University (Weatherford, OK)
Bachelor's degree, Pharmacy
- 1973 University of Oklahoma Health Science Center, School of Medicine (Oklahoma City)
MD
- 1973-1976 University of Texas Southwestern Affiliated Hospitals (Parkland-VA) (Dallas, TX)
1973-1974 Internship (Internal Medicine)
1974-1975 Residency (Internal Medicine)
1975-1976 Chief Resident (Internal Medicine)
- 1975 Married April 12, 1975 to Sue Ann Blakely of Madill, Oklahoma
Children: Brandon, Sarah, Daniel, John
- 1976-1982 Veterans Administration Hospital (Dallas, TX)
Active Attending
- 1976-present University of Texas Health Science Center (Dallas, TX)
1976-1981 Assistant Professor
1976-1983 Division Chief, General Internal Medicine
1979-1982 Assistant Dean for Clinical Affairs
1981-1986 Associate Professor of Internal Medicine
1986-present Professor of Internal Medicine
- 1976-present Dallas County Hospital District-Parkland Memorial Hospital (Dallas, TX)
1976-present Active Attending
1979-1982 Medical Director, Ambulatory Care-Emergency Services
1981-1982 Acting Medical Director
1982-2011 President/CEO
2012-present Senior Advisor to the CEO
- 1986-present University of Texas School of Public Health (Dallas, TX)
Adjunct Professor (Health Policy, Management, and Policy Sciences)
- 1992-2011 Trinity University (San Antonio, TX)
Affiliated Faculty, Department of Healthcare Administration
- 1994-1999 Baylor University School of Law (Waco, TX)
Adjunct Faculty (Advanced Studies in Health Law: Parkland Hospital Internship)

MEMBERSHIPS AND AFFILIATIONS

Academy of Medicine, Engineering and Science of Texas
Member

Action Dallas, Help Our Clinics
Member

AIDS Arms
Co-Chair, Trauma Plan Development Committee
Member, Advisory Board

Alliance for Medical Management Education Advisory Council
Member

American Cancer Society
Member, Advisory Council, Evergreen Gala Benefit

American College of Emergency Physicians
Member

American College of Healthcare Executives
Associate
Member, Leadership Advisory Committee
Member, Physician Executives Committee

American College of Physician Executives
Member

American College of Physicians
Fellow
Master

American Diabetes Association, Dallas Chapter
Member, Board

American Foundation for Trauma
Chairman

American Geriatrics Society
Member

American Heart Association, Dallas Chapter
Member, Board of Directors

American Hospital Association
Member, Board
Member, Governing Council of the Section for Metropolitan Hospitals

Member, Regional Policy Board
Member, NOVA Award Committee
Member, Steering Committee, Community Care Network
Member, Task Force on Health Disparities in Hospitals
Section Delegate, House of Delegates

American Indian Center
Member, Board

American Medical Association
Member
Member, Ethical Force Program Oversight Body

American Public Health Association
Member

American Red Cross
Volunteer Consultant to National Volunteer Chairman

American's Walk for Diabetes
Co-Chair

Association for Health Services Research
Member

Association of American Medical Colleges
Member
Member, Advisory Council to the Generalist Physician Program
Member, Advisory Panel on the Mission and Organization of Medical Schools
Member, Forum on the Future of Academic Medicine

The Bridge, Youth Impact Center
Member, Advisory Board

Brooks-Conrad Association
Co-Chairman, Scholarship Dinner

Center for Community Responsive Care
Member, Board

Child Abuse Prevention Center
Member, Advisory Board

Child Care Partnership
Member, Board

Children's Defense Fund
Member, Texas Advisory Board

Children's Health Fund
Member, Advisory Board

Children's Oncology Services of Texas
Member, Medical Advisory Board

Circle of Life, Donor Awareness Coalition
Member, Advisory Board

Circle 10 Council Exploring Task Force
Member, Membership Committee

Commonwealth/Picker Program on Patient Centered Care
Member, Advisory Panel

Community Council of Greater Dallas
Member, Homeless Services Task Force

Community Hospice Center Committee
Medical Advisor

Community Inpatient Hospice Committee of Dallas
Member

Council of Teaching Hospitals
Member, Board
Representative to AAMC Assembly

Council on Family Violence Prevention
Chair, Board of Commissioners
Member, Board of Commissioners

Dallas Alliance
Member

Dallas Area Infant Immunization Coalition
Member, City-County Health Policy Coordinating Group

Dallas Assembly
Member

Dallas Baptist University
Advisor, Oak Cliff Partnership Advisory Committee

Dallas CASA
Member, 30th Anniversary Committee

Dallas Challenge
Member

Dallas Citizens' Council
Advisory member
Member

Dallas Council on Alcoholism and Drug Abuse
Chairman
President
Vice President

Dallas County Community College District
Member, Health Committee

Dallas County Medical Society
Member

Dallas Family
Member, Advisory Board

Dallas for Children
Member, Advisory Council

Dallas-Fort Worth Council Against Health Fraud
Member

Dallas-Fort Worth Hospital Council
Chairman, Executive Committee of the Board
Member, Education and Research Foundation Board

Dallas Hispanic Health Coalition
Member, Advisory Board

Dallas Medical Resource
Member, Board

Dallas Teaching Hospital Forum
Member

East Dallas Cooperative Parish
Vice President, Advisory Board

East Dallas Cultural Center's Vision Campaign
Corporate Endorser

Environmental Agencies
Member, Transition Committee

George Washington University Medical Center
Member, Advisory Committee for the Study of the Costs and Financing of Primary Care

Governor's Task Force on Indigent Health Care

Greater Dallas Ahead
Member, Board

Greater Dallas Crime Commission
Charter member, Strategies for a Safe Dallas Committee

Greater Dallas Healthy Community
Member

Greater Dallas Injury Prevention Center
Member, Leadership Council

Health & Human Services
Chairman, Goals for Dallas
Member, Coordinating Council

Health Industry Council
Chairman, Board
Founding member, Board
Member, Executive Committee

Health Promotion/Disease Prevention Project
Member, External Advisory Committee

Hogg Foundation's Commission on Community Care of the Mentally Ill
Member

Homeward, Inc., AIDS Hospice Development Effort
Member, Board

Institute of Medicine
Advisor, Committee on Using Performance Monitoring to Improve Community Health
Member
Member, Access to Healthcare Services Project
Member, Health Disparities Committee

Joint Commission Hospital Users Advisory Group
Member

Junior League of Dallas
Member, Community Advisory Board

Kaiser Commission on Medicaid and the Uninsured
Commissioner
Member

Kaiser Foundation Health Plan of Texas
Chairman, Quality Committee
Member, Advisory Board
Member, Facilities Committee

Kappa Psi
Member

KERA Domestic Violence Advisory Committee
Member, Advisory Committee

March of Dimes, Dallas Chapter
Member, Board

March of Dimes, North Texas Chapter
Member at Large, Executive Committee

Mayor's Commission on International Development
Member, Medical Task Force

Medicaid and the Children's Health Insurance Program
Member, Advisory Committee

Mental Health Association of Greater Dallas
Member
Member, Advisory Board

Mexican Earthquake Disaster Relief
Co-Chair, Texas Response

National Academic of Sciences, Institute of Medicine
Member

National Association of Public Hospitals
Chairman
Member, AIDS Committee
Member, Executive Committee
Member
Treasurer

National Foundation for Trauma Care
Co-Investigator, Advisory Committee Member

National Health Leadership Council
Member

National Health Policy Forum
Consultant

National Public Health and Hospital Institute
Chairman
Member, Emergency Preparedness Advisory Group
Member, Executive Committee

National Steering Committee on Hospitals and the Public's Health
Member

Nelson-Tebedo Community Clinic for AIDS Research
Member, Underwriting Committee

Nexus Recovery Center, Inc.
Member, Advisory Board

North Central Texas Council of Governments
Member, Regional Health Planning Committee

North Texas Geriatric Education Center
Member, Steering Committee to Establish the North Texas Geriatric Education Center

North Texas Poison Center
Founder and Member, Medical Advisory Board

Parkland Foundation
Ad Hoc Member
Chair
Founder
Member

Parkland Memorial Hospital
Member, Graduate Medical Education Subcommittee of the Medical Advisory Council

Parkland/Zale Lipshy University Hospital, University of Texas Southwestern
Member, Consortium Committee

Phoenix Houses of Texas
Member, Board of Advisors

Project Graduation Coalition
Member

Public Planning Policy and Capital Spending
Member

Red Cross U.S.-Mexico Border Public Health Association
Member

Robert Wood Johnson Foundation
Site consultant

Robert Wood Johnson Foundation's *Health Futures: A Program to Improve Maternal and Infant Care in the South*
Member, National Advisory Committee

Salesman Club of Dallas, 1986 Class
Member

Salesmanship Club
Member, Camp Board
Member, Program Development and Evaluation Committee

Share the Memories Again, The NAMES Project
Member, Host Committee

Society of General Internal Medicine and American Society of Internal Medicine
Member

Southern Methodist University Maguire Center
Member, Advisory Board/Ethics Advisory Board

Sovereign Nations Preservation Project
Member, Board

Stemmons Corridor Business Association
Member, Board

Texans Care for Children
Member, Advisory Committee
Member, Board

Texas Attorney General's Health Care Committee
Member

Texas Attorney General's Task Force of Non-Profit Hospital Charity Responsibility
Co-Chair

Texas Attorney General's Task Force to Study Not-for-Profit Hospitals and Un-sponsored Charity Care
Co-Chair

Texas Association of Physician Assistants
Advisor

Texas Association of Public and Non-Profit Hospitals
Member, Executive Committee
President

Texas Board of Health
Chairman
Member
Member, COTH Spring Meeting Planning Committee

Texas Cancer Council
Member

Texas Coalition for Juvenile Justice Conference
Member, Advisory Committee

Texas Health and Human Services Commission
Member, Medical Care Advisory Committee

Texas Health Foundation
Member, Board
Member, Life

Texas Health Institute
Chair, Board
Member

Texas Health Policy Task Force
Member, Ex-Officio

Texas Higher Education Coordinating Board
Chairman, Subcommittee on Legislation
Member, Subcommittee on Implementation

Texas Hospital Association
Chairman
Member, Task Force on Teaching Hospitals
Member, various committees

Texas Institute for Health Policy Research
Chairman-Elect, Board
Member, Board

Texas Lt. Governor's Special Task Force on Long Term Health Care
Member

Texas Medical Association
Consultant, Access to Health Care Committee

Texas Public Health Association
Member
Member, various committees

Texas Task Force on Indigent Health Care
Member

Tobacco Settlement Permanent Trust Account
Member, Administration Advisory Committee

United Way of Metropolitan Dallas
Member, Leaders Society Advisory Council

University of Oklahoma Center for Health Policy Research and Development
Member, National Advisory Council

University of Texas at Austin Pharmaceutical Foundation
Member, Advisory Council

University of Texas Health Science Center at Dallas
Ad Hoc Member, Faculty Council
Chairman, Ambulatory Care-Emergency Service Committee
Chairman, Medical Records Committee
Chairman, Neighborhood Clinic Cooperation Planning Committee
Member, Ad Hoc Committee to Evaluate the Mental Diagnostic Center
Member, Administrative Advisory Committee, Mental Health Clinical Research Center
Member, Advisory Board, Southwest Long Term Gerontology Center
Member, Committee on Gerontology and Geriatric Medicine
Member, Chronic Renal Dialysis Development Committee
Member, Committee to Evaluate Clinical Competence, Department of Medicine
Member, Intern Selection Committee for Senior Students
Member, Medical Care Evaluation Committee
Member, Search Committee for Various Deans and Department Chairs
Member, Various advisory, development, and executive committees
Member, Working Committee, Gen. Internal Med./Gen. Pediatrics Fac., Develop. Grant

University of Texas Houston Health Science Center
Member, Dallas MPH Program Strategic Advisory Committee

University of Texas School of Allied Health, Physician Assistant Program
Member, Medical Advisory Committee

Visiting Nurses Association
Member, Capital Campaign

Walk or Run Around the Rock
Member, Advisory Committee

Zale Lipshy University Hospital
Member, Board of Directors
Member, Medical Advisory Board

SELECTED PUBLICATIONS

[Note: Dr. Anderson has been a prolific author and public speaker throughout his career. He has been covered extensively by the press and has appeared on television. The following bibliography represents articles and book chapters that are related to health care administration or policy. Excluded were items related to clinical medicine, stories that appeared in the press, and presentations or testimony.]

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AWARDS AND HONORS

1980 *Who's Who in the South and Southwest*

1981 *Directory of Distinguished Americans*

1981 *Personalities of the South*, 2nd ed.

1982 *Dictionary of International Biography*

1983 *Who's Who in America*, 43rd ed.

1984 Commendation for Meritorious Service on the Indigent Care Task Force, Texas Governor Mark White, Lt. Governor W.P. Hobby, and Speaker of the House Gib Lewis

1985 Anderson Award in Law and Medicine, Baylor University Law School

1985 Spirit of Texas Award, WFAA TV Dallas

1985 Unsung Hero Award, Dallas Council on Alcoholism and Drug Abuse

1985 *Who's Who in Texas*, Texas Sesquicentennial ed.

1986 Public Service Award, Texas Association of Community Health Centers, Inc.

- 1987 Honor and Recognition, Service on the Special Task Force on the Future of Long Term Care, Lt. Governor W.P. Hobby
- 1987 Resolution for Contribution to the Status of Physician Assistants in Texas, Texas Academy of Physician Assistants
- 1987 Texas Leadership in Aging Award, Texas 6th Annual Joint Conference on Aging
- 1988 Dallas Historical Society Award
- 1988 James E. Peavey Memorial Award, Texas Public Health Association
- 1989 Honoree, Texas Health Foundation Roast
- 1989 John P. McGovern Award, Texas School Health Association
- 1989 Resolution/Honoree for AG Task Force Work as Co-Chairman, Texas Hospital Association Board of Trustees Annual Meeting; and, Dallas-Fort Worth Hospital Council
- 1990 Advocacy Award, Dallas Epilepsy Association
- 1990 1st Annual Safety-Net Award for Community Service, National Association of Public Hospitals
- 1990 Health Care Professional of the Year, Texas Nurses Association-American Nurses Association, District Four
- 1990 Honorary Member Alpha Eta Society, The University of Texas Southwestern Medical Center Chapter of the Alpha Eta Society
- 1990 Outstanding Service, Loyalty and Dedication Award, AIDS Services of Dallas
- 1991 The Health Care 500
- 1991 Honorable Mention, Safety Net Award, National Association of Public Hospitals
- 1991 Who's Who in Health Care, *Dallas Business Journal*
- 1992 Distinguished Human Service Professional Award, Community Council of Greater Dallas
- 1992 Doctorate of Public Service, (*hon. caus.*), University of North Texas, Texas College of Osteopathic Medicine, Fort Worth, Texas
- 1992 Earl M. Collier Award, Texas Hospital Association
- 1992 Honorable Mention and Top Honor, Safety Net Award, National Association of Public Hospitals

- 1992 Leadership Award, National Junior League and Junior League of Dallas
- 1992 Who's Who in Health Care, *Dallas Business Journal*
- 1993 Cares Award, American Health Systems
- 1993 Finalist, Foster G. McGaw Prize, American Hospital Association-Baxter Foundation
- 1993 First Place, McKinney, Texas, Job Corp
- 1993 *The Health Care 100*, 1993-1994 ed.
- 1993 Prism Award for Outstanding Mental Health Advocacy, Mental Health Association of Greater Dallas
- 1993 Recognition of contribution to *Bridging Health Care Barriers*, Association of Black Women Physicians
- 1994 John P. McGovern Award for Humanitarian Medicine and Lectureship, Association of Academic Health Centers
- 1995 Curtis P. Artz Award, American Burn Association
- 1995 Public Citizen of the Year Award, National Association of Social Workers
- 1995 Public Citizen of the Year Award for the State of Texas, Dallas Unit of the National Association of Social Workers
- 1995 Tree of Life Award, Jewish National Fund
- 1996 Public Service Excellence Award, Public Employees Roundtable
- 1996 Doctor of Humane Letters, (*hon. caus.*), Southern Methodist University, Dallas, Texas
- 1996 Texas Community Health Promotion Award, Texas Department of Health
- 1996 *Who's Who Among Top Executives*
- 1996 *Who's Who in Medicine and Healthcare*
- 1997 Elected to membership, Institute of Medicine of the National Academy of Sciences
- 1997 NOVA Award, American Hospital Association
- 1997 Torch of Conscience Award, American Jewish Congress
- 1998 Community Based Organization of the Year, Dallas Concilio

- 1998 Paul Harris Fellowship Award, Dallas Market Center Rotary Club
- 1999 Award for Child Advocacy, Children's Defense Fund
- 1999 COPC Initiative, American Cancer Society
- 2000 Champions of Health Award, Texas Medical Association Foundation
- 2000 The Gertrude Shelburne Humanitarian Award, Planned Parenthood of Dallas and Northeast Texas
- 2000 Mentors and Allies Award, YWCA
- 2000 Top 100 Hospitals, HICA-Sachs Institute
- 2000 Vision of Hope Award, Turtle Creek Manor
- 2001 Award for Excellence, American Public Health Association
- 2001 First Annual Ron J. Anderson, M.D., Healthcare Servant Leadership Award, Alliance for HealthCare Excellence
- 2001 Heroes for Babies Award, March of Dimes
- 2001 Oak Cliff Good Samaritan Award, Dallas Baptist University
- 2001 One of America's Best Hospitals, *U.S. News & World Report*
- 2002 Boone Powell, Sr., Award of Excellence, Dallas-Fort Worth Hospital Council
- 2002 Honorary Member, Pi Alpha Alpha, University of Texas at Arlington Chapter
- 2002 Palliative Care Program: Circle of Life, *Celebrating Innovation in End-of-Life Care*, Citation of Honor, American Hospital Association in conjunction with the American Association of Home and Services for the Aging, the American Medical Association, and the National Hospice and Palliative Care Organization
- 2003 Board of Directors Award of Honor, American Society of Hospital-System Pharmacists
- 2003 Champion of Community Hospital, Dallas County Medical Society Alliance
- 2003 Citizen of the Year Award, Dallas-Fort Worth Indian Lions Club
- 2003 J. Erik Jonsson Ethics Award, Cary M. Maguire Center for Ethics and Public Responsibility, Southern Methodist University
- 2003 Max Cole Leadership Award, Dallas County Medical Society

- 2003 Number 41 of the 100 Most Powerful People in Healthcare, *Modern Healthcare*
- 2003 Ohtli Award, Mexican Consulate
- 2003 Parkland Health & Hospital System, Honorable Mention, Safety Net Award, Accountability & Quality Improvement in Reducing Infant Mortality, National Association of Public Hospitals
- 2003 Top 100 Hospitals, Solucient
- 2004 Award of Honor, American Hospital Association
- 2004 Certificate in Homeland Security III, American College of Forensic Examiners Institute
- 2004 Certification of Recognition/Education Recognition, American Diabetes Association
- 2004 Circle of Servant Leaders, Greenleaf Foundation
- 2004 Honorable Mention in the Community and Patient Service, National Association of Public Hospital and Health Systems
- 2004 Honoree for Leadership, Dedication and Commitment to Care of the Elderly, Texas Geriatrics Society
- 2004 Linz Award Nominee
- 2004 Number 58 of the 100 Most Powerful People in Healthcare, *Modern Healthcare*
- 2004 Rosalynn Carter Leadership in Caregiving Award, Rosalynn Carter Institute for Caregiving
- 2004 Safety Net Leadership Award, National Association of Public Hospitals
- 2004 Top 100 Integrated Healthcare Network Systems, Verispan
- 2004 25 Busiest Community Hospital Emergency Departments, *Modern Healthcare*
- 2004 United Who's Who
- 2005 Excellence in Community Service Award, Texas Hospital Association
- 2005 (*hon. caus.*), University of Dallas
- 2005 Max Cole Award, Dallas County Medical Society
- 2005 Number 1 of 50 Most Powerful Physician Executives in the Healthcare Industry, *Modern Physician*
- 2005 Number 17 of the 100 Most Powerful People in Healthcare, *Modern Healthcare*

- 2005 Spirit of CONTACT Award, Contact Crisis Line
- 2006 Angel of Freedom Award, Human Rights Initiative of North Texas
- 2006 Excellence in Healthcare Award, Professional Research Consultants, Healthcare Marketing Report
- 2006 Hall of Fame Health Award, DFW International Community Alliance
- 2006 Local Heroes Award, Bank of America
- 2006 Mastership, American College of Physicians
- 2006 Number 15 of 50 Most Powerful Physician Executives in Health Care, *Modern Physician*
- 2006 Number 31 of the 100 Most Powerful People in Health Care, *Modern Healthcare*
- 2006 1 of the 50 Most Powerful Physician Executives in Health Care, *Modern Healthcare*
- 2006 Safety Net Leadership Award, National Association of Public Hospitals
- 2007 Best Medical Project, *Dallas Business Journal*
- 2007 Best of the Rest, Verispan
- 2007 Best Real Estate Deals of 2006, *Dallas Business Journal*
- 2007 Contributed Poster Session Award, Texas Society of Health System Pharmacists
- 2007 Five Stars for Patient Perception of “Quality of Care,” Professional Research Consultants
- 2007 Innovator of the Year, College of Healthcare Information Management Executives
- 2007 Melvin Jones Fellow Award, Lions Club International Foundation
- 2007 Number 24 of the 50 Most Powerful Physician Executives in Healthcare, *Modern Physician*
- 2007 Number 27 of the 100 Most Power People in Health Care, *Modern Healthcare*
- 2007 Top 25 Innovators in Health Imaging & IT, *Health Imaging*
- 2007 Quality Improvement Achievement Award, TMF Health Quality Institute
- 2008 Man of Influence Trail Blazer Award, The Family Place
- 2008 Named in “Twenty People Who Make Health Care Better,” *HealthLeaders*

- 2008 National Benchmarks for Success Award, Thomson 100 Top Hospitals
- 2008 Number 16 of the 50 Most Powerful Physician Executives in Healthcare, *Modern Physician*
- 2008 Silver Eagle Award / Emeritus Award, National Foundation for Trauma Care
- 2009 Number 18 of 50 Most Powerful Physician Executives in Health Care, *Modern Healthcare*
- 2009 Top 100 Hospitals to Work For, *Nursing Professionals*
- 2009 *Who's Who in Medicine and Health Care*, 7th ed.
- 2010 Distinguished Alumni Hall of Fame, University of Science and Arts, Chickasha, Oklahoma
- 2010 Mayor's Award of Excellence, City of Duncanville, Texas
- 2010 31st Annual CEO Circle, U.S. Hispanic Chamber of Commerce
- 2010 Top Physician Leaders, *Becker's Hospital Review*
- 2011 Award for Advocacy on Behalf of the Underserved, Texas Friends of the Rabin Medical Center, Tel Aviv, Israel
- 2011 Award for Excellence in Service, PHHS Medical Executive Committee
- 2011 Certificate of Appreciation, Operation Cares
- 2011 Lifetime Achievement Award, National Association of Public Hospitals and Health Systems
- 2011 Lone Star Award, The Association of Substance Abuse
- 2011 Parkland Health & Hospital System named as One of America's Best Hospitals for 18 consecutive years, from 1993-2011, *US News & World Report*
- 2011 Peacemaker's Award, Dallas Peace Center
- 2011 President's Award, National Association of Public Hospitals and Health Systems
- 2011 Safety Net President's Award, National Association of Public Hospitals
- 2011 Senior Healthcare Executive of the Year, American College of Healthcare Executives of North Texas
- 2011 Top 65 Physician Leaders, *Becker's Hospital Review*
- 2012 Grassroots Champion, American Hospital Association

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