



DAVID M. LAWRENCE, M.D.
In First Person: An Oral History

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DAVID M. LAWRENCE, M.D.

In First Person: An Oral History

**Interviewed by Larry Walker
On February 25, 2013**

Edited by Kim M. Garber

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EDITED TRANSCRIPT
Interviewed in Healdsburg, California

LARRY WALKER: Today is February 25, 2013. My name is Larry Walker, and we're sitting in the beautiful Gallery 322 in Healdsburg, California, for this interview with Dr. David Lawrence. Dr. Lawrence led Kaiser Foundation Health Plan and Hospitals in various capacities for over 21 years, including serving as President and CEO for a decade. Dr. Lawrence is renowned as one of the health care field's most forward-thinking and thought-provoking executives and a key leader in the quality and patient safety movement. He is known for his advocacy of needed improvements to, and innovation in, the American health care system. Dr. Lawrence retired from his distinguished career from Kaiser Permanente in 2002. Good afternoon, Dr. Lawrence. Let me start out with some questions about your family background. I know that you grew up in Portland, Oregon.

DR. DAVID LAWRENCE: I grew up in a wonderful family and was fortunate to have both sides of my family in Portland. My father's family had moved to Portland as young adults. My mother's family was third or fourth generation in Portland. They were the early influencers—the family and the stories that they told, the things that they did, the kinds of histories that they had. We were surrounded by those stories, which shaped me in ways I can recount, as well as innumerable ways that I can't.

My maternal grandmother, Katherine Wilson, known as “Mom” to all of us, was a tremendous influence on me. What made her unique was, first of all, a very interesting medical history, but I didn't know that until much later. When she was a young woman, she had had a tumor on her thyroid gland. It was operated on by a man who butchered her and left her with a constricted trachea. She was unable to breathe very well, and he severed the nerves that controlled her ability to speak, so she whispered when she spoke. She had no voice. For many years, this athletic and lovely woman was incapacitated. She couldn't do much, she couldn't sleep at night, she had trouble breathing—to the point that after four children, she ended up with a severe depression and was hospitalized at the Oregon State Mental Hospital for over two years. This was back when there were few treatments for depression.

She came out and found a surgeon in Seattle, a renowned ear, nose, and throat surgeon, who tried to remove the scar tissue that had formed and repair the damage that had been done. She couldn't regain her voice, but she regained her breathing ability and lived to be almost 80 years old. The latter part of her life after that surgery was one of freedom. She felt so relieved to have lived through this terrible depression and the terrible physical problems. She was an inspiration. She was remarkable. Of course, when she spoke in this whisper, it sounded like she was always kind and gentle—until you listened to the words! She could be a tough lady, but she was wonderful and became one of my dearest, dearest, dearest friends.

WALKER: That was an example of an early medical error.

LAWRENCE: An early medical error caused this problem. We grew up with it, so it wasn't something that we were aware of as a medical error until much later. There was another part to this story, and that was that I would spend time with her. She had a cabin at Zigzag, outside of Portland, and we spent a lot of time with her there during the summers. I used to spend time with her alone in the summers when I was getting ready to go to medical school. I did summer school at

Lewis and Clark, and Portland State—finished some of my requirements—and I worked at Welches Golf Course when it was new. I lived at her cabin, so she and I spent hours together. We were very close.

She knew I was going to medical school, and she asked me if I would euthanize her when she became too ill to live. This was my first real wrestling with the ethics of medicine. It was quite remarkable. I went to see her when she was dying. She was in a nursing home in Portland and had widespread cancer and was very much in pain. In fact, I didn't recognize her when I walked into the room, she was so emaciated. I hadn't seen her for a number of months. I flew back to see her because she was nearing death. After we had said our greetings, she said, "Davey, please kill me. Please kill me. I can't stand this." As I had told her before—we had had numerous conversations—I said, "I can't do that." This was before the Right to Die legislation in Oregon.¹ It was certainly not part of the medical training we had, except that it was a no-no. This was remarkably influential. It's had a profound effect on me all my life, what she and I talked about, and what she asked me to do that I couldn't do. She was a very important family and personal influence.

My mother was influential. Both my mom and dad were wonderful people. I lived with my dad all during medical school. He was a great guy and influential in his own way. My mother had some of the same qualities of grit and determination and stubbornness that I admire so much in people who are able to get things done—because it isn't easy to change things. It isn't easy to get things done through an organization.

There's one great story about her that we all tell. Her name was Bunny, a nickname that she got when she was a young kid. We were at a family gathering in Portland—a dinner. We were all there, and she came in late. She was kind of gray. This was when she was in her early 80's, and she didn't look good. My brother and I were sitting on either side of her and said, "Mom? What's wrong?" She said, "Oh, nothing." Finally, she admitted that she had been walking in a crosswalk near the club where she was coming to join us for dinner, and she'd been hit by a car! She had rolled up over the hood of the car and down the other side onto the ground. It was in November, pouring rain. She got up, and the driver was really scared. He had just hit an old lady and knocked her over the hood of his car! She said, "Oh, I'm fine. I'm fine. Go on. Don't worry." He said, "Are you going to sue me?" She said, "Oh, no, no, I don't believe in that." She brushed herself off and came on to the dinner. She wouldn't tell us for quite some time that she had gotten hit by a car. We just went bananas! "Mom, you've got to go in and get seen!" She said, "Nah. No, no, no." She was tough.

Another time, she went out from the apartment where she lived with her husband, my stepfather. It was about eleven o'clock at night, pouring rain, and she went out to walk the dog. There was a hole that had been dug by landscapers and left uncovered. She fell into it backwards.

¹ Voters in Oregon passed the Death with Dignity Act in 1994 but, because of an injunction, the Act was not implemented until 1997. Under carefully controlled conditions, the Act permits Oregon physicians to prescribe a lethal dose of a medication (usually a barbiturate) that a patient voluntarily self-administers. Physicians are prohibited in Oregon, as in all states, from themselves administering lethal doses of medications (also known as *euthanasia*). Oregon was the first state to pass legislation of this nature. From the time the law was enacted until 2012, 673 patients have chosen to die in this manner. [Source: Oregon Public Health Division. *FAQs About the Death with Dignity Act*, Aug. 24, 2011. <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf> (accessed June 25, 2013).]

She was in the hole for a half an hour. It was ten feet deep. You couldn't hear her cries, you couldn't hear anything. Finally, my stepfather said, "Where'd she go?" and went outside and started calling for her and found her at the bottom of the hole. She had torn the ACL in her knee, but refused to go to the hospital. She said, "I'm cold. I'll take a shower," and then just went to bed.

I love that quality of grit, and that ability to just live through it and drive through it. She was one of the early people to become divorced in Portland. She married again, and lived through blending two families from three kids to six kids and raised all of us. She lived through the time when my grandmother was in the mental hospital. She was one of her major caregivers. Those are examples that had a major impact on me—stubbornness and, "Damn it, nobody's going to get the best of me. I'm not going to let myself down." I guess that's the lesson. Keep banging away at things.

WALKER: Being stubborn is a good quality for a health care leader to have.

LAWRENCE: You certainly need it if you're going to do anything. You can't do anything easily. I'd also like to mention my dad, who was pretty important to me. My dad was a teacher and a headmaster of a grade school. He had a simple moral structure: as a teacher he found something valuable in each of the students who came into his classroom. That is fascinating to me. He died at age 89 in Lexington, Kentucky. After my parents were divorced, he moved—in his early 40's. Born and raised in Oregon, he moved to Kentucky. He was brought there by a young teacher who had worked at Dad's school when he was headmaster. This teacher said, "I'd like you to be the assistant headmaster." He worked there for a couple of years and then switched to the other private school in Lexington.

I was recently there in the fall at a dinner or two. I can't tell you how often this has happened when I'm in Lexington: people come up to me and say, "Your dad was my teacher, and he helped me." I get teary thinking about it. It's really quite beautiful. They say, "He helped me through this; he helped me through that. He found something in me that nobody else saw." That's a valuable lesson. I never can thank my father enough for that.

WALKER: Let's talk about your early career. You attended the University of Kentucky.

LAWRENCE: For medical school.

WALKER: You later earned a Master's in Public Health at the University of Washington.

LAWRENCE: Yes.

WALKER: You worked in the Peace Corps in the Dominican Republic, which was followed by overseeing Peace Corps volunteers around the country and around the world. Then in 1970, you went to Chile for two years as a public health advisor to the government there as part of Johns Hopkins Hygiene and Public Health program. How did those experiences shape your thinking?

LAWRENCE: Let me take you back just a little bit. I started traveling at about age four or five—when I started reading. Until I could actually do it in person, books were the way I traveled around the world. My parents were both teachers. They read books to us when we were young and helped us find books that gave us experiences of diving into the lives and the cultures of other

countries and also here in the United States.

When I was 16, I worked for a summer on an old freighter, which happened to be a Liberty Ship that I later found out had been produced by Henry Kaiser and his people out of the Vancouver, Washington, shipyards.² I worked in the engine room. We left in June from Portland and traveled first to Japan, then to Korea, and then across the northern route on the Pacific back to Portland, getting back in early August. It was about seven or eight weeks.

That was a remarkable experience because I was the youngest kid on the ship by several years. We had 24 hours in Japan to pick up fuel. Then we were in Pusan, Korea,³ three years after the conflict. It was desolate, desperately poor. That was the first real experience across a culture that I'd had. I'd never really traveled anywhere before that, except in books. I can't even begin to describe how exciting it was to explore another culture. Every day, every night, we were out and around in Pusan. I had a friend that I met there who was born in Korea and was the same age. We corresponded for nearly 20 years—he eventually went on to become an architect and engineer. That was the first experience I had had working with guys who were so different—some were wonderful, some were absolute jerks. It was a cultural experience that was defined by class, by education, by life experiences and so on. I loved it. I couldn't get enough of it.

During medical school, I had a four-month opportunity to do a study with some fellow medical students in Bolivia. We studied medical problems that people encountered at five different altitudes in Bolivia. We studied five villages at different altitudes. We were each assigned a village, and then we did medical surveys, health care surveys, and so on, as part of community medicine.

Community medicine was a huge influence—such as the work done by Kurt Deuschle,⁴ who was the founder of the community medicine movement in medical education at University of Kentucky, and later at Mount Sinai in New York. This influenced many of us in my class in medical school. The idea of going into the Peace Corps and having that experience, first in the Dominican Republic, and then overseeing the medical care for all of the volunteers around the globe, and then going to Chile under the aegis of Johns Hopkins—all of those were an extension of that wanderlust, that interest in experiencing and learning about other cultures and the way things are done.

How much these experiences influenced my thinking about health care is hard to say

² At the end of the Great Depression, the building of ocean-going merchant ships in the United States was nearly at a standstill. When World War II started, enemy submarines took a heavy toll on ocean-going cargo ships, sinking 12 million tons of shipping in 1942 alone. Henry Kaiser (1882-1967), a self-made industrialist who had built the Hoover, Bonneville, and Grand Coulee dams, came to the rescue. With no previous experience, Kaiser revolutionized shipbuilding, slashing the time required to build a ship by introducing the assembly-line concept, among other innovations. The Liberty Ships were an important model of cargo ship produced by the Kaiser shipyards. Henry Kaiser also founded Kaiser Permanente, originally as a way to safeguard the health of Kaiser workers on the Grand Coulee Dam. [Sources: University of Houston College of Engineering. *Liberty Ships*. <http://www.uh.edu/engines/epi1525.htm> (accessed June 25, 2013); and, Oregon Historical Society. *Henry J. Kaiser Biography*. <http://www.ohs.org/the-oregon-history-project/biographies/Henry-J-Kaiser.cfm> (accessed Apr. 25, 2013).]

³ The Port of Pusan (sometimes referred to as Busan) in South Korea is currently among the top 10 busiest container ports in the world. [Source: *Port of Busan*. http://www.worldportsource.com/ports/KOR_Port_of_Busan_1482.php (accessed June 25, 2013).]

⁴ Kurt W. Deuschle, M.D. (1923-2003) was known as the “father of community medicine.” [Source: *The New York Times*, Feb. 11, 2003. <http://www.nytimes.com/2003/02/11/classified/paid-notice-deaths-deuschle-kurt-w-md.html> (accessed June 25, 2013).]

because with those experiences, you don't take away specific how-to's. You take away feelings, and experiences, and perspectives. Those are more inchoate. It's hard to really put your arms around them, but they shaped me. I still love Latin America. I speak Spanish, and every opportunity I get, I'm talking to people in Spanish because I like to practice and show off. Something about the history of Latin America was exciting and has shaped how I think about the world.

It was also a chance to watch the U.S. Government and U.S. international politics in operation. I went to the Dominican Republic in 1967, two years after the Marines had invaded because of fear of a Communist takeover in the D.R., and my background reading enabled me to understand a lot of what was alleged, and then what was found.

Some of the referral doctors we used to take care of the Peace Corps volunteers, the docs that I was referring to, were excellently trained specialists who were on the "no-travel" list in the United States. One OBGYN specialist, for example, had been a major mover and shaker in the family planning movement in the Dominican Republic, trying to bring safe childbirth and prenatal care, as well as contraception, to women. He and several others weren't permitted to come to the United States for international meetings on family planning. I thought, *This is just damn stupid. I can't figure it out. It doesn't make any sense to me.*

Shortly after that, my wife and I went to Chile. That was the last year of Frei and the first year of Allende. We watched Kissinger and Nixon and the ways that they overtly tried to destabilize the election and shift the election against Allende; then, the work they did that eventually led to the coup and Pinochet, and Allende's death, either at his own hands or at the hands of the coup people—probably at his hand. We watched all that. We were there.⁵

I was interacting with USAID and the U.S. Embassy.⁶ Ed Korry was the ambassador at the time, and he later wrote a book about his experiences. He was under immense pressure from Kissinger to use every tool at his disposal to undermine and destabilize Allende. He later wrote about it and was investigated by Congress.⁷ The Deputy Ambassador was Harry Shlaudeman.⁸ He had been in Guatemala during the time that there was a coup that we engineered, and he was

⁵ Eduardo Frei (1911-1982) was President of Chile from 1964 to 1970 when he stepped down because of term limitations. He was succeeded by Salvador Allende (1908-1973), who was inaugurated as the first socialist president of Chile in 1970. Allende served until he was overthrown in 1973 by a military junta led by Augusto Pinochet (1915-2006). Allende died in the coup. Pinochet led a repressive regime until 1990. [Source: *Encyclopedia Britannica*. <http://www.britannica.com/EBchecked/topic/218788/Eduardo-Frei> (accessed June 25, 2013); and, <http://www.britannica.com/EBchecked/topic/16237/Salvador-Allende> (accessed June 25, 2013); and, <http://www.britannica.com/EBchecked/topic/461158/Augusto-Pinochet> (accessed June 25, 2013).]

⁶ The U.S. Agency for International Development was established by President John F. Kennedy in 1961 by an executive order related to the passage of the Foreign Assistance Act. It consolidated several foreign aid programs. In the '70s, USAID shifted focus away from technical assistance and capital and towards "basic human needs." [Source: U.S. Agency for International Development. *USAID History*, June 11, 2012 <http://www.usaid.gov/who-we-are/usaids-history> (accessed June 25, 2013).]

⁷ Edward M. Korry (1922-2003) served as ambassador to Chile from 1967 to 1971. [Source: Edward Korry, 81, is dead: falsely tied to Chile coup. *The New York Times*, Jan. 30, 2003. <http://www.nytimes.com/2003/01/30/world/edward-korry-81-is-dead-falsely-tied-to-chile-coup.html> (accessed June 25, 2013).]

⁸ Harry W. Shlaudeman became Deputy Chief of Mission in Santiago, Chile, in 1969. He later served as ambassador to Venezuela, Peru, Argentina, Brazil, and Nicaragua. In 1992, he was awarded the Presidential Medal of Freedom. [Source: The American Academy of Diplomacy. <http://www.academyofdiplomacy.org/members/bios/Shlaudeman.htm> (accessed June 25, 2013).]

brought to Chile for many of the same reasons. He was a tough guy. He had a very different view of the world than I did.

I had a front-row seat because I was a contract person, not a career foreign service officer. I was invited to all the meetings, and sat in on meetings with Korry and Shlaudeman when they were talking to us about what the expectations were. There was a lot of pushback from the younger members of the Foreign Service about what was going on. It was phenomenal to be there.

All of our friends were Chilean. We didn't socialize much with the US community; our lives were very much involved with the Chileans, most of whom were supporters of Allende. I even got to make a movie while I was there! It was a protest movie made by a group of young Chilean moviemakers, a satire on U.S.-Chilean relationships. Actually, it never came out. I played the roles of a G.I., a CIA agent, and a member of the embassy staff. It was hysterical. I had about five or six roles, all of which looked exactly the same, because I don't know anything about acting. I was non-speaking—that was the other thing. Anyway, it was great fun, mostly because of what we did when we weren't filming. Movies are boring to make. There were hours and hours of sitting around between scenes. It turned into a political science lesson for me because we debated politics in our hours of free time every day on these sets. These were guys who ranged in politics from fairly conservative to very, very radical. It was like going to school. It was wonderful.

I have no idea how these experiences have affected me except that I'm not afraid of cultures. I'm fascinated by the ways you deliver care across the socioeconomic categories that define us in the United States. I've always been concerned about how we get good health care to people who are either prevented by socioeconomic class or by culture or by language from getting it. A lot of my time and energies have been spent at that, but it's hard to say how it really influenced me. It's just part of who I am.

WALKER: What led you back to the States?

LAWRENCE: The main reason was that we didn't want to live and raise a family overseas. We had watched the way expatriates lived, and Steph had had the same experience in Europe. Not that there is anything wrong with it—it can be very exciting—but it wasn't what we wanted to do.

I was scheduled to go back to do a doctorate in public health at Johns Hopkins. The whole time I was in Chile, I was part of the Hopkins faculty and was gaining credit towards my residency in Preventive Medicine. Steph was from Baltimore, but I had no real interest in going back to the East Coast. I am a Westerner by birth and by inclination. She had visited the West when she was a young child and really loved it and was excited about the idea of moving back to the West.

Fortuitously, Bob Day came down.⁹ He was a consultant with the Hopkins project and chair of the Department of Health Services and Community Medicine at the School of Public Health at the University of Washington. Bob and I hit it off, and he offered me a fellowship to come back to the University of Washington and finish my residency and get my master's. That's how I ended up at the University of Washington. Bob became the dean of the School of Public Health at University of Washington and later the head of the Fred Hutchinson Cancer Center. He is an M.D./Ph.D., a

⁹ Robert W. Day, M.D., also holds a master's degree in Public Health and a Ph.D. in epidemiology. He is dean emeritus of the School of Public Health at the University of Washington. [Source: Science and Management of Addictions Foundation. <http://samafoundation.org/about-us/board/dr-robert-day/> (accessed June 26, 2013).]

geneticist, and is quite a remarkable guy. He was very influential, and it was lucky that we met in Chile. It turns out that we bonded over fishing. These things happen.

WALKER: When you came back, you worked at MEDEX Northwest in Seattle and as Health Officer and Director of Human Services at the Department of Health Services for Multnomah County in Portland. While you were working in Multnomah County, you had an opportunity to go to work for Kaiser. What made you look at Kaiser and say, “Maybe this is a place that would be ideal for me and for what I’d like to do?”

LAWRENCE: It was more prosaic than your question implies. We had three children and another on the way. I had poor prospects at Multnomah County because Don Clark was the county executive, and he decided that he was going to run for governor. He was not successful in gaining the Democratic nomination, but in the process, he had to step down as county executive. Although there were good people behind him, we had different views about what needed to happen in county government. I had been appointed by Don and was very close to him.

I was looking around at the time, and it so happened that I got a call from Marv Goldberg,¹⁰ who was the Medical Director of Kaiser Permanente Northwest, and who I had met socially. His wife Sara worked with me. One day, out of the blue, Marv called me and said, “How would you like a job with the Permanente Medical Group?” I said, “Well, let’s talk,” because I had no idea about how this kind of a place operated. I knew it from a distance, but I didn’t know it well.

I went through the whole interview process. I got interviewed by so many doctors—I didn’t know there were that many in Portland! It was kind of interesting, kind of fun. Marv said, “Well, you’ve got the job if you want it.” It gave our family stability at a time when we really needed it, because I knew it was going to be a problem staying at Multnomah County because of a difference of opinion, different ways of doing things. So, it was quite serendipitous.

It was an exciting experience for me. I was the Assistant Medical Director and what was called the Area Medical Director for the Bess Kaiser area. Portland was divided into the Sunnyside area and the Bess Kaiser area. That was a seminal experience for me, because all of a sudden, I was back into clinical operations, including a very busy hospital, and a multi-specialty group of 150 or 160 docs. Learning about how the politics of a medical group operate was fascinating and very different from what was going on in the county while I was there. Going into Permanente and learning about how a Permanente Medical Group operates, in the context of Kaiser Permanente, was a real education. I was there for five years before I was asked to shift out of the Permanente Medical Group to the Kaiser side of the organization as the Regional Manager in Colorado.¹¹

WALKER: Did you have a thought that you might ultimately be a senior leader in the Kaiser organization?

LAWRENCE: Honestly, no, I didn’t. I’ve never approached my life that way. I’ve never thought about what comes next or after that or after that. My experience looking back over my career and talking to many others is that it’s been non-linear, unexpected, and serendipitous. The idea that you plan these steps in a linear fashion is to me unrealistic. Some people have been able to

¹⁰ Marvin H. Goldberg, M.D.

¹¹ The Kaiser Permanente organization includes the Kaiser Foundation Health Plan and Hospitals, and the Permanente Medical Groups. <http://www.kaiserpermanentejobs.org/history.aspx> (accessed June 25, 2013).

do it, but it certainly never worked for me.

Here came an opportunity that was important to me practically, but it also matched many of the things I was interested in. I had a great respect for Kaiser Permanente, and I had dealt with many of the physicians there in my role as the health officer, with the county medical society, and with the state medical association. Going into it was exciting and new, and a challenge that I had never had before. When I was the medical director for the county, I had doctors working for me as we covered the jails, and we covered the safety net clinics, and so on, but it was nothing like running a big hospital.

It was a wonderful experience, but after about four or five years of it, I thought, *This is a dead end for me. I'm getting restless. I've learned what I wanted to learn. I'm beginning to see the limits of this kind of a role.* I began to look outside of Kaiser. All of a sudden, quite unexpectedly, serendipitously, out of the blue, Jim Vohs,¹² who was then the CEO of Kaiser, called me and asked me to come to Oakland to consider a role in Denver.

Denver, interestingly enough, was on Steph's and my short list—one of the few cities in the country that we would move to, the Bay Area being the other, from Portland. Seattle, possibly, but Portland, Denver, the Bay Area, were places that we were interested in. When he offered me the job, I thought, *You know, this could be really interesting. I've learned a lot about how a Permanente Medical Group operates, and how a hospital operates, and how the medical staff does. Now I have the chance to go on the other side and learn how that works.* I mean the insurance side, the buildings, the construction, the staff, the unions, and so on. It was a fascinating experience to me.

I was only there three years. We did quite a bit while I was there. Then out of the blue (again!) there was a vacancy created when Wayne Moon,¹³ who was head of Northern California, moved into the role of COO of the entire organization for Kaiser. Wayne had preceded me in Denver, gone to Northern California, and then moved into the COO role. Wayne called me and said, "We'd like you to be the head of Northern California." That was the largest region in Kaiser. We had been in Denver for three years. We missed the ocean. We missed the West Coast. Steph and I took a walk that night, and she said, "Let's go for it." That's the kind of person she is. She said, "Let's go for it," and two weeks later we had bought a house in Piedmont, had our house in Denver cleaned up and on the market, and our children enrolled in school in California. This was in August. We had them in school three weeks later in Piedmont in California. She went into high gear and made it happen. It wasn't easy because the prices were so different between Denver and the Bay Area for homes.

What I learned from that was: you really can't plan. You can hope for things to happen. You can watch for things to happen, but they happen serendipitously, at least in careers like mine. You throw yourself into whatever you're doing and learn as much as you can, do the best you possibly can, bring all the creativity and energy you can to it. I don't know how it works for other

¹² James A. Vohs was CEO of the Kaiser Foundation Health Plan and Hospitals from 1975 to 1991. At his retirement, the annual Vohs Award for Quality was established. [Source: McPartland, G. Brisk daily walks keep retired CEO Jim Vohs in the pink. *A History of Total Health*, Sept. 21, 2012. <http://www.kaiserpermanentehistory.org/tag/james-vohs/> (accessed June 25, 2013).]

¹³ Wayne R. Moon was president and chief operating officer of Kaiser Foundation Health Plan until 1993. [Source: Mulligan, T.S. President of Kaiser hired by rival Blue Shield. *Los Angeles Times*, Aug. 20, 1993. <http://articles.latimes.com/keyword/wayne-r-moon> (accessed June 25, 2013).]

people, but it has worked for me, and it's turned out for the good. People have taken me under their wing or said, "He is somebody we want to move on to the next level."

The only job I really applied for in Kaiser Permanente was the CEO job. The board committee with responsibility for replacing Jim Vohs, when Jim announced his retirement, asked several of us who had been in the organization for a fairly long time on the health plan side if we would be interested in being candidates. The medical groups came to me and said, "We want you to be a candidate. We'd love it if you became the CEO." I said, "Sure, I'll put my name in the hopper." It looked like it was pretty wired for somebody else to become CEO, so I wasn't sure how likely it was. Wayne Moon was the heir apparent, as the COO, but the board selected me. It was, I think, a shock to everybody in the system, including me. Wayne was made President and COO. Jim and Wayne and I went through almost a two-year transition before I became CEO.

WALKER: One of the things that I know you've talked about in the past is viewing an organization as a whole. How were you able to implement that culture of breaking down the silos and getting people to look at Kaiser in a more holistic way?

LAWRENCE: That was the whole focus of what I tried to do during my tenure as CEO. The words we used to describe it were: "the intellectual economies of scale." We had enormous intellectual capital in the organization. There were about 10,000 physicians when I started. We were in 12 regions then; we're in eight today. We had people who came out of all sorts of health care backgrounds. We had insurance expertise, legal expertise, and so on, but it was dissipated. We had this "not invented here" problem that was endemic. It was the way the group had grown up historically.

I tried all sorts of things to create a better sense of coherence for the organization, to capture those intellectual economies of scale. Some of the things I did worked well, some didn't. What you're doing when you're trying to transform an organization is experimenting all the time. You're trying things. If they don't work, you back up and take another run at it slightly differently. We were experimenting all the time, trying to find ways to do that.

For example, we combined the Northern and Southern California Regions to find economies of scale and opportunities for intellectual combinations. We worked at this for several years without getting very far. The regional perspectives were too strong to overcome, and eventually George Halvorson,¹⁴ my successor, opted to reestablish the individual California Regions. On the other hand, the efforts to build an intellectual base for evidence-based clinical practice were quite successful. The Care Management Institute was founded in the mid-1990s and has become the centerpiece of the Permanente Medical Group efforts to determine evidence-based approaches to common clinical conditions, then ensure that these practices are incorporated into daily practice at the level of the individual physician. This effort replaced multiple, region-based guideline-development efforts that were overlapping and often contradictory.

There were two balancing acts. One was what we were just talking about: how do you balance the local and regional imperatives that had defined Kaiser Permanente historically with an emerging set of national requirements and national opportunities? What's the right balance between

¹⁴ George C. Halvorson is chairman and CEO of Kaiser Permanente. Previously he was head of HealthPartners in Minneapolis. <http://xnet.kp.org/newscenter/aboutkp/bios/national/halvorson.html> (accessed June 25, 2013).

those two?

The other thing that we worked on the whole time I was there was trying to find the right balance between the imperatives that drove the Health Plan Hospitals part of the organization and those that drove the medical group side of the organization. In my view, when I took over as CEO, the medical groups were dominant. Their voice and their role were too powerful for the health of the organization. The imperatives of the medical groups and the clinical imperative that related to individual patient care were trumping the imperatives that the health plan had to care for the entire population that had enrolled with us and entrusted us with their health and their medical care.

We had to find a new way to balance that. It wasn't a matter of seizing power from the docs, although that was part of what had to happen. It was rebalancing the power relationships between the two sides of the organization so that we could present a more complete organization and a more robust organization to the population and to the country going forward.

WALKER: One of the things that you are known for is being a leader in the quality movement and in transforming the way care can be delivered. I was told by one of your colleagues that you were considered a lightning rod at Kaiser as someone who wanted to have a laser-like focus on patient safety and quality. You also were a member of the Institute of Medicine's Committee on Quality of Health Care that produced the two landmark reports, *To Err is Human* and *Crossing the Quality Chasm*.¹⁵

You gave what one of your colleagues told me was a memorable speech in Washington, DC.¹⁶ When you gave this speech, he thought you had lost your mind. You stood up and said that we were “crashing the equivalent of a 757 every day in hospitals across America.” You said that 100,000 people were needlessly dying in our hospitals every year, and nobody was really doing anything about it. It turned out that that was exactly what, according to him, Kaiser needed to do to begin on the journey that he said it's on today—where the organization is working to make sure that any patient in any Kaiser hospital will be as safe as if he or she were a passenger on an airplane. Why did you take the risk to stand up in front of all those people and make that statement?

LAWRENCE: That's a good question. There was a lot of history that led up to that. In about 1995 or 1996, maybe 1997, Don Berwick¹⁷ and Lucian Leape,¹⁸ who had been two leaders in the safety quality movement, worked with the Kennedy School at Harvard to create something they called an Executive Session on Patient Safety. It's a particular academic discipline that allows you to tackle difficult, seemingly intractable issues, and begin to develop programs for trying to address

¹⁵ Committee on Quality of Health Care in America. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 2000. http://www.nap.edu/catalog.php?record_id=9728 (accessed June 25, 2013). Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001. http://books.nap.edu/catalog.php?record_id=10027 (accessed June 25, 2013).

¹⁶ Rosenblatt, R.A. Kaiser CEO injects medical safety into health-care debate. *Los Angeles Times*, July 15, 1999. <http://articles.latimes.com/print/1999/jul/15/business/fi-56158> (accessed June 25, 2013).

¹⁷ Donald M. Berwick, M.D. is president emeritus and senior fellow with the Institute for Healthcare Improvement. He was nominated in 2010 by President Barack Obama as Administrator of the Centers for Medicare & Medicaid Services. [Source: Institute for Healthcare Improvement. <http://www.ihl.org/about/Pages/IHISeniorFellows.aspx> (accessed June 25, 2013).]

¹⁸ Lucian Leape, M.D. is adjunct professor of health policy at the Harvard School of Public Health. [Source: Harvard University. <http://www.hsph.harvard.edu/lucian-leape/> (accessed June 25, 2013).]

them. Community policing, interestingly enough, came out of the Executive Session on Community Safety at the Kennedy School. The people who did that at the Kennedy School ran our session.¹⁹

I was convinced to do the session by a surgeon, Don Parsons,²⁰ who was quite active in the Permanente Medical Groups whom I had known well. He was a good friend in Denver and had represented the Permanente Medical Groups in Washington as a lobbyist. I had a lot of things on my plate, so I wasn't that hot to do it, but I went back and sat down with Berwick and met Lucian for the first time.

The people who were in that group were fascinating. It was Ken Kizer, who was running the VA.²¹ It was Bob Waller, who was running the Mayo Clinic.²² It was Gordie Sprenger, who was running Allina Healthcare.²³ It was Jim Reinertsen, who at the time was running Beth Israel,²⁴ and Jack Rowe,²⁵ who at the time was running NYU Medical Center, as I recall, and me. We were all running reasonably good-sized systems. There was a group of people around us who were doing other parts of the work, from the media, from the epidemiology of patient safety, from the legal issues of patient safety. We spent three years exploring patient safety together.

I vetted that speech with the Executive Session to get the data right and to make sure the words were right. Lucian and Don and Ken Kizer and a few others helped me with it. I was encouraged by them to give the talk because that was coming up on the IOM effort to do the quality of care in America project that led to those two studies you mentioned.

I was encouraged by these guys because I had the first opportunity to do it. It was the National Press Club. I vetted it with a few of our people at Kaiser, but I didn't tell everybody. The usual way at Kaiser was to ask permission when you were going to do something like that. You talk to all of your colleagues. It's very collegial. It's very involved. I had had several years of being told that we couldn't make changes, that we shouldn't make changes, that we were moving too fast. I knew what the answer was going to be about this, because I had talked to a couple of people in the Permanente groups. They said, "We don't have a safety problem and, besides, you can't call them

¹⁹ The Harvard Kennedy School has developed a model for executive sessions. [Source: Harvard Kennedy School. *Executive Sessions*. <http://www.hks.harvard.edu/programs/criminaljustice/research-publications/executive-sessions> (accessed June 25, 2013).]

²⁰ Donald W. Parsons, M.D., served as the Associate Executive Director for the Permanente Federation. [Source: Robert Wood Johnson Foundation. <http://pweb1.rwjf.org/reports/grr/028650.htm> (accessed June 24, 2013).]

²¹ Kenneth W. Kizer, M.D. served as Under Secretary for Health in the U.S. Department of Veterans Affairs from 1994 to 1999. He was named director of the Institute for Population Health at UC Davis Health System in 2010. [Source: UC Davis Health System. http://www.ucdmc.ucdavis.edu/welcome/features/2010-2011/02/20110223_Ken_Kizer.html (accessed June 25, 2013).]

²² Robert R. Waller, M.D., is president emeritus of the Mayo Clinic. [Source: University of Tennessee Health Science Center. <http://www.uthsc.edu/news/ne.php?HYPER=/news/may/may08graduation.htm> (accessed June 25, 2013).]

²³ Gordon M. Sprenger retired as CEO of Allina Health System (Minneapolis) in 2003. [Source: Abbott Northwestern Hospital Foundation. *2008 Report*, p. 7. [http://www.allinahealth.org/ahs/anw.nsf/page/0210_A9192_ANW_Foundation_Report.pdf/\\$FILE/0210_A9192_ANW_Foundation_Report.pdf](http://www.allinahealth.org/ahs/anw.nsf/page/0210_A9192_ANW_Foundation_Report.pdf/$FILE/0210_A9192_ANW_Foundation_Report.pdf) (accessed June 25, 2013).]

²⁴ James L. Reinertsen, M.D. was CEO of CareGroup and Beth Israel Deaconess Medical Center (Boston) from 1998 to 2001. <http://www.reinertsendgroup.com/about-us/jim-reinertsen.html> (accessed June 25, 2013).

²⁵ John W. Rowe, M.D. was CEO of Mount Sinai NYU Health from 1998 to 2000 when he became CEO of Aetna. [Source: Columbia University, Mailman School of Public Health. <http://www.mailman.columbia.edu/our-faculty/profile?uni=jwr2108> (accessed June 25, 2013).]

‘errors’ because the doctors will get mad,” and so on. They said, “You’re crazy to talk about it.” So I said, “The heck with it.” I thought, *This is one of those places where it is right to get out in front, and describe the problem, and talk about an intent to do something about it.* But it certainly created a heck of a potential risk. The risk was going to be that the medical groups and the people inside of Kaiser Permanente would be saying, “Risk? Safety? Not our problem!” Once it was out there and got replayed all the time on C-SPAN, one of the medical directors wrote me an email and said, “That is the stupidest thing I’ve ever seen in my life. I don’t know how you could have done that.” They were livid.

A year later, we had a national patient safety committee inside of Kaiser Permanente. We had programs going on. The medical groups had embraced patient safety as something they needed to take on and work on. In that kind of a setting, the intention to do something about something that was so compelling a problem led to action. But it wasn’t easy. People were pretty upset about it.

I can’t remember who suggested doing this—it may have been Jim Reinertsen—but the six of us got together on the phone at least once a month, and shared our patient safety stories with each other, and our journeys with each other. It was like a “T”-group from the ‘60s. It was like a support group. “I tried this and it didn’t work.” “I tried this and this worked.” “Oh, my God, we’ll all do it!” It was wonderful because everybody was struggling with the fact that the organizations that we all led didn’t want to hear it, didn’t want to face this reality.

I wasn’t alone. I had really good help. I had good friends and colleagues pushing that agenda forward in their own organizations. Some of them were making headway much faster than we were at Kaiser. I didn’t feel as though I was all alone on that. At the time, it might have seemed courageous, but I never thought of it that way. I thought it was mildly stupid and risky to do it, but worth it because of the stakes.

We had done the math at Kaiser. We didn’t know what our experience was, like most organizations. Even if we were above average, we were still causing deaths that could have been prevented. “Look,” I said to the medical groups, “Come on, we’re better than everybody else, right? Okay, let’s say we’re 25 percent better than average, so we’re at the 75th percentile. Here’s how many people die at our hands even if we’re 25 percent better. Can you prove to me that we’re 25 percent better?” No, we couldn’t; we didn’t have the data.

It has a compulsion once you get past the embarrassment of it or the politics of it. It’s a compelling story to think about. To me, that’s the first responsibility we have as an organization. As a clinician, you have it; as an organization, you have it in spades. You have to be a place in which your patients are safe. That’s the bottom line. If you’re not that, why are you in business? Why do you do what you do?

WALKER: I think it’s interesting that today, one of the objectives of Kaiser is to ensure that every patient will be as safe as if he or she were a passenger on an airplane, which given the number of deaths due to airline crashes, is pretty low.

LAWRENCE: It’s almost minuscule.

WALKER: If we could get to that point in health care, it would be great.

LAWRENCE: One of the first times that I heard Don Berwick say what he has often

pointed out was at that Executive Session at Harvard in the '90s. He said that we operate at a one sigma level of reliability, which means that we make an error once every ten times we do anything. No industry in the world can survive at a one sigma level of reliability except health care. Don spoke to a committee that I was co-chairing at the National Cancer Institute, and he said, "Just think of what would happen if we could go from one sigma to two sigma in terms of reliability. That's one error every 100 times we do something. Good God! What an improvement that would be!"

The only places in medicine where we're operating even close to six sigma—which is what most other industries, including service industries, operate to—are in the labs, maybe, in some places, and in anesthesiology, where there has been a lot of work done in this area. To me this was a huge issue, and Kaiser has taken it to whole new levels under George Halvorson, the CEO who followed me. Bernard Tyson,²⁷ who is following George, was there when I was, and he and I worked closely together. He's a believer. He is pushing this agenda. I'm very excited about where Kaiser is going with this.

WALKER: I want to take you back about a decade to an interview that you did with *Managed Care* magazine. The article was entitled "Faith in Quality Never Waned."²⁸ You were asked about your experience in guiding Kaiser through the tumultuous managed care decade, those years of the mid-'90s and beyond. In that article, you described part of that time as "terrible," referring to the three years from 1997 to 1999, when Kaiser experienced the first losses it had had in its 57-year existence. You pointed to the fact that you felt the membership had grown too fast, that enrollees were having to use non-Kaiser hospitals and providers, that costs were exploding. What were you thinking at that time, and how were you trying to resolve some of those challenges for Kaiser?

LAWRENCE: One stream of thought was the recurring tape that I've heard all through my career that says, "Have I blown it? Am I wrong? Have I gone the wrong direction? Have I made the wrong decisions?" If you don't have that tape playing in you all the time, you're having a hard time being honest, because most of us have doubts about everything we do. If you don't have doubts, I have real questions about whether or not you're right. Nobody knows the right answers to these things. That was one tape that was playing and, by God, it was playing overtime during that period.

I found out later that there had been an effort to have me fired. The medical groups had apparently written letters to the board asking for my head because of the losses and the things that we were trying to do to rebalance the organization and rebalance the power. It was a difficult time personally. All through that period, I was engaged in that kind of dialogue with myself, trying to make sure that I wasn't misleading myself about what we were trying to do. By the way, you don't answer that question except in retrospect. It looks like it was okay, but at the time, you're never sure. I admire people who are willing to live in that insecurity, because that to me is much more realistic.

The second was trying to figure out what was going on at the macro level outside of Kaiser that could explain some of the new things that we saw. There was one thing in particular that cost Kaiser Permanente huge amounts of money, but was shared by almost every other health care

²⁷ Bernard J. Tyson is the incoming chairman and CEO of Kaiser Permanente, the culmination of career of over 30 years with Kaiser. <http://xnet.kp.org/newscenter/aboutkp/bios/national/tyson.html> (accessed June 25, 2013).

²⁸ Diamond, F. A look at Kaiser CEO's legacy: faith in quality never waned. *Managed Care*;11(6):16-18, 20-22, 24, 26, June 2002. <http://72.27.255.67/print/archives/0206/0206.lawrence.html> (accessed June 25, 2013).

system or managed care system at the time. Hospital utilization had been dropping steadily for 15 or 20 years. Then in 1997, for reasons we still don't understand, it shot up. There has never been a good explanation for why that happened.

If you're on a prepaid basis and at risk, if your hospital utilization goes up, you're dead in the water because everything you do in terms of staffing and hospital beds and pricing and everything is built on projections about what's going to happen with hospital utilization. That's the main driver of costs. We just got hammered. We never had a good explanation for it. That was the next stream of thought. We were completely at a loss. It gave us some solace to know that everybody else was in the same boat. On a percentage basis of our total revenues, we didn't lose as much as some other people did, but we sure lost.

The third thing was: What did it teach us, and what was going on inside of Kaiser Permanente that represented opportunities or things that we needed to fix? There were several things that were important. The biggest lesson for me was that we had no mechanism for creating a coherent response to the crisis. We had no governance mechanism. We had no decision-making mechanism. In the face of a crisis, everybody retreated to his foxhole and pointed fingers at everybody else inside of Kaiser. That could not continue. That was when it became crystal clear to me about the need to have a better national governance capability, both for the Permanente Medical Groups and the Health Plan. Until we had that, there was simply no way we were going to be able to succeed at the level we felt we should.

The last three or four years of my tenure were involved with trying to work with what the medical groups created in response to that crisis—which was the Permanente Federation. That's been in place now for 14 years, and has served to bring some coherence to the Permanente Medical Groups, each of which is an independent medical group with its own board of directors. At the time, there were 12, going down to 8 regions, each with its own medical group. At a time of crisis, we were trying to get our arms around this, and make reasonable strategic decisions that would allow us to find our way through it. We didn't have any levers. That was scary, but it was really instructive about what the organization needed to do.

WALKER: On the backside of that, during your tenure at Kaiser, the company grew from 6.5 million to 8.3 million members, and annual revenues grew from \$9.8 billion in '91 to nearly \$20 billion in 2002, when you retired.

LAWRENCE: The important story is that many of the ideas I started with in the early and the mid-'90s were transformed by the internal debates, the disagreements, the battles. What emerged by the end of the decade that really paved the way for what's happened, especially since 2001, since George Halvorson came in, was a marriage of ideas and perspectives that grew out of this tension that existed during much of the '90s.

The best answers to a health care organization are not self-evident. They emerge from the debate, and the pushing and pulling and conflict between the clinical perspective of the doctors and the population perspective of the health plan or hospital organization. Both imperatives are ethical, and both are crucial to create an organization that is vibrant and living, but they are not always compatible. There is always going to be tension between those two points of view.

The smart leader must be able to transcend those two perspectives and find the solution

space that lies somewhere in that tension. The error is to say, “We’ve got to be like a corporation, and it’s going to be a top-down organization. Docs have to work for the hospital, and by damn, we’re going to do it this way.” Isn’t gonna work, because you don’t get the perspective and the point of view of the numerator in a health care organization which is: taking care of patients. You’ve got to have that, or you lose the lifeblood of an organization, what we’re all about: taking care of patients. At the same time, if you let the clinicians dominate and don’t have the population perspective or the perspective of the entire organization, that place isn’t gonna be around very long. They’re going to run it into the ground, or they’re going to make decisions that are good for the docs, not necessarily for patients in the population. You have to have both.

That was such an insight for me once I understood that it was in that tension that the future lay for Kaiser Permanente. What we set about doing was really trying to structure the tension. We tried to create the governance systems, the organizational systems, the decision-making systems, so we internalized and created the places where that tension could play itself out with answers emerging, not stalemate.

WALKER: You invested about \$2 billion in a new electronic medical records system. Did you get any pushback about that investment?

LAWRENCE: I’m raising my eyebrows—“pushback” doesn’t begin to describe it! It was one of the major battles we had. Interestingly, it wasn’t over the idea. It was perhaps about the amount. It was clearly about the method. Let me explain what I mean by that.

Like many of the decisions that emerge out of an organization, this decision had been made in bits and pieces around the organization already. One of my favorite insights came from Wayne Moon, which is the notion of “jujitsu management.” You look for the energy that people are bringing at you, and you use it to flip them into the direction you need them to go. It’s a wonderful metaphor.

In this case, the energy had been around information technology of various sorts. In Southern California, Northern California, Colorado, Cleveland, there were regional examples of information systems that were homegrown, except for Oregon, which had Epic.²⁹ The first thing I said in ’95 or ’96 was, “This is stupid. We’re developing it across six or eight regions with everybody doing it his own way. Why can’t you guys get together and pick one, and we’ll do it that way across the whole organization?”

A council was created of physicians, mostly, from across the country. I went in a few times and said, “How are you coming on a decision? Which one are you going to pick?” At the end of a year, they said, “We can’t choose.” I thought, *This cannot continue. We’re spending our members’ money unwisely on trying to come up with an electronic medical record for Northern California that is incompatible with Southern California. It doesn’t make any sense. We’re going to do it one way. Let’s select one.* We set in motion a process for selecting the winner among the demonstrations. It was a very laborious process, and we selected the Colorado Experiment with IBM.

Everybody went up in arms, although everybody had been involved in it. The Northwest had Epic. They said, “Oh, gosh! We think it should be Epic!” Southern California said “We have

²⁹ Epic Systems Corp. is a vendor of electronic health record and practice management software. <http://www.epic.com/software-index.php> (accessed June 25, 2013).

our own.” After about a year of working down this pathway, there was enough pushback that we went back and did the whole beauty pageant again, selected Colorado and the IBM Experiment. Epic at that time was clunky, old fashioned, run on MUMPS, and we would have had to hire every MUMPS programmer on the planet in order to do it for Kaiser Permanente. It wasn’t scalable.

We remade that decision three times during my tenure. The pushback was really strong about which we had chosen—not the idea, not the money. Everybody said, “If you do it our way, it’s going to be a lot cheaper because, of course, we won’t have to put out the money. We’ve already got our way.” When I left, what had happened was, we had a pretty good head of steam going about getting this thing rolling out. But the off-the-shelf providers of electronic medical records had caught up and moved ahead of where our home-grown system was. George Halvorson and the Medical Groups got together and looked at the decision again—not “yes/no,” but which solution—and chose Epic, because Epic had moved from being unacceptable to being an acceptable option. In early 2003, the leaders chose Epic.

Strangely, the decision itself was never really challenged. The amount of money was pretty terrifying, but remember, we were doing \$14 billion, so \$2 billion for a five-to-ten year investment was considered strategic. There was consensus that there was no way we were going to be able to practice medicine in the 21st century without an electronic medical record—couldn’t do it. You sure as heck couldn’t take care of a population without it. That’s what’s guided that.

It was initiated as a national effort in 1997, and I believe it was completed last year. That’s how long it’s taken to roll it out. It’s a very complex process. There is still some pushback, and it’s largely about what it does to interrupt the workflow of the specialists. Many docs who use it in primary care say they can’t go back. It’s just too much information. They couldn’t do it any other way. Those who have really incorporated it into their practices say they can’t imagine going back.

It was a major decision. I think Kaiser should be extremely proud that they have pushed that thing through. It’s expensive, but it is a treasure trove for Kaiser Permanente. I hear patients who are members of Kaiser say, “Isn’t it great? I go to Santa Rosa. I go to San Francisco. I go to Oakland. They’ve all got my medical record. They know what happens to me. Nobody can do that.” We and the VA are the only two places of scale that now have this kind of ubiquitous information access.³⁰ The analytic opportunities with these databases are extraordinary, and when you put it together with the gene bank at Kaiser that was created several years ago and the medical records that actually date back to the inception of Kaiser Permanente in written form, you’ve got this research database that Kaiser and Permanente physicians have used for decades to come up with insights that actually guide the standards for much of the country.

WALKER: I want to talk with you a little bit about the culture at Kaiser and some of the work that you did to stimulate the type of culture that you felt was important. I’ve been told that you nurtured a workforce culture that a lot of organizations across many industries strive to achieve. You developed a labor management partnership with AFL-CIO President John Sweeney, which was the only one of its kind in health care. What kind of challenges did you face as you were putting that kind of relationship together?

³⁰ The Department of Veterans Affairs (VA) has developed the Veterans Health Information Systems and Technology Architecture (VistA). <http://worldvista.org/AboutVistA> (accessed June 25, 2013).

LAWRENCE: It had its genesis in thinking about quality and safety. You can't take care of patients, you can't design patient care systems, without the people who do the work. The solutions aren't expert-driven. They come out of the experiences and the insights and the drive and the emotion and the creativity of the people who are on the front lines doing the work.

If you are in endless labor disputes, you lose the creativity and the energy of that part of the workforce, because you're fighting each other and you're using up your energy on trying to deal with conditions of work that have nothing to do with how you take care of patients. By the time the labor management partnership was conceived of, we had had 12 years of almost continuous labor strife at Kaiser. It started in Northern California with SEIU Local 250 in 1985 before I got there, but the wounds were still extremely deep when I came in. Maybe it was 1986 or 1987—it was relatively recent. Those things went on continuously from about 1986 to '96. It was so bad that at one point, John Sweeney,³¹ who was head of the International of SEIU, which was our largest union, and I couldn't talk to each other. We had no trust whatsoever.

Then John was elected head of the AFL-CIO. I had known John from the Labor Management Committee, a group in Washington, DC. He had been very welcoming to me, and we'd had a good time together on this committee, but in the context of our labor management relationship inside of Kaiser, it was tough. When he got named head of the AFL-CIO, I thought, *This is terrible. John is going to be nothing but a pain.*

Andy Stern³² took over for John as the head of the SEIU International. I got a call from Andy almost immediately after his election saying, "I'm going to Southern California and I'm going to intervene personally in the dispute between SEIU's local there and the management of Kaiser Permanente." It was like a breath of fresh air. I thought, *Holy cow, here is somebody who really understands!* He got that thing, which had been going on for months, settled almost overnight. He worked out a compromise with the union leaders and with our management.

John Sweeney and I still were not getting along, though. Our guys in Human Resources encouraged me to meet John at the Dallas-Fort Worth airport. I said, "Okay, we'll give it one more chance." We met in some colorless, windowless, airless meeting room at DFW. We were like dogs, sniffing each other, tails up in the air. We were waiting to see who was going to screw this up. We sat down. Pete DiCicco,³³ who was head of Research and Development for the AFL-CIO, looked at me and said, "So, what do you want from the unions? Where do you want this organization to go?" He had a really hard Northern Massachusetts accent—I think he was from Lynn, Massachusetts—and was a former boxer. Spontaneously, I said, "We can't do our work if we keep going this way. I want your creativity. We can't solve patient problems and the safety problems if you're not part of those conversations." Pete said, "Damn, you just gave my speech!" We immediately bonded, and

³¹ John J. Sweeney was president of the Service Employees International Union from 1980 until 1995, when he was elected to the first of five terms as president of the AFL-CIO. <http://www.aflcio.org/About/Leadership/AFL-CIO-Top-Officers/AFL-CIO-Officers-Emeritus/John-J.-Sweeney> (accessed June 25, 2013).

³² Andrew L. Stern was president of Service Employees International Union from 1996 to 2010. [The SEIU Andy Stern leaves behind. *The Nation*, July 5, 2010. <http://www.thenation.com/article/seiu-andy-stern-leaves-behind#> (accessed June 25, 2013).]

³³ Peter S. DiCicco had been head of the International Union of Electrical Employees in Lynn, MA, prior to becoming president of the Industrial Union Department at the AFL-CIO. [Source: Eaton, S.C., Kochan, T.A., and McKersie, R.B. *The Kaiser Permanente Labor Management Partnership: The First Five Years*. Massachusetts Institute of Technology, Sloan School of Management, Sept. 2003. www.lmpartnership.org/sites/default/files/lmp_first_five_years.pdf (accessed June 25, 2013).]

out of that came a willingness to consider something the unions called a “labor management partnership.”³⁴

At Kaiser, there are 35 unions with 54 labor contracts, a huge problem. Twenty-six of the 35 unions are in the AFL-CIO, as I recall—it’s been a long time. We’re talking about 26 of our unions, including the biggest one, which is the SEIU. That didn’t include the California Nurses Association, which has always been a difficult union.

We started talking and we met in Washington. It was interesting. I was skeptical; John was skeptical. Our people were talking, and we said all the right words. It was Pete DiCicco and the guy who was COO for Kaiser named Dick Barnaby,³⁵ and Al Bolden, who was head of HR, who were really instrumental in keeping this thing going.

We ended up creating a committee, as we usually do, of doctor leaders and health plan people to work with the unions and come up with a framework for our labor management partnership. They worked for a year, presented it to this brand new organization, this entity that had been created to help govern the organization I mentioned earlier. The medical group leaders said, “We haven’t heard anything about this. Absolutely not!” One year of work down the drain!

I remember meeting with Pete and with Leslie Margolin,³⁶ who by that time had taken over as the head of HR and was helping negotiate this. They said, “What are we going to do? We’ve just spent a year!” My partner, Jay Crosson,³⁷ who was part of the Permanente Medical Group, was as disappointed as I was. Jay and I said, “Let’s go back through it and do it again.” It took them six months—they went back through the whole process, came back with practically the same framework, and everybody signed on and said, “Where have you been?” It was like a piece of legislation. The first time you introduce it, the legislators say, “That’s the stupidest idea we’ve ever heard.” Come back a year later and they say, “Not a bad idea, but the timing is wrong.” Go back the third year and they say, “Where have you been? We’ve been saying this all along.” It’s kind of like that.

We jumped in, and 25 of the 26 AFL-CIO unions ratified it. I don’t think they’ve ever changed that. I don’t think the other unions have ever seen the need to do it. That thing has been in effect since 1997 or 1998, and it’s a master description of what we’re trying to accomplish together, the rules by which we’ll work with each other: complete openness, transparency, books, everything. If you go to Kaiser now, almost never do you see a situation in which there aren’t union members, physicians and health plan people on these committees, working on these problems. When I go to the awards ceremonies for safety and community service, there are always the union

³⁴ More information about this negotiation can be found in the literature. [For example: Kolb, D.M. The shadow negotiation and the interest-based approach at Kaiser Permanente. *Negotiation Journal*, Jan. 2004. http://www.restructassoc.com/articles_neg-journal-shadow.htm (accessed June 25, 2013).]

³⁵ Richard G. Barnaby, became chief operating officer of Kaiser Foundation Health Plan in 1996. [Source: Kaiser Permanente press release, Feb. 15, 1996. <http://www.thefreelibrary.com/RICHARD+G.+BARNABY+APPOINTED+CHIEF+OPERATING+OFFICER+OF+KAISER...-a017996597> (accessed June 25, 2013).]

³⁶ Leslie A. Margolin was chief human resources officer at Kaiser Permanente from 1999 to 2002. He later became the president of Blue Cross of California. [Source: *Who’s Who in Corporate America*. Berkeley Heights, NJ: Marquis Who’s Who, 2011, p 578.]

³⁷ Francis J. Crosson, M.D., was The Permanente Federation’s founding executive director. <http://www.ilr.cornell.edu/events/healthcare/jaycrosson.html> (accessed June 25, 2013).

leaders at the dinner with the board of directors of Kaiser Foundation Health Plan and the medical directors. It's just become natural.

There was a meeting held in Northern California to negotiate the first contract after we'd had this thing in place for a year or two. I walked into a meeting room at the Marriott in downtown Oakland, and there were probably six or seven hundred people in this room representing the different unions and health plan managers. They had started in clusters and rolled it up into a master agreement. When it was announced what they had done, people were crying. It was the most touching thing I saw during my tenure as CEO.

The other part of it, which is crucial to understand, is that my predecessor, Jim Vohs, had been deeply committed to diversity. There had been a diversity program and a diversity effort at Kaiser long before I got there, and I pushed them forward. That room looked like the United Nations, people from all kinds of backgrounds, different languages—it was phenomenal to walk into that place. When you move further and further up the organization in terms of status, it gets whiter and whiter and whiter. Doctors are largely Asian and white, not completely, but largely. The management teams were largely white. Gender was pretty well balanced.

What was beautiful about this was that it forced Kaiser Permanente to come to grips with the people it relied on to do the work, and to learn how to deal with each other across these artificial boundaries; and, by so doing, allow us to understand who our patients were because these people came from the same communities. I can take credit only for exhaustion at what we had accomplished up to then by doing traditional management/labor relations. I can take credit for realizing that we had to have the insights of everyone if we were going to move forward. There's nothing new about that. That's Lean Toyota Production 101—everybody has a voice.

Pete DiCicco was the one who introduced the idea of a formal labor management partnership. They had done it at Caterpillar, and they had done it at Northwest Natural Gas. One of our board members was Bob Ridgley,³⁸ who was the Chairman/CEO of Northwest Natural Gas. Bob was sort of sitting in a corner saying to me, "Dave, it can work. It can work. Don't be afraid of it." I take very little credit, aside from being stubborn and saying, "This is too good to pass up." I think John Sweeney felt the same way.

Ironically, after John Sweeney and I could not talk to each other for two or three years because we didn't trust each other, about year two or three into the partnership, the L.A. County Labor Council gave me an achievement award, and John presented it. The turnaround that we had engineered by then made us both feel excited about the future of our respective organizations together. We got a lot of credit for it, but the amount of work that people have done to make this thing come together is worth noting. It's like patient safety. Once you get past the politics of it—who is going to win, who is going to lose—it just compels you by making so much sense. I can't believe that other people in health care with unions haven't done it. They're still fighting the stupid old labor management strikes and slowdowns that we were fighting forever and that Kaiser still fights with the California Nurses Association.

WALKER: Perseverance, creativity, engagement, trust—what other words characterize what it took for you to get to the final outcome?

³⁸ Robert L. Ridgley was CEO of Northwest Natural Gas from 1985 until 1996. [Source: *Bloomberg Businessweek*.]

LAWRENCE: Execution sharpens the mind. We were slowly executing ourselves by these continuous labor fights. We could not compete. Kaiser is a people organization. There are 175,000 employees at Kaiser. If you've got 75 percent represented by organized labor, and you've got 75 percent of them at war with you, good luck getting anything done. Think of what it means if it's the converse. That's the biggest lesson. What's happened at Kaiser over the last 12 years since I've been gone is the coming to fruition of what the dream was of that labor management partnership. I don't mean that I knew that that's what would happen, but we all hoped desperately that's what would happen. Thankfully, the board, the leadership, the medical directors, and so on have seen how valuable it can be, and they've built on it. I almost have to pinch myself to believe that it really happened. It's one of my happiest memories about Kaiser Permanente.

WALKER: In a recent article, you talked about advances in technology that are going to change the role of patients, increase the reliance on technology experts, and reduce the need for primary care physicians.³⁹ How do you envision the development of technology?

LAWRENCE: Let me give a little bit of background. One of the things that was frustrating to me as CEO was to watch interesting ideas be presented by entrepreneurs, to bring these ideas into Kaiser Permanente, and to watch them die on the vine or get rejected. I thought, *There is so much going on outside of Kaiser Permanente that is exciting. I'd like to understand how that works.* I have no background in business other than running Kaiser. I didn't grow up in a family that was in business. I'm trained as a doc, but running public institutions, that's a different kind of deal. I've never run a business. I didn't know how you started these businesses, how they get scaled, how you finance them, any of that stuff, and I was fascinated by that.

That interest was combined with a growing realization that primary care as we've known it is a dinosaur. It's not a dinosaur because it isn't a wonderful way to practice. It's not a dinosaur because the doctors who do it aren't good. It's not a dinosaur because it isn't needed anymore. It's a dinosaur because there aren't very many primary care physicians left, fewer and fewer, and there is nothing in the pipeline that suggests that it's going to be any different in the foreseeable future. The Association of American Medical Colleges is estimating somewhere in the range of a 40,000 to 75,000 shortage of primary care physicians by 2020 or 2025—I can't remember the number, and it depends on which forecast you use. But that's only looking at the aging of the population and the growth of the population, not the diversity of the population. The problem is worse than AAMC has made it out to be.

There's a mismatch between the people who take care of you and the people who need taking care of, demographically and socioeconomically. Our population in the United States will become a "majority minority" population by around 2050—that means that over half the population in the United States is going to come from cultures that are not white. Yet, the predominant numbers of physicians being trained are white. We haven't moved the needle very much in 30 years of trying.

There's a real imbalance between supply and demand. You have a technological revolution going on that has to do with communications technologies, computing and data management

³⁹ Weber, D.O. Technologies that will keep patients out of hospitals. *H&HN. Hospitals & Health Networks Daily*, Apr. 26, 2011. <http://www.hhnmag.com/hhnmag/HHNDaily/HHNDailyDisplay.dhtml?id=4320008661> (accessed June 25, 2013).

technologies, and presentation technologies—mobile telephony, for example. Then of course, you have the ongoing struggle over the fact that medical care is too expensive.

The way you're going to solve it, help me understand this, is you're going to make medical homes? You're going to turn primary care physicians into medical home managers? You're taking the most expensive input—the doctor—and you're now making them responsible for managing a group of people. But they're coming out of medical schools and residencies where they have no experience managing whatsoever, creating systems of care that they have no experience or training in creating, and that's going to solve the primary care crisis? It's going to solve part of it for some segment of the population, but it's not big enough, it's too expensive, and it's not ubiquitous enough.

Luckily, what's going on now at the same time are breakthroughs that draw on these technologies, and the advances in clinical science. If you stop and think about what molecular science means to diagnosis and treatment—it means bringing certainty and predictability to an art form. When you put the advances in molecular diagnostics and therapeutics together with mobile telephony, and the internet, and data management; and greater ubiquity of those technologies; and a growing demand that cannot be met by the supply; and, medical care that's far too expensive, you've got four streams coming together in what Clay Christensen and Jerry Grossman and Jason Hwang describe in *The Innovator's Prescription*, any one of which is a trigger event for disruptive change.⁴⁰ What you've got for the first time in American health care is all four of them coming together at the same time.

What's fascinating now is to see the third and fourth generation of these solutions in primary care. Now, what are they? Primary care is actually an aggregate of seven or eight jobs. We've always said that a doc should do all those jobs—that's the production model we've used historically. A doctor is supposed to be able to do triage, referral, management of chronic disease, management of death and dying, prevention, wellness, and navigation—help you get through the system—“I'm going to coordinate your care for you, get you to the right people.” How many doctors know how to do that well? How many doctors know the data about how different parts of the medical care system actually operate? Zero. “I send you to the people I know”—that's the referral network, right?

What's happening is that we're seeing a deconstruction of these different elements that we've always classified as primary care and the job of the primary care physician. You have solutions now that deal with each one of those things. There's a navigation solution—a whole raft of companies that are providing direct-to-consumer advice about where and when to go, and what questions to ask when you get there, based on good information about what these different care elements actually produce, not “who is your nearest neighbor?” We have triage solutions that are now on mobile phones. We have chronic disease management systems—either social networking or diabetes management—you name it. Practically every chronic disease has an app.

Think about what it means when all of a sudden I can take a drop of blood and test for 30 or 40 different diseases using protein signatures. I can tell whether or not you have that disease before you even know you have symptoms. That's called disease screening, because then you can really

⁴⁰ Christensen, C.M., Grossman, J.H., and Hwang, J. *The Innovator's Prescription: A Disruptive Solution for Health Care*. New York: McGraw Hill, 2009.

intervene and change the course of those diseases.

There's a company in Boulder that I've been working with for ten years now which has 26 disease-specific protein signatures. They do it on a microscope slide, running it through a multiplex kind of counting machine. Within four hours, they have an answer as to which of those signatures is present. By the end of this year, 2013, they will have close to 2,000 active protein binders. They now have 1,100. It's going to double the chances of finding signatures that are unique.

What happens when you have a signature? That's better than what most docs can do in diagnosis—more accurate. It will probably be a long while before we stop doing all the other stuff. But when you think about this from just a disease screening point of view, it means that you are freed from the tyranny of having to go to a doctor's office to be screened, because this is cheap stuff. I can do a screen on you for less than \$100 when we get this at scale. It can be done anywhere—Wal-Mart, CVS, in your home. The results can be sent wirelessly. I can give you a specific diagnosis—and then make a referral, help you navigate to the right place to get this taken care of, which may or may not be in your community.

There are examples like this all through the workflow of primary care. Now there are certain things you can't take away from a doc. There are certain judgments where the art form really matters, where experience and judgment really matter. When you're faced with a difficult diagnostic conundrum and you want to work with the primary care physician and maybe a general internist or a specialist or something like that—those are the conversations that are really important. But most people don't have those problems.

What I see is an emerging series of things which many of us call “the consumer health ecosystem,” or “pre-primary care,” that are available to consumers directly, either provided through their health system or that they can find themselves or that you market directly to them. We're using a number of techniques to get to them. But when I stand up in front of doctors' groups and health care groups now, I say, “Look, I was in the business of taking care of patients. I did that all my career. For 40+ years, that's what I did. Now, I'm in the business of taking away half your business. I think I can reduce demand for you by 50 percent; and, I think I can provide the service at half the cost that you're now providing it; and, I can deliver it at six sigma levels of reliability. Match it. That's where we're going.”

WALKER: Assuming that those technologies continue to advance, if Moore's Law⁴¹ has some relation to it...

LAWRENCE: Right, prices are coming down like mad.

WALKER: ...who do you see paying the bill?

LAWRENCE: There are several ways that it's being paid for now. For example, the navigation tool MedExpert, located in Redwood City, California, which I've referenced in several of the articles I've written, has between three-and-a-half and four million people enrolled in it, and it's paid for by the employer on a per employee per month basis—\$3.75 per employee per month. They

⁴¹ Gordon Moore, co-founder of Intel said that, “The number of transistors incorporated in a chip will approximately double every 24 months.” <http://www.intel.com/content/www/us/en/history/museum-gordon-moore-law.html> (accessed June 25, 2013).

take care of that many people with about 80 FTEs providing online or telephone or written navigation support. They help people ask the questions, figure out who the best doctors are in a particular community or particular region, and they provide advice about how to approach the doctor and what questions to ask. They don't get in the way of what happens with the doc. They don't disrupt that. Utilization goes way down because people aren't ping-ponging through the system. Based on the MedExpert studies, which seem to me pretty good, costs are somewhere between 15 and 20 percent lower year-on-year for a population than if you do it the traditional way. Employers like to pay for that. That's a pretty good investment.

Secondly, it's fascinating that one of the fastest growing areas of medical expenditure is out-of-pocket for alternative care. There is a lot of untapped cash flow that comes now directly from patients or consumers looking for solutions that are better than the traditional medical care system. Remember, this is not expensive stuff to do. A social network where you've got two million people who are all diabetics talking to each other about how to take care of their diabetes more effectively doesn't cost a lot. Advertisers are very anxious to get into that network with them because you have a group of confirmed interested potential buyers. If you do it in a sensitive way that's appropriate from an advertising and ethical point of view, it can be very powerful. There are several companies that are doing that now.

The issue of who pays is really less cumbersome than you think. We think, and we're starting to get some interest in this arrangement, that health plans and accountable care organizations are going to look for these solutions as they stumble around, trying to figure out how they're going to do the primary care side of things. Everybody wants to have a primary care network out there that's a funnel into your secondary and tertiary care. How are they going to do it? Where are those docs coming from? There's a nuclear war going on trying to buy primary care doctors right now. It's a great time to be an internist. If you're willing to go to someplace fairly far away, you can get paid a great deal. There's not enough. They are starting to look for these other options.

The first place they go is the CVS urgent care centers or RediClinics, the Wal-Mart kinds of things.⁴² That's actually a stopgap, because you can't build enough of them. They are still people-dependent. You have to hire the nurses to do them. They are still place-dependent. They've got to have a clinic and a place where you can go to. The next step is to free yourself from that, as many of the mobile apps have, and places like MedExpert have, and what you're seeing with what Proteus Biomed and what SomaLogic will do, and some of these other companies will do. They're freeing themselves from the tyranny of a clinic and a visit. When that freedom takes place, it's Katy-bar-the-door and we're starting to see that. I don't want to overstate it in terms of how big it is yet. But I would guess that right now in the United States, somewhere around 10 million people get their care that way from those places.

WALKER: You're 11 years into post-retirement.

LAWRENCE: No, I don't call it retirement. I left Kaiser in 2002. I don't call it retirement.

⁴² RediClinic provides walk-in clinics in supermarkets in Texas. This is part of a trend toward the provision of retail clinics in various locations, such as pharmacies, across the country. www.rediclinic.com (accessed June 25, 2013).

WALKER: What is it that keeps you so motivated to want to continue to be involved, especially in these innovative areas of health care technology?

LAWRENCE: There's a personal reason and a professional reason. The personal reason is related to the quote that goes something like this: "I don't want to die before I die." The personal motivation is that curiosity and learning and exploring are the most enlivening things that I can do. I will do that until I can't. That's my source of energy. That's the source for my sense of being. It gives meaning to my life. I'm not religious. I don't believe in an afterlife. What matters most to me is living as fully in as engaged a way as I possibly can—and that means learning and exploring and challenging and testing and seeing things.

Life is like looking through a kaleidoscope. You look through it, and it's beautiful, and then it turns, and a whole new pattern emerges. It's even more beautiful. You turn it again—it's even more beautiful! I can remember as a child looking through a kaleidoscope and couldn't put it down—it was endlessly fascinating. To me, that's how it is personally.

Professionally, I feel as though the medicine of the 20th century that I grew up in and spent my career in is near the end of its useful life as an organizational matter. What we're struggling to find are alternatives that match the science and the technologies and the demands that our changing population are giving to it. Fee-for-service medicine is stupid. It's bad medicine, and it's archaic. It does everything wrong for medical care and we know we're living with all the sequelae of a fee-for-service system in terms of overuse and mediocre care. That is well documented.

Individual physicians practicing independently is the way it used to be. That's stupid in the 21st century because no patient with a complex illness is taken care of by one doctor. If they are, they're in the wrong hands. Count the numbers for Medicare. The numbers for Medicare are that the average person is 65, has X number of chronic illnesses and is being cared for by somewhere between five and seven doctors, and the number goes up from there. Nobody is being taken care of well by a single doctor unless they have a simple problem. The idea of setting yourself up as an independent, autonomous professional is archaic. It makes no sense any more. We're in this transitional wave from an ethic, a method of practice, a production model, a payment system that was appropriate when science was simpler and care was simpler. It's not right for the 21st century.

What's exciting from a professional point of view are two things. How do you take 20th century organizations and help them become appropriate for the 21st century? How do they transform themselves? Secondly, where there are major holes because of supply or because of technology or because the population demands are different, how can we use the engine of entrepreneurship and invention to create solutions? That's exciting. We have more tools to answer those questions than we've ever had.

That's the reason I'm so engaged now. I get jazzed when I sit down with these young entrepreneurs. I'll tell you about one that I started working with about four months ago. In California, it usually takes 7 to 8 years to design and build and open a new hospital. Oregon has really streamlined it—it's six and a half years, maybe. It takes forever. By the time these hospitals are built and open, they're often partially obsolete. Medical office buildings may take three years, with all the permitting and everything else that goes on.

It's still the same old system where a group of people sit down and say, "You know, I'd like

to have a little bit of this and a little bit of that.” You end up with a tailored design. Then the architects bring it back, and the people say, “No, that’s not quite right.” The architects go back and redo it. It goes back and forth, back and forth, back and forth. Then you get to construction drawings. The same thing goes on, because as you actually see it happen, people say, “I didn’t really mean this. I want that.” That whole process is terribly long and unnecessarily expensive.

Along comes a company that takes the technology of designing computer chips and the algorithms involved in building these intricate integrated circuits on tiny pieces of silicon, and says, “Hmm, there’s a lot of analogies between how complex it is to build an integrated circuit that drives this Boeing 777 and what it takes to build a hospital that moves and runs smoothly, with exquisite management of safety and quality, productivity, operating costs, engineering costs, environmental impact, and so on.”

This company, called Aditazz, pulled together top software engineers from Silicon Valley to work with architects to design a whole new alphabet and vocabulary for space design. Here’s a little company funded with about seven or eight million dollars. They competed in Kaiser Permanente’s contest for the innovative design of the small hospital in the 21st century—this was a contest in Southern California. This company and another established architectural firm co-won the competition. Unbelievable! They haven’t built anything, but they’ve put together the software and the demonstration of what they can do. They’ve taken something like 30 percent of the time-related costs out of design, 20 to 30 percent out of the construction drawing process. Because they have built much of hospitals and medical offices in modular form that meet state requirements—they manufacture the modules—it cuts the construction time and cost by 20 to 25 percent.

The net of all this is a huge savings. You can sit with a group of doctors and nurses and others, and design it on the computer real-time and play around with different things. You want to raise the amount of savings you get from energy? You want to decrease this? You play it all, you do it real time—it’s done. It turns around right there while you’re doing it. This changes the way you design these hospitals. Kaiser was so excited about this that they are in the process of actually granting these two companies, these two winners, the responsibility for building the templates for all of the hospitals and outpatient facilities for Kaiser over the next ten years. Now that’s my understanding—I haven’t corroborated this firsthand and I’ve only talked to the Kaiser people once about this—because I just came onto the board.

It’s a brand-new, little tiny company, and it’s got fascinating disruptive potential for health care. Instead of massive edifices that are extraordinarily expensive and terrible uses for capital when everybody is capital-constrained, it turns buildings into beautiful commodities which is, in fact, what these buildings are. The medical care that happens in them is not commoditized, but the buildings themselves, and the processes of getting them up and running and used properly and designed in such a way that they are more flexible over time so they can be reused and repurposed instead of becoming obsolete by the time they’re open—that’s huge, that’s disruptive. That’s happening right now. That’s a cool little company.

WALKER: That’s the kind of technology innovation that people don’t think about.

LAWRENCE: That’s right. This is out of the blue. Here’s another one that I just love. This is completely different. Two entrepreneurs said, “Why can’t we tell when people take meds? What kind of a system could we build around patients when we discover that they haven’t taken

their pills so that they don't fall into some kind of an abyss? How do we do that?" There have been all sorts of attempts to put RFD strips on bottles and weigh the capsules and all that stuff. It doesn't work. It's terrible.

These guys did something fascinating. They said, "How big is a little sliver of silicon? It's basically a grain of sand. What if we could program on a slip of silicon so that when the pill hits the GI tract, and is activated by gastric acid, it sends a radio signal that says, 'This pill [name of medicine] was taken at such and such a time, and has had this physiologic response, and comes out of this batch of medicines?'"

They did it. It's called Proteus Digital Health. Now they're going to the major drug manufacturers who have medications where there is a relative monopoly and where the medication is life-saving. Renal transplants are a good example, where if you don't take that medicine, you're basically out of luck. They're working with Novartis on that one. They're working on another one to explore an anti-psychotic medication.

It's fascinating technology. You can couple it with an on-body monitoring system that then can be tied into a delivery capability, and has no need for a doc. It's another form of primary care because you're doing this for people with chronic illness, where taking medications is absolutely crucial to their safety and their health.

WALKER: Doesn't that also have the capacity to connect wirelessly with a physician, to alert the physician?

LAWRENCE: If you need to. Often the physician is not doing anything. Remember that the doctor is the most expensive labor input in health care by a far margin. He's the last person you want to involve. You only involve him when there's nobody else who can do it. That's Production Management and Cost Management 101. The doctor is the last person in the loop, unless having him first in the loop makes everything else move much more smoothly—and there is no evidence that it does.

WALKER: It's a sea change in thinking for a lot of health care executives.

LAWRENCE: It's huge.

WALKER: Maybe even more so for consumers.

LAWRENCE: Look at the demand increases for the RediClinics, which are run by nurses and nurse practitioners; look at the online kinds of searching going on for information, the growth of WebMD; look at the 3.5 to 4 million people who are served by MedExpert, with patient satisfaction through the roof. I think it's more an issue of what consumers are aware is out there than it is changing them from thinking that everything has to come through the doc. Think how many people have to go the emergency room to get care. They've already given up on having a primary care physician.

WALKER: Is technology going to have that much impact on the future of health care?

LAWRENCE: It's tempting to have that much optimism about what it will look like 20 years from now, and sometimes I fall victim to the same optimism. A medical school classmate of

mine wrote a memoir for his kids that turned out to be a mini-bestseller back in Kentucky. He quotes Arthur Ashe, “You start where you are. You use what you have. You do the best you can.” I think that’s what health care has got to do. You can’t remake it. It’s deeply embedded in our lives and in our psyches. You have to start with what we have and slowly transform it. A couple of years ago, we asked Gary Kaplan⁴³ from Virginia Mason how long they’ve been at this transformation stuff. He said, “Well, we’ve been at it ten years. We’re halfway there.” So, 20 years from now, we’ll be making some good progress.

What I think is explosive is the primary care side because that’s where the real supply/demand match doesn’t exist, and there’s huge pressure for that. The emergency rooms can’t do it. The RediClinics won’t be able to do it. There’s a huge market potential. I’m less worried about the technology for doing that than I am in figuring out what the business model is for that.

What I’d like to do is to create a not-for-profit, foundation-like entity, like Kaiser has been, and make it able to insure for primary care and sell it the same way that medical care and more catastrophic care is insured. I’d also like to assemble as the delivery capabilities what you have in the way of medical homes, but also all of these other direct-to-consumer opportunities. There is growing evidence that if you can put that in front of the medical care system, you radically improve the health status and well-being of the people who have access to it, and you radically reduce the costs.

Part of what’s driving us now is that everyone is defaulting into a medical care system that is horribly organized and horribly prepared to deal with many problems that people have. It’s not, “Does the doctor do a good job putting in a knee?” It’s, “How do I rehab myself so I can go back to work?” That’s not a medical problem, that’s a social-community problem. You can’t solve it just with physical therapy and pills. I’ve had a knee replacement. I had to do most of the rehab myself. I needed a support system around me to do it. It didn’t come from the medical care system, as good as Kaiser was with it—better than most. That’s a simple example. Think about when you have diabetes or hypertension or congestive heart failure or cancer.

WALKER: What advice would you give to young people considering a health care career?

LAWRENCE: I believe it was Malcolm Gladwell, of *Tipping Point* fame,⁴⁴ who said that experts in their fields do things at least 10,000 times, or 50,000, or whatever the number is. They do it a lot. The way to succeed in any of these fields requires you to become really good at it. That means you have to put your shoulder into it. You have to stick to it over and over and over again. There is no easy way to have an impact on health care. There is no easy way to become a leader in health care. A lot of it’s luck, timing, all the usual kinds of things. A lot of it’s grit and a willingness to do whatever is in front of you as well as you can until you master it and then move on to the next thing that’s exciting and engages you.

That’s a very different message than, “Follow your passion. Follow your soul. You’ve got to do what you really believe.” Of course, I don’t want to do anything that compromises my morals or my belief system, but it’s that ability to put yourself into a position of doing it again and again and again and forcing yourself to a higher and higher level of performance. That’s something you learn

⁴³ Gary S. Kaplan, M.D., has been CEO of the Virginia Mason Health System (Seattle) since 2000. <https://www.virginiamason.org/CEO> (accessed May 29, 2013)

⁴⁴ Gladwell, M. *The Tipping Point: How Little Things Can Make a Big Difference*. Boston: Little, Brown, 2000.

early. Parents help, role models help. There's no substitute for it. It's not mastery in the sense that you're mastering how to play the piano or do something else necessarily, unless you're going to be a surgeon or in one of the parts of medicine that requires that kind of repetitive skill-building, in addition to having a great deal of talent. It's mastery of yourself so that even when you're exhausted and depressed and getting beaten up from one side to the other, you get up the next day, and you put your head down and keep going.

WALKER: Are there any other mentors or role models that you'd like to mention?

LAWRENCE: One of the people who was extremely important to me was my baseball coach, Paul Eckley. He had gone to Cornell Medical School, but quit after two years because he really loved coaching. When I met him, he was 62 or 63 and had had three heart attacks, but was still out throwing batting practice every day.

He called me to his office in the winter of my sophomore year at Amherst. He said, "You're going to be my shortstop." I didn't play baseball my freshman year because I had broken my leg skiing. He had never seen me play baseball. I was on the football team, and he was a coach on the football team. He said, "You're going to be the shortstop. I'm going to teach you how to do it."

That was the first time anybody had ever done this with me. Every day before and after classes, he would meet me in the indoor gym, which had a dirt floor with a basketball court laid on part of it. He'd slam grounders at me. I had bad bounces that were taking off the tips of my fingers. I got hit in the face. I had a black eye, and my chest was covered with bruises. He would do it hour after hour after hour until I could barely stand. Then he would say, "Go over to the batting tee and practice your batting."

That first year I practiced three or four hours every day. I was carrying a pre-med load. I loved it. I discovered the beauty of practice and of mastery. I had a wonderful year my sophomore year. I was offered contracts to play professional baseball. This all came through my coach. He said, "I think it's possible for you to go to medical school and have a professional team pay your way through medical school. Take you twice as long, but you can play professional baseball half the year and go to medical school."

Fortunately, my junior and senior year weren't as good as the sophomore year, so I didn't have to make that choice. I probably could have. But the other thing I discovered—again it was an important lesson—the difference between my level of skill and what it would take to get to the majors was a huge delta. There was just no way. That was an important eye-opener for me: don't dream. Or if you do dream, dream with realism.

That idea of doing it day after day, and of him pounding these balls at me, and me standing at that batting tee, taking swing after swing—three or four hundred swings a day—my hands were blistered. I loved the idea of mastery. Going from that to medical school and knowing what it was like to work hard at something was wonderful training for medicine and for leadership. You just keep at it. There were lots of days where I could barely get out of bed or my hands hurt. It sounds gruesome now, but everybody has a certain way of getting an opportunity to learn that kind of discipline. It comes in all sorts of forms. For me, that was it.

Paul Eckley was a powerful figure in my life because my parents had been divorced, and at

that time my dad and I were not terribly close. Paul became a father figure for me during the four years at Amherst, so much so that when I graduated from medical school at the University of Kentucky, he and his wife Bea drove from Amherst, Massachusetts, to Lexington, Kentucky, and spent the weekend with me, celebrating my graduation from medical school. Isn't that amazing?

He was a wonderful man, fiercely competitive. One more anecdote and then I'll stop. During my sophomore year, he made me the shortstop. The captain of the team had been the shortstop the year before and he moved to second base to make way for me. Spring in Western Massachusetts is terrible. It's windy, and it's sort of like spring in the Northwest, it's so drizzly. Our season-opener was against the University of Massachusetts. I had made a bunch of errors. Late in the game, this guy hit a big high pop-up, and the wind was blowing it all over the place. I heard Coach Eckley say, "Dave, if you miss this, you're coming out of the game." I missed it, and I was out of the game just like that. He had me completely frozen with that comment. It was the only time in three years he pulled me out of the game. But I should have been pulled out—I made seven errors, something crazy like that.

What a training that was. That guy was just a wonderful man. He took me from baseball into talking about school, medicine, his life. He was another example of this gritty guy—he had his heart attack after playing two hours of handball, walking home in the snow to his home. He had the heart attack on the road and crawled to his house, and then his wife called the ambulance to take him to the hospital.

WALKER: Let's conclude by talking about your wife, Stephanie, who you've been married to for 43 years. Stephanie owns this beautiful art gallery that we're in here in Healdsburg. How did you meet and what kind of influence has she had on you and your career choices?

LAWRENCE: We met on a blind date set up by my best friend from college, who is a psychiatrist. He and his wife knew that Stephanie and I would be a good couple, so they made arrangements for us to meet in Washington, DC. Stephanie came in on the Greyhound Bus from Baltimore where she lived and had grown up. She was just returning from nearly two years in Italy.

We dated intensively for about six months, and got married because, in part, I was forced into it by the fact that I was leaving for Chile for two years. I knew that if I didn't marry her, she would not wait for me. I had a fear of marriage. I was not a commitment type guy, but this forced my hand. She's never forgotten that fact, or let me forget it! We got married in Baltimore. Almost a month after we were married, we went to Chile, where we lived for two years and where I worked for Johns Hopkins. She painted and taught and volunteered.

You asked what kind of an influence she's had. It's hard to begin to describe it, because we've raised four children, and we're extremely close to our kids and our grandchildren. We did that in the midst of my career, which was demanding and which required that we take on new kinds of experiences. We moved several times. We moved from Seattle to Portland, from Portland to Denver, from Denver to the Bay Area. We lived in two houses in the Bay Area and raised our four children. During that time, I had a variety of jobs, some of them outside of Kaiser, and then coming into Kaiser. None of them would have been possible without a partner who was willing to take risks and say, "Let's do it."

A classic story was when we were leaving Portland to go to Denver. Remember, my family

was all from Portland. The kids had their cousins around, and it was a great environment. However, an opportunity came up for me to become the regional manager of Kaiser Permanente in Denver. Steph said, “Let’s do it,” but this meant that we had to leave Portland, and we were very sad. We had our VW minivan stacked to the gills with our plants and everything we could get in it and all four of our kids. We drove out of Portland crying like mad because my mother and my stepfather, and my brothers, my cousins—everybody was there in Portland. It was so hard. We were driving along, and all these cars were going by honking at us, waving to us. They’d come up next to us and we had tears rolling down our faces; the kids sitting in the back really sad. It wasn’t until we stopped in Prineville, Oregon, for the night that we saw that my brother had spray-painted, “Just Married,” on the back of the minivan. It was so darn funny, because these cars would come up to us, honking for the newlyweds, but what they’d see was these two middle-aged people sobbing and they’d think, “Gee, that must not be a very happy marriage!”

We were in Denver three years, then moved back to the Bay Area, which was a great move for both of us. Stephanie has always made a life for us and for our children—she’s the glue. She’s the person the kids all are still very close to. She’s been an enormous influence. It’s not just that she was willing to take risks. She’s very calming. She’s tough. She’s extremely moral, and uncompromising about morality in the way that she defines it. She’s adventuresome. She loves to travel, and she loves to explore new cultures, as do I. We’ve had a great time together. It’s been remarkable. I couldn’t have done what I’ve done without that.

WALKER: It sounds like a good partnership.

LAWRENCE: That’s the right word, Larry. It is a partnership when you do these things. Some of the jobs were harder than others, and some of them made huge demands. There were periods of great insecurity and uncertainty. If you don’t have a safe harbor and don’t have the opportunity to withdraw from that world into another world where you can become immersed in the lives of your children and your family—I don’t know how people do it, honestly. I just can’t imagine living the life I did without that.

Stephanie was always willing and happy for us to buy homes that were close to work so that I could move seamlessly back and forth. She was not a suburban person. We lived in the cities every place within five to fifteen minutes from my office. That allowed me to get involved in coaching the kids and being involved in their lives. But that was really because of the kind of ambiance and the kind of environment that she created.

WALKER: Thank you for taking time to share your history and insights and stories with us today.

LAWRENCE: Thank you, Larry. I really enjoyed it.

CHRONOLOGY

1940	Born October 5, Portland, OR
1962	Amherst College (Amherst, MA) BA, American History
1966	University of Kentucky (Lexington, KY) MD
1967-1969	US Public Health Service
1967-1969	Peace Corps Physician (Dominican Republic)
1969	Married on November 8 to Stephanie Anne Poche of Baltimore, Maryland Children: Raisa, Jennifer, Mackinnon, Katharine
1970-1972	Ministry of Health (Chile) Advisor
1972-1977	University of Washington, School of Public Health and Community Medicine Faculty in the Department of Health Services
1973	University of Washington, Seattle MPH
1973-1977	MEDEX Northwest Director
1974	Board certified in General Preventive Medicine
1978-1981	Department of Health Services, Multnomah County, Oregon Assistant Health Officer and Medical Director (1977-1978; Health Officer and Director, 1979-1980)
1981-2002	Kaiser Foundation Health Plan and Kaiser Foundation Hospitals 1981-1985 Vice President and Area Medical Director (Northwest Permanente, Portland, OR) 1985-1988 Vice President and Regional Manager (Colorado) 1988-1989 Senior Vice President and Regional Manager (Northern California) 1990-1991 Vice Chairman and COO 1991-1992 CEO 1992-2002 Chairman of the Board & CEO 2002-present Chairman Emeritus
Currently	Estes Park Institute Senior Fellow

SELECTED MEMBERSHIPS AND AFFILIATIONS

Agilent Technologies
Member, board

Alpha Omega Alpha
Member

The Bay Area Council
Member, board

Health Research & Educational Trust
Member, board

Institute of Medicine
Member, Committee on Quality of Health Care in America

International Federation of Health Funds
Chair

McKesson Corporation
Member, board

National Council of MEDEX Programs
Chairman

National Patient Safety Foundation, Lucien Leape Institute
Member, board

Pacific Gas and Electric Company
Member, board

Proteus Digital Health
Member, board

Proventys
Member, board

Raffles Medical Group (Singapore)
Member, board

RAND
Member, Health Advisory Board

The Rockefeller Foundation
Member, board

United Way of the Bay Area
Chair, annual campaign
Member, board

University of California, President's Board on Research and Economic Development
Chair

AWARDS AND HONORS

- 1980 Outstanding Alumnus of the School of Public Health and Community Medicine, University of Washington, Seattle
- 1995 Doctor of Letters, (*hon. caus.*), Colgate University, Hamilton, New York
- 1995 Hall of Distinguished Alumni, University of Kentucky, Lexington, Kentucky
- 1995 Outstanding Alumnus of the College of Medicine, University of Kentucky, Lexington, Kentucky
- 1996 Doctor of Science, (*hon. caus.*), Amherst College, Amherst, Massachusetts
- 2002 Justin Ford Kimball Innovators Award, American Hospital Association
- 2003 Establishment of the David M. Lawrence, M.D., Chairman's Patient Safety Award by the Kaiser Permanente Board of Directors
- 2003 Distinguished Alumni Award, Colgate University, Hamilton, New York

SELECTED PUBLICATIONS

- Lawrence, D.M. A provider's view of prevention approaches in a prepaid group practice. *Cancer*;67(6 Suppl.):1767-1771, Mar. 15, 1991.
- Lawrence, D.M. Fulfilling the potential. As integrated systems, we must demonstrate our relevance and we must do it quickly. *Healthcare Forum Journal*;35(2):31-35, 37, Mar.-Apr. 1992.
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- Lawrence, D.M. Standing still. Medical advances are infused into a system that has changed little since the turn of the 20th century. *H&HN. Hospitals & Health Networks*;77(9):126, Sept. 2003.
- Lawrence, D.M. Chronic disease care: rearranging the deck chairs. *Annals of Internal Medicine*;143(6):458-459, Sept. 20, 2005.
- Lawrence, D.M. A comparison of organized and traditional health care: implications for health promotion and prospective medicine. *Methods of Information in Medicine*;44(2):273-277, 2005.
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