THOMAS F. FRIST, JR., M.D.

In First Person: An Oral History

Interviewed by Kim M. Garber
On January 17, 2013

Edited by Kim M. Garber

Sponsored by
American Hospital Association
Center for Hospital and Healthcare Administration History
and
Health Research & Educational Trust
Chicago, Illinois

2013
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Coordinated by
Center for Hospital and Healthcare Administration History
AHA Resource Center
American Hospital Association
155 North Wacker Drive
Chicago, Illinois 60606

Transcription by Chris D’Amico
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Louis Fabian Bachrach, Micael-Renee Lifestyle Portraiture, Simon James Photography,
and the United Way of Metropolitan Nashville
KIM GARBER: Today is Thursday, January 17, 2013. My name is Kim Garber, and I will be interviewing Dr. Thomas Frist, Jr., chairman emeritus of HCA Holdings, Inc. In the 1960s, together with his father, Dr. Thomas Frist, Sr., Dr. Frist conceived of a company that would own or manage multiple hospitals, providing high quality care and leveraging economies of scale. Founded in 1968, the Hospital Corporation of America, now known as HCA, has owned or managed hundreds of hospitals. Known as the First Family of Nashville, the Frists have made substantial contributions to Music City through their work with the Frist Foundations and other initiatives. Dr. Frist, it’s great to have this opportunity to speak with you.

DR. THOMAS FRIST, JR.: Thank you. Welcome to Nashville.

GARBER: It’s great to be here! Let’s start by talking about your childhood. You were born in 1938 here in Nashville, the eldest of the five children of Dr. Thomas Frist, Sr., and Dorothy Harrison Cate Frist.¹

FRIST: Yes.

GARBER: Your father participated in our oral history series years ago, so we’re fortunate to have his comments about his life and early experiences with HCA on record.² Would you tell us about your parents and their influence on you?

FRIST: I was fortunate to have had great parents. Any successes I’ve had, I attribute to the two of them. My father was beloved and was and is this company’s heart and soul. He was a cardiologist with a large practice. He was a patient’s doctor, a physician’s doctor, he was beloved and respected by everyone. He was conservative, a little bit to the right of center in his beliefs, and it was fascinating to hear the discussions around the dinner table between my parents, because my mother was a brilliant academic type, who had a liberal mindset. In hindsight the give-and-take in those conversations helped formulate my set of beliefs.

My mother was a wonderful person, fiercely protective of her family. While my father was a 24/7 type of physician, giving everything he had to his patients and his patients’ families, she was always there behind the scenes, bringing him back into focus, not letting us be forgotten as children and as a family unit. She was a great person.

GARBER: With those two parents, one more conservative, one more liberal, how did you end up?

FRIST: I’m a closet liberal. For instance, I believe in a health care system that’s more inclusive than we’ve had in the United States. But I also see the pros and cons of both sides of the fence. I’d say I got the best of both of my parents.

GARBER: Did the fact that your father was a physician influence your choice of a profession?

FRIST: Yes, I saw my father make a difference in countless families’ lives by dealing with all sorts of issues, including problems with alcoholism, abusive spouses and other things, while he was taking care of their hearts and lungs. I saw how he did immense good and was able to influence people’s lives for the better through his practice.

He built a prominent practice, caring for five or six governors of Tennessee as well as many of the community leaders. He was able to make a positive impact on society through those relationships and the many other things he did in giving of his time and effort to things outside of medicine. In seeing that, it was a natural thing for me to follow in his footsteps. I never considered doing anything other than going to medical school. It was part of my heritage. I never thought about being a business person or a lawyer or teacher. I was going to be a doctor.

GARBER: Did you have heroes as a boy?

FRIST: Not that I know of. I did not have a picture of a successful athlete or a successful business leader up on my wall. I think my heroes were my parents. I didn’t call them heroes. In my family, on both my mother and my father’s side, there was a lot of interaction among the family. While other people would travel around the world, with us it was mostly the family unit going to state parks or driving to Florida for our vacations. It was a happy time for me but I had no real heroes. As I grew older, there were people who did impact me but they were more like role models.

GARBER: Where did you go to high school?

FRIST: I went to a school called Montgomery Bell Academy in Nashville. It was a single sex private school. Throughout high school, college, and medical school, I was always in the top 10 to 15 percent of the class list but never a valedictorian.

GARBER: Did you have any memorable experiences during high school?

FRIST: Most of my K-through-12 memories revolve around sports. I loved to be involved in football, basketball, tennis—team sports, particularly, were attractive to me. I happened to be decent in most of them. That was an important part of my school life that I fondly remember.
One of the persons who influenced me was my high school football coach, Tommy Owen. From Coach Owen I learned the importance of building a good team of people around you. As the quarterback of the 1955-56 Tennessee State Football Champions, I began to develop my leadership skills. Through my team sports experience I learned I would only succeed when surrounding myself with others more talented than I. Later in life, I translated that into business, civic, and charitable activities—always seeking out others smarter than myself.

GARBER: You went on to Vanderbilt University, which is where your dad had received his MD degree. How did you decide on Vanderbilt?

FRIST: It never occurred to me that I might go some other place. I didn’t even know that Yale, Princeton, or Harvard existed. From living in Nashville and going to all the Vanderbilt basketball and football games from the time I was a very young child, it was expected that I would attend Vanderbilt University. My parents never suggested or encouraged me to consider other universities.

GARBER: What was your undergraduate degree?

FRIST: Undergraduate was a B.A. degree – Pre-Med.

GARBER: Then you went on to medical school at Washington University in St. Louis. How did you end up there?

FRIST: By the time I was in college, I had developed a habit of setting goals for myself. It became a part of my daily routine, like brushing my teeth every morning. What am I going to accomplish today? What am I going to do this year?

One of those goals was to get into the very best medical school. Harvard turned me down. Johns Hopkins turned me down. Stanford and Washington University accepted me. I decided Stanford was a little far away for this Old Southern boy. I picked Washington University in St. Louis, Missouri, and it was a wonderful experience.

Medical school was the first time I had ever been exposed to a more global picture of the world. Most of my life had been fairly insular. All of a sudden, I was thrust into a class with students from 30 to 40 other states and foreign countries. I saw the value in reaching out to the more diverse world in which we live.

That’s when I suggested to my parents and my youngest brother,3 who was 14 years younger,

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that he might think of schools other than Vanderbilt. As a result, he did go to Princeton and, eventually, the Harvard School of Medicine. At the time, my parents thought that was heresy; that if he went off to school, he’d come back a socialist. To the contrary, Bill became an outstanding cardiac surgeon and, eventually, a United States Senator. Anyway, besides being a great medical school, Washington University vastly extended my outlook on the world.

GARBER: What did you find your strengths to be in medical school?

FRIST: It was a time in which a reasonable intelligence and my strong desire to help others in times of need came together to give meaning to my education. Certainly my goal setting and my willingness to work hard served me well. Let’s go back for a moment to Vanderbilt. The greatest value from my four years at Vanderbilt was not from the classroom. It was in the extracurricular activities that I undertook. One of the goals that I had set for myself was to achieve certain financial independence.

I hoped to someday be an outstanding surgeon, but I also set a goal to achieve financial security and wealth created from activities independent from the practice of medicine. While I was at Vanderbilt, I set up a company called Collegiate Advertising. I distributed desk blotters to over 110 college campuses. They were made for the student dormitory rooms and had paid advertising for No-Doz pills, Genesco Jarman Shoes and 30 other companies. By going to New York and dealing with people in the advertising business, I learned lessons about how you get in the door, how you sell to people. I also learned a lot during those three or four years of creating Collegiate Advertising about distribution, finance, borrowing money, and paying down debt. Most importantly I learned about the value of hard work and commitment.

Another important early experience was my first exposure to flying, which has been another passion in my life. While I was distributing those desk blotters to Oklahoma State University, I missed the only flight out of Stillwater, Oklahoma, and had to sleep on a couch. I came back to Nashville and said, “I will never be dependent on the airlines again!” I got my pilot’s license and have always owned an airplane since then. Aviation has changed my life dramatically.

I bought my first airplane rather than buying my wife her engagement ring. She never will let me forget that! I bought a $3,000 fabric-covered 1948 Stinson aircraft, and said, “We’ll put off getting married one more year.” Airplanes sound like an expensive hobby, but it’s always been a part of my life, and I never bought an airplane that I didn’t sell later for more than I paid for it. In the early years of building HCA, private aircraft proved to be invaluable tools that provided the company a great advantage over our competitors.
GARBER: Did you have any other experiences in medical school that you’d like to mention?

FRIST: That was the first time I encountered women as peers in the workplace. It was a fairly new phenomenon to have women in medical school. I had six or seven out of 60 class members who were women. I learned to appreciate early on the value of women in my professional life and in the world. That was an important exposure for me to have classmates who were not only geographically diverse but also of a different gender. Over the years, I and others at HCA have been strong advocates for women.

GARBER: Was this when you met your wife?¹

FRIST: No, I met my wife when she was in the eighth grade and I was in the ninth grade. We married after my first semester in medical school and have been married now 51 years. But all during that time, I courted and chased her. When she would go to Fort Lauderdale at spring break, I’d get in my little fabric airplane and follow her down and make sure no other men moved in to my turf. I can’t remember a time the two of us haven’t been together. “Since eighth grade” is a long time.

GARBER: You went back to Vanderbilt for your internship. What made you choose surgery?

FRIST: Again, I think it is part of my DNA. If you look at things I enjoy—it’s not flying a glider, but it’s a motorized plane. I don’t enjoy sailing, but I love powerboats. Cross-country skiing doesn’t appeal to me, but I’m an avid downhill skier. I would have been okay in internal medicine, but I like something more proactive, making things happen. At that time, open heart surgery was beginning to come into its own. I liked the idea of being an open heart surgeon, pioneering in a new field.

GARBER: You were drafted during your residency?

FRIST: If I had joined the Berry Plan, I would have been deferred from military service through my residency and then I would have served later.² But, I’ve always been a risk-taker—appropriate risk—so I didn’t join. It was at the height of the Vietnam War when I got my draft notice. I had a backup plan. I thought that if this ever happened, I’d go to my father (who had had the last five governors as his patients) and say,

⁴ Patricia Gail Champion
⁵ The Berry Plan, in effect from 1954 to 1974, was named for Dr. Frank B. Berry, an official in the Department of Defense. It offered three choices of draft deferment to medical school students: service upon completion of internship, after one year of residency, or after residency training was completed. [Source: Berry, F.B. The story of “The Berry Plan.” Bulletin of the NY Academy of Medicine; 52(3):278-282, Mar.-Apr. 1976. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1808239/pdf/bullnyacadmed00149-0016.pdf (accessed Aug. 16, 2013).]
“Dad, I’ve gotten a draft notice. Could you call Governor Ellington⁶ and ask him to get me in the Air National Guard so I can continue on with my residency?” I called my father, but he said, “Tommy, you never discussed this with me. I went to World War II, and I think you ought to serve in the Vietnam War.” I ended up serving as a Strategic Air Command Flight Surgeon at Robins Air Force Base in Warner Robins, Georgia, for two years, and it was a life-changing experience, a wonderful experience. I wouldn’t trade it for anything, but it did interrupt my first year residency.

During that military experience, for the first time in almost a decade of being very focused on pre-med and medical school, I had a chance to have some time to think outside of the box. That’s when I reflected back on some of my other goals and how I was going to achieve them. I had developed that discipline of setting goals for each day, *What am I going to do? What are my goals?* It was a fairly formal thing that I went about in setting those types of targets for the day, and month, and year. One fortunate happening that occurred during my residency was my introduction to the stock market by a fellow resident. I began by investing $3,000 in the KFC IPO⁷ when I was an intern and three years later, I had pyramided the initial investment into $150,000. These funds plus an additional $150,000 I borrowed provided me the seed money I invested in 1968 as one of the three founders of HCA.

While I was in the military, I came up with the idea of a hospital company similar to what had developed in other sectors of the economy. Back then, you had A&Ps, Krogers, Publix and other grocery chains created to share resources. You had other industries provide models for taking advantage of size and scope. However, the delivery and administration of health care in the United States was 20 to 30 years behind most other industries in best practices.

The idea came partly from a fraternity brother at Vanderbilt University, Spence Wilson, whose father, Kemmons Wilson,⁸ was one of the two founders of Holiday Inns of America, a company which created a new industry. Up until then, there were only hotels for people to stay in. They started a new industry—motels—which ultimately changed the whole leisure field sector.

I took that concept to my father, who by that time had one hospital that he and some other doctors owned and were in the process of converting it in to a freestanding not-for-profit facility which would be sold to the city. I said, “Dad, you love this hospital. You talk about what a great job it does in taking care of its patients in a warm and caring environment. Maybe we ought to do something that hasn’t been done, and that is put a group of hospitals together and share their resources and maybe change the way that health care is delivered in the United States.”

That’s how it all happened. If I hadn’t been drafted in the military, hadn’t had the opportunity to see the rapid growth of the Holiday Inn and KFC, hadn’t had these past experiences to reflect back on, hadn’t had a father who was a prominent physician with contacts around the

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Southeast, there wouldn’t be today an HCA.

**GARBER:** The hospital that your father was involved with was the Park View Hospital here in Nashville. Did he discuss his management experiences there with you?

**FRIST:** No, he wasn’t really involved in management. Like I had found important over the years, he surrounded himself with other good doctors. In the case of Park View Hospital, they worked on getting the very best administrator along with the best department heads. To this he added something else that was invaluable, a set of beliefs and practices that put the patient first.

That’s more what I saw versus the skills of actually administering a hospital. In the 1960s, universities providing MHA's were just beginning to emerge. Back then when somebody said to me, “You might go get an MBA,” the first MBA that came to mind was Montgomery Bell Academy, where I went to prep school, rather than a “master’s in business administration.”

**GARBER:** At that time in the late ‘60s, there was not a whole lot of multi-institutional system building going on, was there?

**FRIST:** I did not know of any. From the time we started the company until today, there have been three barriers to entry that have discouraged investment in the hospital sector. One, hospitals are capital-intensive. That’s very important and always a constant. Why would you want to go into an industry with high capital requirements? Two, hospitals are government-regulated. That’s a negative. Why would you want to go into something where the government is constantly telling you what you can and what you can’t do? Constantly changing the rules. Third, it’s labor intensive.

At any one time, those things will change in importance. If any two of them are aligned against you, the hospital sector is severely challenged. What our vision in 1968 included were answers for changing these three hurdles into opportunities. By creating a multihospital system, we could take advantage of its size to raise capital in the public debt and equity markets. At the same time, it would use its newfound purchasing power to gain favorable prices for supplies and equipment. For the first time we began to develop and install operating systems to reduce costs while increasing quality. It was more taking things that other industries had done and transferring those practices over into being better managers of hospitals. This was a time prior to computers, prior to digital radiography and so many other things, such as the internet, we take for granted today.

**GARBER:** There was interest at that time in shared services.

**FRIST:** As far as shared services, in the early years we developed a vision for what might could and would happen as the technology evolved. We learned that to achieve the true potential of a multihospital system you need to own the hospitals. At one time, we managed 140 or 150 hospitals for their owners. Even with all our expertise and resources, we could take a non-owned managed hospital and maybe achieve 50 to 60 percent of what we could realize if we owned 100 percent of a facility. The control through the balance sheet and governance brings many more opportunities for economies of scale and improved operational and clinical outcomes. One of the big missed

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opportunities during the ‘60s, ‘70s and ‘80s involved the big medical schools—the Vanderbilts, the Johns Hopkins, the Mayo’s and others. They developed their own campuses, but they never took full advantage of the government’s regional medical program initiative. They were perfectly positioned to be the consolidator of hospitals into multihospital systems.

**GARBER:** How did you build a system of hospitals?

**FRIST:** First, there has to be a need in society for something to be created to fulfill that need. There was a need in the United States for modern new hospitals. Part of that was created by air conditioning. HCA wouldn’t be here today if air conditioning had not been invented. Much of the early growth of the investor-owned sector was in the Sun Belt. Much of the reason for that was because of the huge population shift from the Rust Belt in the Northeast to the Southeast which would not have occurred if the quality of life throughout the whole Sun Belt area hadn’t been greatly improved through air conditioning.  

The first priorities in government spending in these rapidly growing communities were for schools, highways, utilities, and other infrastructure needs. The last on the agenda was hospitals. At that same time, the Federal Hill-Burton program was terminated so there wasn’t that source of capital for the freestanding not-for-profit hospital. State governments were under duress. Local governments had all their infrastructure challenges. The religious orders were withdrawing back into the big cities. We were the last choice. But HCA would come in and fulfill a need.

We happened to have a young doctor in myself, a prominent businessman in Jack C. Massey, who had been in the surgical supply business for many years and was experienced in dealing with hospital CEOs and boards, and then my father, a prominent cardiologist with a great reputation. We came together at the right time, the stars aligned, and we saw an opportunity to fill a need in society.

One other key thing in the beginning was that Park View Hospital was about to be converted to a not-for-profit owned by the City of Nashville because the doctors had made it so successful that it was taking too much of their capital to keep expanding the hospital. That’s when I said, “Consider creating a publicly-owned multihospital company.”

At the time we decided to pursue our vision, I had three months remaining in my two-year term in the military. I was in Georgia, and my father and Mr. Massey were in Nashville. On the weekends, I’d get in my airplane, fly back home, and we’d talk about it—do we really want to do this? One day, we announced in the newspaper we were moving forward. However, the next day my father and Mr. Massey got cold feet and had second thoughts. My mother came to my rescue. She said to my father, “Tommy is going to do this, even if you aren’t, so you might as well join him.” Well, I couldn’t have done it, but it was my mother who gave the final impetus to get HCA off the ground.

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10 Engineer Willis Carrier (1876-1950) is credited as the inventor of air conditioning, patenting the design in 1902. First intended for commercial use, after World War II, air conditioners spread to public buildings and homes. [Source: Willis Carrier. Who Made America. PBS. http://www.pbs.org/wgbh/theymadeamerica/whomade/cARRIER_hi.html (accessed Aug. 16, 2013).]

That’s when we went to the other shareholders in Park View and said, “Let’s use this as the launching pad to start a new company called Hospital Corporation of America.” It came together because of Mr. Massey’s image in the business community and his great success in buying Kentucky Fried Chicken from Colonel Sanders and making it a tremendous success. The physicians saw the potential of putting their hospital into this new company. I, as a young person, was the cheerleader, the person who was running around the country saying, “Sell me your hospital. Let us build you a hospital.” Mr. Massey was helping raise money and Dad was talking to people about quality and all the things that were important to us, things that we could do. We were able to put together 11 hospitals in that first year.

We could not have done that in a not-for-profit environment. Cash flow has been, and always will be, a key ingredient to what can be done in the capital-intensive hospital sector. We had, for the first time, brought hospitals together using stock. People had such faith in Mr. Massey and his track record on Wall Street and also his background in the medical supply business that before we even went public we could print stock certificates and give them to people and say, “This is worth $30 a share. This is worth $40 a share. We’ll trade you this for your hospitals.”

It didn’t have to come out of the cash flow of Park View Hospital to acquire a hospital in Athens, Tennessee, or Selma, Alabama. It came from us having a tradable security, a stock certificate. We were able to quickly put together those first 11 hospitals. Then we had an IPO that raised the capital to let us accelerate our expansion plans.¹²

GARBER: That first IPO happened fast.

FRIST: 1969.

GARBER: 1969, within one year of your founding.

FRIST: Yes, very quickly. You seize the moment. In business and life, there is risk. In case we weren’t successful, I always could go back to complete my surgical residency. Fortunately, I’ve never had to use my medical degree as a practicing physician.

Some people had suggested we should organize HCA as a franchise business similar to Kentucky Fried Chicken. Mr. Massey, knowing both hospitals and the franchise business, said, “No, to accomplish what we want to do, you must own the facilities.” Other people said, “Why don’t you let the hospitals remain not-for-profit and manage them for a fee?” Mr. Massey was insightful in saying, “You must own these facilities,” and so we went down that path.

GARBER: What was it like preparing for the IPO?

FRIST: I mentioned earlier that I had set certain financial goals for myself, my family, and things I wanted to do in philanthropy. To realize that dream before I was 30—I was 28 at the time we went public—those were pretty exciting times for me as a young person with his life ahead of him. It was nice, to get it out public, and I did achieve those goals. The stock went from $18 to $40 the first day. Over the next 45 years, our stock price has moved through many cycles of highs and

lows; however, the valleys were shallower and the peaks higher with each cycle. For those investors who treated HCA as a marathon rather than a sprint, they have been well rewarded.

**GARBER:** Was it difficult emotionally to deal with these roller coaster-like moves?

**FRIST:** Not really, because my long-term goal was always to build a great health care company. Since I was a long-term investor, it did not matter whether the stock was up or down so long as I had staying power to weather the down cycles. I never sold a share of stock. If anything, I kept buying stock in HCA in the down times. I am now 74 years old and I still believe in the mission of HCA and the strength in the underlying assets of the company. Most importantly, I believe in the integrity and vision of HCA’s leadership.

For me, it was never how much I was worth. It was—how are our hospitals doing? Are they contributing to the local community? Are they contributing to better health care in the United States? Are they doing a good job in the other countries where we were? I think we have been true to our mission statement, which is key. We put down our beliefs for all to see back in 1969 or 1970. That mission statement has been the glue that has held this company together over the years, in good and bad times.

**GARBER:** Do you still have the same mission statement?

**FRIST:** Absolutely. It is timeless—it is the thread interwoven through the organization—and has been particularly important as we increased in size. It is one thing to run one hospital, five hospitals, or 11 hospitals in a narrow geography, but entirely a different challenge to manage 100 hospitals spread throughout the United States. It is imperative to have a strong set of beliefs to provide the glue to hold the organization together.

**GARBER:** Let’s move on to the 1970s, which was a time of building and growth. How did you go about acquiring hospitals? Did you acquire existing hospitals or build new ones?

**FRIST:** Both. At the same time we were acquiring the original hospitals, we established an aggressive construction program to meet the huge demand for new hospitals. In the 1970-80 era, the needs for new hospital capacity in the Sun Belt states was so great that we would have to be selective in how, when, and where we would commit our capital. In fact, in 1971 or 1972, we had to slow down our construction projects when the capital markets, both equity and debt, came under real duress. The answer is that we did both, but at certain times we had to slow down development of greenfield hospitals until the capital markets improved.

**GARBER:** Historically, investor-owned companies tended to acquire investor-owned
hospitals and then later began to look at acquiring not-for-profit hospitals. Was that true of HCA?

**FRIST:** Yes, out of the first 11 hospitals, there was one, in Livingston, Tennessee, that was a not-for-profit that we acquired.13 Over the next two or three years, things happened in the macro environment—which accelerated the conversion of hospitals from not-for-profit to investor-owned. One example was the Nixon price/wage controls in 1970-71. This put price controls on hospitals. Yet labor and other costs were not controlled. It put the hospital sector into a crisis.14

Frequently, when the government has done something over the years, it has created opportunities for us at HCA. This was one of those cases. While we had talked about our purchasing power and our administrative expertise and all of the other economies of scale brought to the table, some of them were pretty embryonic in their development. But the Nixon price/wage control period did force many not-for-profits to reluctantly turn to us for help. This did lead to HCA establishing a management contract division to manage hospitals for other owners.

We could write a book about various other times when the federal government’s actions have created opportunities for HCA. One of those was in 1980-81, when the federal government, trying to control inflation, precluded the domestic banks from lending money for acquisitions. We were now global in our reach, so we went outside the United States to access capital from European and Asian banks. HCA’s global presence created opportunities for us to acquire not-for-profits when others were unable to do so.

Another factor that fostered the increasing acceptance of HCA as a viable alternative to the traditional not-for-profit hospital was that the image and role of the investor-owned hospitals has changed significantly. In the 1960s, the typical for-profit was a small hospital located behind a doctor’s office in the rural south. In the 1970s and early 1980s, with the advent of the multihospital investor-owned systems, the perception evolved into “overflow/skim the cream” limited service hospitals; however, under the radar, the investor-owned sector was taking on more and more challenges. We were no longer building overflow hospitals in these communities. As we were gaining greater credibility and as pressures came on the traditional freestanding not-for-profit hospitals in cities like Aiken and Myrtle Beach, South Carolina, the communities would come to HCA and agree to turn over their not-for-profit hospitals if we would build them a modern state-of-the-art replacement medical center. A good example is the Kings Daughters Hospital in Frankfort, Kentucky, which turned to HCA and asked, “Will you replace our facility?”15 It was the only hospital in the state capitol of Kentucky. Thirty-five years later we are still the sole hospital provider for Frankfort.

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15 Established in 1894, the King’s Daughters’ Hospital in Franklin, KY, was in need of expansion and modernization in the early 1970s. HCA bought the facility and built a total replacement hospital, known today as Franklin Regional Medical Center. [Source: Hospital website. http://frankfortregional.com/about/history.dot (accessed Aug. 16, 2013).]
More and more, we were given the opportunity to acquire larger hospitals, in some cases teaching hospitals and hospitals that were the sole provider in a community. That meant we must take everyone that comes to the door. There’s good and bad with that commitment. But on balance at HCA, we have demonstrated we could do it and do it well. A hospital today in HCA is entirely different from a proprietary hospital back many years ago. I don’t know about freestanding investor-owned facilities, and I can’t speak for other investor-owned companies, but I know at HCA today its hospitals are fulfilling the role of the traditional not-for-profit hospital. One of the main differences in 2013 between a HCA hospital and a not-for-profit is capital formation, i.e. access to the equity markets and the fact that we pay federal income taxes. The mission, the mix of patients, the commitment to quality and excellence are indistinguishable from top-tiered not-for-profit and HCA hospitals.

**GARBER:** Is there an HCA prototype design for new hospitals?

**FRIST:** Yes, there have been many prototypes over the years. At one time, we had prototypes for rural hospitals, for suburban hospitals in major markets, and then we built the big tertiary care hospitals. Each of them had certain things in common. The pressure to have prototypes and move quickly was particularly felt during the Reagan era, as the country was moving towards hyperinflation. At that time, inflation and cost of capital were in the high teens. Being able to build a hospital quickly was very important. We would have a 150, 200-bed prototype. It would be modified somewhat—exterior appearance and otherwise—but for the most part, it was the same layout. We didn’t reinvent the wheel each time. That let us get to the market quickly, start, get it open, and when money was costing you 18, 20 percent, that was a huge advantage for us. That’s obviously not the case today.

**GARBER:** Did you have input into the design of a well-built hospital?

**FRIST:** Somewhat, but that wasn’t my interest. My father loved it. That was a real interest he had. He enjoyed working with architects and sitting down and translating into the design what he had experienced in his practice, both in his office and in the hospitals. It drove me crazy—the detail and discipline brought to the table. That wasn’t me. I’d rather get in the airplane and fly to develop another project. But I did understand the value of it and made sure that we had the very best architects and engineers and brought together the key CEOs and department heads with our medical staffs to design the state-of-the-art facilities.

**GARBER:** Both of you must have derived an immense sense of personal pleasure and satisfaction when you went down and cut the ribbons for those new hospitals.

**FRIST:** Yes, very much so, after dedicating these modern, well-equipped and staffed hospitals, it has been particularly satisfying to me to return years later to see the positive impact HCA has had on the community. It is very rewarding to go back to a community and see how it has changed the lives of people. Equally important is the role the HCA system has played in stimulating change in the way health care is delivered by others. Frequently, the old traditional not-for-profit hospitals would say, “Well, if HCA can do it, surely we can do it.” In many ways HCA has served as a research laboratory for delivery systems. After we’d pioneer many things, others would follow. Sometimes, by the way, they would follow too soon before we had really proven out whether or not we could successfully do things. Another beneficiary of the HCA system has been the state and federal governments who see the company as a trustworthy, reliable source of information as they
test out the impact of their proposed actions.

**GARBER:** Do you have a particular example in mind?

**FRIST:** One example was maybe 15 years ago, when technology had evolved to the point where each hospital didn’t need its own back office. We were able to consolidate 180 back offices into 11 service centers. Those service centers are able to attract and retain more talented staff, particularly if the service center is located in Atlanta, Dallas, or Nashville, versus in a more rural area. This service center approach has been so successful as to improving quality, while lowering costs, that there are now three serving the entire 190 hospitals. In addition, we are now providing these and other consolidated services through our Parallon Division to thousands of other providers.

Another example is today we have a freestanding purchasing arm, Healthtrust Purchasing Group, that buys over $20 billion worth of supplies a year. At least 50 percent of those supplies are bought for not-for-profits and other hospitals. The size and scope of HCA is such that while developing these valuable tools for our system we can, as a byproduct, make them available to other investor-owned and not-for-profit hospitals.

We have a $6 billion or $7 billion captive insurance company that insures our malpractice exposure. These are a few of the hundreds of resources HCA has to give us an umbrella not available to most others. Freestanding hospitals and smaller not-for-profit and investor-owned companies cannot afford to do these things. Size and scalability do make a difference.

**GARBER:** The corporate organization of HCA is a good topic to address next. HCA has been organized from the early days into a regional structure?

**FRIST:** Yes. We’ve always stressed to the communities we serve that the delivery of health care is a local phenomenon. As much as you can, you try to have a local orientation with community leaders on your local board.

**GARBER:** Your father remarked in his oral history that one of the great changes that HCA has made in the hospital field has been to encourage the inclusion of physicians on boards. Do you have any further comment on that?\(^\text{16}\)

**FRIST:** Back in the late ’60s and early ’70s when we were starting HCA, it was not considered appropriate to have doctors on a hospital’s board of directors. When we started HCA, most hospitals we were acquiring were investor-owned, and most of the owners were physicians. We used that to our advantage and said, “We’ll acquire your hospital, but we want you to be on our board.” At the same time, I have had a strong feeling since 1968, when we formed HCA, that doctors should not own part or all of hospitals. Besides real conflicts of interest, there are perceived conflicts of interest and issues of public trust. While we did encourage the active involvement in the life and governance of a hospital, we discouraged and prohibited doctors from owning pieces of HCA hospitals.

\(^{16}\) Dr. Thomas Frist, Sr. said in his 1986 oral history, “All hospitals in America, because of us, I think, have at least one to five physicians on their board. That’s one of the greatest changes we have made in the face of American medicine in the hospital, physicians on the hospital board.” [Source: Weeks, Thomas F. Frist, Sr. in First Person, 71.]
Over the past 40 years, the composition of HCA’s hospitals’ boards has changed to reflect their roles in the community. Most of HCA’s hospitals back 30 and 40 years ago were overflow hospitals. By the mid ‘80s, we had acquired Scripps (Green) Hospital in La Jolla, Lovelace Hospital in Albuquerque, Wesley Methodist in Wichita and Presbyterian Hospital in Oklahoma City. Over $1.25 billion dollars in foundations were created in these communities. Over the following decades, these foundations, along with more than $7 billion in other acquisition-related foundations, have been invaluable contributors to the well-being of those communities. These were big community hospitals and very important market leaders. Governance needed to change, and today, HCA’s community-leading hospitals have boards of trustees that represent the community at large, which includes physicians.

GARBER: You’ve mentioned “overflow hospitals” a number of times. What’s your definition of an overflow hospital?

FRIST: In the 1960s and 1970s, there was a massive shift in the population to the Sun Belt that resulted in a shortage of hospital beds and services. Who was going to meet the demand? The local governments’ financial resources were stretched, and the not-for-profits didn’t have the wherewithal to meet the need. So, we would come in and build a second hospital or a third hospital in the suburbs—places like Ocala, Florida, and Rome, Georgia. Those hospitals frequently did not have an emergency room because the doctors didn’t want to cover another emergency room. They may or may not have had obstetrics. Today, if we didn’t have an emergency room, we’d be in real trouble because over 50 percent of our admissions come through the emergency room, but at that time, an overflow hospital didn’t have those services. Likewise, in the early years most of the overflow hospitals did not provide many of the rapidly emerging tertiary services such as open heart surgery. Of course, all of that has changed.

GARBER: What does governance look like today in an HCA hospital?

FRIST: It would mirror what one would expect to be in the typical not-for-profit hospital.

GARBER: Let’s go back to the ‘70s. HCA is up and running and growing. There must have been competitors, as far as other for-profit management companies. Can you talk a little bit about that competition?

FRIST: Yes. When we started HCA in 1968, I didn’t know there were other companies. It turned out there was one on the West Coast called AMI—American Medical International. We were in the Southeast. They were in the Sun Belt in California. They were developing their own market. At the same time, one called National Medical Enterprises started up on the West Coast, and in Louisville, Extendacare, a nursing home company converted to a hospital company, Humana. In Nashville, Tennessee, a group of physicians and business people saw what we were doing at HCA and started Hospital Affiliates. By the late ‘70s or ‘80s, there were seven, eight, nine other investor-owned companies.

Over the ensuing years, pressures started developing on hospitals as a result of the sudden change in 1984 from cost-plus reimbursement to DRGs.\(^\text{17}\) The shorter length of stays and the shift

\(^{17}\) For nearly two decades under the newly-created Medicare program, hospitals were paid based on what it cost to provide care. This cost-based reimbursement resulted in a ten-fold increase in Medicare hospital expenditures during that period and prompted Congress to mandate a change in reimbursement methodology. The Social Security
from inpatient to ambulatory care led to massive excess capacity within the hospital sector. There was pressure on these hospital management companies, as well as individual hospitals, to consolidate.

That was a time when HCA was able to take advantage of its leadership position, its size, and its reputation. We found that it was a tremendous asset that my father and I were physicians, lending credibility when we would come into a community saying we would do this or that, and being able to talk with doctors about medicine from a physician’s standpoint. We had a lot of things going for us.

In 1980, 1981, we acquired Hospital Affiliates, General Care, General Health, and another smaller company called HCC. Over the years there have been several Harvard Business School case studies on HCA. One of them was about the four acquisitions in 1981 and how could we possibly assimilate successfully over 100 hospitals while significantly increasing the leverage of our balance sheet? The authors of the case study did not understand all the resources we had to bring to bear or our plans to divest certain of the less desirable facilities. Within a year and a half, our balance sheet was stronger than ever. At the same time the mergers had greatly increased our presence in many markets.

The combination of Hospital Affiliates and HCA clearly established the company as a leader among operators of psychiatric hospitals. It also brought us to a leadership position in managing hospitals for other owners. It gave us a chance to start running more as a group to bring consistency in the way we deliver health care.

GARBER: You mentioned the importance of span of control in determining the regional structure of HCA. What did HCA find to be the best span of control?

FRIST: In 1981-82, the entire company was reorganized around geographic divisions. Over the following decades, HCA has continuously reorganized its organization to reflect the make-up of its assets. At times, the organization might be along rural, suburban, and large urban hospital divisions. At other instances, the distribution of assets might reflect service lines such as psychiatric,
women’s, ambulatory surgery, etc. Usually, the division would consist of 10-15 hospitals.

**GARBER:** Did the company ascertain that there is an optimum span of control?

**FRIST:** No. Sometimes the restructuring is related to people resources, and at other times, the span of control would be determined by the resources we had to enable us to be more productive. Over the decades, we have evolved from the calculator/typewriter era to the present day internet/handheld/wireless period. Likewise, the advancement of medical science and technology (i.e. digital radiography) has enabled HCA to do things organizationally that one could only have dreamed of before. HCA’s reorganization just in the last two months going from three regions down to two—East and West—reflects the influence of both people and technology on organizational structure.

After the Columbia debacle, we spun hospitals out into Triad and LifePoint. We put most of the rural hospitals into LifePoint. They would be organized within HCA today probably as a freestanding rural hospital entity similar to how it is operating as an independent company.

The Triad hospitals were different in that they were more overflow suburban hospitals. Our approach at HCA in the last 15 years to 20 years has been to own larger hospitals representing significant market share in major urban markets. In fact, we have a significant market position in the 18 to 20 fastest-growing markets in the country. For HCA, it is strategically important to have a certain critical mass in these markets.

As we spun out hospitals in 1997 or 1998, we made the decision to remain in these fastest-growing markets. We’d operate as a system in those markets under a brand name. For instance it is HealthONE in Denver where we have seven hospitals. In Nashville, Tennessee, it is TriStar where we used a hub-and-spoke model with Centennial in the center surrounded by five hospitals. In this market strategy, we do operate differently. We will have one or two open heart programs rather than six or seven. The market may have only one stroke center or NICU program. They’ll reallocate their resources, both people and physical resources.

In 1997, we sold to HealthSouth 60 to 70 surgery centers. Ambulatory surgery centers were still going to be an important part of HCA, but not as a freestanding line of business. As part of a market strategy, we kept those ambulatory surgery centers where HCA had a major hospital presence. That was important to do and particularly so when dealing with the third party insurers.

If you were to ask me what we’re going to look like in 2020, I don’t know. I used to think when I was early in my career I could, like a doctor, write a prescription for the hospital sector or write a prescription for the future of health care and the way it’s going to be delivered. Maybe if I were a benevolent dictator that would be true, but that is not the case. Happily, I have found over the years, that by being a responsible part of the system, HCA can impact positively the ultimate local, state, and federal decisions.

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20 Spun off in 1999, Triad Hospitals, Inc. (Dallas) was formerly HCA’s Pacific Group and had 33 hospitals; and, Lifepoint Hospitals, Inc. (Nashville), formerly HCA’s America Group, had 23 rural hospitals. [Source: Kirchheimer, B. Launching the baby Columbias. *Modern Healthcare*;29(18):28-30, May 3, 1999.]

Much of HCA’s formula for success has been its willingness, regardless of what comes down the road, to make quick, decisive moves to change our business plan and the way we go about delivering our services. If I knew exactly what the “rules of the road” for health care were going to be in 2020, I could better predict what it’s going to be like. For instance, in 1986, 95 percent of our business and revenues came from inpatient care. Today it is more like 40 percent. If we hadn’t evolved quickly and repositioned our physical assets and the way we went about our business, we’d be out of business.

I’ll give you another example. We talked about multihospital system competition. We’re the only one remaining of the six or seven companies operating in the 1970s. There are others out there but they are not very significant. All the rest of them, if you roll them up, don’t come anywhere near the size of HCA. Those that did not maintain a strong balance sheet and were not able to make the tough decisions to adapt to the ever changing world did not survive.

One of the key strengths of this company has been its ability to analyze its environment and develop contingency plans. What are the needs in the communities we serve, in the regions we serve, in the nation, and now globally? Then to reposition ourselves and move to meet those needs. It would be difficult to say exactly what we’ll look like, other than holding true to the mission statement—putting the patient first, never compromising quality, and recognizing our greatest asset is our employees.

GARBER: I’d like to go back to the hub-and-spokes concept you mentioned, which is a concept that comes out of the regional medical programs. Could you speak a little bit more about that?

FRIST: Where the regional medical programs missed it was that they didn’t own the assets. There was no glue, such as a balance sheet, to hold them together, so they didn’t realize their potential. Today, there is true strength in that hub-and-spoke.

GARBER: For those not familiar with the concept, could you describe what the hub-and-spokes model is supposed to be? Is that something that you were deliberately trying to build from early on?

FRIST: The answer is yes, both administratively and clinically, but in the early decades we didn’t have the tools to realize the vision to the extent we can today. In the early ’70s, we would have liked to have had our small hospitals in towns of 25,000 or 30,000 refer their critical patients requiring special care in to HCA tertiary care hospitals like Centennial here in Nashville. We never did get the formula down as to how you capture those patients. Back then, the doctors were fiercely independent. They had their own referral patterns. Patients needing open-heart surgery in Smithville, Tennessee, were not always referred to our hospital in Nashville, Tennessee. We’d only capture 30 to 40 percent of those patients.

Today, the capture rate is far greater because now the referring physician is frequently an HCA employee. Frequently, the emergency room physicians are your doctors, and it’s much more likely now that they will refer to your central hub. All along, in theory, you’d like to say they were going to send you patients because it was the best place with the highest quality to send them but that was not necessarily the case. It has only been in the last decade we have the ability to measure and communicate outcomes. To be able to demonstrate the value added to the patient to remain
within the HCA system. The more recent adoption of systems with electronic health records has provided a great advancement in HCA being able to operate clinically as a system.

**GARBER:** How did certificate of need affect HCA?

**FRIST:** Certificate of need is something HCA has had to deal with over the years. It can be either a pro or con. If you happen to be in the 18 to 20 fastest growing markets in this country and you have 25, 30, 40 percent of the market or more, certificate of need is great. It deters new entrants, which for the existing provider is good. If you own 10 percent of the market, you might like not to have certificate of need. Once again, it’s not writing a prescription, but dealing with whatever set of circumstances you have today. Over the years, I have not seen certificate of need either advance the quality of medicine or decrease the cost in any way.

Most of our hospitals west of the Mississippi River operate in a very competitive environment where states for the most part do not have CONs. Most of the states east of the Mississippi—Virginia, Tennessee, others—still have certificate of need. We do well in both environments. It’s just more hassle in the CON states. For the most part, HCA will prosper in any environment where everyone plays by the same rules.

**GARBER:** I think we’re about ready to move on to the ‘80s. Do you recall the significant business challenges during the Reagan years?

**FRIST:** The primary challenges during the Reagan years were capital—access to capital and cost of capital. Access, more than cost, has always been the most critical factor. A part of the Reagan strategy to attack inflation was to limit access to debt and capital. That put pressure on the private sector including hospitals as to where to source the money needed to expand and grow.

One thing that did help during the Reagan era was where he took on the controllers union as well as other major unions. That was at the time the Rust Belt was hitting its peak outmigration and organized labor was losing big chunks of their manufacturing constituency. To offset those membership losses, the unions began targeting the service sector and particularly the hospital sector.

The Reagan era gave us some reprieve and hope that if we continued to run hospitals well, staff them properly, and treat our employees as our most valuable asset, then they did not need organized labor. That tone was set for all industries, but certainly because of the shift in emphasis of many of those organized labor forces towards health care, I believe the Reagan labor policy did provide a better work environment in hospitals. It was very important.

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22 State certificate of need programs were established by the National Health Planning and Resources Development Act (Public Law 93-641) which was passed in 1974, although a number of states had already put CON in place. The idea was to control health care costs by planning for local health care needs, and by regulating the availability of health resources, such as the building of new hospitals. [Source: American Health Planning Association. CON Background. http://www.ahpanet.org/copn.html (accessed Aug. 16, 2013).]
Another issue that HCA faced in the mid ‘80s was related to antitrust. We had basically maxed out our potential to add new hospitals through acquisitions in the 17 states in which we were predominantly located. At that time I thought, If you want to continue to grow and be within your mission statement of being a health care company, then maybe there was a case to be made for diversifying into other segments of health care. My thoughts were that HCA could become a large diversified health care company by combining HCA with a surgical supply, a health insurance, a pharmaceutical, a laboratory, and a hospital computer company.

Beginning in about 1984, I began to develop relationships with the CEOs of several large health care companies and started quietly pursuing that plan. The first piece that was going to be put in place was American Hospital Supply, based in Chicago.23 American Hospital Supply’s CEO, Karl Bays24, who was highly respected within the health care industry, had a similar vision of the merits for creating a major diversified health care company.

However, Vernon Loucks,25 the CEO of Baxter, called me 48 hours before the scheduled closing to say, “Baxter would like to acquire American Hospital Supply,” and Baxter would pay HCA $300 million to “go away.” There were significant synergies to be realized from the merger of these two Chicago-based competitors and the AHS/Baxter merger was the best outcome. During the twelve months spent pursing the American Hospital Supply merger, there had been significant changes occurring in the hospital sector as the result of the implementation of DRGs and the acceleration of the growth in HMOs. As we discussed earlier, the new “competitive marketplace” resulted in shorter length of stays and shifts to more ambulatory care which created within the hospital sector significant excess capacity.

Putting further stress in the 1985-88 years on the hospital sector and HCA was the failure of the federal government to let the providers keep the gains realized from operating more efficiently. With the unprecedented challenges facing the hospital sector, HCA decided it was imperative that it must terminate its diversification efforts and refocus on its hospital operations. On a small scale, during the 1984-88 period HCA had acquired several HMOs and a clinical laboratory company. We proceeded to spin out with management these entities into freestanding companies. One positive byproduct of the DRG era was it did open up

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to HCA other states as reimbursement shifted nationwide to a prospective payment system. Suddenly, other states, other markets, became more attractive in which to expand. At the same time, we again found it necessary to reposition HCA, and that’s what led to spinning out 50 hospitals to Healthtrust in 1987, ’88. We took the cash proceeds gained from the Healthtrust transaction to reward our HCA shareholders with a major repurchase of stock at a premium.

One other important thing happened, and that was in the financial markets. In 1987, HCA stock was depressed. This was during the junk bond takeover era, when anyone could walk in your door and say, “We want to buy your company,” and two individuals actually did come in with such an offer. They had very little—maybe a million dollar net worth—and wanted to take over our $6 billion company. They had a letter from Citibank saying they had the financing.

I said, “Wait a minute. We’re putting ourselves at risk as we reposition HCA for the future.” Every time we would dispose of a noncore asset it would have a one-time negative impact on the profit and loss statement. As a publicly-owned company, we found ourselves too exposed to a hostile takeover. We needed to get HCA into a private setting if we wanted to successfully reposition HCA. That’s what led to the first LBO. It was a defensive/offensive move. We took the company private, repositioned it, and then returned to the public market in 1992.

In summary, there was a strong case for operating HCA in a private setting. Our world had been suddenly changed with the advent of DRGs in 1994 and the resultant excess capacity created in hospitals. You were asking before, what’s it going to be like in 2020? Those same questions—what’s it going to be like in 1986, 1987—we were asking ourselves. Those were difficult times. The only thing we knew for certain was our future would be far different from our past. So, we made the tough decision to take HCA private. It turned out to be a wonderful three years. The senior management team and I loved it. We were focused on repositioning HCA for the future. In many ways it was too bad we came back public again.

GARBER: We’ve come to a challenging decade for you personally and for the company, and that would be the ’90s. This was when you were coming out of the leveraged buyout.

FRIST: Yes, you might ask, “If the 1989 LBO of HCA was so enjoyable and one of the high watermarks of my career, why did we take it back public, and so soon—three years after the LBO?” The main reason was J. P. Morgan Bank, our largest shareholder, had invested $65 million in the LBO along with management. That $65 million was worth $1.25 billion three years later. They were in the banking business, not the hospital business, so they were looking for a means to monetize their investment and realize their gains. One of the other nice outcomes of the successful LBO and resultant IPO was for our 65,000 employees whose pension fund had a similar gain for its $65 million investment.

We did take it back public very successfully. That was in 1992, about the time the Clintons were appearing on the scene at the national level. There was a young man by the name of Rick Scott, who had started a company called Columbia in Texas with a mutual friend of mine, Richard

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27 Governor Richard L. Scott (b. 1952), Republican, was elected the 45th governor of Florida in 2011. An entrepreneur, he had started Columbia Hospital Corp. in 1987 and became CEO of Columbia/HCA after the two
Richard had invested $25 million in the 1989 HCA LBO.

Rick Scott and Richard Rainwater had started Columbia in 1987. They began with the acquisition of two hospitals in El Paso. One of them was a former HCA facility they had purchased from Healthtrust.

Rick Scott had a charismatic personality that was well received by Wall Street. He also had the ability to spin a good story about bringing efficiency and quality to the health care system. Many people thought he would be the future Jack Welch, CEO of GE, for the health care sector. He was 38, 39 years of age. There were numerous hospital acquisition opportunities developing because hospital boards were increasingly fearful of the negative impact of the proposed Clinton health care reform.

In 1990, the CEO of Humana, David Jones, approached me about HCA’s interest in acquiring Humana’s hospitals which he strategically wanted to separate from his growing health insurance enterprise. HCA was in the midst of its LBO and I turned it down because HCA’s balance sheet from the LBO was still too leveraged to make the acquisition. Humana proceeded to spin its hospitals into a separate company named Galen in 1991. That positioned the smaller Columbia, with HCA’s blessings and with its high multiple stock, to acquire the publicly owned Galen.

This acquisition was so well received in the marketplace that I thought, Maybe Rick Scott is what he’s built up to be, and is the right person to lead the consolidation of the hospital sector. Furthermore, it occurred to me that we should consider using Columbia’s high performance stock to merge HCA with Columbia. A larger Columbia/HCA would be better positioned to deal with health care reform. I believed it could take another ten years to reposition HCA to deal with those new challenges. I felt a better course would be to turn a merged Columbia/HCA over to this dynamic young man. Before the ink had dried on putting Humana’s Galen hospitals together with Columbia, we merged HCA together with them. The HCA shareholders received a 30 percent premium. The HCA merger with Columbia was enthusiastically received by Wall Street. The stock more than doubled over the following twelve months and J.P. Morgan was able to liquidate its holdings.

While Columbia continued to expand at a meteoric pace, much to my disappointment, its arrogant style of “take no prisoners” seemed to alienate the not-for-profit sector’s elected officials, The New York Times, The Wall Street Journal, and news media in general—just about everyone with the possible exception of Wall Street. Columbia under Rick Scott’s leadership became so big so fast, and with an in-your-face leadership style that set it up as a ripe target for the government to use as a

“poster child.” The Clinton Administration and the federal government wanted to change nationwide behavior among physicians and hospitals in coding and a whole host of other regulatory/policy issues. What better way to send a message to all health care providers than to launch an investigation into the business practices of a high-profile Columbia?

By that time, Columbia had also acquired Healthtrust which HCA had spun out a decade earlier. With the Healthtrust merger, I stepped down as the nonexecutive chairman. In fact, in the Columbia era, I was never CEO, never part of management.

GARBER: What was your role at the time?

FRIST: I was a goodwill ambassador. Basically, I had retired but remained on the board of directors. During that period, I never took a salary. In the six months prior to the February 1996 FBI raid of the El Paso hospitals, there was no communication between Rick Scott and me. I am told that Rick was intentionally freezing me out which would include my removal from the Columbia board. I finally wrote him a letter with a 14-point list of recommended changes and suggested he consider them, but I never received an acknowledgement. The FBI raid was the catalyst for me to go to the Columbia board with the message, “Change has got to take place or this company is not going to make it.”

Fortunately, there was a slight majority of board members who were former members of the HCA or Healthtrust board who trusted my judgment. After about three months, the board agreed, and I was elected its CEO. By that time, Columbia had grown to be a $20 billion company with over 300,000 employees. In the first 48 hours, I let go 14 of the top 16 officers in this huge company. One or two of them didn’t deserve to be terminated, but the federal government perceived them to be a part of a systemic effort to defraud the government. Without a complete change in senior management and a significant rebuilding of a world-class board of directors, the federal government could and would bring Columbia down as they did Arthur Andersen a few years later. Among the many faults of Rick Scott was his lack of understanding of the power of the government.

At the time we merged HCA into Columbia, we had 67 or so hospitals. Jack Bovender was our COO. He and other key HCA people decided they could not operate under the Columbia modus operandi and decided to resign and take their severance. For them, it was a culture and style issue. When I realized I would be asked to be the CEO of the new Columbia/HCA, the first thing I did was call Jack Bovender and the second was to call Phil Patton, the former head of HCA’s human

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30 Arthur Andersen, once one of the “Big Five” accounting firms, became involved in the investigation of the financial mismanagement of its audit client, the energy company Enron, which collapsed in 2001. A conviction of Andersen officials in 2002 was overturned by the Supreme Court in 2005, but the firm has become essentially defunct, reduced from 28,000 employees to about 200. [Source: Andersen conviction overturned. CNNMoney, May 31, 2005. http://money.cnn.com/2005/05/31/news/midcaps/scandal_andersen_scotus/ (accessed Aug. 16, 2013).]

resources. They both not only possessed great professional skills but, more importantly, understood the HCA culture and beliefs that had to be instilled companywide if we were to be successful in restoring HCA to its leadership position. For credibility, we went outside and got a new general counsel, Bob Waterman, and a new internal audit officer, Joe Steakley, as well as a top ethics and compliance officer, Alan Yuspeh, and proceeded to rebuild a best-in-the-health-industry management team.

At the peak of the crisis, we discovered HCA had an $8 billion line of credit that could be called. If it were to be called, it would have put us into a Chapter 11 bankruptcy. At the same time we were rebuilding the senior management team, we committed ourselves to the mission statement that we had created in 1968 that had been cast aside during the Columbia era. We spent the next year and a half on the road, humanizing ourselves—Jack and I and others—to these 200-plus hospitals that didn't know us. It was imperative that we regain the employees’ trust, and that we institutionalize our beliefs and values system wide.

In the meantime, we had to address how much substance there was to the government investigation. We secured a team of well-qualified third party resources to assist us and the government with the investigation. It was approximately a year and a half after gaining control in August 1997 that we finally determined that, yes, there were some errors similar to those to be found among hospital providers throughout the United States. But we did not discover a systemic plan to defraud the government—many of the accusations had been that Rick Scott and his team were trying to systemically defraud the government. We had to search hard to find a few cases of willful fraud in order to achieve a satisfactory settlement with the federal government and the plaintiff lawyers representing the whistleblower.

Rick Scott today is the Governor of Florida. People have frequently asked me over the intervening years, “What about him?” I didn't like his management style. I didn't think it was appropriate for a hospital company, but I do think he had a lot of good ideas—some of which were ahead of the times. Besides not having the people or the ability to execute his vision, his headstrong, know-it-all, “I'll tell you what you need to do, you do it,” management style was not a formula for success. His main failing was he enabled others in a decentralized system to go across the line.

Great company, got control of it—we sold off assets, downsized it, rebuilt the management team, rebuilt the board. We settled for $1.7 billion with the federal government, one third of which we got back in taxes. It was a heavy price to pay. In retrospect, the irony is we should be grateful to the whistleblowers and the federal government for launching the charges of fraud. Within six to nine months after we returned, we found out that we had inherited a company that was literally a train out of control going down the tracks—it would have imploded regardless of the government because of a lack of systems and financial controls.

Contrary to the public’s belief that Columbia was a well-run tightly controlled system, it became apparent the unprecedented rapid expansion from 1994 to ‘97 was accomplished without putting in place the policies, procedures, and people required for long-term success. Too frequently, the tried and proven systems of HCA, Galen and Healthtrust were discarded without tried and proven replacements. So, thank goodness for the crises, for otherwise there would not be an HCA today. Yes, the pieces would be present because the hospitals that were assimilated were important to the communities they served, but they wouldn’t be part of an HCA system.
It was an interesting time. It wasn’t as much fun as the 1989 LBO; but, reflecting on that era, I wouldn’t have missed it for anything. When I came back as CEO, I was concerned that people would think—the old man is coming back in for ego reasons or for other ulterior motives—so I worked for a dollar a year, and I did not take any stock options. Since 1997, other than the dollar a year and health benefits, I received no compensation; however, I’ve done very well financially because I bought $90 million of HCA stock in those perilous times of uncertainty. I believed in HCA, its people, and what we were trying to accomplish. My personal hopes for HCA have far exceeded those dreams and, as a result, I have received unimaginable personal satisfaction and financial rewards.

GARBER: That’s a remarkable story. I wonder if you might talk a little bit about your friend and colleague, Jack Bovender, particularly his leadership characteristics.

FRIST: Well, he is the best. His mind is like a vise and he understands health care. His wife is a nurse. He came in to health care through the Duke MHA program to join the company as an assistant administrator in a hospital. Over the years he distinguished himself at every opportunity given him. He was my COO when the Columbia deal was done, and was the first person I sought to bring back to the company. He has an unbelievable mind; he’s well read; he’s got great humanistic traits. He has unbelievable integrity. Whatever success I have achieved would not have happened if Jack had not teamed up with me in 1997. The same could be said for our colleague, Phil Patton. The two of them had plans to go to the seminary. I had to talk them out of it and said, “I need you more than the Lord does!”

GARBER: Were there any other individuals you would like to mention who were particularly helpful at the time you were rebuilding the company?

FRIST: Many of them are still here. One of the first four or five individuals I called was Richard Bracken, who is the current CEO of HCA. He had already decided to leave Columbia to be the CEO of a nursing home company. Among the former HCA managers who would join Jack Bovender (COO), and Phil Patton (HR), Richard Bracken, and me was Milton Johnson, who is now COO of HCA. Other key members of the newly-constructed senior management team were Noel Williams, senior vice president for Information Systems, Beverly Wallace, senior vice president, Shared Services Group, and Trish Lindler, head of Reimbursement.

What had happened during the Columbia era was that they said all the right things. They

would have their “phrase of the day,” but they lost the trust of the employees by having these statements about their beliefs without putting them into practice. Whereas HCA’s belief is: people are our greatest asset—Columbia’s actions sent a message that its employees were expendable. Columbia’s lack of respect for its employees resulted in too many good employees leaving while the weak ones remained.

It was very important to rebuild the right team. In order to assist in attracting a world-class senior management team, I created a ten-point action plan that would be accomplished within the first six months. This “to do” list was extracted from my April 22, 1997, eight-point letter to Rick Scott. This plan included such items as selling the home health care division, eliminating doctor ownership in the company’s hospitals, and terminating Columbia’s national branding campaign. The revamping of the board of directors and the senior management, along with the action plan, would send strong signals to the federal government that the company going forward was far different from Columbia. The new leadership would operate with the highest standard of ethics and integrity.

As for the issue of rebuilding the board of directors—at every stage in my career, I’ve had a strong board of directors. Over the years I have found it is when times are difficult that a strong board is of utmost importance. A good board can truly make a difference. Fortunately, for me and HCA in 1997-98, there were such individuals who understood the importance of saving HCA. They recognized the significance of its hospitals to hundreds of communities. They also recognized the constructive role HCA could play in the ever-evolving United States health care system. In many ways, I consider these courageous men and women who joined the board as independent directors to be missionaries. Each took a “leap of faith” to work with the newly-constituted senior management team to save the company. They were:

- C. Michael Armstrong, chairman, Comcast
- Magdalena Averhoff, M.D.
- Elaine L. Chao, distinguished fellow, The Heritage Foundation
- J. Michael Cook, chairman & CEO emeritus, Deloitte & Touche LLP
- Martin Feldstein, president & CEO, National Bureau of Economic Research
- Frederick W. Gluck, senior counselor, McKinsey and Company, Inc.
- Glenda A. Hatchett, judge
- Charles O. Holliday, Jr., chairman & CEO, Dupont
- T. Michael Long, partner, Brown Brothers Harriman & Company
- Thomas S. Murphy, chairman & CEO emeritus, Capital Cities/ABC, Inc.
- Kent C. Nelson, chairman & CEO emeritus, United Parcel Service
- Carl E. Reichardt, chairman and CEO emeritus, Wells Fargo & Company
- Frank S. Royal, M.D.
- Harold T. Shapiro, president, Princeton University

GARBER: Perhaps this would be a good time to talk about the LBO in 2006.

FRIST: Yes. Let’s refresh our memory—the first LBO in 1989 was a defensive/offensive move. That was in the era of junk bonds when corporate raiders could take over companies at a time when their stock might be out of favor with Wall Street. In 1989, HCA was particularly
vulnerable for we needed to reposition the assets of the company which would result in one-time losses to the financial statements. The answer for us was to turn the disadvantages of the junk bonds to our advantage by initiating a management-led LBO.

When attempting to take a public company private, you have “put it in play.” Others could decide to bid against a management-led buyout. After carefully analyzing our position, I, along with HCA’s CFO, Roger Mick, decided that it was worth the risk to be able to have HCA in a private setting where it could best be repositioned for the future.

Fortunately for senior management, within a week of HCA’s announced plans for a management-led LBO, all of the large private equity firms, such as Kohlberg Kravis Roberts (KKR) and Forstmann Little, chose to pursue the RJ Reynolds Tobacco Company when it disclosed its plans to go private. No other competitive bids surfaced for HCA, and the company closed six months later on the largest management-led buyout in corporate America—approximately $7 billion. The subsequent three-and-a-half years proved to be one of the most satisfying and rewarding times in my, and other members of the management team’s, careers. The team gelled. We were focused and able to devote our attention to restructuring the company without the concerns of a quarterly reporting required of a New York Stock Exchange-listed company. All the stakeholders—patients, employers, physicians, committees—benefited from the 1989 LBO. HCA emerged a stronger company repositioned for the future.

As for the 2006 LBO—from the time in 1997 when Jack and I came back to address the multitude of issues related to Columbia—we had proceeded to downsize the organization. All non-core hospital assets were sold. We spun out over 100 hospitals into LifePoint (rural) and Triad (single suburban), as well as many to not-for-profit hospitals. We basically kept the large tertiary care hospitals in fast-growing urban markets where we had a significant market share. At the same time, we initiated major realignment of our organization’s structure. We took advantage of new technology that enabled the company to centralize hospital back offices. Our data center, which still serves the LifePoint and Triad hospitals, likewise consolidated from 11 to 3 data centers. With the proceeds from the sale of assets, HCA opportunistically took advantage of its depressed stock to initiate an $11 billion stock repurchase program. In spite of this aggressive deploying of cash, the stock price remained flat from 1998 to 2006, as did the stock of most New York Stock Exchange companies. This LBO was different from 1989 in that it was primarily an offensive move to reward our loyal stockholders.

The HCA senior management team began in the spring of 2006 its annual update of the strategic plan in preparation for developing its 2007 operating budget. As part of the process, Merrill Lynch presented the team its financial analysis of HCA and the various alternatives for consideration as a means to possibly increasing shareholder value. In addition to the usual list of

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dividends, acquisitions, stock repurchases, etc., for the first time in over a decade an LBO was added to the list. This was a surprise to senior management and to me, for we thought that the total capital requirements of $37 billion to $38 billion to take HCA private exceeded the capacity of the debt and equity markets.

Even with the $11 billion buyback over the prior decade, at least $5 billion in new equity would be required. Merrill Lynch thought a window of opportunity had developed in the equity and debt markets that would enable HCA to complete the largest LBO in the history of corporate America. If management, with the Frist family, chose to pursue this route it would require at least three large private equity firms to join together in a “club deal” for the equity. Likewise, it would require a huge consortium of banks to be aggregated to provide the debt financing. When I was first approached by Jack Bovender (CEO), Richard Bracken (COO), and Milton Johnson (CFO) with the idea, I immediately liked it from a financial standpoint but wanted to reflect over the next 48 hours on the pros and cons for such a bold strategic move. The following (Exhibit 1) is what I presented to Jack, Richard and Milton as my “gut feelings” of why I thought it was the right move for all the stakeholders.

EXHIBIT 1

Shareholders

- **All Stakeholders**: After five years of essentially no appreciation there would be an opportunity to receive a minimum 25% gain at Fair Market Value.
- **Large Institutional Shareholders (12-14)**: an opportunity to exit their large holdings without taking a discount and instead receive FMV.
- **HCA – Senior Management: (approximately 20)**: Opportunity to receive FMV rather than be limited to narrow windows. Removes exposure from public criticism and possible lawsuits. Creates $210 million plus additional value years ahead of schedule. Accelerates options. Would provide maximum value for the 20-30% of senior officers who after nine years of rehabilitating HCA were ready to retire. For those who choose to stay they could roll tax free their stock and options into the LBO. They would also receive a carried interest in newco. A successful LBO would provide opportunities for estate planning.
- **HCA Middle Management (40-50)**: Many of same benefits that accrue to senior management. Approximately $30-40 million added value for this group. Very important to 20-30% who will retire over next 2-3 years. Both from appreciation in stockholdings, stock options and their HCA stock in 401K’s.
- **HCA Pension Fund**: 17 million shares in 401K and trust. Gives opportunity to fully diversify at FMV while creating over $200 million in additional value.
- **HCA Outside Directors (excluding Frist and Management)**: Receive FMV for stock and options at a time when many are nearing retirement. $20 million plus added value.
- **Thomas F. Frist, Jr., Family, and Foundation: (24.5 shares)**: Family has maintained significant ownership since founding HCA. This will enable various family members to receive FMV on a portion of holdings while rolling at least 50% into LBO. Thomas Frist, Jr. will be rolling over 80-90% of his net worth into LBO after paying off approximately $115 million in short term debt. Frist family plans to be major shareholders for many years. We look at this as just replacing one group of stockholder
partners for another. At this time Thomas Frist, Jr. is unable to fully participate in governance, etc., in a publicly held company and yet has the limitations associated with being unable to maximize value in HCA to reduce debt. This event will create over $300 million in additional value for the Frist Family. Main negative outside of the LBO risk for Frist family is it will cost us over $20 million in deferred taxes owed from unwinding a i.e. short against the box position related to the first LBO. Additionally, we will lose $17 million per year in dividends.

**Bondholders:** The proposed LBO structure assures cash flow to service debt and provide CAP.

**Hospitals, Hospital Employees and Communities we serve:**

- Capital expenditures have been protected in the LBO model.
- There are no required divestitures.
- Management structure is same going forward.
- There are no assumptions of increased productivity through a reduction in the labor force at the hospitals.
- More favorable environment to deal with organized labor.
- Employees’ pension funds significantly increase in value due to HCA holdings and diversify proceeds ($210 million).
- Less public focus on HCA’s earnings and compensation of senior officers.

**Operating Implications:**

- More focused on operations. Senior management will have 20-30% more time to devote to primary business versus dealing with governance, regulatory requirements of a New York Stock Exchange listed company.

**Governance:**

- HCA had one of, if not the, finest boards demonstrating best practices in Corporate America. It was primarily rebuilt from the Columbia era (pre-1998) by attracting tried and proven leaders in their respective fields (i.e. corporations, higher education, etc.) who made sacrifices and commitments to becoming board members at a troubled company. Many of these dedicated men and women were approaching retirement over the next 2-3 years from the HCA board. This LBO enabled each to realize at FMV the liquidity of their HCA equity holdings. It also enabled the company to reevaluate and establish a “new board over the next 3-5 years which would include my retiring and adding my two sons. It will enable the Frist family to once again in perception and reality fully participate in the governance of HCA.

- There are certain significant and growing costs associated with governance of large New York Stock Exchange companies that can be eliminated and/or drastically reduced.

**Zero Base Budgeting:** In a private LBO setting there are many vestiges of the past that will be eliminated. Over the next 3-5 years one can reevaluate each of these from a ZERO based budgeting and value added standpoint.

- Dividends – redeploy $300 million a year internally.
- Employee stock purchase plan will be eliminated.
• SERPs
• Aircraft number and how they are used.

**AN LBO USES LEVERAGE** and its tax advantages to a far greater extent than one could or should do in a large publicly traded company.

**Presidential elections**, possible changes in control of Congress over the next 2-3 years.

**Other Factors**: Our major competition in markets are the private Not for Profit hospitals.

• Does not give us credit for investment income (HCI) and malpractice reserves.
• LBO at this time was not my idea but when presented to me I quickly embraced it.
• Jack Bovender and senior management have been focused over the past five years in seeking ways to create shareholder value while always balancing out the impact on patient care and quality. The consideration of an LBO has had the same requirements.
• Jack Bovender and senior officers are putting what is best for other stakeholders before themselves.
• Jack even offered to step aside if it was necessary to get it done.
• I cannot overemphasize what operating in an LBO (nonpublic) environment will do to rejuvenate the senior and middle management. It would create a renewed entrepreneurial environment companywide.

**Finally, there is a right final price!**

I, along with Jack, Richard, and Milton immediately set about selecting and approaching our choices for our private equity partners—Bain Capital, Kohlberg Kravis Roberts, and Merrill Lynch. All enthusiastically accepted, and we proceeded to set up an extensive due diligence process that lasted for three months. In the meantime, together with our three sponsors, we initiated the formation of the banking consortium which was to be led by J.P. Morgan, Bank of America, and Citibank. The need for $27 billion in debt financing would stretch the capacity of the bank market. In hindsight, the financing of both the equity and debt for this mega-LBO occurred during a very narrow window of opportunity. Nine months later, it had closed due to financial crises in the global capital market. Six years later, I appreciate even more how critical were the bold, decisive, and courageous decisions made by senior management to move forward as quickly as possible. The result was one of the most successful large LBOs ever accomplished.

Even more important to me than the financial gains realized by the Frist family’s investment of $800 million in the LBO, is that all of the goals I had established for the LBO were accomplished and in many cases exceeded. HCA emerged from the 2006 LBO in its strongest position ever and is well positioned to meet the challenges and capitalize on the opportunities presented over the coming decade. Clearly, HCA exited the LBO as the leader among the investor-owned companies and, by size, quality, and financial strength, among all the health care providers in the United States.

**GARBER:** Are there any role models who influenced your business career, civic, and philanthropic endeavors?

**FRIST:** Yes, there were four individuals who I admired greatly, and from whom I tried to
adopt their best attributes. I often equate what I learned from them to one’s gaining a kindergarten through doctorate education. The first one was my father. He gave me my basic education—kindergarten through high school—of life. My values, my basic beliefs, my commitment to hard work, going the extra mile, and helping others provided the underpinnings of everything that I’ve used over the years to make decisions.

The second one was Jack Massey, one of the founders of HCA, who gave me what I would call my “B.A. degree” in business. He taught me basic entrepreneurial skills, business principles, and from him I learned the satisfaction of succeeding in a risk/rewards capitalistic society. I also had my innate love of philanthropy reinforced by Jack Massey. He was a very generous person who shared his good fortune with others.

The third one was a man named John Hill,38 who provided me my “Masters.” John Hill was recruited to be HCA’s CEO in 1970. As the former president of Aetna Life Insurance Company, John brought to the company its first experienced corporate manager. He had come up through the sales ranks at Aetna. I learned a lot from him about marketing and sales. He was the quintessential networker who knew how to nurture business contacts across the United States. I also learned from him the value of extracurricular activities including the enjoyment received from the visual and performing arts.

Fourthly, I had a mentor in Don MacNaughton.39 Don had, at 62 years of age, announced his plan to retire from The Prudential, where he was CEO. At that time, Prudential was the largest financial institution in the world. I was 38 years old when he was brought in to specifically mentor me and a young management team. He rounded out my on-the-job education with my “doctorate.” One of the most valuable lessons I learned from Don was the importance of the big picture—a global perspective. One of the things he said was, “Tommy, while you’re called HCA—Hospital Corporation of America—don’t think hospital. Think bigger—think health care—not hospitals. Think worldwide, not just the United States. The world is shrinking and becoming flatter every day.” Since then there have been many books written on this subject, but this was back in the late ‘70s and early ‘80s, when he introduced me to that concept.

By that time, we had taken on a project in Saudi Arabia. It was a great learning experience. We had over 3,000 employees in Riyadh where we were operating the King Faisal Specialist

John A. Hill
Photo courtesy of Fabian Bachrach


Hospital. We managed the King Faisal Specialist Hospital for 20 years and were handsomely paid for our efforts. We kept the money received offshore rather than repatriating and paying taxes.

**GARBER:** Was this the origin of HCA’s international activities?

**FRIST:** Yes, with our global perspective, we reinvested the capital in hospitals in Central America, Brazil, United Kingdom, Australia, and Italy. At one time, we owned over 70 hospitals outside of the United States. It was during the first LBO when we took those non-strategic assets and sold them to other entities.

During the Columbia era, there were many things that were difficult and challenging for us; however, one of several good outcomes was that we re-entered the international arena with very fine hospitals that Columbia acquired in the Galen merger. To the portfolio were added market-leading hospitals in London as well as two in Geneva, Switzerland.

Since that time, we have looked at hospitals outside the United States, but the opportunities to spend our capital were more attractive in the United States. The risks/rewards were more favorable in the United States through expanding our existing hospitals, making acquisitions, or building new greenfield facilities.

Over the years, many foreigners have come to us seeking our advice and counsel. We have always been open and sharing with these foreign visitors. As a result, there are international hospital companies—Apollo, Parkway, Ramsay Group, and others—that are flourishing and doing well in foreign markets.

There’s a large one with 30-some hospitals in South Africa that has been successful. All of them have come to us over the last 20, 25 years. They have returned to their countries to start and successfully build hospital companies, many with vestiges of hospitals HCA had divested in the 1989 LBO, and many with ex-HCA’ers leading their senior management teams. For me, this has been a nice extension of HCA’s commitment to improving the access and delivery of health care globally.

During the 2000-2013 period, HCA, with its longstanding commitment to keep its existing hospitals modern and up to date, has continued to expand rapidly in the United Kingdom. We are more and more joint venturing with their government to have a hospital within a hospital. We’re doing outpatient facilities on the campuses of United Kingdom governmental hospitals. This strategy has resulted in the United Kingdom being one of HCA’s most successful markets. Time will tell over the next decade just how much we continue to expand our international presence.

**GARBER:** Have you remained involved at HCA since your retirement as CEO in 2001?

**FRIST:** One thing is for certain—I have not lost my interest in the company. I believe

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41 The “hospital within a hospital” concept may involve locating all resources needed for the care of certain types of patients together on one floor—such as a heart institute as in the example cited below. The hospital within a hospital is sometimes owned by a different entity than that which owns the larger hospital. [Example: Regional Medical Center of Acadiana to complete heart institute this month. Press Release, Dec. 5, 2012. http://hcare.acareerathca.com/regional-medical-center-of-acadiana-to-complete-heart-institute-this-month/ (accessed Aug. 16, 2013).]
even more today in its important role in the ever-evolving United States health care system. As the only remaining living founder, I enjoy visiting the hospitals to meet with the employees, physicians, and volunteers. In each case, I try to reinforce our company’s commitment to its mission statement and core set of beliefs. It is those values that provide the glue to hold our vast system together as an effective, trustworthy deliverer of quality health care.

Secondly, I have always been available to HCA’s senior management team and the board of directors when they have sought my advice and counsel. Hopefully, I have been judicious when responding and have been able to bring some added value. Let me give you examples of how I would give meaningful input to management and the Board of Directors:

1. 2006 LBO—My personal support and that of the Frist family was key to the HCA senior management’s, the private equity sponsors’, and the consortium of banks’ decisions to move forward with the LBO. I believe my strong endorsement for the LBO also was important to the independent members of the HCA board who approved the transaction.

2. My advice and counsel to the private equity sponsors regarding a mid-LBO transition of the CEO title from Jack Bovender to Richard Bracken. The smooth passing of the baton, along with other senior management changes, was a critical and important factor in the ultimate success of the 2006 LBO.

3. My initiating in September 2011 the successful purchase of a $1.5 billion block of Bank of America’s HCA stock. I called on the former HCA board member, Chad Holliday, who was the nonexecutive chairman of Bank of America with the thought that an $18/share at market cash transaction could be attractive to both Bank of American and HCA. With his concurrence, I then briefed HCA’s CEO Richard Bracken, and CFO Milton Johnson, and Chad made a similar call to Bank of America’s CEO Brian Moynihan. In less than 24 hours, the transaction was conceived, negotiated, approved by both boards, and completed. When considering the size and speed of the execution, it was one of the more amazing transactions in my career. Much of the success in this repurchase should be credited to Richard Bracken and Milton Johnson’s willingness to once again truly listen to an idea, quickly evaluate the merits, and then swiftly move to seize the moment.

Through the 2006 to 2012 era, I tried to be respectful of senior management’s needs for independence, but they were extraordinarily attentive to keeping me informed and up to date. One of the ways I was able to give HCA management space and at the same time keep my mind and energy active was my personal involvement in China.

GARBER: Why China?

FRIST: Coincidentally, in early 2007, I attended a Business Council meeting where a panel of six renowned economists spoke about the Asian rim countries, especially the rapidly-growing Chinese market. After years of believing HCA should not enter the Chinese market, my “gut feel” was that the time had finally arrived. I returned to HCA to share my thoughts about why China now; however, with $27 billion in debt resulting from the 2006 LBO and other reasons, the senior management and the board of trustees both decided it was not the time for HCA to enter the China
market; however, they approved and supported the Frist family’s interest in the market.

With HCA’s blessing and at times support, I and my son-in-law Chuck Elcan\textsuperscript{42} founded and capitalized China Healthcare Corporation (CHC) in 2007. This undertaking had several side benefits—one being it was an exciting new major entrepreneurial adventure for me that had so many of the ingredients of needs and opportunities that existed in the United States in 1968 when we founded HCA. Secondly, it did serve to appropriately divert much of my time away from the day-to-day affairs of HCA.

The thing that excited me about China was not just building an international company, because that would be relatively easy. People frequently come to my office asking, “Won’t you come to India? Won’t you come to Thailand? Won’t you come to Mexico?” That wouldn’t have excited me. What excited me is a 1.3 billion population, 20,000 hospitals, 7,000 of which need to be replaced immediately, a government that can make decisions crisply, and, whether you like it or not, make decisions that are best for the total population. China provided the opportunity of focusing on one country, rather than going from Thailand to Cambodia to South Korea to Mexico to Italy to various other places. It will take not only the rest of my lifetime, but my children and grandchildren and great-grandchildren’s lifetimes, to begin to scratch the surface of fulfilling the hospital needs of the Chinese population.

When HCA started in ’68, health care was 20 years behind other industries in our country as far as modern day best practices in delivering, administering, and running hospitals. Today, I look at the Chinese hospital system overall as 40 years behind what we’re doing in this country as far as delivering quality outpatient care and measuring it. They’ve first built modern day state-of-the-art airline terminals, high-speed trains, superhighways, and many other things. They now are turning their attention to health care and it will not take them 40 years to catch up to the United States.

It’s exciting for me to be able to have the opportunity of playing a small role once again in taking a leadership position in the rapidly evolving hospital sector of health care in China. We see the same problems: a dramatic shift in population like we saw in the United States 40 years ago, only the magnitude is much greater in China. The needs are great. One of the concerns I had for CHC would be dealing with corruption and foreign abuses. I am pleased to say CHC hasn’t in five years been approached to do anything fraudulent or in any way unethical. Everything I see is the government and others truly wanting to improve the quality of health care available to their citizens. It’s an exciting time.

Rather than starting in China with niche hospitals for ex-pats in Beijing and Shanghai, we’re taking a higher risk road of hoping that Blue Cross-like insurance products will develop for the rapidly developing middle class. We’re taking somewhat of a leap of faith in China that those same products will be developed—that there will be a private sector as well as their governmental payment system.

We are taking the risk of not building a niche hospital, but instead building hospitals for the total population, 500-bed and 600-bed hospitals that are replacing old, antiquated facilities. Many of

the hospitals that we’re replacing are government-owned. For the most part the hospitals that we’re building and acquiring are in joint ventures with the local or provincial governments, where CHC—our hospital company—owns 70 percent and the local government owns 30 percent. That was required by law five years ago when we started. Today, the regulations and laws have changed so that a foreign entity can own 100 percent of a hospital.

One benefit of having HCA’s encouragement and support is that HCA is large enough that CHC is able to search out and find, among our 200,000-plus employees, people who understand the HCA system and what we’re doing and trying to accomplish in the United States, but who are ethnically Chinese and are bilingual. That is very nice for us to have that resource. The family is not doing this on a consulting or management contract basis. We’re actually investing money in China. Time will tell whether it’s successful or not.

GARBER: You mentioned a shift in population in China, did you mean rural to urban?

FRIST: Yes. As they have become the manufacturing center for the world, creating products for such companies as Walmart and Target, there have been massive shifts in population from agrarian to large urban cities. In China, a “small” city could have 1.9 million.

GARBER: Do they have an increased percentage of older people like our Baby Boom?

FRIST: Yes, but it is even more of a problem there because of the one-child policy. How do you care for the elderly parents when there’s only one child to do that?

GARBER: How many hospitals is CHC operating?

FRIST: At the end of 2013, CHC will have a 500-bed and a 650-bed hospital operating. We’ve got two or three others under contract. Both are within 120 miles of Shanghai. This would be, in number of beds and adjusted patient admissions equivalent to the 11 small hospitals HCA had in 1969 when we had an IPO. These hospitals in China are all big 500-bed to 1,000-bed hospitals. The idea is to have a Sino-American partnership, where CHC has melded the best of Chinese medicine and culture with the best of America’s medicine.

GARBER: What does the typical Chinese hospital look like?

FRIST: They typically have three to five beds in a room up to some 40-bed wards. The outcomes, by the way, are comparable to the United States. While the United States health care system has much to learn from China, I don’t see us ever being able to put the genie back in the bottle. In the United States, the ownership and management of providers is too fragmented and diverse to achieve significant economies of scale. It will be far too difficult, if not impossible, to change the expectations of the United States population from its “whatever I want” mentality, such as private rooms, televisions, etc. We’re too far gone in the way our hospitals are owned and organized and the expectations of people.

The advantage China has is that the vast majority of the hospitals are government-owned. As in the United Kingdom, the government can permit and encourage the small private sector without destroying the large public hospitals. As a result, I think they’ll have the ability to better manage health care expenditures as a per cent of GDP than the United States. Like an artist with a canvas before him, painting a picture, China is able to start from scratch. Even if we know what we
want to achieve, that would be very difficult to do here.

**GARBER:** As far as the physical plant of the Chinese hospital, with the 3 to 5-bed patient room, would the diagnostic and treatment facilities be recognizable? There’s a lab, there’s an imaging department?

**FRIST:** Absolutely. Major suppliers—Philips, Siemens, and GE—are there. It’s only in the last year or so that the manufacturing of high tech is starting to occur in that country. Most of the MRIs, PET scanners, CAT scanners, laboratory diagnostic equipment are still manufactured elsewhere and imported into China. HCA’s $20 billion Health Purchasing Group (HPG) has an outlet in China that is sourcing directly many of the low technology items that we purchase, and this is reducing our costs significantly in the United States.

**GARBER:** Do you have a feel for what the average length of stay is in China?

**FRIST:** Yes. It’s similar to the United States in the cost-plus, pre-1984 era—10 to 11 days. The question is: how quickly will that change? Also, because of the demographics with the one-child culture, who will be the caregivers for the elderly? How do you shorten the length of stay without the infrastructure in place? Home health care, ambulatory surgery, nursing homes, rehab, assisted living services are almost nonexistent. Over the coming years, as the middle class grows, these needs will provide many opportunities for others to enter the Chinese health care market. It’s déjà vu. It’s very exciting. I just wish I were 25 years younger.

**GARBER:** How are the Chinese hospitals paid?

**FRIST:** In 2007, they passed a national health program whereby every Chinese citizen is covered to a lesser or greater extent by some form of government reimbursement. It used to be that if you lived outside of a province and came to get health care in that province, but if you didn’t have cash, you weren’t going to be treated. A universal health care system is evolving much faster than in the United States. This is important for CHC. We have negotiated for each of our hospitals to have access to the equivalent of our Medicare/Medicaid. Everything the public hospital has—we have access to that same payment system at comparable rates.

The question in my mind that’s not answered yet is: how quickly, if at all, will the private insurance sector occur? For instance, in the United Kingdom, where HCA is the largest private provider in the London MSA, most of our patients come from the 10 percent that have Bupa, or another private insurance. They will jump the queue to have their baby or to have their elective surgery in our facilities. The doctors are the same doctors practicing in the National Health Service who come to our hospitals where they realize 80 percent of their income from 20 percent of their overall patient load.

We’ll have to see how that’s going to evolve in China. As far as the payment system, is it going to be more like the English system, the Canadian system, or the U.S. system? In China, I would hope that we can take care of the masses of people in three- and four- and five-bed wards with the same or better outcomes as in the United States; however, you won’t have a TV before every bed. Maybe the family will be more involved in patient care, which is compatible with the

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43 Formed in 1947 in the United Kingdom, Bupa today offers health insurance in the UK and around the world. [http://www.bupa.co.uk/about-bupa-uk](http://www.bupa.co.uk/about-bupa-uk) (accessed Aug. 16, 2013).
Chinese culture. Maybe sheets won’t be changed every day unless they’re soiled. If they are changed, the family will do part of that. We’ll find a way to take care of those people at a lower price. Yet there will be a VIP service, like they have in England, so that the top neurosurgeons, orthopedists, and others can take care of their VIP patients in a different section of the hospital.

The outcome is the same. It’s a matter of amenities. Today at HCA, probably 90 percent of our hospitals are single patient rooms. In the United States, the patient for which Medicaid pays $200 a day or Medicare pays $500 a day is in the same kind of room and expects, and is required by law to receive, the same services as the patient that is paying $2,000 or $5,000 a day. China needs to be careful not to get into that position.

**GARBER:** What are key changes that have occurred in health care over your career that have affected HCA? What are constant factors?

**FRIST:** The ten most important macro factors over the past 50 years that enabled the HCA success story are:

1. Medicare/Medicaid—1965
2. Shift in the United States population from the Rust Belt to the Sunbelt—began in the early 1960’s
3. Nixon price/wage controls—1971-72
4. Reagan presidency—labor relations (air traffic controllers); attacked inflation
5. Cost-plus reimbursement changed to prospective payment – DRGs, HMOs
6. Junk bonds/high yield (Mike Milliken-Drexel Burnham)—1985
7. Clinton presidency—proposed universal health/Hillary care; massive fraud and abuse investigation of healthcare providers
8. Medical technology advances beginning in the 1970s till the present time
9. Creation and implementation of the internet—late 1980s and early 1990s to present
10. Global financial markets dominated by “too big to fail” mega-banks—2000 to present; large private equity funds—mid ‘80s to present

There are three important constants always impacting hospitals. The hospital sector is capital intensive, labor intensive, and government regulated. Together, many feel they are three good reasons not to invest in hospitals. They certainly can pose a significant barrier for entry. For those committed to the hospital sector, depending upon the status of each of these factors, they can create times of prosperity or times of crises. When all three are relatively quiet, the times are good, and hospitals are stable. If one is problematic, challenges and/or opportunities are created. If two of the three are problematic at the same time—watch out! If all three are out of sync at once, it can be a life-threatening time for hospitals.

Of course, the most important constant is the ever-present truism: in the provider sector of health care—particularly for hospitals—quality will always prevail. The great hospitals will always put the patient and the patient’s family first, and the really great institutions will provide care with warmth, compassion, and dignity for the individual.

**GARBER:** What are the five most important business decisions you’ve made?
FRIST:

1. Founding HCA in 1968 with my father and Jack Massey. At 28 years of age, it let me combine my love of medicine with the thrill of business and my passion for aviation (airline transport pilot).

2. The 1989 management-led HCA LBO. The banks required that if they were to loan $4 billion at 50 y/o, I would roll 100 percent of my net worth into the LBO.

3. My decision to return as CEO in August 1997 to attempt to save a very troubled Columbia/HCA. Even more than the financial risk, I worried about the risk of damaging the Frist name and reputation if I were to fail.

4. Encouraging, supporting, and investing $800 million of Thomas F. Frist, Jr. family funds in the 2006 HCA LBO.

5. Our Frist family at the time of the 2012 IPO of HCA decided once again not to sell any of its HCA holdings. Let’s revisit the question in 2020 to determine the outcome of the passage of Obamacare in 2012, and whether or not we made the right decision.

The above five decisions, along with many others over the decades, have resulted in financial achievements beyond imagination. The following is a brief synopsis of public information regarding the Thomas F. Frist, Jr. and family net worth.

1966 I invested $3,000 in the KFC IPO and over the next 18 months leveraged it into $150,000.

1968 I invested $300,000 in the founding of HCA—$150,000 from the proceeds of KFC and $150,000 from borrowing new capital.

1989 I invested $35 million (100% of my net worth) in the HCA LBO.

1998-99 I borrowed in short-term debt over $100 million to invest in the severely-depressed ($17-$18 share) Columbia/HCA stock.

2006 The Thomas Frist, Jr. family invested $800 million in the HCA LBO.

The result was the $3,000 in 1966 grew to over $5 billion in 2013 (Forbes 400).

GARBER: That remarkable achievement leads us to talk of philanthropy.

FRIST: Philanthropy has been a lifelong journey for me. As a young child putting a dime in the collection plate at church to later years of giving away hundreds of millions of dollars, I have received much personal satisfaction from my charitable activities. I often wonder if the joy of giving back to individuals, institutions, and the community at large is part of my DNA. Hopefully, the giving of my time and financial resources over the years to worthwhile charitable and civic entities has served to have a positive influence on my personal family as well as the HCA corporate family.

When it is all said and done, each generation of our Frist family will be generous, not
because someone said, “Do it,” but because they observed their parents involved in making the world a better place for others. Likewise, HCA from its earliest days has fostered a culture of being a good corporate citizen. It has always encouraged its employees to be generous with their time and resources for philanthropic purposes. The remarkable success story of HCA over the past 45 years has resulted in financial gains for several generations of employees far greater than anyone could ever have imagined or expected. It has been quite rewarding for me to observe the unselfish sharing of their wellbeing through responsible and thoughtful philanthropy.

While HCA provides literally billions of dollars annually in free patient care to the poor and uninsured, we also see the need to make corporate gifts. To assist our philanthropic activities, we used a creative entrepreneurial approach in 1981 to establish the first HCA Foundation. After receiving a favorable private letter ruling from the IRS, HCA gave a nonqualified stock option to fund a significant foundation.

In the same entrepreneurial spirit in 1983, while chairing the annual capital campaign for the United Way of Middle Tennessee (UWMT), I established a new leadership giving program that was life changing for not only the UWMT but the entire United Way system worldwide. As a result of this $10,000-plus giving program, which we branded as The Alexis de Tocqueville Society, our UWMT campaign led all United Way organizations in its year-over-year increase. The following two years, our Tocqueville Model was piloted in twenty cities and over the next ten years it was expanded to 200-plus communities throughout the United States. I gained a great deal of pleasure and many new friends over the decade (1985-1995), as I traveled throughout the United States working with community leaders to establish their local Tocqueville Societies. By 2012, the Alexis de Tocqueville Program had raised over $7 billion dollars for the United Way system and at the same time served as a catalyst for many other nationwide social service agencies, such as the Red Cross, to create their leadership’s giving programs.

Once again, without HCA’s encouragement and support of me, this important giving program would not have been possible. While by any measure the Alexis de Tocqueville Society program was a “home run,” it was just one of many charitable/civic endeavors I was able to undertake over my career at HCA.

Separate from the charitable giving of HCA and its employees, but thanks in large part to the appreciation in the stock of HCA since 1968, our Frist family has been able to fund a broad-based group of charities that include education, health, arts, and social services. Over the past twenty years, the family has made charitable gifts either directly or through our foundations of over $400 million. Upon the death of my wife and me, 95 percent of our estate will go to charitable trusts that
will be managed under the umbrella of the $275 million Frist Foundation. If we were to pass away in 2013, over $1.5 billion would be transferred to these charitable trusts which, hopefully, will perpetuate our Frist family’s charitable legacy for generations to come. It is good to see that HCA, through its network of facilities, does so much good in the world through providing quality patient care and at the same time provides a by-product where the Frist family can share its success through its charitable activities.

**GARBER:** The Nashville Healthcare Council (NHC), which was created in 1995/96, has approximately 250 members in 2013. I am told that you and HCA played an important role in its founding. What is its origin and purpose?

**FRIST:** In the mid-1990s, I, along with several other CEOs of Nashville-headquartered health care companies, established the Nashville Healthcare Council. The majority of the founding group was former HCA officers who were then running significant companies. At the time of the founding of the Nashville Health Care Council, Clayton McWhorter and Charlie Martin were leading Healthtrust; Joel Gordon and Woody Miller—Surgical Care Affiliates; Joe Hutts—Phycor; Jim Dalton—Quorum Healthcare Group; Sam Brooks—Renal Care America; Ken Melkus—HealthWise. Each played a key role in the founding of the Nashville Healthcare Council.

The many mergers and acquisitions made by HCA in the decades of the ‘70s, ‘80s, and ‘90s resulted in reorganizations and divestitures that created opportunities for many of the deep bench of talented, seasoned HCA executives to seek new career challenges through leading these HCA spinouts. In other cases, newly-acquired wealth from either HCA stock appreciation or the selling of a company to HCA enabled entrepreneurial-motivated individuals to found new companies.

Regardless of the origin, by the mid-1990’s, there were over fifty health care companies based in middle Tennessee, and it became obvious to several of us that we should establish a health care council whose mission would be twofold. First, it would provide a forum for its member companies’ executives to examine industry-wide issues. Second, it would provide an organized approach to selling middle Tennessee as the location of choice for health care companies or for subsidiary offices of large health care companies.

The first goal has proven to be an invaluable resource not only for the smaller emerging companies but also the larger, more established organizations’ executives to network among themselves as well as with suppliers/vendors. The second goal’s achievements has exceeded all our

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founding members’ expectations. Since the founding of the Nashville Healthcare Council, the growth of our membership has been exponential. Today, Nashville is frequently referred to as the Silicon Valley for healthcare companies.

I highly recommend interested parties to contact the Nashville Healthcare Council for additional information and specifically request a copy of the annually updated Family Tree which graphically displays the multiplier effect of HCA on the Nashville health care community.45

GARBER: I wonder if you would speak about Mrs. Frist.

FRIST: First I would like to say whatever success I have achieved has been “our success.” Trisha and I have literally made this lifelong journey together. I first met her when she was in the eighth grade and I was in the ninth. We dated, and she was like a member of our family all through high school and college. Trisha and I married in 1961 after we both graduated from Vanderbilt University. She was always the more outstanding of the two of us. She was president of almost everything (class, sorority, etc.) and in her senior year was voted Miss Vanderbilt. Throughout our lives she has always been supportive and encouraging of all my varied interests in life.

From day one we have been 50/50 partners in all of our financial affairs including the founding of HCA. This continues today in our high risk but exciting China Healthcare Corporation commitments. Together, our first priority has been our three children and nine grandchildren. Over the years, my responsibilities at HCA have been inordinately time-consuming and Trisha was the one who was the linchpin for our family. Trisha was always there with our children, and she saw that I was there as well. It has been a good partnership. The three children are now in their mid-40's, happily married to great spouses. Each has three children for a total of nine grandchildren.

The bottom line is I have been extremely blessed throughout my life. I certainly would not want to relive my life again. I fear it would not turn out so well the next time around.

GARBER: Dr. Frist, thank you very much for your time this afternoon.

FRIST: My pleasure. Come back any time!

CHRONOLOGY

1938   Born August 12, Nashville, TN

1961   Vanderbilt University (Nashville, TN)
        BA

1961   Married to Patricia Gail Champion of Ridgely, TN
        Children: Patricia C., Thomas F. III, William R.

1965   Washington University School of Medicine (St. Louis, MO)
        MD

        Vanderbilt University
        Surgical internship

1966-1968 United States Air Force
           Flight Surgeon

1968-1994 Hospital Corporation of America
           1968   Co-founder with Dr. Thomas F. Frist, Sr., and Jack C. Massey
           1977-1987 President and Chief Operating Officer
           1987-1994 Chairman, President and CEO

1994-2001 Columbia/HCA Healthcare Corporation
           1994   Chairman of the Board
           1995-1997 Vice Chairman of the Board
           1997-2001 Chairman and CEO

2001-present HCA-The Healthcare Company
            2001-2002 Chairman
            2002-2009 Board member
            2009-present Chairman Emeritus

Lifetime   Airline Transport Pilot (11,000 hours total time as of 2013)
            Ratings: airplane multi-engine land
            N-265 (Sabreliner), CE—560 (Citation), C525 (CJ4)
            Commercial privileges
            Airplane single engine land and sea
Dr. and Mrs. Frist with their grandchildren
Photography courtesy of Simon James Photography
MEMBERSHIPS, AFFILIATIONS, AND PHILANTHROPY

Alexis de Tocqueville Society
   Founder
   Donor

Dorothy Cate Frist Building at Harpeth Hall School
   Donor

Ensworth High School (Nashville)
   Major lead donor, new school

Ensworth School—Red Gables (Nashville)
   Donor of Frist Hall

Frist Campus Center at Princeton University
   Major lead donor

Frist Center for the Visual Arts
   Board chairman
   Major lead donor
   Founding director

Frist Faculty Commons at Harvard Business School's Baker Library
   Donor

The Frist Foundation
   Founder
   Board chairman

Frist Gym, and scholarships, at Curry Ingram Academy
   Donor

Frist Learning Center at Cheekwood
   Donor

Frist Nursing Informatics Center at Vanderbilt University School of Nursing
   Donor

Frist Scholars Financial Aid Fund at Harvard University
   Donor

Frist Teen Center at Green Hills YMCA
   Donor

Harvard Business School, Board of Dean’s Advisors
   Board member
   Donor, Frist Financial Aid Fund
HCA
  Board member

HCA Foundation
  Board chairman

IBM
  Board member

Montgomery Bell Academy
  Board member

Nashville Chamber of Commerce
  Board chairman
  Board member

Nashville Health Care Council
  Board chairman
  Board member

Nashville Zoo
  Major donor

National Business Aviation Association
  Board member

Patricia Champion Frist Hall at Vanderbilt University School of Nursing
  Donor

Third National Bank
  Board member

Thomas and Patricia Frist Chair of Excellence in Business at Tennessee State University
  Donor

Thomas F. Frist Centennial Sportsplex
  Donor

Thomas F. Frist, Jr., Scholars at Washington University
  Donor

United Way of America
  Board chairman
  Board member

United Way of Middle Tennessee
  Alexis de Tocqueville Society of Middle Tennessee founder and chairman
Board chairman
Board vice chairman
Donor
General campaign chairman

Vanderbilt University
Board vice chairman

YMCA East Nashville Waterpark and Playground
Donor
AWARDS AND HONORS

High school 1st string All-City quarterback, 2nd string All-State quarterback, All-City basketball guard

1981  Frist Humanitarian Award
1981  Kenneth H. Cooper Prize for Aerobic Leadership, Tyler Corporation
1981  Leadership Award, Florida Governor’s Council on Physical Fitness and Sports
1981  Third Annual Kenneth Cooper Prize (for contributions toward physical fitness)
1982  Business Person of the Year, Nashville City Bank
1982  CEO of Dun’s Business Monthly “Five Best Managed Companies”
1982  CEO of the Year—Silver Award, Financial World magazine
1983  CEO of the Year—Hospitality Management Industry, Wall Street Transcript
1983  CEO of the Year—Silver Award, Financial World magazine
1984  CEO of the Year—Hospitality Management Industry, Wall Street Transcript
1985  Alexis de Tocqueville Award, United Way of Middle Tennessee
1985  Applause Award, Tennessee Performing Arts Center
1985  Outstanding CEO in Hospital Management, Financial World Magazine
1985-1989  Business Roundtable
1986  Cum Laude Society Honorary Member, Montgomery Bell Academy
1987  Alexis de Tocqueville Award, United Way of America
1987-2010  Business Council
1987-present  American Society of Corporate Executives
1989  Distinguished Alumni of the Year, Washington University School of Medicine
1989  Tennessee Football Hall of Fame
1990  Fred Russell Distinguished American Award, National Football Hall of Fame
1992-present  Forbes 400

46
1993  National Board of Directors Award, Institute of Living
1994  Alexis de Tocqueville Award and award for founding the Alexis de Tocqueville Society, United Way of America
1996  Business in the Arts Leadership Award, Tennessee Repertory Theatre
1998  Distinguished Alumni of the Year, Montgomery Bell Academy
1999  John Harvard Fellows Award, Harvard University School of Business
1999  Salt Wagon Award, Meharry Medical College
2000  Alexis de Tocqueville Award, United Way of America
2000  Red Shield Award, Salvation Army
2002  Board of Directors Award, Healthcare Financial Management Association
2002  Distinguished Alumnus Award, Vanderbilt University
2002-2003  100 Most Powerful People in Healthcare, *Modern Healthcare*
2003  Distinguished Alumnus Award, Phi Delta Theta International Fraternity
2003  Healthcare Hall of Fame, *Modern Healthcare*
2003  Philanthropists of the Year (Dr. & Mrs. Frist), Association of Fundraising Professionals
2003-2004  Volunteer of the Year, Nashville Chamber of Commerce
2005  Entrepreneur of the Year, Ernst & Young
2006  Hall of Fame, Business Tennessee Leadership
2006  Swan Award, Cheekwood (Nashville)
2007  Health Care Heroes Lifetime Achievement Award, *Nashville Business Journal*
2007  “Nashville’s Top 50 Business & Community Leaders,” *Celebrate Nashville* [official publication - year anniversary of Nashville]
2007  National Promise of America Award, White House
2008  US Business Hall of Fame, Junior Achievement
2009  Best in Business Lifetime Achievement Award, *Nashville Business Journal*

2010  “The Tommy,” HCA Innovator Award

2011  Award, Aircraft Owners & Pilots Association

2012  Lifetime Achievement Award, United Way

2013  Philanthropists of the Year (Dr. & Mrs. Frist), Association of Fundraising Professionals
SELECTED PUBLICATIONS


## INDEX

Air conditioning, 8  
Aircraft, 4, 5, 8, 12  
Alexis de Tocqueville Society, 38  
American Hospital Supply Corp., 19  
American Medical International, 14  
Antitrust laws, 19  
Apollo Hospitals Enterprise, Ltd., 31  
Armstrong, C. Michael, 25  
Athens (Tennessee), 9  
Averhoff, Magdalena, M.D., 25  
Bain Capital, 29  
Bank of America, 29, 32  
Baxter International, 19  
Bays, Karl, 19  
Berry Plan, 5  
Bovender, Jack O., Jr., 22, 23, 24, 26, 27, 29, 32  
Bracken, Richard M., 24, 27, 29, 32  
Brooks, Sam A., 39  
Bupa, 35  
Certificate of need, 18  
Chao, Elaine L., 25  
China, 32, 33, 34, 35, 36  
China Health Corp., 33, 34, 35  
Citibank, 20, 29  
Clinical integration, 18  
Clinton, William J.  
  administration, 20, 21, 36  
Collegiate Advertising, 4  
Columbia Hospital Corp., 20, 21  
Columbia/HCA Healthcare Corp., 20, 21, 22, 37  
Competition, 14, 17, 27  
Consolidation, 13, 15  
Conversion  
  ownership, 8, 11  
Cook, J. Michael, 25  
Dalton, James E., Jr., 39  
Diagnosis related groups, 14, 15, 19, 20, 36  
Diversification, 19  
Diversity, 5  
Economic Stabilization Act, 11  
Economy of scale, 7, 13  
Elcan, Charles A., 33  
Entrepreneurship, 4, 10, 11, 12  
Ethics, business, 25  
Extendacare (Louisville, Kentucky), 14  
Federal government, 11, 19, 21, 22, 23, 25  
Feldstein, Martin, 25  
Forstmann Little & Co., 26  
Foundations, 14  
Franchises (retail trade), 9  
Frist Foundation, 38  
Frist, Dorothy Cate, 1, 8  
Frist, Patricia Champion, 4, 5, 40  
Frist, Thomas F., Sr., M.D., 1, 2, 5, 6, 7, 8, 9, 15, 30, 37  
Frist, William H., M.D., 3  
Future problems and trends, 16, 17, 20  
Galen Health Care, Inc., 21, 23, 31  
General Care Co., 15  
General Health Services, Inc., 15  
Gluck, Frederick W., 25  
Goal setting, 4, 9  
Gordon, Joel, 39  
Governing board, 13, 14, 25  
Green Hospital of Scripps Clinic (La Jolla, California), 14  
Hatchett, Glenda A., 25  
Health care  
  ambulatory care, 19  
  delivery system, 13  
Health Care Corp., 15  
Health facility merger, 15  
Health services needs and demand, 10, 15  
HealthONE (Denver), 16  
HealthSouth Corp., 16  
Healthtrust Purchasing Group, 13  
Healthtrust, Inc., 20, 21, 22, 23  
HealthWise of America, 39  
Hill, John A., 30  
Holiday Inns of America, 6  
Holliday, Charles O., Jr., 25, 32  
Home health care, 25  
Hospital administration  
  span of control, 16  
Hospital Affiliates International, 14, 15  
Hospital bed capacity, 15  
Hospital Corp. of America  
  Saudi Arabia, 30
Hospital Corporation of America
    founding of, 6
Hospital design and construction, 10, 12, 36
Hospital Survey and Construction Act, 8
Hospitals
    acquisitions, 11, 12
    in foreign countries, 31, 32, 34, 35
    new, 10
    overflow, 14
    proprietary, 8, 10, 11, 12
    psychiatric, 15
Hub and spokes model, 16, 17
Humana, Inc., 14, 21
Hubbs, Joseph, 39
Inflation, economic, 12
IPO
    Going public (securities), 6, 9, 20, 34, 37
J.P. Morgan, 20, 21, 29
Jones, David A., Sr., 21
Junk bonds, 20, 25, 26, 36
Kentucky Fried Chicken, 6, 9, 37
Kings Daughters Hospital (Frankfort, Kentucky), 11
Kohlberg Kravis Roberts & Co., 26, 29
Labor unions, 18
Leveraged buyouts, 15, 20, 21, 23, 25, 26, 27, 29, 31, 32, 37
LifePoint Hospitals, Inc., 16, 26
Long, T. Michael, 25
Loucks, Vernon R., Jr., 19
Loveland Medical Center (Albuquerque, New Mexico), 14
MacNaughton, Donald S., 30
Malpractice
    insurance, 13
Marketing of health services, 25
Martin, Charles N., Jr., 39
Massey, Jack C., 6, 8, 9, 30, 37
McArthur, John H., 25
McWhorter, Ralph Clayton, 39
Melkus, Kenneth J., 39
Merrill Lynch, 26, 27, 29
Mick, Roger E., 26
Miller, Andrew W., 39
Mission, 10, 12, 32
Montgomery Bell Academy (Nashville), 2, 7
Moynihan, Brian T., 32
Multihospital systems, 8, 9, 10, 11, 14, 17
Murphy, Thomas S., 25
Nashville Healthcare Council, 39, 40
National Medical Enterprises, 14
Nelson, Kent C., 25
Nixon, Richard M., 11
    administration, 11, 36
Owen, Tommy, 3
Park View Hospital (Nashville), 6, 7, 8, 9
ParkwayHealth, 31
Patients’ rooms, 36
Patton, Philip R., 22, 24
Philanthropy, 37, 38
Physcor, 39
Physicians
    ownership of hospitals, 25
Presbyterian Hospital (Oklahoma City), 14
Prospective payment, 20
Prudential Insurance Co., 30
Quorum Healthcare Group, 39
R. Milton Johnson, 24, 27, 29, 32
Rainwater, Richard E., 21
Ramsay Health Care, 31
Reagan, Ronald
    administration, 12, 18, 36
Referrals, 17
Reichardt, Carl E., 25
Renal Care America, 39
Robins Air Force Base (Warner Robins, Georgia), 6
Royal, Frank S., M.D., 25
Saudi Arabia, 30
    King Faisal Hospital, 31
Scott, Richard L., 20, 21, 22, 23, 25
Selma (Alabama), 9
Shapiro, Harold T., 25
Shared services, 7, 13
Steakley, Joseph N., 23
Stock market, 20, 26
Surgical Care Affiliates, 39
Surgicenters, 16
Triad Hospitals, Inc., 16, 26
TriStar Centennial Medical Center (Nashville), 16
TriStar Health (Nashville), 16
U.S. Air Force, 6
U.S. Federal Bureau of Investigation, 22
United Kingdom, 31, 34, 35
United Way, 38, 44, 46
Vanderbilt University, 3, 4, 5, 6, 40, 41
Vietnam War, 5
Wallace, Beverly B., 24
Washington University (St. Louis), 3, 4, 5
Waterman, Robert A., 23

Wesley Methodist Center (Wichita, Kansas), 14
Williams, Noel, 24
Wilson, Clark Kemmons, Jr., 6
Wilson, Spence, 6
Yuspeh, Alan R., 23