UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

BOARD OF GOVERNORS

BOARD OF GOVERNORS' MEETING

AND

GOVERNORS' COMMITTEE MEETINGS

JUNE, 1984

OFFICE OF THE BOARD OF GOVERNORS

B-390 MAYO

- C O N T E N T S -

University of Minnesota Hospitals and Clinics

Board of Governors

June 20, 1984

1:30 P.M.

Dale Shepherd Room - Campus Club

Coffman Memorial Union

University of Minnesota Campus

Agenda

I. Minutes - May 23, 1984 (Approval)

II. Chairman's Report - Mr. David Cost, Board Chair (Information)

III. Hospital Director's Report - Mr. C. Edward Schwartz, Hospital Director (Information)

IV. Committee Reports

A. Joint Conference Committee, Ms. Barbara O'Grady, Comm. Chair

1. Credentials Committee Report & Recommendations 1984-85 (Approval)
2. Committee Chairmen Appointments 1984-85 (Approval)
3. Clinical Chief Reappointments 1984-85 (Approval)
4. Clinical Chiefs Retreat Report (Information)
5. Nurses Strike Update (Information)

B. Planning and Development Committee, Mr. Al Hanser, Comm. Chair

1. Renovation Renewal Committee Update (Information)
2. UMH&C Capital Gifts Planning Study (Information)
3. Purchasing Update (Information)
4. Unit J. Progress Report (Information)

C. Finance Committee, Mr. Al France, Committee Chair

1. May Year to Date Financial Statements (Information)
2. Hospital Budget 1984-85 - Operating & Capital (Endorsement)

V. Adjournment

- TOUR OF NEW THERAPEUTIC RADIOLOGY FACILITY IMMEDIATELY FOLLOWING MEETING -

Minutes

Board of Governors

University of Minnesota Hospitals and Clinics

May 23, 1984

CALL TO ORDER: Chairman David Cost called the May 23, 1984 meeting of the Board of Governors to order at 1:40 p.m., in Room 555 Diehl Hall.

ATTENDANCE:

Present: David Cost, Chair
Phyllis Ellis
Al France
Robert Goltz, M.D.
Al Hanser
Lynn Hornquist
Robert Latz
J. E. Meilahn
Virgil Moline
Barbara O'Grady
C. Edward Schwartz
Neal A. Vanselow, M.D.

Absent: Carl Drake
David Lilly
Paul Quie, M.D.

APPROVAL OF MINUTES: The Board seconded and unanimously passed a motion to approve the minutes of the April 25, 1984 meeting as written.

INTRODUCTIONS: Chairman David Cost introduced Ms. Sally E. Howard, the newly appointed Health Sciences Public Relations Director. Mr. Cost highlighted Ms. Howard's educational background and experience and welcomed Sally to the University on behalf of the Hospitals Board of Governors.

CHAIRMAN'S REPORT: Chairman Cost noted the May 22nd dedication of the new Therapeutic Radiology facility and acknowledged the presence of several Board members at that event. President C. Peter Magrath and Vice President Neal A. Vanselow joined Dr. Seymour Levitt and Mr. C. Edward Schwartz in marking the occasion with a brief ribbon cutting ceremony. Chairman Cost asked for a show of interest in a tour of the facility for those Board members who were unable to attend the dedication and asked that arrangements be made for a tour immediately following the June 20th Board meeting.

Chairman Cost also announced the dates for the Fall Board Retreat and asked that members reserve September 4 - 6, 1984 for the trip to Minnesuing Acres in Wisconsin. Mr. Robert Latz noted his unavailability on those dates. Chairman Cost asked that the Board members begin giving thought to the retreat agenda, as they would be asked for input in the near future.

HOSPITAL DIRECTOR'S REPORT:

Mr. Schwartz presented the fiscal year 1984-85 Institutional Objectives for the Board review, noting that both the Planning and Development and the Joint Conference Committees had reviewed and commented on the document. He highlighted the six categories of objectives for the Board and indicated that two additional objectives, one on Biomedical Ethics and one on a Clinical Program Development Fund were in the process of being drafted for inclusion. With the understanding that these two objectives would be added, the Board seconded and unanimously passed a motion to approve the objectives.

Secondly, Mr. Schwartz reviewed for the Board the progress made to date on the recommendations of the Cost Containment Task Force. In sum, he noted, that a majority of those objectives could be classified as having been accomplished, while another substantial portion are currently in process. Discussion followed regarding the impact on hospital operations that the implementation of these recommendations have had. Mr. Latz suggested that it would be useful, if possible, to quantify and document this impact, while Chairman Cost suggested that the Cost Containment Task Force members might be interested in knowing of the progress made.

Thirdly, Mr. Schwartz apprised the Board of the potential for a June Minnesota Nurses Association (MNA) strike. On May 21st, he reported, the MNA had given the employer group, Health Employers Inc., notice of intent to strike on Friday, June 1st. Mr. Schwartz indicated that the University of Minnesota Hospitals and Clinics had been working with the Hennepin County Medical Society in the development of a strike contingency plan and that the objective of the University Hospitals during a strike would be ensure the availability of services for those patients in need of medical care.

Lastly, Mr. Schwartz invited the Board members to attend a reception in honor of Dr. Eugene Gedgaudas immediately following the Board meeting. He explained that Dr. Gedgaudas, Chairman of Radiology, was being honored for his recent election as President-Elect of the American Roentgen Ray Society.

FINANCE COMMITTEE REPORT:

Committee Chair Al France introduced three Finance Committee items including the year to date April financial reports, the 1984-85 Budget, and the 1984-85 Employee Compensation Plan and asked Mr. Cliff Fearing to detail the first of those three items. During the month of April, Mr. Fearing reported, total admissions were just 22 below budget levels. Further, he indicated, due to a lower overall length of stay for the month, the patient day total of 14,099 was about 2,000 days below the budget level. The average length of stay for April was 8.7 days. Recapping the year to date inpatient census, Mr. Fearing reported a 2.5% negative variance in admissions, a 5.2% negative variance in average length of stay and a 6.5% negative variance in patient days. Additionally, he reported that the outpatient census year to date remains slightly above projected visits.

Mr. Fearing summarized the Hospitals Statement of Operations as showing a total of revenue over expenses of about $8 million. This favorable variance, he explained, continues to be due to a larger than expected investment income. Turning to accounts receivable, Mr. Fearing reported a balance of patient accounts receivable as of April 30, 1984 of almost $42 million with an average of 84.9 days of revenue outstanding. This increase in receivables, he explained, occurred primarily in the Medical Assistance, commercial insurance and HMO categories. Board discussion followed regarding hospital industry practices in the handling of accounts receivable.

Mr. Al France introduced the second major Finance Committee item, the Budget for the 1984-85 Fiscal Year, noting that the volatility of the 1983-84 census and revenue levels necessitated the development of two separate operating budgets. The two budgets, he explained, were developed using two different sets of assumptions regarding utilization levels. The first, or the base budget, assumes the patient day level of 178,861 patient days, while the second, or the contingency budget, assumes a patient day level of 163,465. With the background Mr. Cliff Fearing detailed the two separate budgets for the Board. Highlights of that budget review included the fact that both budgets are based on a 7% rate increase, both incorporate the Cost Containment Task Force recommendations, both provide the necessary cash flow to fund the financing obligations resulting from the Renewal Project Bonding and both provide, in sum, the capital and operating resources necessary and essential to fulfill the hospitals mission. Substantial Board discussion followed regarding the criteria and methodology that would be applied in determining whether the base or the contingency budget would be better utilized. In conclusion, the Board agreed to reconsider the Operating Budget at the June 20th meeting.

Per Mr. France's request, Mr. Greg Hart presented proposed Capital Equipment and Remodeling/Renovation Budget for the fiscal year 1984-85. Mr. Hart detailed the five year capital budget projections, the equipment items of $100,000 or more and the 1984-85 detailed equipment budget by department for the Board. Highlights of Mr. Hart's presentation included the idea that Diagnostic Radiology, Labs, Operating Rooms, Patient Monitoring and Respiratory Therapy represent the departments that customarily have the larger capital equipment expenditures and that the idea that a five year capital equipment plan this year would facilitate the prudent planning for both recurring capital and Unit J new equipment needs. Board discussion followed regarding the idea that budget approval of a large non-recurring capital expense is not intended, in any way, to eliminate the need for subsequent program analysis to determine the wisdom of purchasing these respective pieces of machinery. Mr. Hart asked that the Board review the Capital Budget over the course of the next month in anticipation of a second review for approval at the June 20th meeting.

Mr. Hart also presented the Annual Employeee Compensation Plan, noting that annual Board approval of the plan is required by the new Personnel Policies and Procedures. The basic plans increases, he explained, follow those of the University very closely. The plan included in the following components: A 4.5% increase salary scales and individual employeee salaries effective July 1, 1984; an additional 1.0% increase effective January 1, 1985; comparable worth adjustments for employees in 35 job classifications amounting to approximately $475,000; $900,000 in market

place related salary adjustments for a number of classifications, two-thirds of which are in nursing related classes. Each of the components of the plan, Mr. Hart explained, are incorporated into the 1984-85 budget projections. Following brief discussion the Board seconded and unanimously passed a motion to approve the Annual Employee Compensation Plan as written.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Committee Chair Al Hanser introduced three items covered at the May 9th Planning and Development Committee meeting including a Renewal & Renovation Steering Committee Report, the Allocation of Shell Space in Unit J, and a status report on the Extracorporeal Lithothripter. He noted that the allocation of shell space item would require Board approval and that the scheduled Planning and Development Committee review of the Bentz, Whaley, Flessner & Associates Capital Gifts Planning Study had been postponed until the June meeting.

Mr. Hanser reported that 99% of all bid packages for the Unit "J" project had been awarded and that the project remains on schedule for substantial completion by March, 1986. Mr. Hanser also apprised the Board of a current issue regarding the installation of coaxial cable in Unit "J" and whether that cable would most appropriately be installed by the Northwestern Bell Telephone workers or by the Electrical Repair and Construction workers. Although the telephone workers bid was well below that of the electrical workers, he explained, the electrical workers, on the national level, have been disputing the issuance of coaxial cable contracts to telephone workers.

Thirdly, Mr. Hanser presented background information on the options considered for the allocation of Unit "J" shell space and proposed the following resolution for the allocation of that unfinished space in Unit "J".

RESOLUTION:

RESOLUTION

1. The allocation of Unit J shell space be accomplished in accordance with the schematic drawing date May 8, 1984. Approximate assignments of space are as follows:

Endoscopy	2930 NSF
Cardiopulmonary Labs	6750 NSF
Nutrition	1900 NSF
Materials Management	500 NSF
Therapeutic Radiology	200 NSF
Pediatric Dialysis	1200 NSF

2. Detailed planning, department review and construction shall commence on all spaces listed, total planning and construction costs not to exceed $2.4 million.

The Board seconded and unanimously passed the resolution as written.

Lastly, Mr. Hanser noted that hospital representatives had met with representatives of the Dornier Corporation, manufacturer of the Extracorporeal Lithothripter. He indicated that as FDA approval of the Lithothripter is not expected until late 1984 or early 1985, that the Dornier Corporation is not prepared to develop agreements for acquisition of this technology at present. He did note that the Dornier representatives are well aware of the continued interest on the part of the University Hospitals in obtaining a Lithothripter and that Dr. Fraley would continue to communicate closely with the corporation.

JOINT CONFERENCE COMMITTEE REPORT:

Committee Chair Barbara O'Grady reviewed three items from the May 9th Joint Conference Committee meeting for the Board. The first item she explained, involved a case study recently reviewed by the Biomedical Ethics Committee which raised several ethical issues. Following a brief description of the case, Mrs. O'Grady indicated that a satisfactory conclusion had been reached in this difficult case and that the Biomedical Ethics Committee expected that cases such as these would likely become more frequent in the future. In anticipation of the increased frequency of such cases, the Biomedical Ethics Committee is in the process of developing guidelines for this consultative role, and Mrs. O'Grady indicated that the Joint Conference Committee had asked to review these guidelines.

Secondly, Mrs. O'Grady summarized the Clinical Chiefs Report presented to the Joint Conference Committee, noting that the Clinical Chiefs are planning a second retreat on June 9, 1984. The focus of that Retreat, she reported, will be on program development, volume levels and marketing. The Chiefs and the Hospitals are also in the process of review the organization and financing of ambulatory care at the hospitals with the assistance of a Seattle based consulting firm. Mrs. O'Grady noted that this study is expected to begin shortly.

Thirdly, Mrs. O'Grady reported that the Joint Conference Committee had passed a resolution commending Dr. Paul Quie for his outstanding contribution over the course of the past five years to the Joint Conference Committee and the Board of Governors in his role as Chief of Staff. Mr. Schwartz assured the Board that there would be ample opportunity to honor Dr. Quie for his contributions at a formal event being planned for the month of July.

ADJOURNMENT:

There being no further business, the meeting of the Hospital Board of Governors was adjourned at 4:15 p.m.

Respectfully submitted,

Nancy C. Janda

Nancy C. Janda
Executive Assistant
to the Board of Governors

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S E
Minneapolis, Minnesota 55455

May 21, 1984

TO: Board of Governors

FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee

SUBJECT: Credentials Committee Report & Recommendations 1984/1985

The Credentials Committee having considered the reappointment of Medical Staff including the recommendations from the clinical chief of each service, and documentation of the required malpractice insurance, hereby recommend all those included in the Credentials Committee report (pages 1 - 25) for reappointment to the Medical/Dental Staff for 1984/1985.

Also included are the Credentials Committee's recommendations for Regular Medical/Dental Staff appointments (page 26); change in staff category and addition of clinical privileges (page 27); Provisional Medical/Dental Staff appointments and requests for clinical privileges (page 28); Specified Professional Personnel Appointment & Psychology Privileges (page 28); Clinical Chief recommendation for termination of Medical Staff appointment (page 29); and resignations from the Medical/Dental Staff (page 30).

HB/cf

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF ANESTHESIOLOGY	CATEGORY	JOINT APPOINTMENTS
William W. Anderson	Attending	
Kumar G. Belani	Attending	
Joseph C. Belshe	Clinical	
Jon F. Berlauk	Attending	
Joseph Buckley	Attending	
James F. Cumming	Attending	
Jorge Estrin	Attending	
Ian J. Gilmour	Attending	
John Gordon	Attending	
Edward Hanisch	Attending	Obstetrics & Gynecology
Douglas Koehntop	Attending	
Russell Larsen	Attending	
Ji-Chia Liao	Attending	
Josephine N. Lo	Attending	
Eugene R. Lucier	Clinical	
Wen Y. Yue	Clinical	

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

HOSPITAL DENTISTRY	CATEGORY
James L. Baker	Clinical
Carl L. Bandt	Clinical
Richard R. Bevis	Attending
Gerald D. Cavanaugh	Clinical
David Clay	Clinical
Richard T. Ford	Clinical
James R. Fricton	Attending
Daniel J. Gatto	Attending
Richard J. Goodkind	Clinical
Robert J. Gorlin	Attending
James E. Hinrichs	Clinical
Norman O. Holte	Attending
Mark Jaspers	Clinical
James R. Jensen	Attending
James R. Jensen, Jr.	Clinical
William H. Kuhlmann	Clinical
Hak-Joo Kwon	Attending
Ronald E. LaBelle	Clinical
Thomas D. Larson	Clinical
Michael W. Lehnert	Attending
Myer S. Leonard	Attending
Andrew T. Morstad	Clinical
Dale Olson	Clinical
Allan D. Petersen	Clinical
Bruce L. Pihlstrom	Attending
Edgar Rajek	Clinical
Herbert W. Schulte	Attending
Mark S. Simmons	Clinical
T. Michael Speidel	Attending
Michael J. Till	Attending
Robert Vickers	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

HOSPITAL DENTISTRY CONTINUED	CATEGORY
Daniel E. Waite	Attending
Paul O. Walker	Clinical
Carl J. Witkop	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF DERMATOLOGY	CATEGORY
Bruce J. Bart	Clinical
Garrett T. Bayrd	Clinical
Mark V. Dahl	Attending
John Fenyk	Clinical
William Gentry, Jr.	Attending
Robert Goltz	Attending
Noel A. Hauge	Clinical
Maria Hordinsky	Attending
Willard C. Peterson	Clinical
Steven E. Prawer	Clinical
Harold G. Ravits	Clinical
J. Corwin Vance	Attending
C. Gordon Vaughn	Clinical
Alvin S. Zelickson	Clinical

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF FAMILY PRACTICE & COMMUNITY HEALTH	CATEGORY	JOINT APPOINTMENTS
Sharon Smith Allen	Clinical	
Thomas M. Altemeier	Attending	
James Canine	Attending	
Edward Ciriacy	Attending	
Joseph P. Connolly	Attending	
Michael L. Daly	Attending	
John T. Kelly	Attending	
John W. McConnell	Attending	
John B. O'Leary	Clinical	
Sharon B. Satterfield	Attending	Psychiatry
Harold C. Sein	Clinical	
Leif I. Solberg	Clinical	
John E. Verby	Attending	

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF LABORATORY MEDICINE & PATHOLOGY	CATEGORY	JOINT APPOINTMENT
Diane C. Arthur	Attending	Pediatrics
Fritz Bach	Attending	
Henry Balfour	Attending	Pediatrics
Bonnie S. Bean	Attending	
Ellis Benson	Attending	
Robert J. Bowman	Clinical	
G. Mary Bradley	Attending	
David M. Brown	Attending	Pediatrics
Richard Brunning	Attending	
Barbara Burke	Attending	
Donald P. Connelly	Attending	
Louis P. Dehner	Attending	
J. Roger Edson	Attending	
Richard D. Estensen	Attending	
Patricia Ferrieri	Attending	Pediatrics
Glauco Frizzera	Attending	
K. Gajl-Peczalska	Attending	
Duane Hasegawa	Attending	Pediatrics
John Kersey	Attending	Pediatrics
Larry C. Lasky	Attending	
Angeline R. Mastri	Attending	
John J. McCullough	Attending	
Robert W. McKenna	Attending	
James J. O'Leary	Attending	
Juan Rosai	Attending	
Richard K. Sibley	Attending	
Dale C. Snover	Attending	
Michael W. Steffes	Attending	
R. Sorothy Sundberg	Attending	
Joo Ho Sung	Attending	
Lee W. Wattenberg	Attending	
Jorge J. Yunis	Attending	

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

	DEPARTMENT OF MEDICINE	CATEGORY
	John I. Allen	Clinical
	Silvia H. Azar	Attending
	Robert J. Bache	Attending
	John Bantle	Attending
	Jose Barbosa	Attending
	David Benditt	Attending
*	Jonathan Bishop	Attending
	Joseph R. Bloomer	Attending
	Clara Bloomfield	Attending
	Malcolm N. Blumenthal	Clinical
	John H. Bond, Jr.	Clinical
	Joseph M. Cardamone	Clinical
	Jay N. Cohn	Attending
	Dennis L. Confer	Attending
	Walter Dorman	Clinical
*	Ronald Eggert	Clinical
	Thomas F. Ferris	Attending
	Patrick J. Flynn	Clinical
	Benjamin Fuller, Jr.	Clinical
	Joyce L. Funke	Attending
	Robert L. Gebhard	Clinical
	Stephen Gilberstadt	Clinical
	Richard F. Gillum	Attending
	Frederick C. Goetz	Attending
	Dale E. Hammerschmidt	Attending
*	Daniel Hathaway	Clinical
	Robert P. Hebbel	Attending
	Linda L. Hedemark	Attending
	Marshall I. Hertz	Attending

* Outstanding Malpractice Information Forms

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF MEDICINE CONTINUED:	CATEGORY
Charles A. Herzog	Attending
David C. Homans	Attending
Bryon J. Hoogwerf	Attending
Thomas H. Hostetter	Attending
Robert Howe	Attending
William Hrushesky	Attending
Donald B. Hunninghake	Attending
David Hurd	Attending
Scott Hutton	Attending
Harry S. Jacob	Attending
Fran E. Kaiser	Clinical
Kalle Kang	Attending
Lawrence Kaplan	Clinical
Joseph R. Kelly	Clinical
B. J. Kennedy	Attending
David T. Kiang	Attending
Richard King	Attending
Robert G. Knodell	Clinical
Thomas E. Kottke	Attending
Richard Kronenberg	Attending
John W. LaBree	Attending
Stuart Lancer	Clinical
Robert Lasser	Clinical
Herbert Lauritzen	Clinical
Wayne F. Leebaw	Clinical
Irving Lerner	Clinical
T. Barry Levine	Attending
John I. Levitt	Clinical
F. Bruce Lewis	Clinical
Constantinos Limas	Attending
Michael Lobell	Clinical
Phillip Wm. Ludwig	Attending
Russell V. Leupker	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF MEDICINE CONTINUED:	CATEGORY	JOINT APPOINTMENT
Sharon D. Luikart	Attending	
Raymond L. Marecek	Clinical	
Cary N. Mariash	Attending	
Robert J. McCollister	Attending	
Philip McGlave	Attending	
James L. McKenna	Clinical	
Nancy L. Meryhew	Attending	
Ronald P. Messner	Attending	
Wesley Miller	Attending	
Charles Moldow	Clinical	
M. J. Murray	Attending	
William O'Brien	Clinical	
Jack H. Oppenheimer	Attending	
Mark S. Paller	Attending	
Bruce Peterson	Attending	
David Plimpton	Clinical	
David Plut	Attending	
Richard A. Pfohl	Clinical	
Claire Pomeroy	Attending	
Brian H. Rank	Attending	
Fred Rasp	Clinical	
Frank S. Rhame	Attending	Laboratory Medicine & Path.
Fred A. Rice	Clinical	
Kathryn L. Rice	Attending	
Stephen C. Riendl	Attending	
Thomas J. Rose	Clinical	
Joseph M. Ryan	Clinical	
Leon D. Sabath	Attending	
Mark Schmidt	Clinical	
Eric Schned	Clinical	
William Schoenwetter	Clinical	
Lawrence D. Schuster	Clinical	

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

	DEPARTMENT OF MEDICINE CONTINUED:	CATEGORY
	Jeffrey S. Schwartz	Attending
	Peter T. Silberstein	Attending
	Stephen E. Silvis	Clinical
	Thomas R. Smith	Clinical
	Ronald D. Soltis	Attending
*	Wesley W. Spink	Emeritus
	Masanao Takahaski	Clinical
	Joel D. Taurog	Attending
	Robert J. Tierney	Clinical
	Louis Tobian	Attending
	Joseph Tombers	Clinical
	Dace L. Trence	Clinical
	Naip Tuna	Attending
	Neal A. Vanselow	Attending
	Jack A. Vennes	Clinical
	Gregory M. Vercellotti	Attending
	Yang Wang	Attending
	John Arnold Wangness	Clinical
	Daniel J. Weisdorf	Attending
	I. Dodd Wilson	Attending
	C. Paul Winchell	Attending
	David C. Zoschke	Attending

* Outstanding Malpractice Information Forms

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF NEUROLOGY	CATEGORY	JOINT APPOINTMENTS
Gary Birnbaum	Attending	
Daniel E. Cohen	Attending	
Miguel E. Fiol	Clinical	
John R. Gates	Attending	
Robert J. Gumnit	Attending	
Ronald I. Jacobson	Attending	Pediatrics
William R. Kennedy	Attending	
Arthur C. Klassen	Attending	
David Knopman	Attending	
Myoung C. Lee	Attending	
Ilo E. Leppik	Attending	
Lawrence A. Lockman	Attending	Pediatrics
James A. Moriarty	Attending	
Venkat Ramani	Attending	
Joseph A. Resch	Attending	
Robert I. Roelofs	Attending	
Phyllis K. Sher	Attending	Pediatrics
Stephen A. Smith	Clinical	
Kenneth F. Swaiman	Attending	Pediatrics
Fernando Torres	Attending	

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF NEUROSURGERY	CATEGORY
Shelley N. Chou	Attending
Donald Erickson	Attending
Lyle A. French	Attending
Stephen J. Haines	Attending
Robert E. Maxwell	Attending
Gaylan L. Rockswold	Clinical
Edward L. Seljeskog	Attending
Dennis A. Turner	Attending
Erich S. Wisiol	Clinical

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF OBSTETRICS & GYNECOLOGY	CATEGORY	JOINT APPOINTMENT
Leon Adcock	Attending	
Arthur H. Bearon	Clinical	
Irving C. Bernstein	Clinical	Psychiatry
Doris C. Brooker	Attending	Laboratory Medicine & Path.
Julius Butler	Attending	
Harry F. Farb	Clinical	
John D. Farr	Clinical	
Peter E. Fehr	Clinical	
Howard W. Fisher	Clinical	
Harry Foreman	Attending	
Marilyn S. Joseph	Attending	
Thomas M. Julian	Attending	
Beni Katz	Clinical	
Howard M. Levine	Clinical	
John Wm. Malo	Clinical	
Theodore Nagel	Attending	
Robert Nordland	Clinical	
Takashi Okagaki	Attending	Laboratory Medicine & Path.
Shaila A. Phansey	Attending	
Konald A. Prem	Attending	
John E. Savage	Attending	
Leslie A. Sharpe	Clinical	
Gaius J. Slosser, II	Clinical	
Charles A. Stepeman	Clinical	
George E. Tagatz	Attending	
Roger C. Toffle	Attending	
Leo B. Twiggs	Attending	
Preston P. Williams	Attending	
Ernest C. Wynne, III	Clinical	

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF OPHTHALMOLOGY	CATEGORY	JOINT APPOINTMENT
J. Douglas Cameron	Attending	
Herbert L. Cantrill	Attending	
Donald Doughman	Attending	
William H. Knobloch	Attending	
Robert Letson	Attending	
Richard L. Lindstrom	Attending	
John Daniel Nelson	Attending	
Jonathan E. Pederson	Attending	
Robert C. Ramsay	Attending	
George T. Tani	Clinical	
Jonathan Wirtschafter	Attending	Neurology

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF ORTHOPAEDIC SURGERY	CATEGORY
Alfred F. Behrens	Clinical
David Bradford	Attending
Edward V. Craig	Attending
James H. House	Attending
Robert E. Hunter	Attending
John Lonstein	Attending
John H. Moe	Emeritus
James W. Ogilvie	Attending
James D. Priest	Clinical
Harry J. Robinson, Jr.	Attending
Roby C. Thompson	Attending
Francis J. Trost	Clinical
Robert Winter	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF OTOLARYNGOLOGY	CATEGORY
George Adams	Attending
Norman T. Berlinger	Attending
Lawrence R. Boies, Jr.	Clinical
Arndt J. Duvall	Attending
Ekrem Gozum	Clinical
Peter A. Hilger	Attending
Timothy T. K. Jung	Attending
Severin H. Koop	Clinical
Stephen L. Liston	Attending
Robert Maisel	Attending
Michael M. Paparella	Attending
Kurt Pollak	Attending
Richard A. Schlorf	Clinical
Leighton G. Siegel	Clinical
Melvin E. Sigel	Clinical

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF PEDIATRICS	CATEGORY	JOINT APPOINTMENTS
Don P. Amren	Clinical	
Arnold S. Anderson	Clinical	
Stuart L. Arey	Clinical	
Sol Austrian	Clinical	
John Bass	Attending	
Lowell L. Becker	Clinical	
D. Woodrow Benson, Jr.	Attending	
F. Blanton Bessinger	Clinical	
David Bloom	Clinical	Medicine
Robert Wm. Blum	Attending	
Stephen J. Boros	Clinical	
Robert H. Bugenstein	Clinical	
Edwin C. Burklund	Clinical	
Blanche M. Chavers	Attending	
John A. Cich	Clinical	
C. Carlyle Clawson	Attending	
Richard T. Cushing	Clinical	
Amos Deinard	Attending	
Stanley Einzig	Attending	
Gregory R. Elliott	Attending	
Donnell D. Etzwiler	Clinical	
Alexandra Filipovich	Attending	
Robert O. Fisch	Attending	
Alfred J. Fish	Attending	
Lloyd Fish	Clinical	
Deborah K. Freese	Attending	
Bradley Fuhrman	Attending	
G. Scott Giebink	Attending	
Thomas P. Green	Attending	
J. Margaret Horrobin	Clinical	
Margaret K. Hostetter	Attending	
Dana Johnson	Attending	
Edward L. Kaplan	Attending	
Robert Kriel	Clinical	Neurology

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF PEDIATRICS CONTINUED:	CATEGORY
Youngki Kim	Attending
William Krivit	Attending
Stanley A. Leonard	Clinical
Carolyn J. Levitt	Clinical
James Lock	Attending
Russell V. Lucas	Attending
Richard N. Matus	Clinical
S. Michael Mauer	Attending
Kenneth L. McClain	Attending
Carolyn J. McKay	Clinical
Alfred F. Michael	Attending
Bernard L. Mirkin	Attending
James H. Moller	Attending
Richard F. Nelson	Clinical
Mark E. Nesbit	Attending
Thomas Nevins	Attending
Robert O'Dea	Attending
Karen N. Olness	Clinical
Arthur R. Page	Attending
Mary Ella Pierpont	Attending
Charles E. Pitzele	Clinical
John R. Priest	Clinical
Paul G. Quie	Attending
Norma M. C. Ramsay	Attending
Warren E. Regelmann	Attending
Thomas F. Rolewicz	Clinical
Richard E. Sand	Clinical
Sylvester Sanfilippo	Clinical
Leon Satran	Attending
Steven A. Seelig	Attending
Harvey L. Sharp	Attending
Lewis Sher	Clinical
Lawrence J. Sholler	Clinical
Alan R. Sinaiko	Attending

DEPARTMENT OF PEDIATRICS CONTINUED	CATEGORY
Amarjit Singh	Clinical
Lawrence J. Singher	Clinical
Clark M. Smith, II	Attending
Theodore S. Smith	Clinical
Joseph J. Sockalosky	Clinical
Frederic M. Stone	Clinical
Edward L. Strem	Clinical
Robert W. ten Bensel	Attending
Theodore R. Thompson	Attending
Robert A. Ulstrom	Attending
R. James Vaccarella	Clinical
Homer D. Venters	Clinical
Robert L. Vernier	Attending
Norman L. Virnig	Clinical
Warren J. Warwick	Attending
James G. White	Attending
Walter L. Wilder	Clinical
William Woods	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF PHYSICAL MEDICINE & REHABILITATION	CATEGORY
James Agre	Attending
Thomas P. Anderson	Attending
Alan S. Bensman	Clinical
Jeffrey S. Cameron	Attending
Dennis D. Dykstra	Attending
Glenn Gullickson, Jr.	Attending
Miland Knapp	Clinical
Frederic Kottke	Attending
John L. Magness	Attending
Mark A. Moret	Attending
* Mary M. Price	Clinical
Keith B. Sperling	Attending

* Outstanding Malpractice Information Forms

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF PSYCHIATRY	CATEGORY	JOINT APPOINTMENT
Faruk S. Abuzzahab	Clinical	
Paula J. Clayton	Attending	
David W. Cline	Clinical	
Elke Eckert	Attending	
Lawrence Greenberg	Attending	
Ronald Groat	Clinical	
William Hausman	Attending	
Leonard Heston	Attending	
John R. Hughes	Attending	
Jonathan B. Jensen	Attending	
Allan Josephson	Clinical	
Jerome L. Kroll	Attending	
Richard D. Lentz	Clinical	
Thomas B. Mackenzie	Attending	Medicine
Richard Meisch	Attending	
Richard Miner	Attending	
James E. Mitchell	Attending	
Michael C. Moore	Clinical	
Joanne M. Pearson	Attending	
Michael K. Popkin	Attending	
Richard L. Pyle	Attending	
George M. Realmuto	Attending	
Thomas R. Stapleton	Clinical	
Myron R. Stocking	Clinical	
Charles M. Van Valkenburg	Attending	
Joseph J. Westermeyer	Attending	
Ronald C. Young	Attending	

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF RADIOLOGY	CATEGORY
Kurt Amplatz	Attending
Wilfrido R. Castaneda	Attending
Jeffrey R. Crass	Attending
Deborah L. Day	Attending
Samuel B. Feinberg	Attending
Leroy A. Forstrom	Clinical
Mathis Frick	Attending
Eugene Gedgaudas	Attending
Lawrence H. A. Gold	Attending
Marvin E. Goldberg	Attending
Merle Loken	Attending
Harry C. Walker	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF SURGERY	CATEGORY
David H. Ahrenholz	Clinical
Robert W. Anderson	Attending
Nancy L. Ascher	Attending
Ralph M. Bolman, III	Attending
Henry Buchwald	Attending
Frank B. Cerra	Attending
Bruce L. Cunningham	Clinical
John P. Delaney	Attending
John E. Foker	Attending
Victor A. Gilbertsen	Attending
Stanley Goldberg	Clinical
Robert L. Goodale	Attending
Theodor B. Grage	Attending
Hovald K. Helseth	Clinical
Arnold S. Leonard	Attending
Felix A. McParland	Clinical
J. Ernesto Molina	Attending
Richard Moore	Attending
John S. Najarian	Attending
Santhat Nivatvongs	Attending
William D. Payne	Clinical
W. Steves Ring	Attending
Alan R. Shons	Attending
Richard L. Simmons	Attending
W. Albert Sullivan	Attending
David E. R. Sutherland	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF THERAPEUTIC RADIOLOGY	CATEGORY
Taehwan Kim	Attending
Chung Kyu Kim Lee	Attending
Seymour Levitt	Attending
Rober A. Potish	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL AND DENTAL STAFF REAPPOINTMENTS JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF UROLOGY	CATEGORY
Ralph V. Clayman	Clinical
Elwin E. Fraley	Attending
Richardo Gonzalez	Attending
Paul Lange	Clinical
Pratap K. Reddy	Attending

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

RECOMMENDATIONS FOR REGULAR MEDICAL/DENTAL STAFF APPOINTMENTS

JULY 1, 1984 - JUNE 30, 1985

DEPARTMENT OF ANESTHESIOLOGY	CATEGORY	DATE ELIGIBLE
Michael D. Montgomery	Attending	March 28, 1984
Michael F. Sweeney	Attending	March 28, 1984
HOSPITAL DENTISTRY		
Sandra Cole	Attending	March 28, 1984
DEPARTMENT OF PEDIATRICS		
Elizabeth A. Braulin	Attending	March 28, 1984
Ann C. Dunnigan	Attending	March 28, 1984
T. Bruce Ferrara	Attending	March 28, 1984
Thomas J. Kulik	Attending	March 28, 1984
Bonnie G. Landrum	Attending	March 28, 1984
Sally A. Weisdorf	Attending	March 28, 1984
DEPARTMENT OF PSYCHIATRY		
Eduardo A. Colon	Clinical	March 28, 1984
DEPARTMENT OF RADIOLOGY		
Deborah S. Albin	Attending	March 28, 1984
Robert J. Boudreau	Attending	March 28, 1984
Monte E. Golditch	Attending	March 28, 1984
David W. Hunter	Attending	March 28, 1984
Charles W. Maile	Attending	March 28, 1984
Steven A. Sirr	Attending	March 28, 1984
Antony T. Young	Attending	March 28, 1984
DEPARTMENT OF UROLOGY		
Timothy D. Moon	Attending	March 28, 1984
Marcos H. Pinto	Attending	March 28, 1984

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

RECOMMENDATIONS FOR ADDITIONAL CLINICAL PRIVILEGES

DEPARTMENT OF OTOLARYNGOLOGY	CATEGORY
Arndt Duvall	Attending

DEPARTMENT OF SURGERY	
Robert L. Goodale	Attending

RECOMMENDATION FOR CHANGE IN STAFF CATEGORY

DEPARTMENT OF MEDICINE	PRESENT CATEGORY	RECOMMENDED CATEGORY
C. Paul Winchell	Attending	Emeritus

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

RECOMMENDATIONS FOR PROVISIONAL MEDICAL/DENTAL STAFF APPOINTMENTS

DEPARTMENT OF LABORATORY MEDICINE & PATHOLOGY	CATEGORY
Joan L. Bundtzen	Attending
DEPARTMENT OF PEDIATRICS	
Susan A. Berry	Attending
DEPARTMENT OF RADIOLOGY	
John F. Cardella	Attending

RECOMMENDATIONS FOR APPOINTMENT OF SPECIFIED PROFESSIONAL PERSONNEL (PSYCHOLOGIST)

DEPARTMENT OF PSYCHIATRY	CATEGORY
Caryl E. Boehnert	Clinical

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

CLINICAL CHIEF RECOMMENDATION FOR NON-RENEWAL OF MEDICAL STAFF APPOINTMENT

DEPARTMENT OF OPHTHALMOLOGY	CATEGORY
Howard David Gilbert	Clinical

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

RESIGNATIONS FROM THE MEDICAL/DENTAL STAFF

DEPARTMENT OF HOSPITAL DENTISTRY

Timothy A. Peterson

DEPARTMENT OF MEDICINE

John G. Bergstrom

Ivan D. Frantz

Peter D. Kenyon

James L. Reinertsen

Bruce A. Schwartz

DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Paul L. Ogburn, Jr.

DEPARTMENT OF OPHTHALMOLOGY

James Allen

Robert C. Campbell

Richard Carroll

DEPARTMENT OF PEDIATRICS

Jon I. Scheinman

DEPARTMENT OF PHYSICAL MEDICINE & REHABILITATION

Dennis J. Matthews

DEPARTMENT OF PSYCHIATRY

William Erickson

DEPARTMENT OF ORTHOPEDICS

E. Harvey O'Phelan

APPLICANTS TO THE MEDICAL/DENTAL STAFF

JUNE 1984

NAME & DEPARTMENT	CATEGORY	FACULTY RANK	SPECIALITY	MEDICAL SCHOOL-COMPLETION DATE	INTERNSHIP, RESIDENCY & FELLOWSHIP-COMPLETION DATES	LAST POSITION
LABORATORY MEDICINE & PATHOLOGY						
Joan L. Bundtzen	Attending I	Instructor	Chemical Pathology	University of Tennessee Memphis, Tennessee 1975	Internship (medicine) University of Wisconsin Hospital Madison, Wisconsin 1976-1977 Residency (Laboratory Medicine and Pathology) University of Minnesota Hospitals 1978-1982 Research Fellowship - University of Wisconsin Middleton V.A. Hospital Madison, Wisconsin 1979-1980 Fellowship - Health Computer Sciences and Chemistry University of Minnesota Hospitals 1982-1983	
DEPARTMENT OF PEDIATRICS						
Susan A. Berry	Attending	Instructor	Genetics	University of Kansas Kansas City, KS 1978	PL-1,2,3, Internship, Residency, University of Minnesota Hospitals 1978-1981 Fellowship (Medical Genetics) University of Minnesota Hospitals 1981-present	
DEPARTMENT OF RADIOLOGY						
John F. Cardella	Attending	Instructor	Diagnostic & Interventional Radiology	University of Michigan Ann Arbor, MI 1978	Internship (Dept. of Family Practice) University of Minnesota Hospitals 1978-1979 Residency - (Dept. of Radiology) Mayo Clinic Richester, MN 1979-1982	Private Practice: Loraine, Ohio 1982-1983

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL STAFF-HOSPITAL COUNCIL COMMITTEE CHAIRMEN APPOINTMENTS

1984/1985

1. Bed Allocation Committee

   Seymour Levitt, M.D.

2. Bylaws Committee

   Glenn Gullickson, M.D.

3. Biomedical Ethics Committee

   Theodore Thompson, M.D.
   Diane Bartels, R.N., Co Chair

4. Cardio-Respiratory Advisory Committee

   Russell H. Larsen, M.D.

5. Credentials Committee

   Henry Buchwald, M.D.

6. Disaster Committee

   Michael Daly, M.D.

7. Emergency Department Committee

   David Hurd, M.D.

8. Infection Control Committee

   Frank Rhame, M.D.

9. Operating Room Committee

   Roby Thompson, M.D.

10. Outpatient Committee

    Amos Deinard, M.D.

11. Pharmacy & Therapeutics Committee

    Russell Lucas, M.D.

12. Product Evaluation & Standardization Committee

    Bradley Fuhrman, M.D.

13. Quality Assurance Steering Committee

    James Moller, M.D.

14. Tissue & Procedure Review Committee

    Robert Maxwell, M.D.

15. Transfusion Therapeutics Committee

    Jeffrey McCullough, M.D.

16. Utilization Management Committee

    Donald Doughman, M.D.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

June 5, 1984

TO: Board of Governors

FROM: C. Edward Schwartz, Hospital Director
Paul G. Quie, M.D., Chief of Staff

RE: Annual Reappointments of Chief of Clinical Services

The Bylaws of the Board of Governors - University of Minnesota Hospitals and Clinics were amended in November, 1982, requiring the following:

Article V. Section 5 (B)

After consultation with the Joint Conference Committee, at its June meeting each year, the Board of Governors shall appoint the chief of each clinical service of the Medical Staff to serve at the discretion of the Board for an initial term of three years, execept in the case of a chief of a clinical service who is an individual other than the Head of the corresponding medical or dental school clinical department, in which case the initial appointment shall be for one year. Reappointment thereafter by the Board of Governors shall be yearly. Vacancies in the office of the chief of a clinical service may be filled at any time by the Board. In the event that a chief of a clinical service is appointed at some time other than the June meeting, and if the appointment is made no later than December, for purposes of determining the time of reappointment the appointment shall be deemed to have commenced the preceding June. In the event that the appointment is made after December, for purposes of determining the time of reappointment the computation of time shall be deemed to commence at the next succeeding June.

The Hospital Director in consultation with the Chief of Staff hereby recommends the reappointment of the following Clinical Chiefs for 1984-85.

The following persons are subject to re-appointment;

NAME	DEPARTMENT
Dr. Ellis Benson	Laboratory Medicine & Pathology
Dr. Joseph Buckley	Anesthesiology
Dr. Shelley Chou	Neurosurgery
Dr. Edward Ciriacy	Family Practice
Dr. Paula Clayton	Psychiatry
Dr. Donald Doughman	Ophthalmology

NAME	DEPARTMENT
Dr. Thomas Ferris	Medicine
Dr. Elwin Fraley	Urology
Dr. Eugene Gedgaudas	Radiology
Dr. Robert Goltz	Dermatology
Dr. Glenn Gullickson	Physical Medicine & Rehabilitation
Dr. Arthur Klassen	Neurology
Dr. William Krivit	Pediatrics
Dr. Seymour Levitt	Therapeutic Radiology
Dr. John Najarian	Surgery
Dr. Michael Paparella	Otolaryngology
Dr. Konald Prem	Obstetrics & Gynecology
Dr. Roby Thompson	Orthopedic Surgery
Dr. Daniel Waite	Dentistry

CES/sds
Enclosure

FUNCTION OF CLINICAL CHIEFS*

1. Be accountable for all professional and administrative activities within his or her service.

2. Be a member of the Council of Chiefs of Clinical Services giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his or her own service in order to assure a high quality of patient care.

3. Maintain continuing review of the professional performance of all individuals with clinical privileges in his or her service and report thereon on the Credentials Committee as necessary.

4. Be responsible for enforcement within his or her service of the hospital bylaws, policies and directives and of these medical staff bylaws, rules and regulations.

5. Be responsible for implementation within his or her service of actions taken and policies set by the Board, the Council of Chiefs of Clinical Services and the Medical Staff-Hospital Council.

6. Transmit to the Credentials Committee his or her recommendations concerning the appointment, reappointment, and delineation of clinical privileges for all individuals in and applicants to his or her service.

7. Participate in every phase of administration of his or her service with the hospital management in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.

8. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her service as may be required by the Chief of Staff or the Board.

*Article 3, Section 5 of the Bylaws

CLINICAL CHIEFS BIOGRAPHICAL SUMMARIES

1. Ellis S. Benson, M.D.
   Professor & Head
   Laboratory Medicine & Pathology

   Medical School: University of Minnesota Medical School
   Internship: Cincinnati General Hospital
   Residency: Veterans Administration Hospital, Minneapolis, MInnesota
   Certified: American Board of Pathologists

2. Jospeh J. Buckley, M.D.
   Professor and Head
   Department of Anesthesiology

   Medical School: New York Medical College
   Internship: U.S. Laval Hospita, Chelsea (Boston), Massachussetts
   Residency: University of Minnesota Medical School
   Certified: American Board of Anesthesiology

3. Shelley Chou, M.D., M.S., PHD
   Professor and Head
   Department of Neurosurgery

   Medical School: University of Utah Medical School
   Internship: Providence Hospital, Detroit, Michigan
   Residency: University of Minnesota Hospitals, Minneapolis, Minneosta
   Certified: American Board of Neurosurgery

4. Edward W. Ciriacy, M.D.
   Professor and Head
   Family Practice & Community Health

   Medical School: Temple University Medical School
   Internship: Frankford Hospital
   Residency: Frankford Hospital and Temple Hospital
   Certified: American Board of Family Physicians

5. Donald J. Doughman, M.D.
   Professor and Head
   Department of Ophthalmology

   Medical School: University of Iowa College of Medicine
   Internship: Los Angeles County General Hospital, Los Angeles, California
   Residency: University Hospital, Iowa City, Iowa
   Certified: American Board of Ophthalmology

6. Thomas F. Ferris, M.D.
   Professor and Head
   Department of Medicine

   Medical School: Yale University
   Internship: Osler Service, John Hopkins Hospital
   Residency: Yale-New Haven Hospital
   Certified: American Board Of Internal Medicine

7. Elwin E. Fraley, M.D.
Professor and Head
Department of Urologic Surgery

Medical School: Harvard Medical School
Internship: Massachusetts General Hospital, Boston, Massachusetts
Residency: Massachusetts General Hospital, Boston, Massachusetts
Certified: American Board of Urology

8. Eugene Gedgaudas, M.D.
Professor and Head
Department of Diagnostic Radiology

Medical School: University of Munich, Germany
Internship: St. Boniface General Hospital, Canada
Residency: St. Boniface General Hospital, Canada
Certified: The American Board of Radiology

9. Robert W. Goltz, M.D.
Professor and Head
Department of Dermatology

Medical School: University of Minnesota
Internship: Ancker Hospital, St Paul, Minnesota
Residency: University of Minnesota, Minneapolis, MN, School of Medicine
Certified: American Board of Dermatology

10. Arthur C. Klassen, M.D.
Professor and Acting Head,
Department of Neurology

Medical School: University of Manitoba Medical School
Internship: Winnipeg General Hospital, Winnipeg, Canada
Residency: University of Minnesota
Certified: American Board of Psychiatry and Neurology

11. Glenn Gullickson, Jr., M.D.
Professor and Interim Head,
Department of Physical Medicine and Rehabilitation

Medical School: University of Minnesota
Internship: Gallinger Municipal Hospital
Residency: University of Minnesota
Certified: American Board of Physical Medicine and Rehabilitation

12. William Krivit, M.D. Ph.D
Professor and Head
Department of Pediatrics

Medical School: Tulane University Medical School
Internship: Charity Hospital, New Orleans
Residency: Utah School of Medicine
Certified: Diplomat of the American Board of Pediatrics

13. Seymour H. Levitt, M.D.
Professor and Head
Department of Therapeutic Radiology

Medical School: University of Colorado
Internship: Philadelphia General Hospital
Residency: University of California
Certified: American Board of Radiology

14. John S. Najarian, M.D.
Professor and Head
Department of Surgery

Medical School: University of California, San Francisco
Internship: University of California Medical School
Residency: University of California Medical School
Certified: American Board of Surgery Diplomate

15. Michael M. Paparella, M.D.
Professor and Head
Department of Otolaryngology

Medical School: University of Michigan
Internship: Emanuel Hospital, Portland, Ohio
Residency: Henry Ford Hospital, Detroit, Michigan
Certified: American Board of Otolaryngology

16. Konald A. Prem, M.D.
Professor and Head
Department of Obstetrics and Gynecology

Medical School: University of Minnesota
Internship: Minneapolis General Hospital, Minneapolis, Minnesota
Residency: University of Minnesota Medical School
Certified: American Board of Obstetrics and Gynecology

17. Roby C. Thompson, Jr., M.D.
Professor and Head
Department of Orthopaedic Surgery

Medical School: University of Virginia School of Medicine
Internship: Columbia Presbyterian Medical Center, New York
Residency: Columbia Presbyterian Medical Center, New York
Certified: American Board of Orthopaedic Surgeons

18. Daniel E. Waite, D.D.S., M.S.
Professor and Hhad
Department of Oral and Maxillofacial Surgery, School of Denistry

Dental School: State College of University of Iowa
Residency Certificate: State University of Iowa
Certified: American Board of Oral Maxillofacial Surgery

19. Paula J. Clayton, M.D.
Professor and Head
Department of Psychiatry

Medical School: Washington University, St. Louis, Missouri
Internship: St. Luke's Hospital, St. Louis, Missouri
Residency: Barnes and Rehard Hospitals
Certified: American College of Neuropsychopharmacology

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

June 13, 1984

TO: Board of Governors Finance Committee

FROM: Clifford Fearing
Senior Associate Director

SUBJECT: Report of Operations for the period July 1, 1983 through May 31, 1984

The Hospitals' operating position for the month of May continues to reflect lower than anticipated inpatient census levels and further reductions in the average inpatient ancillary service revenue per admission. To highlight our position:

Inpatient Census: During the month of May, admissions totaled 1,670 or 55 below projected admissions of 1,725. Admissions this month were at or above budgeted levels in all areas except Surgery, Obstetrics, Rehabilitation, and the Intensive Care Units. Due to a lower overall length of stay for the month, the patient day total of 14,514 was 1,919 days below the budgeted level of 16,433. The overall length of stay for the month of May was 8.7 days compared to the year-to-date average through April of 9.1 days.

To recap our year-to-date inpatient census:

	1982-83 Actual	Budget	Actual	Variance	% Variance
Admissions	19,208	18,691	18,219	(472)	(2.5)
Avg. Length of Stay	9.5	9.6	9.1	(0.5)	(5.2)
Patient Days	182,635	179,443	166,897	(12,546)	(7.0)
Percent Occupancy	74.0	72.5	67.5	(5.0)	(6.9)
Avg. Daily Census	545.2	534.1	496.7	(37.4)	(7.0)

Outpatient Census: May clinic census totaled 18,692 compared to projected visits of 17,969. Our year-to-date clinic census total of 191,471 visits is 1409 visits, or 0.7% above projected visits of 190,062. However, the clinic census through May of this fiscal year is 412 visits over our total of a year ago.

Financial Operations: The Hospitals' Statement of Operations shows total revenues over expenses of $ 8,589,378, a favorable variance of $ 320,284. This favorable variance continues to be due to our investment income being higher than projected by approximately $ 2,578,000. The net revenue from operations through May shows a net loss of $ 9,049,753, which is nearly $ 2,255,000 greater than the budgeted loss of $ 6,794,284.

Patient care charges through May totaled $ 164,967,706 and are $ 7,527,768 (4.4%) below budgeted levels. Routine revenue is 6.5% below budget and reflects the overall patient day variance. Ancillary revenue levels declined during the month of May reflecting a lower average acuity level. Inpatient ancillary charges per admission declined from the April year-to-date average of $ 4,754 to an average of $ 4,546 for the month of May.

Operating expenditures through May totaled $ 145,585,352, and are approximately $ 3,526,000 (2.4%) below budget. Overall spending levels during May continue to reflect reduced personnel costs, and supply and expense costs associated with our lower census levels and with the actions taken by management in November.

Accounts Receivable: The balance in patient accounts receivable as of May 31, 1984 totaled $ 40,410,868 and represents 83.4 days of revenue outstanding. Total receivables decreased $ 1,421,488 during the month of May with the decrease occurring primarily in the Medical Assistance and commercial insurance categories. Receivables are still reflecting backlogs in Medicare, Blue Cross, and out-of-state Medicaid programs. The length of time to collect third party receivables continues to be a problem in this region.

Conclusion: The Hospitals' overall financial position through the end of May continues to remain within the fiscal plan implemented in November. We continue to assess changes in acuity level and ancillary service utilization and make necessary and appropriate changes consistent with this fiscal plan.

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1983 TO MAY 31, 1984

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$172,495,474	$164,967,706	$-7,527,768	-4.4%
Deductions from Charges	33,121,083	31,621,007	-1,500,076	-4.5
Other Operating Revenue	2,942,283	3,188,900	246,617	8.4
TOTAL REVENUE FROM OPERATIONS	$142,316,674	$136,535,599	$-5,781,075	-4.1%
Expenditures				
Salaries	$ 71,788,028	$ 70,226,871	$-1,561,157	-2.2%
Fringe Benefits	13,333,954	14,079,889	745,935	5.6
Contract Compensation	6,861,234	7,352,740	491,506	7.2
Medical Supplies, Drugs, Blood	23,437,865	22,394,004	-1,043,861	-4.5
Campus Administration Expense	4,797,638	4,797,638	0	0.0
Depreciation	5,949,700	5,576,869	-372,831	-6.3
General Supplies & Expense	22,942,539	21,157,341	-1,785,198	-7.8
Total Expenditures	$149,110,958	$145,585,352	$-3,525,606	-2.4%
Net Revenue from Operations	$ -6,794,284	$ -9,049,753	$-2,255,469	-33.2%
Non-Operating Revenue				
Appropriations	$ 11,402,380	$ 11,402,380	0	
Interest Income on Reserves	1,687,891	4,265,946	$ 2,578,055	
Shared Service	338,960	336,658	-2,302	-0.7%
Investment Income on Trustee Held Assets	1,634,147	1,634,147	0	
Total Non-Operating Revenue	$ 15,063,378	$ 17,639,131	$ 2,575,753	17.1%
Revenue Over / -Under Expenses	$ 8,269,094	$ 8,589,378	$ 320,284	(1)

(1) Variance equals 0.2% of total budgeted revenue.

MINUTES

JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

June, 13, 1984

ATTENDANCE:

Present: Barbara O'Grady, Chair
Paula Clayton, M.D.
Phyllis Ellis
Glenn Gullickson, M.D.
Robert Howe, M.D., (for Paul Quie, M.D.)
Robert Latz
Robert Maxwell, M.D.
C. Edward Schwartz

Absent: Paul Quie, M.D.

Staff: Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt

Guests: Jan Brockway
David Gawaluck
Kim Werner

APPROVAL OF MINUTES:

The minutes of the May 9, 1984 meeting of the Joint Conference Committee were approved as submitted.

NURSING STRIKE UPDATE:

Ms. Tebbitt reported on the status of the nursing strike in the community and its impact on University Hospitals. She indicated that University Hospitals has seen a moderate increase in census as a result of the strike and is making internal accommodations to respond to this increase in activity. She indicated that the largest impact is being felt in Pediatrics, the Neonatal Intensive Care Unit, and the other ICUs. Staffing levels in these areas in particular have been tight, and as a result some temporary hiring has been done to meet increased patient care needs.

Ms. Tebbitt also reported on the status of the negotiations between MNA and the community hospitals. The Committee discussed the policy implications of the strike, particularly its impact on the nursing profession and the future availability of nursing manpower.

CREDENTIALS COMMITTEE REPORT AND RECOMMENDATIONS:

Dr. Howe presented the report and recommendations of the Credentials Committee. The recommendations include annual medical staff reappointments, regular medical staff appointments, changes in staff category and addition of clinical privileges, provisional medical staff appointments and request for clinical privileges, specified professional personnel and Psychology privilege recommendations, Clinical Chief recommendation for non-renewal of medical staff appointment, and resignations from the medical staff. Dr. Howe also described the Credentials Committee process used for appointments and reappointments to the medical staff.

In discussion of the reappointments, it was noted that a number of the medical staff have not yet submitted full information relative to malpractice information as required. It was also noted that one member of the medical staff is being recommended for emeritus status without clinical privileges given that this individual no longer maintains malpractice insurance coverage.

After discussion the Joint Conference Committee acted to endorse the recommendations of the Medical Staff Hospital Council and the Credentials Committee, with the stipulation that the reappointment of those staff members who have not yet submitted malpractice insurance information be made pending receipt of such information by August 31, 1984.

The Committee also discussed the future role of the clinical medical staff and its use of University Hospitals, and the use of facilities other than University Hospitals by attending members of the medical staff.

MEDICAL STAFF HOSPITAL/COUNCIL REPORT:

Dr. Howe reported on the June 12 meeting of the Medical Staff Hospital Council. He indicated that the Council approved the appointment of the chairs of the medical staff committees at this meeting. Dr. Howe presented the committee chair recommendations for the Joint Conference Committee's endorsement. He indicated that two new chairs are recommended for the coming year; Dr. Seymour Levitt will become chair of the Bed Allocation Committee and Dr. Robert Maxwell will become chair of the Tissue and Procedure Review Committee. The Joint Conference Committee endorsed the recommendations for Medical Staff Hospital Council chair appointments.

Dr. Howe also indicated that the Medical Staff Hospital Council reviewed a study performed by the Tissue and Procedure Review Committee on DRG 354, non-radical hysterectomies. Ms. Brockway and Ms. Werner reported on the results of this study. The findings relative to quality of care, appropriateness, cost, and reimbursement were reviewed, as were the recommendations from the study.

CLINICAL CHIEFS RETREAT REPORT:

Dr. Clayton reported on the Clinical Chiefs Retreat held on June 9. She indicated that the Chiefs had held a retreat in January focused on cost containment; the June retreat was oriented toward planning and marketing issues. The early sections of the retreat revolved around a review of financial and volume trends and reports from several groups who had made site visits to other universities to look at HMO and PPO programs. One of the outcomes of the retreat was the endorsement of the establishment of a clinical program development fund, targeted at enabling increased volumes to occur at University Hospitals. Dr. Clayton also noted that the Chiefs had acted to appoint a task force to develop specific recommendations for the creation of an executive body of the Clinical Chiefs.

This executive body will be charged with the responsibility to represent the clinical departments in HMO/PPO planning and negotiations, joint venture and joint billing arrangements, coordinating outreach efforts, and developing publicity programs. Ms. O'Grady indicated that the Regents, at their most recent meeting, had expressed interest in and support of these kinds of actions.

CLINICAL CHIEF REAPPOINTMENTS:

Mr. Schwartz drew the Committee's attention to the letter of recommendation for the annual reappointments of the Chief of Clinical Services. The Joint Conference Committee acted to endorse the recommendations for reappointment, after briefly reviewing the function and background of the Clinical Chiefs.

There being no further business the meeting adjourned at approximately 8:45 p.m.

Respectfully submitted,

Greg Hart

Greg Hart

Minutes
Finance Committee
University of Minnesota Hospitals & Clinics
May 23, 1984

MEMBERS PRESENT:	Al France, Chair Shelley Chou, M.D. Clifford Fearing Jerry Meilahn C. Edward Schwartz
MEMBERS ABSENT:	Mary DesRoches Carl Drake Richard Kronenberg, M.D.
STAFF:	Greg Hart Nancy Janda Nels Larson Jane Morris Barbara Tebbitt
GUESTS:	David Cost Lynn Hornquist Virgil Moline Barbara O'Grady

CALL TO ORDER: The meeting of the Finance Committee was chaired by Mr. Al France and was called to order at 9:45 a.m. in Room 608 of the Campus Club.

MINUTES APPROVED: The minutes of the April 25, 1984 meeting of the Finance Committee were approved.

APRIL YTD FINANCIAL STATEMENTS (INFORMATION): Mr. Fearing reviewed the Report of Operations for the period July 1, 1983 through April 30, 1984. He stated that the month of April showed some improvement in census levels over the month of March. Inpatient admissions for April were only 22 below the projected level of 1,718, however the average length of stay was 8.7 days compared to the year to date average through March of 9.2 days. The outpatient clinic census is fairly stable for the year to date at 172,779.

Total revenues over expense are $8,104,094, a favorable variance of $525,392, and this variance continues to be due in most part to investment income. The net revenue from operations through April showed a net loss of $7,840,500 compared to the budgeted loss of $6,098,655.

Patient care charges are 4% below budget, routine revenue is 6% below budget and ancillary revenue is down 2.8% from budgeted levels. Data from the first 20 days of May shows a slight increase in routine revenue over April levels. Ancillary utilization has declined since January and is now down to an average charge of $4,299 per admission through April.

Expenses remain below budget by 2.1% reflecting the decline in census levels and reduction in personnel costs.

Accounts Receivable continue to be above the expected level of 80 days of revenue outstanding at 84.9 days. Mr. Fearing stated that the original year end target of 78 days is optimistic and the 80 day level will be used as a base for projecting the 1984-85 budget.

Mr. Fearing gave a review of the Statement of Operations with explanations of areas showing the most variation from budgeted levels. The large variance in physicians compensation is mostly due to over-budgeting for Medicare Part B charges and under-budgeting Part A charges in Lab Medicine and Pathology.

The Operating Cash Flow statement shows negative cash available of $572,295 after transfers to Renewal Project of $3,333,333, transfers to debt retirement of $2,333,333, and transfers to Plant of $3,129,614. Mr. Fearing added that the negative cash available is being offset by $3.8 million that is being held by the University for interest on reserves.

OPERATING BUDGET 1984-85 (ENDORSEMENT):

Mr. Fearing gave a complete review of the 1984-85 operating budget being proposed for the Hospitals and outlined the objectives and variables used to develop the budget. He explained that the volatility of the recent census and revenue levels has necessitated the development of a contingency budget that would assume this current trend to continue into 1984-85. A 7% price increase is assumed for both the contingency and base budget. Mr. Fearing noted that since FTEs generated the primary area of expense, the current FTE count of 3,460 would be reduced to 3,476.4 in the base budget and to 3,286.4 in the contingency budget. He suggested that the 1984-85 operating budget as outlined be presented to the full Board of Governors for their information.

A motion was made and passed by the Committee to endorse this budget and submit it to the full Board of Governors for their information now and seek final Board approval at their June meeting.

1984-85 EMPLOYEE COMPENSATION PLAN (ENDORSEMENT):

Mr. Hart outlined a proposed annual employee compensation plan for fiscal year 1984-85. This plan recommends a 4.5% salary increase effective July 1, 1984 and an additional 1.0% increase on January 1, 1985. He noted that some comparable worth adjustments will be implemented as well effecting 35 job classifications with increases ranging from 2.7% to 7.7%. Adjustments will also be necessary for a number of Nursing-related classifications, and $600,000 has been budgeted for these adjustments. Another $300,000 has been budgeted for salary adjustments to non-nursing personnel.

A motion was made and passed by the Committee to endorse the 1984-85 Employee Compensation Plan and recommend it for approval to the full Board of Governors.

ADJOURNMENT:

Because of the time restriction, it was decided to defer the remaining agenda items to the full Board of Governors meeting later this day. The meeting of the Finance Committee was adjourned at approximately 12:15 p.m.

Respectfully submitted,

Jane Morris

Jane Morris
Recording Secretary

Minutes
Joint Meeting of the Finance Committee
and the Planning and Development Committee
University of Minnesota Hospitals & Clinics
May 23, 1984

MEMBERS PRESENT:

Al France
Shelley Chou, M.D.
Clifford Fearing
Clinton Hewitt
William Krivit, M.D.
Jerry Meilahn
Virgil Moline
Barbara O'Grady
C. Edward Schwartz

STAFF AND GUESTS:

David Cost
Greg Hart
Lynn Hornquist
Nancy Janda
Mark Koenig
Nels Larson
Jane Morris

CALL TO ORDER:

The joint meeting of the Finance Committee and the Planning and Development Committee was chaired by Mr. Al France and was called to order in Room 608 of the Campus Club.

CAPITAL BUDGET (ENDORSEMENT):

Mr. Koenig introduced the Proposed Capital Equipment and Remodeling/Renovation budget for fiscal year 1984-85 and gave a detailed review of a schedule showing five year capital budget projections. For 1984-85, recurring and Unit J requests total $5,102,365. Mr. Hart reviewed the schedules showing the proposed equipment budget (totaling $3,875,808) and remodeling/renovation budget of $578,427. He stated that since Nursing is assigned the majority of space, it has the most repairs and remodeling needed. Remodeling of the Mayo Building will occur only where absolutely necessary and where nursing stations need to be merged. A laboratory replacement computer was the only capital equipment item requiring certificate of need.

A motion was made and passed by the committee to endorse the proposed 1984-85 capital equipment and remodeling/ renovation budget and to recommend it to the full Board of Governors for their approval.

ADJOURNMENT:

There being no further business, the joint meeting of the Finance Committee and the Planning and Development Committee was adjourned at approximately 1:15 p.m.

Respectfully submitted,

Jane Morris

Jane Morris
Recording Secretary

Six years ago, *Town & County* published what became one of our most requested features—a guide to the best medical specialists and specialty treatment centers across the country. Since then, new treatments have been developed and new medical stars have arisen. In May we published Part One of our revised list; its completion is in this issue.

T&C's EXCLUSIVE DIRECTORY

THE BEST MEDICAL SPECIALISTS IN THE U.S.

PART TWO

BY JOHN PEKKANEN

ENDOCRINOLOGISTS

This section is devoted to specialists who treat a wide range of endocrine problems, from thyroid gland problems to diseases of the adrenal glands, such as Cushing's disease or Addison's disease.

LOUIS AVIOLI
Jewish Hospital of St. Louis
St. Louis, MO 63110
Professor of medicine, Washington University.

KENNETH BECKER
George Washington University Hospital
Washington, DC 20037
Chief of endocrinology.

EDWARD BIGLIERI
University of California Medical Center
San Francisco, CA 94143
Professor of medicine; chief of endocrinology, San Francisco General Hospital.

ALBERT RICHARD CHRISTLIEB
Joslin Clinic
Boston, MA 02215
Associate professor of medicine, Harvard.

NICHOLAS P. CHRISTY
Brooklyn VA Medical Center
Brooklyn, NY 11209
Professor of medicine, Downstate Medical Center

EUGENE P. CLERKIN
Lahey Clinic
Burlington, MA 01803
Chairman of medicine.

PHILIP CRYER
4989 Barnes Hospital Plaza
St. Louis, MO 63110
Associate professor of medicine, Washington University.

WILLIAM DAUGHADAY
Barnes Hospital Plaza
St. Louis, MO 63110
Professor of medicine, Washington University.

LESLIE J. DEGROOT
University of Chicago Hospitals
Chicago, IL 60637
Professor of medicine, chief of endocrinology.

PHILIP R. EATON
University of New Mexico Medical School
Albuquerque, NM 87131
Professor of medicine.

STEFAN FAJANS
University of Michigan Medical Center
Ann Arbor, MI 48109
Professor of internal medicine, head, division of endocrinology and metabolism.

DANIEL D. FEDERMAN
Massachusetts General Hospital
Boston, MA 02214
Professor of medicine, Harvard.

JAMES FIELD
Baylor College of Medicine
Houston, TX 77030
Professor of medicine; head, division of endocrinology and metabolism.

LAWRENCE FISHMAN
University of Miami Medical School
Miami, FL 33101
Professor of medicine.

BOY FRAME
2799 West Grand Boulevard
Detroit, MI 48202
Clinical professor of medicine, University of Michigan.

NORBERT FREINKEL
Northwestern University Medical School
Chicago, IL 60611
Director of Center for Endocrinology, Metabolism & Nutrition.

FRANCIS S. GREENSPAN
University of California Medical Center
San Francisco, CA 94143

Clinical professor of medicine; chief of thyroid clinic.

JOHN HARE
Joslin Clinic
Boston, MA 02215

DOROTHY T. KRIEGER
Mt. Sinai School of Medicine
New York, NY 10028
Professor of medicine.

ANN M. LAWRENCE
Loyola University School of Medicine
Maywood, IL 60153
Professor of medicine.

JAMES C. MELBY
University Hospital
Boston, MA 02118
Professor of medicine, Boston University

THOMAS MERIMEE
University of Florida
Medical School
Gainesville, FL 32610
Chief of endocrinology and metabolism.

ROBERT NEY
Johns Hopkins Hospital
Baltimore, MD 21205
Professor of medicine, director of endocrinology and metabolism

CHARLES A. NUGENT, JR.
University of Arizona
Health Sciences Center
Tucson, AZ 85724
Professor of medicine.

WILLIAM D. O'DELL
University of Utah Medical Center
Salt Lake City, UT 84132
Professor and chairman of medicine.

[illegible] OPPENHEIMER
University of Minnesota Hospitals
Minniapolis, MI 55455
Professor of medicine.

DAVID N. ORTH
Vanderbilt Medical Center
Nashville, TN 37232
Professor of medicine.

JOHN T. POTTS, JR.
Massachusetts General Hospital
Boston, MA 02114
Professor of medicine, Harvard.

THADDEUS E. PROUT
Greater Baltimore Medical Center
Baltimore, MD 21204
Associate professor of medicine. Johns Hopkins.

ERIC REISS
University of Miami Medical School
Miami, FL 33101
Professor and chairman of medicine.

LAWRENCE RIGGS
Mayo Clinic
Rochester, MN 55901
Chief of endocrinology

ALAN ROBINSON
Presbyterian University Hospital
Pittsburgh, PA 15213

NAGUIB A. SAMAAN
M.D. Anderson Hospital and Tumor Institute
Houston, TX 77030
Chief, section on endocrinology; professor of medicine, University of Texas System Cancer Center, M.D. Anderson.

THEODORE B. SCHWARTZ
Rush-Presbyterian-St. Luke's Medical Center
Chicago, IL 60660
Professor and chairman, department of medicine, Rush Medical College

FREDERICK SINGER
Los Angeles County—USC Medical Center
Los Angeles, CA 90033
Professor of medicine.

PENN SKILLERN
Cleveland Clinic
Cleveland, OH 44106
Chief of endocrinology.

PETER J. SNYDER
University of Pennsylvania Medical School
Philadelphia, PA 19104
Associate professor of medicine

DAVID H. SOLOMON
UCLA Medical Center
Los Angeles, CA 90024
Chairman, department of medicine.

RONALD S. SWERDLOFF
Harbor-UCLA Medical Center
Torrance, CA 90509
Professor of medicine, UCLA

WILLIAM THOMAS
Veterans Administration Hospital
Gainesville, FL 32610
Professor of medicine, University of Florida Medical College.

ROBERT UTIGER
University of North Carolina
Medical School
Chapel Hill, NC 27514
Professor of medicine.

COLON & RECTAL SURGEONS

Colon and rectal cancer is the third most common cancer and is one of the types of cancer that is increasing in incidence. Like many cancers, if it is detected early, the outcome can be very favorable. Besides cancer, colon and rectal surgery involves operations for ulcerative colitis and Crohn's disease, as well as hemorrhoids (perhaps the most common procedure).

HERAND ABCARIAN
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ROBERT W. BEART, JR.
Mayo Clinic
Rochester, MN 55901
Head of colon and rectal surgery

H. WHITNEY BOGGS
1534 Elizabeth Place
Shreveport, LA 71101

ALEJANDRO CASTRO
11125 Rockeville Pike
Rockville, MD 20852
Associate professor of surgery, Georgetown.

VICTOR W. FAZIO
Cleveland Clinic
Cleveland, OH 44106
Chairman, department of colon and rectal surgery

DONALD GALLAGHER
3838 California Street
San Francisco, CA 94118
Associate clinical professor of surgery, University of California

J. B. GATHRIGHT, JR.
Ochsner Clinic
New Orleans, LA 70121
Associate professor of surgery, Tulane

STANLEY GOLDBERG
323 Southdale Medical Building
Minneapolis, MN 55435
Clinical professor of surgery, University of Minnesota

BARTON HOEXTER
60 Cutter Mill Road
Great Neck, NY 11021
Assistant clinical professor of surgery, Cornell

JOHN MADDEN
123 East 69th Street
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Professor of clinical surgery, New York Medical College

GERALD MARKS
111 South Eleventh Street
Philadelphia, PA 19107
Professor of surgery, Jefferson Medical College

NORMAN D. NIGRO
22811 Greater Mack Avenue
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Clinical professor of surgery, Wayne State.

BERTRAM A. PORTIN
1616 Kensington Avenue
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Chairman, of colon and rectal surgery, State University of New York

STUART H. Q. QUAN
178 East End Avenue
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Chief of the rectal clinic, Roosevelt Hospital

JOHN RAY
Ochsner Clinic
New Orleans, LA 70121

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1010 Park Avenue
Plainfield, NJ 07060
Clinical professor of surgery, Rutgers

THEODORE SCHROCK
University of California
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EUGENE SULLIVAN, JR.
Portland Medical Center
Portland, OR 97205

FRANK THEUERKAUF, JR.
3216 State Street
Erie, PA 16508

G. BRUCE THOW
Carle Clinic
602 West University Avenue
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Head, department of colon and rectal surgery, Carle Clinic, clinical associate professor of surgery, University of Illinois

MALCOLM C. VEIDENHEIMER
Lahey Clinic
Burlington, MA 01803

NEPHROLOGISTS

Approximately 60,000 Americans are on kidney dialysis today. Many are on hemodialysis, which usually requires four to six hours a day, three days a week, but a growing number are on peritoneal dialysis, a more portable form of dialysis, and which offers kidney patients more freedom and for many, a more energetic life. One nephrologist warned that patients must always seek out a nephrologist who at least offers patients peritoneal dialysis.

Nephrologists often perform a second function for their patients: evaluating them for kidney transplant. The physician's expertise is vital because he must select the surgeon and the center which has the skill and the resources to offer the patient the best chance of having a successful transplant. (Please see Kidney, Liver and Pancreas Transplant Specialists for important breakthroughs in transplantation.)

TOM ANDREOLI
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Professor of medicine.

ALLEN ARIEFF
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Associate professor of medicine, University of California.

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New York, NY 10021
Professor of medicine, New York University.

CHRISTOPHER BLAGG
Northwest Kidney Center
700 Broadway
Seattle, WA 98122
Associate professor of medicine, University of Washington.

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Massachusetts General Hospital
Boston, MA 02114
Professor of medicine, Harvard.

T. F. FERRIS
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Minneapolis, MN 55455
Professor of medicine.

WILLIAM J. FLANIGAN
University of Arkansas for Medical Sciences
Little Rock, AR 72205
Professor of medicine; director, department of dialysis and transplantation.

RICHARD B. FREEMAN
University of Rochester
Medical Center
Rochester, NY 14642
Head of nephrology unit; associate professor of medicine.

ELI A. FRIEDMAN
Downstate Medical Center
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Professor and chairman of medicine, UCLA.

ROBERT GROSSMAN
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Professor of medicine.

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CARL KJELLSTRAND
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Chief of nephrology.

SAULO KLAHR
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Professor of medicine, Washington University

JAMES KNOCHEL
University of Texas
Southwestern Medical School
Dallas, TX 75235

NEIL KURTZMAN
University of Illinois Hospital
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Chief, nephrology section.

JACOB LEMANN, JR.
Medical College of Wisconsin
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Professor of medicine.

MANUEL MARTINEZ-MALDONADO
University of Puerto Rico
School of Medicine
San Juan, PR 00931
Professor of Medicine.

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USC School of Medicine
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Chief, division of nephrology; Bernard J. Hanley professor of medicine.

KARL D. NOLPH
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Professor of medicine; director, division of nephrology.

VICTOR POLLAK
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Professor of internal medicine.

EDWIN RUTSKY
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Professor of medicine.

GEORGE E. SCHREINER
Georgetown University Hospital
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Professor of medicine.

ROBERT W. SCHRIER
University of Colorado
Medical Center
Denver, CO 80262
Professor and chairman, department of medicine.

BELDING H. SCRIBNER
University of Washington
Seattle, WA 98195
Professor of medicine.

DONALD W. SELDIN
University of Texas
Southwestern Medical School
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Professor and chairman of internal medicine.

FRED L. SHAPIRO
Hennepin County
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Professor of medicine, University of Minnesota.

WADI N. SUKI
Methodist Hospital
Houston, TX 77030
Chief, renal section; professor of medicine, Baylor.

SAMUEL O. THIER
Yale University
School of Medicine
New Haven, CT 06510
Professor and chairman of internal medicine.

KIDNEY, LIVER & PANCREAS TRANSPLANTATION SPECIALISTS

In 1983, the Food and Drug Administration approved the use of the drug Cyclosporin A, which transplant surgeons around the world believe is the most important drug breakthrough in transplantation in the past 20 years. This drug is dramatically increasing the chances for keeping a transplanted kidney, liver or pancreas.

CLYDE BARKER
Hospital of the University of
Pennsylvania
Philadelphia, PA 19104
Head of transplant service; also noted for pancreatic transplantation.

FOLKERT BELZER
University of Wisconsin Medical School
Madison, WI 53706
Professor and chairman of surgery.

ROBERT CORRY
University Hospitals
Iowa City, IA 52242
Chief of transplantation, University of Iowa.

ARNOLD G. DIETHELM
University of Alabama Medical Center
Birmingham, AL 35294
Professor of surgery.

RONALD D. GUTTMANN
Royal Victoria Hospital and
McGill University
Montreal, Quebec
Canada H3A 1A1
Chief of transplantation.

H. Myron Kauffman, Jr.
Medical College of Wisconsin
Milwaukee, WI 53226
Head of transplant service

H. M. Lee
Medical College of Virginia
Richmond, VA 23219
Professor of surgery

Thomas L. Marchioro
University of Washington
School of Medicine
Seattle, WA 98195
Head of transplant surgery

John S. Najarian
University of Minnesota Hospitals
Minneapolis, MN 55455
Professor and chairman of surgery. Major center for liver and pancreas transplantation.

Oscar Salvatierra, Jr.
University of California Medical Center
San Francisco, CA 94143
Professor of surgery

Thomas E. Starzl
University of Pittsburgh Medical School
Pittsburgh, PA 15261
Head of transplantation, major center for liver and pancreas transplantation

G. Melville Williams
Johns Hopkins Hospital
Baltimore, MD 21205
Head of transplant surgery

UROLOGISTS

The urological system includes the urinary tract, kidneys and bladder, prostate gland and male genital system. Although most urologists operate on all the parts of the urinary system, they may have interests in specific areas, such as kidney stones, prostate surgery, infections or bladder cancer.

Terry D. Allen
University of Texas
Southwestern Medical School
Dallas, TX 75235
Associate professor of urology

Samuel S. Ambrose, Jr.
Emory University Clinic
Atlanta, GA 30322
Professor of urology

John Barry
Oregon Health
Sciences University
Portland, OR 97201
Professor of urology

William H. Boyce
Bowman Gray School of Medicine
Winston-Salem, NC 27103
Professor and chairman, urology section, special interest in stones.

William Brannan
Ochsner Clinic
New Orleans, 70121

C. Eugene Carlton, Jr.
Baylor College of Medicine
Houston, TX 77030
Professor and chairman of urology, special interest in cancer.

Abraham T. K. Cockett
University of Rochester
Medical Center
Rochester, NY 14642
Professor and chairman of urology

Roy J. Correa, Jr.
Mason Clinic
Seattle, WA 98111

Kenneth Cummings
University of Wisconsin
Clinical Science Center
Madison, WI 53792
Professor of medicine, chief of urology

John Donohue
Indiana University Medical Center
Indianapolis, IN 46202
Professor and chairman of urology

George W. Drach
1501 North Campbell Avenue
Tucson, AZ 85274
Chief of urology, University of Arizona; special interest in stones

William Fair
Washington University
Medical School
St. Louis, MO 63110
Professor and chairman, division of urology. Special interest in infections

William L. Furlow
Mayo Clinic
Rochester, MN 55901
Professor of urology, special interest in impotence and incontinence

Robert Gibbons
Mason Clinic
Seattle, WA 98111

J. Y. Gillenwater
University of Virginia Medical Center
Charlottesville, VA 22908
Chief of urology

Ruben F. Gittes
Brigham and Women's Hospital
Boston, MA 02115
Professor of urological surgery, Harvard; special interest in stones, cancer.

John T. Grayhack
Northwestern Memorial Hospital
Chicago, IL 60611
Professor and chairman, department of urology, Northwestern; special interest in prostate

Donald Griffith
Baylor College of Medicine
Houston, TX 77030
Professor of urology, special interest in stones

Robert Hackler
Medical College of Virginia
Richmond, VA 23298
Associate professor of medicine, special interest in neurogenic bladder problems which are caused by spinal cord injury

Thomas R. Hakala
University of Pittsburgh
Pittsburgh, PA 15261
Professor and chief, department of urological surgery

Frank Hinman, Jr.
University of California
Medical Center
San Francisco, CA 94143
Clinical professor of urology

Joseph J. Kaufman
UCLA Medical Center
Los Angeles, CA 90024
Chief of urology, special interest in incontinence, renal vascular surgery

Warren W. Koontz, Jr.
Medical College of Virginia
Richmond, VA 23298
Professor and chief of urology

Robert Krane
University Hospital
Boston, MA 02118
Associate professor of urology, Boston University; special interest in neurogenic bladder disorders

Bernard Lytton
Yale University Medical School
New Haven, CT 06510
Professor and chief of urology

John H. McGovern
53 East 70th Street
New York, NY 10021
Professor of urology, Cornell

Edward McGuire
University of Michigan Medical School
Ann Arbor, MI 48109
Chairman of urology

J. William McRoberts
University of Kentucky
College of Medicine
Lexington, KY 40506
Professor and chairman of urology

Richard G. Middleton
University of Utah
Medical Center
Salt Lake City, UT 84132
Professor and chairman of urology

Terrence R. Malloy
Pennsylvania Hospital
Philadelphia, PA 19107
Chief of urology

Vincent J. O'Conor, Jr.
Northwestern University
Medical School
Chicago, IL 60611
Professor of urology

Carl Olsson
Columbia-Presbyterian
Medical Center
New York, NY 10032
Professor and chairman, department of urology, special interest in cancer

David F. Paulson
Duke University Medical Center
Durham, NC 27710
Professor of urological surgery, special interest in cancer

Lester Persky
University Hospitals
Cleveland, OH 44106
Professor of urology, Case Western Reserve

Paul C. Peters
University of Texas
Southwestern Medical School
Dallas, TX 75235
Professor and chairman, division of urology, special interest in prostate

Victor A. Politano
Jackson Memorial Hospital
Miami, FL 33136
Professor and chairman of urology, University of Miami

Jerome P. Richie
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Boston, MA 02115
Associate professor of urology, Harvard; special interest in cancer.

DONALD G. SKINNER
Los Angeles County-USC Medical Center
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Chairman of urology; special interest in cancer, reconstructive surgery.

THOMAS A. STAMEY
Stanford Medical Center
Stanford, CA 94305
Professor of surgery, chairman, division of urology. Special interest in infections.

RALPH A. STRAFFON
Cleveland Clinic
Cleveland, OH 44106
Head, department of urology.

DAVID UTZ
Mayo Clinic
Rochester, MN 55901
Special interest in cancer.

E. DARRACOTT VAUGHAN, JR.
New York Hospital-Cornell Medical Center
New York, NY 10021
Professor and chairman of urology.

PATRICK WALSH
Brady Urological Institute
Johns Hopkins Hospital
Baltimore, MD 21205
Professor and chairman of urology; special interest in prostate surgery.

ALAN J. WEIN
University of Pennsylvania
Philadelphia, PA 19104
Professor and chairman of urology; special interest in neurogenic bladder disorders.

WILLET F. WHITEMORE, JR.
Memorial Sloan-Kettering Cancer Center
New York, NY 10021
Professor of surgery, Cornell; special interest in cancer.

LEONARD ZINMAN
Lahey Clinic
Burlington, MA 01803

RHEUMATOLOGISTS

Rheumatologists could accurately be called arthritis specialists because that is the vast share of their medical practice and research. Arthritis is in fact a catch-all term for any one of a number of different bone and joint disorders such as gout, infectious arthritis, ankylosing spondylitis and rheumatoid arthritis, usually the most crippling form of this disease. Other diseases treated by rheumatologists include lupus, more formally known as Systemic Lupus Erythematosus (SLE), a disease of the immune system which usually strikes young women.

ROY D. ALTMAN
University of Miami Medical School
Miami, FL 33101
Associate professor of medicine.

GENE V. BALL
University of Alabama Medical Center
Birmingham, AL 35294
Professor of medicine; head of rheumatology section.

JOHN BAUM
Monroe Community Hospital
Rochester, NY 14603
Professor of medicine and pediatrics, and preventive, family, and rehabilitation medicine, University of Rochester.

GERSON BERNHARD
Medical College of Wisconsin
Milwaukee, WI 53226
Clinical professor of medicine.

PAUL BILKA
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Clinical professor of medicine, University of Minnesota.

WILBUR J. BLECHMAN
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North Miami Beach, FL 33162
Clinical associate professor of medicine, University of Miami.

RODNEY BLUESTONE
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Professor of medicine, UCLA.

GILES BOLE, JR.
University of Michigan Medical Center
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KENNETH BRANDT
University of Indiana Medical Center
Indianapolis, IN 46223
Professor of medicine; chief, arthritis division.

JOHN J. CALABRO
St. Vincent Hospital
Worcester, MA 01604
Professor of medicine and pediatrics, University of Massachusetts.

JACQUES R. CALDWELL
7106 NW 11th Place
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Clinical associate professor of medicine, University of Florida.

ANDREI CALIN
Stanford University Medical Center
Stanford, CA 94305
Associate professor of medicine.

CHARLES L. CHRISTIAN
Hospital for Special Surgery
New York, NY 10021
Physician-in-chief.

ALAN S. COHEN
Thorndike Memorial Laboratory
Boston City Hospital
Boston, MA 02118
Professor of medicine; director of the Thorndike Lab and the Arthritis Center of Boston University School of Medicine.

WILLIAM A. D'ANGELO
Catholic Medical Center
Jamaica, NY 11432
Chief of rheumatology.

JOHN S. DAVIS
University of Virginia Medical Center
Charlottesville, VA 22908
Professor of internal medicine; chief, arthritis unit.

JOHN L. DECKER
National Institutes of Health
Bethesda, MD 20814
Like all care at the NIH, it is free. However, patients must be referred and must fit within the research protocols to qualify for treatment.

RUSSELL DEL TORO
Ashford Medical Center
San Juan, Puerto Rico 00907
Chief, department of medicine, San Juan City Hospital.

HERBERT DIAMOND
Long Island Jewish Hospital
New Hyde Park, NY 11040

EDMUND DUBOIS
435 North Bedford Drive
Beverly Hills, CA 90201
Clinical professor of medicine, director of Lupus Clinic, University of Southern California Medical School.

GEORGE E. EHRLICH
Hahnemann Medical College and Hospital
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Professor of medicine; director, division of rheumatology.

EPHRAIM P. ENGLEMAN
University of California Medical Center
San Francisco, CA 94143
Clinical professor of medicine.

JAMES FRIES
Stanford University Medical Center
Stanford, CA 94305
Associate professor of medicine.

ESTHER GONZALES-PARES
University Hospital
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Director of rheumatic disease section, University of Puerto Rico.

NORTIN M. HADLER
University of North Carolina Medical School
Chapel Hill, NC 27514
Professor of medicine.

BEVRA H. HAHN
UCLA Medical Center
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Chief of rheumatology section.

DAVID HAMERMAN
Montefiore Hospital
Bronx, NY 10467
Chairman, department of geriatrics.

EDWARD D. HARRIS, JR.
New Jersey College of Medicine
Piscataway, NJ 08854
Chief of medicine.

LOUIS A. HEALEY, JR.

ROBERT F. WILLKENS

KENNETH WILSKE
University of Washington Medical School
Seattle, WA 98195
All are on the medical faculty at the University of Washington.

EVELYN V. HESS
University of Cincinnati Medical Center
Cincinnati, OH 45267
McDonald professor of medicine, director, division of immunology.

DAVID S. HOWELL
University of Miami Medical School
Miami, FL 33101
Professor of medicine

GENE G. HUNDER
Mayo Clinic
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THOMAS G. KANTOR
New York University
Medical Center
New York, NY 10016
Director, Rheumatic Disease Study Group; chief, section on clinical therapy

STEPHEN R. KAPLAN
Roger Williams General Hospital
Providence, RI 02908
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E. CARWILE LEROY
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Charleston, SC 29425
Professor of medicine, director, rheumatology and immunology

DANIEL J. MCCARTY, JR.
Medical College of Wisconsin
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Professor and chairman, department of medicine

ALFONSE MASI
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THOMAS A. MEDSGER, JR.
University of Pittsburgh
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Professor of medicine

RONALD P. MESSNER
University of Minnesota Hospitals
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Professor of medicine, director of rheumatology and clinical immunology

ROLAND W. MOSKOWITZ
2073 Abington Road
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DAVID NEUSTADT
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Louisville, KY 40202
Clinical professor of medicine, University of Louisville

WILLIAM O'BRIEN
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Medical Center
Charlottesville, VA 22901
Professor of medicine

J. D. O'DUFFY
Mayo Clinic
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HAROLD E. PAULUS
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Los Angeles, CA 90024
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ROBERT H. PERSELLIN
205 East Evergreen
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PAULDING PHELPS
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CHARLES M. PLOTZ
Downstate Medical Center
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GERALD P. RODNAN
University of Pittsburgh
Medical School
Pittsburgh, PA 15261
Professor of medicine

SANFORD ROTH
St. Luke's Hospital
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NAOMI FOX ROTHFIELD
University of Connecticut
Health Center
Farmington, CT 06032
Professor of medicine, chief, division of rheumatic diseases

EMMANUEL RUDD
Hospital for Special Surgery
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FRANK R. SCHMID
Northwestern University
Medical School
Chicago, IL 60611
Professor of medicine, chief, section on arthritis and connective tissue disease

GORDON C. SHARP
University of Missouri
Medical School
Columbia, MO 65201
Professor of medicine

JOHN SIGLER
Henry Ford Hospital
Detroit, MI 48202
Chief of rheumatology

MARY BETTY STEVENS
Good Samaritan Hospital
Baltimore, MD 21239
Director, rheumatology division; associate professor of medicine, Johns Hopkins

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Arthritis & Back Pain Center, Inc.
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Director of the Center, clinical professor of medicine, UCLA

CHARLES TOURTELOTTE
Temple University Hospital
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Professor of medicine, chairman, rheumatology section

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Philadelphia, PA 19118

STANLEY WALLACE
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JOHN R. WARD
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HOWARD J. WEINBERGER
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COLON WILSON, JR.
Emory University Hospital
Atlanta, GA 30322
Professor of medicine

JACK ZUCKNER
St. Louis University Medical School
St. Louis, MO 63141
Director, arthritis section; professor of clinical medicine

ROBERT ZURIER
Hospital of the University of
Pennsylvania
Philadelphia, PA 19104

NATHAN ZVAIFLER
University Hospital
San Diego, CA 92103
Professor of medicine, University of California

ORTHOPEDIC SURGEONS

Like many other medical specialties, orthopedic surgery has become an area of special concentration. Within the field are these specific interests:

Joint replacement. This involves total replacement of joints with metal and plastic parts, and some specialists concentrate on one joint rather than another.

Fracture treatment. Most broken bones can be set routinely at most hospitals, but in cases of complex or non-healing fractures, the procedure becomes far more difficult.

Spinal surgery. Includes both neck and back spinal surgery.

Bone and soft tissue tumor surgery. The removal of these rare tumors requires very specialized expertise.

Arthritis surgery. Surgery to repair damage caused by arthritis.

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University Hospital
San Diego, CA 92103
Professor of orthopedic surgery, University of California

HARLAN AMSTUTZ
UCLA Medical Center
Los Angeles, CA 90024
Professor and chief of orthopedic surgery, special interest in joint replacement

LEWIS D. ANDERSON
University of Southern Alabama
Medical School
Mobile, AL 36617
Professor and chairman of orthopedic surgery, special interest in fractures

RODNEY K. BEALS
Oregon Health Sciences University
Portland, OR 97201
Professor of orthopedic surgery

CARL T. BRIGHTON
Hospital of the University of
Pennsylvania
Philadelphia, PA 19104
Chairman of orthopedic surgery, special interest in non-union fractures

RICHARD BRYAN
Mayo Clinic
Rochester, MN 55901
Special interest in joint replacement

ROCCO CALANDRUCCIO
Campbell Clinic
Memphis, TN 38103
Professor and chairman of orthopedic

surgery, University of Tennessee; special interest in fractures.

TERRY CANALE
Campbell Clinic
Memphis, TN 38103

MACK L. CLAYTON
Denver Orthopedic Clinic
Denver, CO 80205
Associate clinical professor of orthopedic surgery, University of Colorado; special interest in joint replacement and arthritis surgery.

REGINALD COOPER
University Hospitals
Iowa City, IA 55240
Professor and chairman of orthopedic surgery, University of Iowa; special interest in neuromuscular disorders.

RONALD DEWALD
Rush-Presbyterian-St. Luke's Medical Center
Chicago, IL 60612
Professor of orthopedic surgery, Rush Medical College; special interest in spinal problems.

WILLIAM F. ENNEKING
University of Florida Medical Center
Gainesville, FL 32610
Professor of orthopedic surgery; special interest in bone tumors.

CHARLES H. EPPS, JR.
Howard University Hospital
Washington, DC 20060
Professor and chairman of orthopedic surgery; special interest in fractures.

C. MCCOLLISTER EVARTS
University of Rochester Medical School
Rochester, NY 14627
Chairman of orthopedic surgery; special interest in joint replacement.

ALBERT B. FERGUSON, JR.
University of Pittsburgh Medical School
Pittsburgh, PA 15213
David Silver professor of orthopedic surgery; special interest in joint reconstruction.

J. WILLIAM FIELDING
105 East 65th Street
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Chief of orthopedics, St. Luke's Hospital; special interest in spinal surgery.

F. JAMES FUNK, JR.
105 Collier Road, NW
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JORGE O. GALANTE
Rush Medical College
Chicago, IL 60612
Professor and chairman of orthopedic surgery; special interest in joint replacement.

BRUCE HAPPENSTALL
Hospital of the University of Pennsylvania
Philadelphia, PA 19104
Special interest in fractures.

WILLIAM H. HARRIS
Massachusetts General Hospital
Boston, MA 02114
Special interest in hip replacement.

DAVID HUNGERFORD
Johns Hopkins Hospital
Baltimore, MD 21205
Special interest in knee replacement.

ALLAN E. INGLIS
Hospital for Special Surgery
New York, NY 10021
Special interest in arthritis surgery

JOHN INSALL
Hospital for Special Surgery
New York, NY 10021
Special interest in knee replacement.

PATRICK KELLY
Mayo Clinic
Rochester, MN 55901
Special interest in bone infections.

DONALD B. KETTLEKAMP
Indiana University Medical Center
Indianapolis, IN 46202
Professor and chairman of orthopedic surgery; special interest in arthritis surgery.

JOSEPH LANE
Hospital for Special Surgery
New York, NY 10021
Chief of bone tumor section.

GERALD LAROS
University of Chicago Hospitals
Chicago, IL 60637
Special interest in fractures.

HENRY J. MANKIN
Massachusetts General Hospital
Boston, MA 02114
Edith M. Ashley professor of orthopedic surgery, Harvard; special interest in bone tumors and metabolic bone disease.

DANA MEARS
3601 Fifth Avenue
Pittsburgh, PA 15213
Professor of orthopedic surgery, University of Pittsburgh; special interest in fractures.

EUGENE R. MINDELL
462 Grider Avenue
Buffalo, NY 14215
Professor and head of orthopedic surgery, SUNY; special interest in bone tumors.

WILLIAM R. MURRAY
University of California Medical Center
San Francisco, CA 94143
Professor of orthopedic surgery; special interest in joint replacement.

CHARLES S. NEER II
161 Fort Washington Avenue
New York, NY 10032
Professor of clinical orthopedic surgery, Columbia; special interest in shoulder repair and replacement.

CARL NELSON
University of Arkansas for Medical Sciences
Little Rock, AR 72205
Professor and chairman of orthopedic surgery; special interest in arthritis surgery.

DOUGLAS J. PRITCHARD
Mayo Clinic
Rochester, MN 55901
Special interest in bone tumors.

CHITRANJAN S. RANAWAT
Hospital for Special Surgery
New York, NY 10021
Special interest in joint replacement.

LEE H. RILEY, JR.
Johns Hopkins Hospital
Baltimore, MD 21205
Professor of orthopedic surgery; special interest in joint replacement.

CHARLES A. ROCKWOOD, JR.
University of Texas Medical School
San Antonio, TX 78284
Professor and chairman of orthopedics; special interest in fractures, shoulder problems.

RICHARD ROTHMAN
Hospital of the University of Pennsylvania
Philadelphia, PA 19104
Professor of orthopedic surgery; special interest in lumbar spine, hip surgery.

AUGUSTO SARMIENTO
Los Angeles County-USC Medical Center
Los Angeles, CA 90033
Chairman of orthopedics, special interest in fractures.

CLEMENT B. SLEDGE
Brigham and Women's Hospital
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Chief of orthopedic surgery, special interest in joint replacement.

WAYNE O. SOUTHWICK
Yale-New Haven Hospital
New Haven, CT 06510
Chief of orthopedic surgery; special interest in cervical spine.

LEE RAMSAY STRAUB
Hospital for Special Surgery
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Special interest in joint replacement, arthritis and hand surgery

LLOYD TAYLOR
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Special interest in fractures

ROBY THOMPSON, JR.
University of Minnesota Hospitals
Minneapolis, MN 55455
Professor and chairman of orthopedic surgery; special interest in spinal surgery

ROBERT TOOMS
Campbell Clinic
Memphis, TN 38103
Special interest in arthritis surgery

AUGUSTUS A. WHITE III
Beth Israel Hospital
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Professor of orthopedic surgery, Harvard; special interest in spinal surgery.

THOMAS WHITESIDE
Emory University Hospital
Atlanta, GA 30322
Professor of orthopedic surgery; special interest in spinal surgery and fractures.

ALAN WILDE
Cleveland Clinic
Cleveland, OH 44106
Chairman of orthopedic surgery; special interest in joint replacement.

LEON WILTSE
2888 Long Beach Boulevard
Long Beach, CA 90806
Special interest in lumbar spine.

PHILIP D. WILSON, JR.
Hospital for Special Surgery
New York, NY 10021
Surgeon-in-chief; special interest in hip replacement.

DERMATOLOGISTS

Dermatologists treat skin diseases and many of them also have special interest in certain conditions, such as psoriasis, skin cancer (including melanoma), hair disorders, acne, fungal infections, light sensitivity, pigmentation diseases, and contact dermatitis and eczema. Some dermatologists specialize in dermatopathology, which involves the analysis of skin tissue to determine the nature of the lesion. Dermatopathologists do much of their work in the laboratory, but they do see occasional patients, and are so designated in the listings. Some dermatologists do dermabrasion, or cosmetic dermatology, which removes superficial facial scarring.

BERNARD A. ACKERMAN (dermatopathology)
NYU Medical Center
New York, NY 10016
Professor of dermatology and pathology

PHILIP BAILIN
Cleveland Clinic
Cleveland, OH 44106
Special interest in melanoma

WILMA BERGFELD
Cleveland Clinic
Cleveland, OH 44106
Special interest in hair disorders, melanoma

DAVID R. BICKERS
University Hospitals of Cleveland
Cleveland, OH 44106
Professor and chairman of dermatology, Case-Western Reserve, special interest in light sensitivity

DONALD BIRMINGHAM
Wayne State School of Medicine
Detroit, MI 48201
Professor of dermatology, special interest in contact dermatitis

HARVEY BLANK
University of Miami Medical School
Miami, FL 33101
Professor and chairman of dermatology, special interest in infectious skin disorders

IRWIN M. BRAVERMAN
Yale-New Haven Hospital
New Haven, CT 06510
Professor of dermatology, special interest in psoriasis

THOMAS K. BURNHAM
Henry Ford Hospital
Detroit, MI 48202
Clinical associate professor of dermatology, University of Michigan, special interest in connective tissue diseases of the skin

WILLIAM A. CARO
Northwestern University
Medical School
Chicago, IL 60611
Professor of dermatology

WALLACE H. CLARK (dermatopathology)
University of Pennsylvania
School of Medicine
Philadelphia, PA 19104
Professor of dermatology, pathology

WILLIAM CLENDENNING
Mary Hitchcock Memorial Hospital
Hanover, NH 03755
Clinical professor of medicine, Dartmouth

DAVID L. CRAM
University of California Medical Center
San Francisco, CA 94143
Chief of dermatology clinic, special interest in psoriasis and dermabrasion

LUIS DIAZ
University of Michigan Medical Center
Ann Arbor, MI 48109
Professor of dermatology, special interest in skin immunology disorders

RICHARD DOBSON
Medical University of South Carolina
Charleston, SC 29425
Professor and chairman of dermatology, special interest in dermatitis

ERVIN H. EPSTEIN, SR
400 30th Street
Oakland, CA 94609

JOHN EPSTEIN
450 Sutter Street
San Francisco, CA 94108
Special interest in skin cancer, light sensitivity

MARK ALLEN EVERETT
University of Oklahoma
Health Sciences Center
Oklahoma City, OK 73190
Professor and chairman of dermatology, special interest in skin cancer

EUGENE M. FARBER
Stanford Medical Center
Stanford, CA 94305
Professor and chairman of dermatology, special interest in psoriasis

ROBERT FINE
487 Winn Way
Decatur, GA 30030
Clinical professor of dermatology, Emory

THOMAS FITZPATRICK
Massachusetts General Hospital
Boston, MA 02114
Edmund Wigglesworth professor of dermatology, Harvard, special interest in psoriasis

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LOREN GOLITZ
University of Colorado Health Sciences Center
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Professor of dermatology

ROBERT W. GOLTZ (dermatopathology)
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Minneapolis, MN 55455
Professor and chairman of dermatology

LEONARD HARBER
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Professor and chairman of dermatology, special interest in psoriasis, light sensitivity

E. RICHARD HARRELL, JR
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Clinical professor of dermatology, University of Michigan, special interest in fungal infections

JOHN HASERICK
Pinehurst Medical Center
Pinehurst, NC 28374
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J. TERENCE HEADINGTON (dermatopathology)
University of Michigan Medical Center
Ann Arbor, MI 48109
Professor of dermatology and pathology

J. B. HOWELL
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HARRY J. HURLEY, JR
39 Copley Road
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Professor of dermatology, University of Pennsylvania

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MICHAEL T. JARRATT
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Skin and Cancer Hospital
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Professor of dermatology, Temple

HENRY W. JOLLY, JR
LSU Medical School
Baton Rouge, LA 70112
Head of dermatology

HENRY JONES
Emory University School of Medicine
Atlanta, GA 30322
Professor and chairman of dermatology, special interest in fungal infections

ROBERT E. JORDAN
University of Texas Medical School
Houston, TX 77030
Professor and chairman of dermatology, special interest in immunologic disorders

WILLIAM P. JORDAN, JR
Medical College of Virginia
Richmond, VA 23298
Professor of dermatology, special interest in contact dermatitis, eczema

STEVEN I. KATZ
National Institutes of Health
Building 10
Bethesda, MD 20814
Special interest in immunology, like all NIH care, it is free, but patients must fit the research protocols

JOHN A. KENNEY, JR
Howard University Hospital
Washington, DC 20060
Professor and chairman of dermatology, special interest in pigmentation diseases of black people

JOHN KNOX
Baylor College of Medicine

Houston, TX 77030
Professor and chairman of dermatology; special interest in skin cancer.

ALFRED W. KOPF
NYU Skin and Cancer Hospital
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Professor of dermatology; special interest in skin cancer.

EDWARD KRULL
Henry Ford Hospital
Detroit, MI 48202
Chairman of dermatology; special interest in skin surgery.

AARON B. LERNER
Yale-New Haven Hospital
New Haven, CT 06510
Director of dermatology; special interest in pigmentation disorders.

JAMES J. LEYDEN
Hospital of the University of Pennsylvania
Philadelphia, PA 19104
Special interest in acne.

ALLAN L. LORINCZ
University of Chicago Hospitals
Chicago, IL 60637
Professor of dermatology.

PETER J. LYNCH
University of Arizona Medical Center
Tucson, AZ 85724
Chief of dermatology; special interest in genital skin disorders.

HOWARD MAIBACH
University of California Medical Center
San Francisco, CA 94143
Professor of dermatology; special interest in contact dermatitis.

FRE[illegible]RICK MALKINSON
Rush-Presbyterian-St. Luke's Medical Center
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Chairman of dermatology.

[illegible]ENO MICHEL
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Cleveland, OH 44106
Associate clinical professor of dermatology, Case-Western Reserve; special interest in immunology problems.

MARTIN C. MIHM, JR. (dermatopathology)
Massachusetts General Hospital
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Chief of dermatopathology; special interest in melanoma.

[illegible]MUEL MOSCHELLA
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Special interest in skin cancer.

[illegible]ANK PARKER
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[illegible]N PARRISH
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Boston, MA 02114
Special interest in psoriasis; light sensitivity.

[illegible]OLD PERRY
May[illegible]inic
Rochester, MN 55901
[illegible]rofessor and head of dermatology.

[illegible]R E. POCHI
University Hospital
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Professor of dermatology, Boston University; special interest in acne.

THOMAS PROVOST
Johns Hopkins Hospital
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Professor of dermatology; special interest in immunology.

PERRY ROBINS
NYU Medical Center
New York, NY 10016
Professor of dermatology, special interest in skin cancer.

HENRY H. ROENIGK, JR.
Northwestern University Medical School
Chicago, IL 60611
Professor of dermatology; special interest in psoriasis.

W. MITCHELL SAMS, JR.
University of Alabama Medical Center
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Professor and chairman of dermatology; special interest in light sensitivity, lupus, bullous diseases.

GORDON C. SAUER
6400 Prospect Avenue
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Clinical professor of dermatology, University of Kansas.

WILLIAM F. SCHORR
Marshfield Clinic
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Clinical professor of dermatology, University of Wisconsin.

WALTER B. SHELLEY
University of Illinois Medical School
Peoria, IL 61637
Professor of dermatology.

EDGAR B. SMITH
University of Texas Medical Branch
Galveston, TX 77550
Chairman of dermatology; special interest in fungal infections.

SAM STEGMAN
350 Parnassus Avenue
San Francisco, CA 94117
Special interest in skin surgery.

RICHARD STOUGHTON
University Hospital
San Diego, CA 92103
Professor of medicine, University of California; special interest in psoriasis.

JOHN S. STRAUSS
University Hospitals
Iowa City, IA 52242
Professor and chairman of dermatology, University of Iowa; special interest in acne.

JAMES S. TAYLOR
Cleveland Clinic
Cleveland, OH 44106
Special interest in contact dermatitis.

THEODORE A. TROMOVITCH
350 Parnassus Avenue
San Francisco, CA 94117
Clinical professor of dermatology, University of California; special interest in skin cancer, hair transplants, cosmetic dermatology.

DENNY TUFFANELLI
450 Sutter Street
San Francisco, CA 94108
Clinical professor of dermatology, University of California; special interest in immunology.

EUGENE VAN SCOTT
Skin and Cancer Hospital
Philadelphia, PA 19140
Professor of dermatology, Temple; special interest in skin cancer, psoriasis.

JOHN J. VOOHREES
University of Michigan Medical Center
Ann Arbor, MI 48109
Professor and chairman of dermatology; special interest in psoriasis.

MORRIS WAISMAN
220 Madison Street
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Clinical professor of dermatology and pharmacology, University of South Florida.

PEYTON WEARY
University of Virginia Medical Center
Charlottesville, VA 22904
Professor and chairman of dermatology

HARRY WECHSLER
502 5th Avenue
McKeesport, PA 15132
Clinical professor of dermatology, University of Pittsburgh.

GERALD D. WEINSTEIN
University of California Medical School
Irvine, CA 92717
Professor and chairman of dermatology; special interest in psoriasis, skin cancer

WILLIAM WESTON
University of Colorado Medical Center
Denver, CO 80220
Chairman of dermatology; special interest in immunology.

CLAYTON WHEELER, JR.
North Carolina University Memorial Hospital
Chapel Hill, NC 27514
Professor and chairman of dermatology; special interest in infections.

ISAAC WILLIS
Northwest Medical Center
3280 Howell Mill Road, NW
Atlanta, GA 30327
Professor of dermatology, Emory; special interest in light sensitivity, skin cancer

PLASTIC SURGEONS

There are two different areas of plastic surgery. One is reconstructive surgery which involves the repair of injuries, burns, congenital defects and repair of scars after cancer surgery. The second is aesthetic plastic surgery, which involves the beautifying of features. Most all of the plastic surgeons listed here do both, but some concentrate on one area more than the other.

THOMAS J. BAKER, JR.
1501 South Miami Avenue
Miami, FL 33129
An aesthetic plastic surgeon.

MILTON T. EDGERTON
University of Virginia Medical Center
Charlottesville, VA 22908
Professor and chairman of plastic sur-

gery; special interest in cranial and facial reconstruction.

NICHOLAS G. GEORGIADE
Duke University Medical Center
Durham, NC 27710
Chairman and professor of plastic, maxillofacial and oral surgery, special interest in aesthetic, facial and breast reconstruction.

V. MICHAEL HOGAN
799 Park Avenue
New York, NY 10021
Associate professor of plastic surgery, NYU.

JOHN E. HOOPES
Johns Hopkins Hospital
Baltimore, MD 21205
Professor and head of plastic surgery.

NORMAN E. HUGO
Columbia-Presbyterian Medical Center
New York, NY 10032
Chief of plastic surgery

M. J. JURKIEWICZ
Emory Affiliated Hospitals
Atlanta, GA 30308
Chief of plastic and reconstructive surgery, special interest in head and neck surgery

JOHN R. LEWIS, JR.
3316 Piedmont Road, NE
Atlanta, GA 30305
Special interest in aesthetic surgery.

WILLIAM K. LINDSAY
Hospital for Sick Children
Toronto, Ontario
Canada M5G 1X8
Special interest in repairing birth defects.

JOSEPH MCCARTHY
NYU Medical Center
New York, NY 10021
Special interest in cranial reconstruction.

D. RALPH MILLARD
1444 NW 14th Avenue
Miami, FL 33125
Chief of plastic surgery, University of Miami

TIMOTHY MILLER
UCLA Medical Center
Los Angeles, CA 90024
Professor of plastic surgery, special interest in lymphedema, a lymphatic condition causing excessive leg swelling

JOSEPH E. MURRAY
Brigham and Women's Hospital
Boston, MA 02115
Professor of surgery, Harvard. Special interest in head and neck surgery

REX PETERSON
2525 East Arizona Biltmore Circle
Phoenix, AZ 85016
Special interest in aesthetic work

PETER RANDALL
Hospital of the University of Pennsylvania
Philadelphia, PA 19104
Chief of plastic surgery; special interest in birth defects, cleft lip and palate.

THOMAS D. REES
176 East 72nd Street
New York, NY 10021
Professor of clinical plastic surgery, NYU; special interest in aesthetic surgery.

RONALD RIEFKOHL
Duke University Medical Center
Durham, NC 27710
Special interest in aesthetic surgery.

JACK H. SHEEN
9201 Sunset Boulevard
Los Angeles, CA 90069
Associate clinical professor of plastic surgery, UCLA; special interest in aesthetic, surgery, noses and eyelids.

MELVIN SPIRA
Baylor College of Medicine
Houston, TX 77030
Professor and head of plastic surgery; special interest in jaw and mouth.

RICHARD STARK
115 East 67th Street
New York, NY 10021
Professor of clinical surgery, Columbia; special interest in aesthetic, cleft palate.

HUGH THOMPSON
Hospital for Sick Children
Toronto, Ontario
Canada M5G 1X8
Special interest in repairs of congenital defects, especially hands.

LUIS VASCONEZ
University of California Medical Center
San Francisco, CA 94143
Director of plastic surgery.

JOHN E. WOODS
Mayo Clinic
Rochester, MN 55901
Special interest in head and neck reconstruction.

HARVEY A. ZAREM
UCLA Medical Center
Los Angeles, CA 90024
Professor of surgery; chief of plastic surgery division.

REPRODUCTIVE ENDOCRINOLOGISTS

The specialty of reproductive endocrinology deals mostly with the problems of infertility among women.

What defines infertility? If a couple attempts to have a child for a period of a year and the female does not become pregnant, physicians consider this a sign that there may be a problem with conception. In the majority of cases the problem is with the woman; however in 30 to 40 percent of the cases, the problem is with the male. Unfortunately, there is generally less that can be done to correct the problem with the male. Urologists generally treat male infertility problems.

When reproductive endocrinologists are not dealing with problems of infertility, they also consult on menstrual problems and problems such as hair growth on women, as well as other gynecological problems.

SEZER AKSEL
University of Southern
Alabama Medical School
Mobile, AL 36617
Professor of obstetrics and gynecology.

ALAN BEER
University of Michigan
Medical Center
Ann Arbor, MI 48109
Professor and chairman of obstetrics and gynecology.

S. JAN BEHRMAN
William Beaumont Hospital
Royal Oak, MI 48072
Professor of obstetrics and gynecology, Wayne State.

B. JEFFREY CHANG
UCLA Medical School
Los Angeles, CA 90024
Professor of obstetrics and gynecology.

C.D. CHRISTIAN
University of Arizona
Medical Center
Tucson, AZ 85724
Professor and chairman of obstetrics and gynecology.

MELVIN R. COHEN
Fertility Institute Ltd.
333 East Superior Street
Chicago, IL 60611
Director of institute; professor of obstetrics and gynecology, Northwestern.

VAL DAVAJAN
Los Angeles County-USC
Medical Center
Los Angeles, CA 90033
Professor of obstetrics and gynecology

ALAN DECHERNEY
Yale-New Haven Hospital
New Haven, CT 06510

WILLIAM J. DIGNAM
UCLA Medical Center
Los Angeles, CA 90024
Professor of obstetrics and gynecology

CELSO-RAMON GARCIA
Hospital of the University
of Pennsylvania
Philadelphia, PA 19104
William S. Shippen, Jr., professor of reproduction; director, division of human reproduction.

CHARLES B. HAMMOND
Duke University Medical Center
Durham, NC 27710
E.C. Hamblen professor of obstetrics and gynecology; chairman of the department.

ROBERT JAFFE
University of California
Medical Center
San Francisco, CA 94143
Professor of obstetrics and gynecology.

HOWARD L. JUDD
UCLA Medical Center
Los Angeles, CA 90024
Professor of obstetrics and gynecology; chief, division of reproductive endocrinology

NATHAN G. KASE
Mt. Sinai Medical Center
New York, NY 10029
Professor of obstetrics and gynecology

MOON H. KIM
University Hospital
Columbus, OH 43210
Professor of obstetrics and gynecology, Ohio State.

WILLIAM LEMAIRE
University of Miami
Medical School

Miami, FL 33101
Professor of obstetrics and gynecology.

A. Brian Little
Royal Victoria Hospital
Montreal, Quebec
Canada H3A 1A1
Associate professor and chairman of obstetrics and gynecology, McGill.

Paul C. MacDonald
University of Texas
Southwestern Medical School
Dallas, TX 75235
Professor of obstetrics and gynecology.

John Marshall
Harbor-UCLA Medical Center
Torrance, CA 90509
Chairman of obstetrics and gynecology.

Luigi Mastroianni, Jr.
Hospital of the University
of Pennsylvania
Philadelphia, PA 19104
Professor and chairman, department of obstetrics and gynecology.

Paul G. McDonough
Medical College of Georgia
Augusta, GA 30902
Professor of obstetrics and gynecology

Daniel R. Mishell, Jr.
Los Angeles County-USC
Medical Center
Los Angeles, CA 90033
Professor and chairman of obstetrics and gynecology.

Kamran S. Moghissi
Wayne State
School of Medicine
Detroit, MI 48201
Professor of obstetrics and gynecology; chief, division of reproductive endocrinology and infertility

Robert Nachtigall
490 Post Street
San Francisco, CA 94102

Frederick Naftolin
Yale University Medical School
New Haven, CT 06510
Professor and chairman of obstetrics and gynecology.

Kenneth Ryan
Brigham and Women's Hospital
Boston, MA 02115
Professor of obstetrics and gynecology, Harvard.

Antonio Scommegna
Michael Reese Hospital and
Medical Center
Chicago, IL 60616
Professor of obstetrics and gynecology, University of Chicago.

Leon Speroff
Case-Western Reserve
Cleveland, OH 44106
Professor and chairman of gynecology.

Sergio C. Stone
University of California at
Irvine Medical Center
Orange, CA 92668
Director, department of reproductive endocrinology and infertility.

George Tagatz
University of Minnesota Hospitals
Minneapolis, MN 55455
Professor of obstetrics and gynecology.

Luther Talbert
University of North Carolina
Medical School
Chapel Hill, NC 27514
Professor of obstetrics and gynecology.

Edward E. Wallach
Hospital of the University of
Pennsylvania
Philadelphia, PA 19104
Professor of obstetrics and gynecology.

James C. Warren
4911 Barnes Hospital Plaza
St. Louis, MO 63110
Chairman of obstetrics and gynecology, Washington University.

Samuel S.C. Yen
University of California
Medical School
La Jolla, CA 92093
Chairman of reproductive medicine.

HIGH-RISK PREGNANCY SPECIALISTS

Over the past several years, advances in this specialty have permitted more and more women to have healthy babies, while at the same time increasing their chances of remaining healthy. Such problems as toxemia, diabetes, early labor, and hemolytic diseases (RH disease) no longer prevent women from bearing children.

Tom Barden
University of Cincinnati
Medical Center
Cincinnati, OH 45267
Professor of obstetrics and gynecology.

Watson A. Bowes, Jr.
University of North Carolina
Medical School
Chapel Hill, NC 27514
Professor of obstetrics and gynecology.

Marion Carlyle Crenshaw, Jr.
University of Maryland Hospital
Baltimore, MD 21201
Professor and chairman of obstetrics and gynecology.

Thomas Dillon
St. Luke's-Roosevelt
Hospital Center
New York, NY 10019
Professor of obstetrics and gynecology, Columbia.

Preston Dilts, Jr.
University of Tennessee
College of Medicine
Memphis, TN 38163
Professor and chairman of obstetrics and gynecology.

Roger K. Freeman
University of California at
Irvine Medical Center
Orange, CA 92668
Professor of obstetrics and gynecology.

Emanuel Friedman
Beth Israel Hospital
Boston, MA 02215
Professor of obstetrics and gynecology, Harvard; special interest in abnormal labor.

Frederic D. Frigoletto, Jr.
Brigham and Women's Hospital
Boston, MA 02115
Professor of obstetrics and gynecology, Harvard.

Steven G. Gabbe
Hospital of the University
of Pennsylvania
Philadelphia, PA 19104
Director, Jerrold R. Golding division of fetal medicine.

Guy M. Harbert, Jr.
University of Virginia
Medical Center
Charlottesville, VA 22901
Professor of obstetrics and gynecology.

John Hobbins
Yale University Medical School
New Haven, CT 06510
Professor of obstetrics and gynecology.

Calvin Hobel
UCLA Medical Center
Los Angeles, CA 90024
Professor of obstetrics and gynecology

John W. C. Johnson
University of Florida
Medical Center
Gainesville, FL 32610
Professor of obstetrics and gynecology

William J. Ledger
New York Hospital-Cornell
Medical Center
New York, NY 10021
Professor and chairman, department of obstetrics and gynecology, Cornell; special interest in gynecologic infections.

William A. Little
University of Miami Medical School
Miami, FL 33152
Professor and chairman of obstetrics and gynecology.

John Morrison
University of Mississippi
Medical Center
Jackson, MS 39216
Professor of obstetrics and gynecology.

Jennifer Niebyl
Johns Hopkins Hospital
Baltimore, MD 21205
Associate professor of obstetrics and gynecology.

M. L. Pernoll
Tulane University School
of Medicine
New Orleans, LA 70112
Professor and chairman of obstetrics and gynecology.

Roy M. Pitkin
University Hospital
Iowa City, IA 52242
Professor and chairman of obstetrics and gynecology, University of Iowa.

Jack A. Pritchard
University of Texas
Southwestern Medical School
Dallas, TX 75235
Gillette professor of obstetrics and gynecology.

John Queenan
Georgetown University Hospital
Washington, DC 20007
Professor and chairman, obstetrics and

gynecology; special interest in RH diseases.

Edward J. Quilligan
University of Wisconsin
Clinical Science Center
Madison, WI 53792
Professor and chairman of obstetrics and gynecology. University of Wisconsin.

Robert Resnik
University of California
Medical Center
San Diego, CA 92103
Professor and chairman of obstetrics and gynecology.

John J. Schruefer
Georgetown University Hospital
Washington, DC 20007
Professor of obstetrics and gynecology.

Richard H. Schwarz
Downstate Medical Center
Brooklyn, NY 11230
Professor and chairman of obstetrics and gynecology.

James Scott
University of Utah
Medical Center
Salt Lake City, UT 84132
Professor and chairman of obstetrics and gynecology.

William Spellacy
University of Illinois
Medical Center
Chicago, IL 60612
Professor and chairman of obstetrics and gynecology.

Alan Weingold
George Washington University
Medical Center
Washington, DC 20007
Professor and chairman of obstetrics and gynecology.

Frederick P. Zuspan
University Hospital
Columbus, OH 43210
Professor and chairman of obstetrics and gynecology, Ohio State, special interest in toxemia.

PAIN CENTERS

Pain centers are a relatively new addition to medical care, largely because pain has always been considered a symptom of a problem, not the problem itself. That has now changed and these centers treat pain with a variety of techniques including nerve blocks, biofeedback, electric current, hypnosis and steroid injections. These centers also bring a multi-disciplinary approach to diagnosis and treatment by including neurologists, anesthesiologists, neurosurgeons, psychiatrists and other specialists.

John Adams
Yoshio Hosobuchi
Pain Clinic
University of California Hospital
San Francisco, CA 94122

Gerald Aronoff
Boston Pain Unit
Massachusetts Rehabilitation Hospital
Boston, MA 02114

Steven F. Brena
Emory Pain Control Center
Atlanta, GA 30322

Charles Burton
Charles Ray
Sister Kenny Institute
Minneapolis, MN 55407

Harold Carron
Pain Clinic
University of Virginia Medical Center
Charlottesville, VA 22903

Benjamin Crue, Jr.
New Hope Pain Center
100 South Raymond Avenue
Alhambra, CA 91801

Edith Kepes
Norman Marcus
Pain Treatment Center
Montefiore Hospital
and Medical Center
Bronx, NY 10467

Donlin Long
Pain Treatment Center
Johns Hopkins Hospital
Baltimore, MD 21205

Toshi Maruta
Pain Management Center
Mayo Clinic
Rochester, MN 55901
An inpatient clinic.

Richard Morse
Pain Control Center
Touro Hospital
New Orleans, LA 70115

Terence Murphy
Pain Clinic
University of Washington
Medical Center
Seattle, WA 98195

Ivan G. Podobnikar
Ohio Pain & Stress Center
1460 W. Lane Avenue
Columbus, OH 43221
An outpatient center.

Hubert L. Rosomoff
Comprehensive Pain Center
University of Miami Medical School
Miami, FL 33136

Joel Seres
Northwest Pain Center
10615 SE Cherry Blossom Drive
Portland, OR 97216

Frank Skultety
Bradley Berman
Nebraska Pain Management Center
University of Nebraska
College of Medicine
Omaha, NB 68105

Richard Sternbach
Pain Treatment Center
Scripps Clinic
La Jolla, CA 92037

Josef K. Wang
Pain Clinic
Mayo Clinic
Rochester, MN 55901
An outpatient clinic.

Alon P. Winnie
Pain Clinic
University of Illinois
College of Medicine
Chicago, IL 60612

OUTSTANDING HOSPITALS & CLINICS

Although it is generally agreed that the choice of a physician is probably more important than your choice of hospital, good hospitals provide the depth of staff in all areas, from nursing to dietary, that improve your chances for good care. It is widely agreed that teaching hospitals offer superior medical care. Here are some guidelines.

- They should have at least 400 beds because this will likely mean a wealth of staff people who may be needed to consult on your problem.
- The hospital should be affiliated with a medical school.
- The hospital should be accredited by the Joint Committee on Hospital Accreditation (JCHA). This is a minimum requirement.

Hospitals

Barnes Hospital
St. Louis, MO
Affiliated with Washington University.

Beth Israel Hospital
Boston, MA
Affiliated with Harvard.

Brigham and Women's Hospital
Boston, MA
Affiliated with Harvard.

Columbia-Presbyterian Medical Center
New York, NY
Affiliated with Columbia.

Duke University Medical Center
Durham, NC
Affiliated with Duke University.

Hospital of the University of Pennsylvania
Philadelphia, PA
The major teaching hospital for the University of Pennsylvania.

Johns Hopkins Hospital
Baltimore, MD
Affiliated with Johns Hopkins University.

Massachusetts General Hospital
Boston, MA
The major teaching hospital in the Harvard system.

Mt. Sinai Medical Center
New York, NY
The major teaching hospital for Mt. Sinai Medical School.

New York Hospital-Cornell Medical Center
New York, NY
Cornell's major teaching hospital.

Stanford Medical Center
Stanford, CA
Affiliated with Stanford University.

Strong Memorial Hospital
Rochester, NY
Affiliated with University of Rochester.

UCLA Medical Center
Los Angeles, CA
UCLA's major teaching hospital.

University of California Medical Center

San Francisco, CA
The major teaching hospital for the University of California.

University of Chicago Hospitals
Chicago, IL
The major teaching hospital for University of Chicago.

University of Michigan Medical Center
Ann Arbor, MI
The major teaching hospital for University of Michigan.

University of Minnesota Hospitals
Minneapolis, MN
The major teaching hospitals for the University of Minnesota.

University of Washington Medical Center
Seattle, WA
The major teaching hospital for University of Washington.

Yale-New Haven Hospital
New Haven, CT
The major teaching hospital for Yale.

Clinics

Cleveland Clinic
Cleveland, OH

Emory University Clinic
Atlanta, GA

Lahey Clinic
Burlington, MA

Mayo Clinic
Rochester, MN
A private clinic which now has its own graduate school of medicine.

Ochsner Clinic
New Orleans, LA

Scripps Clinic
La Jolla, CA
A small clinic but considered excellent.

SLEEP DISORDER CENTERS

Sleep centers seek to diagnose and treat the more serious sleep disorders, from chronic insomnia, nightmares, restless leg syndrome, sleep apnea to night terrors. These centers also treat people who've become dependent on sleeping pills—which usually worsen insomnia—and offer a wide range of therapies for different sleep problems.

Richard P. Allen, Ph.D.
Philip C. Smith, M.D.
Sleep Disorders Center
Baltimore City Hospital
Baltimore, MD 21224

Roger Broughton
Ottawa General Hospital
Ottawa, Ontario K1H 8L6

Rosalind Cartwright, Ph.D.
Sleep Disorders Clinic
Rush-Presbyterian-St. Luke's Medical Center
Chicago, IL 60612

Martin Cohn
Sleep Disorder Unit
Mt. Sinai Hospital
Miami Beach, FL 33140

William Dement
Sleep Disorder Clinic
Stanford University Medical Center
Stanford, CA 94305

Milton G. Ettinger
Sleep Disorders Center
Hennepin County Medical Center
Minneapolis, MN 55415

Peter Hauri, Ph.D.
Sleep Disorders Center
Dartmouth Medical School
Hanover, NH 03756

Milton Kramer
Sleep Disorders Center
University of Mississippi Medical Center
Jackson, MS 39216

David Kupfer
Western Psychiatric Institute
3811 O'Hara Street
Pittsburgh, PA 15261

Helio Lemmi
BMH Sleep Disorders Center
Baptist Memorial Hospital
Memphis, TN 38146

Merrill Mitler
Sleep Disorders Center
Scripps Clinic
La Jolla, CA 92307

William Orr, Ph.D.
Sleep Disorders Center
Presbyterian Hospital
Oklahoma City, OK 73104

Elliott Phillips
Sleep Disorders Center
Holy Cross Hospital
Mission Hills, CA 91345

Charles Pollak
Sleep-Wake Disorder Center
New York Hospital-Cornell Medical Center
White Plains, NY 10605

Gerald B. Rich
Sleep Disorders Program
Good Samaritan Hospital
Portland, OR 97210

Thomas Roth
Sleep Disorders and Research Center
Henry Ford Hospital
Detroit, MI 48202

Helmut S. Schmidt
Sleep Disorders Center
Ohio State University Hospital
Columbus, OH 43210

Michael J. Thorpy
Sleep-Wake Disorder Unit
Montefiore Hospital
Bronx, NY 10467

CANCER & BLOOD DISEASES

Cancer and blood diseases are linked because hematologists often specialize in oncology, which involves cancer chemotherapy. Because of the type of disease it is, cancer often requires the help of several different specialists, from surgeons to radiation therapists. This section includes the different types of cancer specialists.

Hematologists and Oncologists who have an interest in one specialty over the other will be so designated. However, most all practice both of these areas, treating non-cancer blood diseases as well as prescribing chemotherapy for cancer patients.

Radiation Oncologists specialize in radiation treatment of cancer.

Surgical Oncologists specialize in cancer surgery. Many have special interest in certain cancers, such as melanoma or breast cancer. Also, surgeons in other specialties sometimes have interests in certain types of cancers and they are so designated.

Gynecological Cancer Specialists concentrate on cancers of the female reproductive system.

Adult Hematologists & Oncologists

Raymond Alexanian (oncology)
M.D. Anderson Hospital and Tumor Institute
Houston, TX 77025
Professor of medicine, University of Texas Graduate School, special interest in myeloma.

Tom Anderson (oncology)
Medical College of Wisconsin
Milwaukee, WI 53226
Head, section on hematology oncology, Milwaukee General Hospital.

John Athens (hematology)
University of Utah Medical Center
Salt Lake City, UT 84112
Chief of hematology-oncology.

Daniel Bergsagel (oncology)
Ontario Cancer Institute
Princess Margaret Hospital
Toronto, Ontario
Canada M4X 1K9
Chief of medicine, University of Toronto; interest in myeloma and lymphomas.

Joseph R. Bertino (oncology)
Yale University Medical School
New Haven, CT 06510
Professor of medicine; special interest in leukemia, lymphomas, breast, and head and neck cancers.

John Bertles (hematology)
St. Luke's Hospital Center
New York, NY 10025
Professor of medicine, Columbia. Noted for his work with abnormal hemoglobin and sickle cell anemia.

Ernest Beutler (hematology)
Scripps Clinic and Research Foundation
La Jolla, CA 92037
Noted for his work with anemias.

Clara Derber Bloomfield (oncology)
University of Minnesota Hospitals
Minneapolis, MN 55455
Professor of medicine; special interest in leukemia and lymphomas.

Franklin Bunn (hematology)
Brigham and Women's Hospital
Boston, MA 02115
Director, hematology research; professor of medicine, Harvard.

George P. Canellos (oncology)
Sidney Farber Cancer Institute

Boston, MA 02115
Associate professor of medicine, Harvard; special interest in chronic leukemia, lymphomas and breast cancer.

Peter Cassileth (oncology)
University of Pennsylvania
Medical School
Philadelphia, PA 19104
Professor of medicine, special interest in leukemia

Samuel Charache (hematology)
Johns Hopkins Hospital
Baltimore, MD 21205
Professor of medicine, special interest in hemoglobin disorders, including sickle cell anemia

Paul Chervenick (hematology)
University of Pittsburgh
Medical School
Pittsburgh, PA 15213
Professor of medicine, noted for his work in white cell problems

Bayard Clarkson (oncology)
Memorial Sloan-Kettering
Cancer Center
New York, NY 10021
Special interest in acute leukemia

Marcel E. Conrad, Jr (hematology)
University of Alabama Medical Center
Birmingham, AL 35294
Professor of medicine, director, division of hematology and oncology; special interest in anemia

Richard Cooper (oncology)
85 High Street
Buffalo, NY 14203
Associate clinical professor of medicine, State University of New York; special interest in breast cancer.

Richard A. Cooper (hematology)
University of Pennsylvania
Medical School
Philadelphia, PA 19104
Professor of medicine, noted for his special interest in red cell problems

Jane F. Desforges (hematology)
Tufts-New England Medical Center
Boston, MA 02111
Professor of medicine

Thomas Duffy (hematology)
Yale University Medical School
New Haven, CT 06510
Professor of medicine

John Durant (oncology)
University of Alabama Medical Center
Birmingham, AL 35294
Director of the Comprehensive Cancer Center.

Rose Ruth Ellison (oncology)
Columbia-Presbyterian
Medical Center
New York, NY 10032
Professor of medicine, chief, oncology division; special interest in leukemia

Emil Frei III (oncology)
Sidney Farber Cancer Institute
Boston,MA 02115
Professor of medicine, Harvard; special interest in leukemia and lymphomas.

Emil J. Freireich (oncology)
M.D. Anderson Hospital
and Tumor Institute
Houston, TX 77025
Professor of medicine, University of Texas; special interest in leukemia and lymphomas

Eugene P. Frenkel (hematology)
University of Texas
Southwestern Medical School
Dallas, TX 75235
Professor of internal medicine, special interest in pernicious anemia.

John Glick (oncology)
University of Pennsylvania
Medical School
Philadelphia, PA 19104
Associate professor of medicine

Ezra Greenspan (oncology)
1045 Fifth Avenue
New York, NY 10028
Chief of oncology/hematology, Mt. Sinai Medical Center, clinical professor of medicine, Mt. Sinai Medical School.

Donald Harkness (hematology)
Clinical Science Center
Madison, WI 53792
Professor of medicine, University of Wisconsin; special interest in anemia

William J. Harrington (hematology)
University of Miami Medical School
Miami, FL 33101
Professor and chairman, department of medicine, special interest in immune disorders.

Robert C. Hartmann (hematology)
University of South Florida
Tampa, FL 33620
Professor of medicine, special interest in anemia. Director of the section on hematology and oncology

Paul Heller (hematology)
University of Illinois Medical School
Chicago, IL 60612
Professor of medicine, special interest in anemia

Edward Henderson (oncology)
666 Elm Street
Buffalo, NY 14263
Research professor of medicine, State University of New York; special interest in leukemia

James F. Holland (oncology)
Mt. Sinai Medical Center
New York, NY 10029
Director of the Cancer Center; special interest in leukemia, carcinomas and sarcomas

Harry S. Jacob (hematology)
University of Minnesota Hospitals
Minneapolis, MN 55455
Professor of medicine; special interest in anemia

Wallace N. Jensen (hematology)
Albany Medical College
Albany, NY 12208
Professor and chairman, department of medicine; special interest in anemia.

Manuel E. Kaplan (hematology)
University of Minnesota Hospitals
Minneapolis, MN 55455
Professor of medicine; special interest in anemia and immunohematology

B. J. Kennedy (oncology)
University of Minnesota Hospitals
Minneapolis, MN 55455
Masonic professor of medicine, special interest in breast and testicular cancers and leukemia

Robert Kyle (oncology)
Mayo Clinic
Rochester, MN 55901
Noted for his interest in myeloma as well as general hematological problems

Burton Lee III (oncology)
Memorial Sloan-Kettering
Cancer Center
New York, NY 10021
Special interest in myeloma

Lawrence S. Lessin (hematology)
George Washington University
Hospital
Washington, DC 20037
Professor of medicine and pathology, special interest in anemia

Virgil Loeb, Jr. (oncology)
4989 Barnes Hospital Plaza
St. Louis, MO 63110
Professor of clinical medicine, Washington University; special interest in leukemia and lymphomas.

Charles Mengel (hematology)
University of Missouri
Medical Center
Columbia, MO 65212
A special interest in anemia

Elliott F. Osserman (oncology)
Health Sciences Center
701 West 168th Street
New York, NY 10032
Professor of medicine, Columbia; special interest in myeloma.

John C. Parker (hematology)
University of North Carolina
Medical School
Chapel Hill, NC 27514
Professor of medicine and biochemistry

Harold Roberts (hematology)
University of North Carolina
Medical School
Chapel Hill, NC 27514
Known for his interest in coagulation disorders

Saul A. Rosenberg (oncology)
Stanford University Medical Center
Stanford, CA 94305
Professor of medicine and radiology; special interest in lymphomas and Hodgkin's disease. Researchers at Stanford did much pioneering work in treatment of Hodgkin's disease and lymphomas, both in oncology and radiology

Wendell Rosse (hematology)
Duke University Medical Center
Durham, NC 27710
Chief of hematology; special interest in immunological problems

Sydney Salmon (oncology)
University of Arizona Health
Sciences Center
Tucson, AZ 85724
Director of the Cancer Center; special interest in myeloma

Philip Schein (oncology)
Vincent Lombardi Cancer Center
Georgetown University Hospital
Washington, DC 20007

Special interest in cancers of the digestive system.

Robert Silber (hematology)
NYU Medical Center
New York, NY 10016
Director, division of hematology/oncology.

Harold R. Silberman (hematology)
Duke University Medical Center
Durham, NC 27710
Professor of medicine.

Marvin J. Stone (oncology)
Baylor University Medical Center
Dallas, TX 75246
Chief of oncology; clinical professor of internal medicine, University of Texas.

John E. Ultmann (oncology)
University of Chicago Hospitals
Chicago, IL 60057
Director of the Cancer Center; special interest in Hodgkin's disease and lymphomas.

William Valentine (hematology)
UCLA Medical Center
Los Angeles, CA 90024
Professor of medicine.

Edward Viner (oncology)
Pennsylvania Hospital
Philadelphia, PA 19107
Clinical professor of medicine, University of Pennsylvania; special interest in lymphomas.

Ralph O. Wallerstein (hematology)
3838 California Street
San Francisco, CA 94118
Clinical professor of medicine, University of California; special interest in anemia.

Irwin Weinstein (hematology)
8635 West Third Street
Los Angeles, CA 90048
Clinical professor of medicine, UCLA.

Harvey Weiss (hematology)
St. Luke's-Roosevelt Hospital
New York, NY 10019
Professor of medicine, Columbia; special interest in coagulation problems.

William J. Williams (hematology)
State University of New York
Syracuse, NY 13210
Edward C. Reifenstein professor and chairman of medicine; special interest in coagulation problems.

Robert C. Young

Eli Gladstein
National Cancer Institute
Building 10
National Institutes of Health
Bethesda, MD 20014
Noted for ovarian cancer, lymphoma and Hodgkin's disease treatment. Like all National Institutes of Health care, there is no charge. However, in order to be accepted for treatment, you must be referred by a physician and you must meet the established National Institutes of Health research protocols.

Ralph Zalusky (hematology)
Beth Israel Medical Center
New York, NY 10003
Chief, division of hematology/oncology; professor of medicine, Mt. Sinai Medical School.

Radiation Oncologists

Malcolm A. Bagshaw
Stanford Medical Center
Stanford, CA 94305
Professor and chairman of radiology.

Luther W. Brady, Jr.
Hahnemann Medical College
Philadelphia, PA 19102
Professor and chairman of radiation oncology.

Raymond Bush
Ontario Cancer Institute
Princess Margaret Hospital
Toronto, Ontario
Canada M4X 1K9

Chu H. Chang
Columbia-Presbyterian Medical Center
New York, NY 10032
Director of radiation therapy.

Don Goffinet
Stanford University Hospital
Stanford, CA 94305
Associate professor of radiology.

Melvin L. Griem
University of Chicago Hospitals
Chicago, IL 60637
Professor of radiology.

Samuel Hellman
Memorial Sloan-Kettering
Cancer Center
New York, NY 10021
Chief of staff.

Frank Hendrickson
Rush-Presbyterian-St. Luke's
Medical Center
Chicago, IL 60612
Professor of radiation therapy, Rush Medical College.

Henry S. Kaplan
Stanford University Hospital
Stanford, CA 94305
Professor of radiology; did pioneer work in radiation treatment for cancer.

Simon Kramer
Thomas Jefferson University Hospital
Philadelphia, PA 19107

Seymour Levitt
University of Minnesota Hospitals
Minneapolis, MN 55455
Professor and chairman of therapeutic radiology.

Rodney Million
University of Florida Medical Center
Gainesville, FL 32610
Professor and chairman of radiology.

William Moss
Oregon Health Sciences University
Portland, OR 97201
Professor and chairman of radiology.

Stanley Order
Johns Hopkins Hospital
Baltimore, MD 21205
Professor and chairman of radiation oncology.

Robert G. Parker
UCLA Medical Center
Los Angeles, CA 90024
Professor of radiology.

Carlos A. Perez
Mallinckrodt Institute of Radiology
St. Louis, MO 63110
Professor of radiology, Washington University.

Ruheri Perez-Tamayo
Loyola University Hospital
Maywood, IL 60153
Professor and chairman of radiology.

Lester Peters
M.D. Anderson Hospital and
Tumor Institute
Houston, TX 77030
Head of radiation oncology.

Theodore L. Phillips
University of California Medical Center
San Francisco, CA 94143
Head of radiation oncology.

Marvin Rotman
Downstate Medical Center
Brooklyn, NY 11203
Professor and chairman of radiology.

Philip Rubin
Strong Memorial Hospital
Rochester, NY 14642
Chairman of radiation oncology, University of Rochester.

Glenn E. Sheline
University of California Medical Center
San Francisco, CA 94143
Professor of radiology.

J. Robert Stewart
University of Utah Medical Center
Salt Lake City, UT 84132
Director of radiation therapy.

Herman Suit
Massachusetts General Hospital
Boston, MA 02114
Chief of radiation medicine.

Jerome Vaeth
St. Mary's Hospital and Medical Center
San Francisco, CA 94117
Chief of radiation oncology.

C. C. Wang
Massachusetts General Hospital
Boston, MA 02114
Professor of radiology, Harvard.

Surgical Oncologists

Harvey W. Baker
2222 NW Lovejoy Street
Portland, OR 97210
Clinical professor of surgery, University of Oregon.

R. Robinson Baker
Johns Hopkins Hospital
Baltimore, MD 21205
Director of the breast clinic; professor of surgery and oncology.

Blake Cady
Lahey Clinic
Burlington, MA 01803
Special interest in breast cancer.

Avram Cooperman
18 East 82nd Street
New York, NY 10028
Professor of surgery, New York Medical College.

T. K. DasGupta
University of Illinois
Oncology Clinic
Chicago, IL 60612
Head of surgical oncology.

Memorial Sloan-Kettering
Cancer Center
New York, NY 10021
Chairman of surgery; special interest in GI cancer.

Frederick Eilber
UCLA Medical Center
Los Angeles, CA 90024
Professor of surgery; special interest in sarcomas.

Donald Ferguson
University of Chicago Hospitals
Chicago, IL 60637
Professor of surgery; special interest in breast cancer.

William S. Fletcher
Oregon Health Sciences University
Portland, OR 97201
Professor of surgery; special interest in breast cancer.

Frederick M. Golomb
910 Fifth Avenue
New York, NY 10021
Professor of clinical surgery, NYU; special interest in melanoma

Robert Hermann
Cleveland Clinic
Cleveland, OH 44106
Head of general surgery; special interest in breast and GI cancers

Alfred Ketcham
University of Miami Medical School
Miami, FL 33101
Professor of surgical oncology

Edward Krementz
Tulane University Medical Center
New Orleans, LA 70112
Professor of surgery, special interest in melanoma.

Walter Lawrence, Jr
Medical College of Virginia
Richmond, VA 23298
Professor of surgery, director of the cancer center.

LaSalle Leffall, Jr
Howard University Hospital
Washington, DC 20060
Professor and chairman of surgery

William A. Maddox
University of Alabama
Birmingham, AL 35294
Professor of surgery

Charles McBride
M.D. Anderson Hospital
and Tumor Institute
Houston, TX 77030
Special interest in breast cancer and melanoma.

Donald L. Morton
UCLA Medical Center
Los Angeles, CA 90024
Professor of surgery; special interest in melanoma and sarcomas

Yosef Pilch
University Hospital
San Diego, CA 92103
Special interest in breast cancer.

John F. Potter
Georgetown University Hospital
Washington, DC 20007
Director, Lombardi Cancer Research Center.

Edward F. Scanlon
Evanston Hospital
Evanston, IL 60201
Chairman of surgery, special interest in breast cancer.

Harry Southwick
Rush-Presbyterian-St. Luke's
Medical Center
Chicago, IL 60612
Professor and chairman of surgery, Rush Medical College; special interest in head and neck cancer

John Stehlin, Jr
777 St. Joseph Professional Building
Houston, TX 77002
Director of the Stehlin Foundation for Cancer Research. A pioneer in heat treatment for cancer. Special interests include melanoma, sarcoma, breast, and liver cancers

Jose J. Terz
City of Hope Medical Center
Duarte, CA 91010
Head of general and oncological surgery

Jerome Urban
Memorial Sloan-Kettering
Cancer Center
New York, NY 10021
Director of the breast cancer service. Specializes in breast cancer surgery only

Gynecological Cancer Specialists

Hervy E. Averette
Jackson Memorial Hospital
Miami, FL 33136
Professor of obstetrics and gynecology, University of Miami

Hugh R. K. Barber
Lenox Hill Hospital
New York, NY 10021
Director of obstetrics and gynecology

Richard Boronow
1600 N. State Street
Jackson, MS 39202
Clinical professor of obstetrics and gynecology, University of Mississippi

Carmel Cohen
Mt. Sinai Medical Center
New York, NY 10029
Professor of obstetrics and gynecology

Phillip J. DiSaia
University of California
Irvine Medical Center
Orange, CA 92668
Professor and chairman of obstetrics and gynecology

Leo Dunn
Medical College of Virginia
Richmond, VA 23298
Chairman of obsterics and gynecology

Creighton Edwards
M.D. Anderson Hospital
and Tumor Institute
Houston, TX 77030

Arthur Herbst
University of Chicago Hospitals
Chicago, IL 60637
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Howard Jones III
Vanderbilt Medical Center
Nashville, TN 37232
Head of gynecological oncology.

Leo D. Lagasse
UCLA Medical Center
Los Angeles, CA 90024
Director of gynecological oncology service

George C. Lewis, Jr
Jefferson Medical College
Philadelphia, PA 19107
Director of gynecological oncology

William Lucas
University Hospital
San Diego, CA 92103
Head of gynecological oncology

Richard Mattingly
Medical College of Wisconsin
Milwaukee, WI 53226
Head of gynecological oncology

John Mikuta
Hospital of the University of
Pennsylvania
Philadelphia, PA 19104
Director of gynecological oncology

George W. Morley
University of Michigan Medical Center
Ann Arbor, MI 48109
Professor of obstetrics and gynecology

C. Paul Morrow
USC Medical School
Los Angeles, CA 90033
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James H. Nelson, Jr.
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Felix N. Rutledge
M.D. Anderson Hospital and
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Peter E. Schwartz
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Julian P. Smith
Wayne State
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Richard E. Symmonds
Mayo Clinic
Rochester, MN 55901

Paul B. Underwood, Jr
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Charlottesville, VA 22901
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John R. Van Nagell, Jr
University of Kentucky Medical Center
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Professor of obstetrics and gynecology

J. Taylor Wharton
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Tumor Institute
Houston, TX 77030

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

BOARD OF GOVERNORS

BOARD OF GOVERNORS' MEETING

AND

GOVERNORS' COMMITTEE MEETINGS

MAY 1984

OFFICE OF THE BOARD OF GOVERNORS

B-390 MAYO

CONTENTS

Board of Governors

May 23, 1984

1:30 P.M.

555 Diehl Hall

University of Minnesota Campus

Agenda

I. Minutes - April 25, 1984 (Approval)

II. Chairman's Report - Mr. David Cost, Board Chair (Information)

III. Hospital Director's Report - Mr. C. Edward Schwartz, Hosp. Director

- A. University Hospitals & Clinics Institutional Objectives (Approval)
- B. Cost Containment Task Force Response (Information)
- C. Other

IV. Committee Reports

A. Finance Committee, Mr. Al France, Committee Chair

1. April YTD Financial Statements (Information)
2. Budget 1984-85 (Discussion)
3. 1984-85 Employee Compensation Plan (Approval)

B. Planning & Development Committee, Mr. Al Hanser, Committee Chair

1. Renewal & Renovation Steering Committee Report (Information)
2. Allocation of Unit "J" Shell Space (Endorsement)

C. Joint Conference Committee, Ms. Barbara O'Grady Committee Chair

1. JCAH Review (Information)
2. Medical Staff/Hospital Council Report
   a. Appointment of Chief of Staff (Approval)

V. Other

VI. Adjournment

Minutes
Board of Governors
University of Minnesota Hospitals and Clinics
April 25, 1984

CALL TO ORDER: Chairman David Cost called the April 25, 1984 meeting of the Board of Governors to order at 1:40 p.m., in Room 555 Diehl Hall

ATTENDANCE:

Present: David Cost, Chair
Mary DesRoches (for David Lilly)
Phyllis Ellis
Al France
Robert Goltz, M.D.
Al Hanser
Lynn Hornquist
J. E. Meilahn
Virgil Moline
Barbara O'Grady
Paul Quie, M.D.
C. Edward Schwartz

Absent: Carl Drake
Robert Latz
David Lilly
Neal Vanselow, M.D.

APPROVAL OF MINUTES: The Board seconded and unanimously passed a motion to approve the minutes of the March 28th meeting as written.

INTRODUCTIONS: Chairman David Cost welcomed Ms. Margaret Kelly, a second year Pharmacy Administration student, and Ms. Dee Ryan, a first year Pharmacy Administration student as observers to the Board of Governors meeting.

CHAIRMAN'S REPORT: Chairman David Cost announced the appointments of Mrs. Phyllis Ellis, Mr. Robert Latz, Dr. Paul Quie, and Mr. C. Edward Schwartz to the Board of Governors Bylaws Committee. He indicated that Mr. Latz had agreed to chair that committee and that Mr. Jan Halverson had agreed to act as staff to the committee.

Secondly, Chairman Cost asked that the members of the Board reserve the afternoon of May 22, 1984 for the dedication of the new Radiation Therapy facility. He noted that formal invitations would be sent out in mid-May.

SPECIAL PRESENTATION: The Board of Governors paused to recognize Mr. David R. Preston for his seventeen years of dedicated service to the University of Minnesota Hospitals and Clinics and to the Health Sciences. Mr. Preston will be assuming the position as Vice President for Corporate Affairs at Allegheny Health Services, Inc., Pittsburgh, Pennsylvania on May 1, 1984.

HOSPITAL DIRECTOR'S REPORT:

Mr. C. Edward Schwartz apprised the Board of progress made in searches for the Medical School Dean, the Dean of the School of Public Health, the Hospitals' Senior Associate Director for Planning and Marketing and the Health Sciences Public Relations Director. Mr. Schwartz reported that the Medical School Deanship Search Committee had narrowed its consideration to two candidates and was in the process of conducting final interviews. Secondly, Mr. Schwartz reported that the Public Health Deanship was in the process of being finalized and that an announcement would be forthcoming. Thirdly, in reference to the Hospitals' Senior Associate Director for Planning and Marketing Search, Mr. Schwartz reported that the qualified candidate pool had been narrowed to 40 and that a review of those candidates was in progress. Lastly, Mr. Schwartz announced that Ms. Sally Howard had accepted the Health Sciences Public Relations Director position, noting that Ms. Howard is expected to begin her work at the University on May 1st.

Mr. Schwartz indicated that budgeting for the 1984-85 fiscal year was well underway, noting that Mr. France would be elaborating on the development of that budget under the Finance Committee Report. Mr. Schwartz did note that a series of institutional objectives had been developed for the next fiscal year and that following review and comment by a variety of Medical Staff and Management groups, these objectives would be presented to the Board of Governors.

Under the heading of marketing, Mr. Schwartz overviewed several current efforts. Those efforts included the Minnesota Association of Public Teaching Hospitals (MAPTH) marketing study being conducted with the assistance of Mr. Eric Berkowitz, a service assessment being conducted by the Clinical Chiefs under the leadership of Dr. Robert Goltz, and, to go hand-in-hand with that service assessment, an assessment by the administrative staff of the hospitals internal environment. On June 9th a Clinical Chiefs Retreat will be held to review the findings of those assessments.

Mr. Schwartz also reported on two separate studies, one being conducted by the MAPTH group on the costs of graduate medical education, and one being conducted by the Council on Teaching Hospitals (COTH) examining capital reimbursement. The MAPTH graduate education study, Mr. Schwartz, explained is similar to a national study being conducted for the Health Care Financing Administration (HCFA) by Arthur Young & Company. Both the Arthur Young and MAPTH studies, he indicated, will assist the University of Minnesota Hospitals and Clinics in formulating their position on the best methodology for funding of graduate medical education. Secondly, Mr. Schwartz noted that he and Mr. Cliff Fearing continue to participate on the COTH study on capital reimbursement, noting that the next sub-committee meeting would be held on May 7th.

Mr. Schwartz turned to Dr. Paul Quie for an update on the Chief of Staff election process. Dr. Quie reported that a committee consisting of Drs., Doughman, French, Ferrari, Heston and Wilson had nominated Dr. James Moeller, of the Department of Pediatrics, as the next Chief of Staff. Dr. Quie also indicated that three positions on the Medical Staff/Hospital Council were up for re-election. Per the Bylaws, a mail ballot of the medical staff at large will be conducted. Dr. Quie indicated that the results of that mail ballot would be presented

at the May Medical Staff/Hospital Council meeting.

Mr. Schwartz announced the election of Ms. Barbara Tebbitt as the President of the Midwest Alliance of Nursing, a professional nursing organization composed of nursing administrators, educations and researchers in thirteen Midwest states. There are approximately 330 agencies who belong to the organization, Mr. Schwartz added, whose purpose is to improve health care in the Midwest as well as to facilitate communication and cooperation between nursing administrators, educators and researchers.

Lastly, Mr. Schwartz indicated that Board members would be contacted for potential dates for a Fall 1984 Board of Governors Retreat and that a synoposis of the progress made in response to the Cost Containment Task Force Recommendations would be presented to the Board in May.

JOINT CONFERENCE COMMITTEE REPORT:

Committee Chair, Barbara O'Grady explained that the Joint Conference Committee did not meet in the month of April but did ask that the Board as a whole consider the recommendations of the Medical Staff/Hospital Council Credentials Committee for clinical privileges of several physicians and dentists. Per Mrs. O'Grady's request, Dr. Quie summarized the application requests as listed in the Board packet. The Board seconded and unanimously passed a motion to approve the recommendations of the Credentials Committee as written.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Committee Chairman Al Hanser summarized five items considered at the April 11th Planning and Development Committee meeting. The first of those items was a presentation by Dr. Elwin Fraley, Chairman of the Deparment of Urology, on a new piece of equipment developed in Munich, Germany called the extracorporeal lithothripter, which provides a non-invasive method for the treatment of stones in the kidney. Mr. Hanser explained that treatment of stones using the lithotripter, involves immersing the patient in a waterbath and directing sound waves as the stone, causing it to disintegrate. Mr. Hanser did note that FDA approval of the lithothripter is expected in late 1984 or early in 1985 and that the question of reimbursement for this procedure would be further investigated. The Planning and Development Committee, he added, would be further exploring this issue at their May meeting.

Secondly, Mr. Hanser reported the review by the committee of the allocation of shell space in Unit "J". The report by Mr. Mark Koenig outlined the available shell space and current consideration for utilization of that space. The committee will be reviewing final recommendations for endorsement at their May meeting.

Thirdly, Mr. Hanser highlighted three aspects of the Hospital Development Report presented to the committee. Response to the distribution of the Annual Report, he indicated, had been very positive. Mr. Hanser also reported that Development Office experience with patient solicitation had led them to conclude that solicitation of patients who are younger had not proven to be cost effective and that the Development Office, would therefore

FOUNDATION PROPOSAL ENDORSEMENT:

be concentrating its efforts on those persons who were born before 1940. Mr. Hanser also presented a foundation proposal for Board endorsement. The proposal seeks funding in the amount of $11,400 for continuing education for Nursing Assistants in in rural health care settings. The programs, as projected, will involve a series of four sessions in 4-6 pilot communities where such an opportunity has been requested. The Board seconded and unanimously passed a motion to endorse that proposal as written.

Lastly, Mr. Hanser reported that the Planning and Development Committee received a Quarterly Purchasing Report presented by Mr. R. Edward Howell and an update on Unit "J" Construction presented by Mr. Mark Koenig. Mr. Hanser also announced that the Certificate of Need for Nuclear Nagnetic Resonance had been approved by the Commissioner of the State Board of Health and that the area to house the equipment was under construction.

FINANCE COMMITTEE REPORT:

Committee Chairman Al France began the Finance Committee report with an overview of the March and the March year-to-date financial statements, noting that the Hospitals operating position for the month of March reflected a decline in both in-patient and out-patient activity levels. Mr. Cliff Fearing detailed the March activities for the Board. He indicated that admissions during March were down in all areas except Obstetrics and Newborn and that due to a lower overall length of stay, the patient days for March were 2.6% below budget. In recaping the year-to-date in-patient census, Mr. Fearing reported that patient days, per cent occupancy and average daily census were all 5.8% below budgeted levels. Mr. Fearing also reported that nearly all clinic areas experienced activity levels that were below budget in March, but that year-to-date, we remain slightly above budget. The financial statements, Mr. Fearing explained, reflect a percipitious decline in revenues during the month of March resulting in a year-to-date revenue figure that is 3.2% below budget. Expenses, he noted, are also under budget (1.8%). The Hospitals Statement of Operations does continue to show a favorable variance of revenue over expenses of just above $1 million, due largely, as in the past, to investment income earnings.

Mr. Fearing also explained that the global census indicators projected for the 1984-85 fiscal year, which serve as a guideline for development of the budget, will be re-evaluated given the recent decline in activity levels. He indicated that the finance department had developed a tentative year-end projection based on March year-to-date data. This model produced a net total cash available from operations of about $15 million, which is below the $16.4 million budgeted level.

Mr. France indicated that the Finance Committee had been reviewing preliminary data for the 1984-85 budget and noted that the Committee would be reviewing the entire budget at their May meeting. Mr. France specifically asked that members of the Board who do not sit on the Finance Committee feel free to attend the May Finance Committee meeting to participate in this review.

Lastly, Mr. France reviewed the third quarter bad debt statistics, noting a net bad debt of $520,000. The Board seconded and unanimously

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S E
Minneapolis Minnesota 55455

TO: Board of Governors

FROM: C. Edward Schwartz, Hospital Director C. E Schwartz

DATE: May 15, 1984

SUBJECT: University Hospitals and Clinics Institutional Objectives

During your next meeting we will be reviewing the proposed Institutional Objectives for our Hospital and Clinics relative to our next fiscal year. Attached you will find the most recent draft of those objectives which were prepared by our Administrative Staff and reviewed by several different Management and Medical Staff groups.

You will note in the background statement that this is our first effort in recent years at establishing Institutional Objectives. Last year our efforts in this area served only to aid management in coordinating its efforts. This year we hope to institutionalize our objectives by involving the Medical Staff and the Board of Governors. In future years we plan to enhance the involvement of these and other groups in the actual development of the objectives via a more formal strategic planning process.

I am forwarding these Institutional Objectives to you in advance of our meeting with the request that you review the document and be prepared to suggest changes or additions.

Thank you.

CES/slk

Enclosure

UNIVERSITY OF MINNESOTA HOSPITALS

INSTITUTIONAL OBJECTIVES

FISCAL YEAR 1984-85

DRAFT #5
May 17, 1984

I. Background

During the mid stages of the fiscal 1983-84 budget process, a series of management objectives were prepared to aid in the setting of administrative priorities during that period. Because these objectives were developed later in the budget cycle, they were not presented to the Medical Staff or to the Board of Governors. As such, they represented "management objectives" and not "institutional objectives". These management objectives for 1983-84 are enclosed as attachment "A".

The University of Minnesota Hospitals and Clinics' statement of Mission and Goals are enclosed as attachment "B". This document was adopted by the Board of Governors and Board of Regents in 1978 and has not been updated since that time. The Board of Governors is anticipating a review of that statement in the coming year.

For 1984-85 it is intended that objectives for the institution be established as a part of the budget process. The objectives are intended to guide the development of the annual budget or financial plan and to represent the desired accomplishments on the part of the Hospital, including its Governance and Medical Staff.

The proposed Institutional Objectives for fiscal 1984-85 are presented in the second section of this paper. It is intended that these objectives will be reviewed broadly by the Management Staff and the Medical Staff before being presented to the Board of Governors.

II. Institutional Objectives

A. Medical Staff and Programmatic Development Objectives

1. Implement new program initiatives endorsed by Management and the Medical Staff Budget Advisory Committee and approved by the Hospital's Board of Governors.

2. Work with the Council of Chiefs to finalize a plan to maximize the operational efficiency and revenue flow in Ambulatory Services and implement that plan during the fiscal year.

3. Organize administrative efforts and Hospital resources available to support to Dean of the Medical School in the recruitment of Departmental Chairman and Departmental Chairman in the recruitment of Clinical Faculty, to fill known vacancies.

4. Work with the University to finalize a site selection for a new patient parking structure. Complete architectural, operational and financial plans to assure the availability of that facility by December 1986.

5. Complete discussions with the Management of the new University Radisson Hotel to provide adequate low cost rooms for University Hospital.

6. In cooperation with the Clinical Chiefs, establish a second site to house outpatients and their families who are receiving care at the University Hospitals.

7. Develop alternate organizational models directed at enhancing continuity of care. Emphasis should be given to cooperative relationships with other providers as well as to enhanced communication with referring physicians, discharge planning, delivery of services in the outpatient clinics and through home health care.

8. Work with Hospital and Clinical Departments to implement a hospital wide patient care management information system which provides the Hospital and Medical Staff with timely information about the quality, safety and appropriateness of patient care.

9. Expand the role of the Hospital Auxiliary to incorporate new areas that involve a greater number of support activities.

B. External Market Share Objectives

1. Complete planning for a private payor sponsored University Faculty and Staff Preferred Provider Organization and make recommendations to the Board of Governors and/or University Executive Officers regarding implementation by December of 1984.

2. Negotiate at least ten service arrangements resulting from Medical Staff/Hospital joint ventures to realize new referral and/or income sources.

3. Finalize planning grant applications to the Commonwealth Fund involving UMHC and five out-state hospitals and their medical staffs, preparatory to the implementation of referral, continuing education and specialty service arrangements by October of 1984.

4. Facilitate the rapid successful integration of the Senior Associate Director for Planning and Marketing into the Hospital and Medical Staff organizations by September of 1984.

5. Implement a long range strategic planning process by June of 1985 that includes a thorough assessment of the internal and external environments.

6. Evaluate and strengthen the UMH&C Marketing and Public Relations efforts in accordance with the findings of the Brum and Anderson study.

C. Financial Objectives

1. Finalize the preparation for the Medicare Prospective Payment System, including the establishment of a subprovider for Rehabilitation and Psychiatry by September 1, 1984. Continue planning toward the "Childrens Hospital" provider concept, targeted toward Unit J opening date in 1986.

2. Monitor the institutional advantages and disadvantages of participation in the Blue Cross Blue Shield of Minnesota AWARE program and make recommendations to the Board of Governors in December of 1984 regarding the continuation of participation after December 31, 1984.

3. Budget and manage hospital finances to assure an excess of revenue over expenses sufficient to assure the payment of Hospital obligations that come due during 1984-85 relative to abandonment cost and equity contributions for the Unit "J" Project.

4. Maintain a high level of Management and Medical Staff accountability for the achievement of Cost Containment Task Force objectives. Quarterly status reports will be made to the Hospital Board of Governors.

5. Monitor the Bond Market and maintain an ongoing status of preparedness to refinance the Unit "J" Bond issue when interest costs are sufficiently reduced to accomplish debt savings objectives.

6. Develop an institutional long range financial plan that is consistent with the mission, role and institutional objectives of the Hospitals.

7. Working through the University, establish relationships with key state legislators to make them more directly aware of significant reimbursement issues of major teaching hospitals that will arise as a result of the prospective payment system and competitive environment.

8. Continue the development of federal congressional linkages to advise and represent the interest of UMHC on general and reimbursement matters as the prospective payment system implementation continues. Special emphasis in this area for fiscal 84-85 will center on reimbursement for capital costs, severity indexing, graduate medical education funding and the maintenance of quality clinical care.

D. Operating and Activity Objectives

1. Work to strengthen Hospital employee relations consistent with the newly established Hospital Personnel policies, particularly in the areas of compensation policy and labor relations.

2. Work to strengthen the Hospitals' Purchasing system, consistent with the newly developed Hospital Purchasing Policies, particularly in the areas of accounts payable and storehouse distribution; to include exploration of strengthening the Hospitals purchasing position through group purchasing agreements with similar institutions.

3. Manage an ongoing bed complement consistent with projected demand and occupancy standards established for UMHC as a part of the Unit "J" Certificate of Need and implement required organizational changes consistent with patient Unit configuration once Unit "J" is operationalized.

4. Finalize the Unit "J" activation plan and begin departmental training and orientation activities to assure a smooth transition to the new facility with a minimum of service interruption.

5. Assure the successful integration of the Health Sciences Director of Public Relations with the Hospital Administrative structure and finalize the Hospital Public Relations organization, including recruitment, as appropriate.

6. Re-evaluate the Hospital Administrative structure to assure that it continues to be sufficient to meet organizational needs.

7. Continue the Hospitals annual giving program and secure $1,250,000 in gifts during the fiscal year.

8. Establish a capital giving campaign to assure funds to acquire equipment for the public and patient areas of Unit "J".

E. Construction and Renovation Objectives

1. Manage the Unit "J" construction activities, including recently approved facility upgrades and shell space completion, to assure that the project is completed on time and within budget.

2. Complete the construction of the Nuclear Magnetic Resonance space on schedule to meet the August 1984 delivery schedule of equipment.

3. Complete the Mayo/Heart Hospital renovations Planning Project by December of 1984 and work with the Board of Governors, the Board of Regents in determining the appropriateness of planned renovations directed at patient care delivery efficiency and cost.

4. Establish a plan by December of 1984 relative to the completion of the fourth and sixth level of building B/C shell space that is integral to the Unit "J" construction and Mayo/Heart renovation projects.

5. Renovate physical facilities in accordance with the guidelines set forth in the Mayo/Heart Renovation Plan and the 1984-85 Capital Budget only.

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

MANAGEMENT OBJECTIVES

FISCAL YEAR 1983 - 84

1. Refinance series 1982 Bonds in a manner which maximizes potential savings resulting from lower interest costs and greater equity contribution. Such refinancing is to be consummated at the most opportune time per the bond market, assuming there is a reduction in interest rates before the end of the current fiscal year.

2. Continue to closely manage the Unit J bid process and construction schedule to assure that Unit J will be completed in 1986, within the certified construction price. As a continuation of this management effort, identify the appropriate administrative person responsibile for the creation of a move-in plan and indentify and seek approval for the major elements of that plan prior to the end of the current fiscal year.

3. Continue planning relative to the renovation of vacated facilities that will be utilized by the Hospitals after Unit J occupancy. Complete a facilities plan and obtain the Hospital Director's approval of that plan by March 1, 1984. Seek approval of that plan by the Board of Governors and Board of Regents by June 1, 1984.

4. Establish a three year major capital acquistition plan by May 1, 1984. This major capital acquisition plan should give particular attention to the prioritization in timing, major technological advances, and the manner in which new major equipment and technology is incorporated into the operations of the Hospitals.

5. Obtain approval for a Unit J capital contributions development program by January 1, 1984 and initiate that program within 90 days of approval. This capital development program will solicit contributions over a three year period. Proceeds from that effort will be used to purchase equipment and furnishings for programs and functions located in Unit J.

6. Obtain annual giving contributions to the hospital in the amount of one million dollars for the period beginning July 1, 1983 and ending June 30, 1984.

7. Develop, by January 1, 1984, a list of prime candidates to suggest to the medical staff regarding the election of the new Chief of Staff. Provide sufficient lead time for the newly elected Chief of Staff to be acclimated to the office prior to July 1, 1984.

8. Influence the selection of key University officials by obtaining sufficient and succinct input on the part of University Hospitals and by providing that input to those responsible for the selection process of such individuals. The specific areas where searches are underway that effect University Hospitals are the Dean of the Medical School, Vice President for Finance and the Dean of the School of Public Health.

9. Facilitate management and medical staff adaptation to prospective payment through the development of the necessary data base, systems and tools for case mix management, clinical decision making, budget management and reimbursement maximization, consistent with the completion dates outlined in the July 1983 Prospective Payment Management Program document. Support the conclusion of the

efforts of the Cost Containment Task Force study and integrate the recommendations where appropriate, into these Hospital activities.

10. Reinforce and strengthen the communication link between Universtiy Hospitals and the schools and colleges within the Health Sciences. This exchange of information will be aimed at enhancing the integration of decision making processes throughout the Health Sciences.

11. Gain approval from the Board of Regents for the delegation of the Purchasing function to the Board of Governors by September of 1983 and implement the actions detailed in the June 1983 plan, consistent with the time frame in that document.

12. Gain approval from the Board of Regents for the delegation of the Personnel function to the Board of Governors by September of 1983 and implement the actions detailed in the June 1983 plan, consistent with the time frame in that document.

13. Develop, utilize and monitor a performance planning, evaluation and compensation system for the Hospital Director, Senior Associate Directors, Associate Directors, and Assistant Directors for fiscal year 1983-84 that enhances the clear identification and assessment of individual performance objectives.

14. Strengthen the posture of University of Minnesota Hospitals and Clinics in fiscal year 1983-84 as an influential body in the formulation of local, state, and national health policy through active administrative interface with other provider organizations, third-party payors, law makers, and community groups.

15. Develop a comphrehensive three to five year plan during the current fiscal year. for institutional information systems development and computer hardware investment.

16. Provide the capital and operating resources in fiscal year 1983-84 that are necessary to fulfill the Hospitals mission and to fund the financial obligations resulting from renewal project bonding, consistent with the targets established in the financial feasibility study and legal obligations contained within the Bond Idenure.

17. Monitor the ongoing development of Preferred Provider Organizations and the Blue Cross AWARE Program in the community. Evaluate the consequences to the institution of AWARE participation by January 1, 1984.

18. Achieve a full complement of administrative leadership by July 1, 1984 by assuring the successful integration of the Hospital Attorney with current Hospital and Medical staff, recruiting and hiring a Senior Associate Director for Planning and Marketing, and by recruiting and hiring a Marketing Manager and a Public Relations Manager.

19. Improve the capacity of the institution to respond effectively to the demands of its environment through the development of a strategic planning process by July 1, 1984 and the development of a comphrensive strategic plan by July 1, 1985.

20. Assure a successful acclimation of the Board of Governors to the Hospitals and its operations in 1983. Foster an environment for positive interaction between the Board and its respective constituencies through the cooperation and support of the Medical and Administrative staff on an ongoing basis.

Mission and Goals of University Hospital

In 1975, University Hospitals acquired its own Board of Governors. This Board is responsible for the policy-related issues which are resolved at the hospital level within the University structure. In 1978, the Board revised the Statement of Mission and Goals for University of Minnesota Hospitals and Clinics. Following is this revised mission and goal statement as adopted by the Board of Regents of the University of Minnesota.

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

STATEMENT OF MISSION AND GOALS

PREAMBLE

The University of Minnesota Hospitals and Clinics has many different responsibilities and goals. The primary mission of the institution is rooted in the early recognition by the University of Minnesota Medical School of a need for a clinical teaching environment. In the early 1900's, the Minnesota Legislature determined that this need be met by the University of Minnesota Hospitals and Clinics. (As provided in Laws of Minnesota, 1907, Chapter 80, and as perpetuated in Minnesota Statute, Chapter 15B, first enacted in 1921.)

The Legislature mandate underlies the Hospitals' role in providing health care services, programs of education and research, and referral relationships with other health care providers and institutions in the State of Minnesota. In this role, University of Minnesota Hospitals and Clinics serves various constituent groups by making health care services available to all residents of Minnesota, to those of the upper Midwest region, and in the case of some more specialized service programs, by serving as a national resource. Its programs of education, developed in conjunction with the units of the University of Minnesota Health Sciences (the Medical School, School of Nursing, College of Pharmacy, School of Dentistry, and School of Public Health), serve students, faculty, it own medical and professional staff, many other practicing health care deliverers, and the general public. Further, the research conducted in association with University Hospitals benefits both providers and recipients of health care services nationally and internationally.

The University of Minnesota Hospitals and Clinics is obligated to the people of Minnesota to fulfill its special role as a health care resource for the state. Thus, the Board of Governors of the University of Minnesota Hospitals and Clinics, on behalf of the Board of Regents, representing the people of Minnesota, set forth this statement of mission and corresponding goals which has been developed to meet the unique responsibilities of this institution.

MISSION

The responsibilities of the University of Minnesota Hospitals and Clinics require that its mission be uniquely broad, allowing it to serve as a principal medical and health care resource for the State of Minnesota. Elements of its mission must also permit the institution to provide a wide range of specialized health care delivery programs designed to advance quality health care.

In this pursuit:

- University Hospitals and Clinics provides patient care services which respond to local, state, and in some instances, national needs.

- University Hospitals and Clinics is an integral part of the Health Sciences Center of the University of Minnesota. Through its multiple health care programs, University Hospitals and Clinics will provide an environment for the clinical education of Health Sciences students; continuing education for its medical staff and other health practitioners; and, in the course of patient care, health education in the areas of preventive care, and in personal management of patients' own health.

- University Hospitals and Clinics provides a distinctive environment for the advancement of bio-medical research and technological development, as well as innovations in the delivery of medical care and health services.

- University Hospitals and Clinics also fulfills a role in education for health services management. In this role, it will serve as a statewide and national resource for the management of the health delivery system.

GOALS

I. PATIENT CARE: Services for the sick and convalescing to give comfort, assist in recovery, and maintain health.

A. To offer sensitive, quality patient care programs at the lowest possible cost.

B. To provide innovative primary and preventive care programs and models, both within the University setting and at other sites and to provide well functioning, specialized and advanced or tertiary care for patients of referring physicians.

C. To provide well organized modern medical care services for ambulatory patients not requiring hospitalization, thus promoting the appropriate use of health care resources, and to provide emergency medical services consistent with the developing regional referral emergency medical services care network and the educational needs of the institution.

D. To provide programs of home health care and other outreach services as alternative and less costly methods for providing medical care.

E. To assure quality health care delivery 24 hours a day, 7 days a week through a highly specialized medical and professional staff.

II. EDUCATION: programs for students, faculty, staff, practitioners and others interested in learning, teaching, practicing, maintaining and using health skills.

A. To participate in and develop health care programs in support of the educational objectives of the Health Sciences Units.

B. To provide patient education programs as a means of helping patients become involved in the process of improving their health status.

C. To support continuing education programs for health care professionals both within the Hospital and throughout the State of Minnesota.

D. To participate in the dissemination of community health education information to health professionals throughout the State.

E. To expose students to a wide variety of management experiences both in internal Hospital operations and external health policy.

III. RESEARCH: projects and programs which support the commitment of the University Health Sciences as a major research resource for the State and nation in bio-medical and clinical research.

A. To encourage and support the medical staff and other health professionals in research inquiries and investigations.

B. To recognize the relationship between a variety of investigative programs so that research findings can be used for patient care.

In pursuit of all these goals, University of Minnesota Hospitals and Clinics strives to provide leadership through the development of model programs. These model programs serve as examples for individuals and institutions in the health care system. Excellence, therefore, is sought in these patient care, education and research models so that they may be shared with confidence. Thus, University of Minnesota Hospitals and Clinics attempts to provide a health care services environment for Health Sciences students, practitioners, and clinical investigators which will be of benefit to all other health care programs in Minnesota. In respect to this, University of Minnesota Hospitals and Clinics will serve as a resource to public groups studying health issues and policy and will participate fully in local, state, and national health systems planning. University of Minnesota Hospitals and Clinics will continue to provide a governance model which reflects the public accountability of a statewide health care resource.

to the May 16, 1984

Recommendations of the Hospital Cost Containment Task Force

Recommendations	Accomplished	In Process	Future
I. Staffing			
1. Develop a plan for phased in staff reductions throughout Hospital	X	X	
2. Target staff reductions at areas of most intense cost competition to allow Hospitals to compete without cost shifting			X
3. Future Staffing increases should be offset by cost reductions	X	X	
4. Create standing Medical Staff Committee to advise Administration in the prioritization of new programs, major acquisitions, plant renovation and staffing increases	X		
II. Physician Use of Resources			
1. Educate physicians and house staff regarding effects of DRG based payment (New House Staff each July 1)	X	X	
2. Educate physicians and house staff regarding costs of tests, procedures, drugs, ect. (New House Staff each July 1)	X		
3 & 4. Provide physicians with daily update of total charges incurred, applicable charge limits and up to date comparision of costs of their patients verses patients of peers	X		X
5. Continue present policy of minimizing length of stay whenever possible	X	X	
6. Impose ceiling on growth of Respiratory Therapy and Patient Monitoring services	X		
7. Develop ongoing utilization review process for other departments analogous to that presently used in Respiratory Care, Patient Monitoring and Pharmacy		X	

	Completed	In Process	Future
8. Analyze alternative models for risk/incentive sharing between Hospitals and Medical Staff		X	

Department Recommendations Endorsed by the Task Force

A. Respiratory Therapy			
1. Modify charge to Cardio-Respiratory Advisory Committee to include development of policies aimed at restricting resources	X		
2. Expand Respiratory Care medical directors' role to include responsibility for determination of appropriateness of service	X		
3. Give Respiratory Care medical directors authority to review and discontinue inappropriate therapy	X		
B. Patient Monitoring			
1. Involve ICU medical directors in limiting growth and expansion of Patient Monitoring services	X		
2. Merge departments of Respiratory Therapy and Patient Monitoring	X		
C. Pharmacy			
1. Expand charge to Pharmacy and Therapeutics Committee to include consideration of Cost effectiveness of drugs	X		
2. Establish small work groups in P & T Committee to recommend ways to control costs of pharmaceutical therapy	X	X	
3. Department of Pharmacy will work through P & T Committee to develop mechanisms for controlling costs of services	X	X	
4. Delete eleven positions in Pharmacy upon move to Unit J		X	X
D. Nursing			
1. Develop plan to review following eight areas for changes resulting in increased work efficiency:			

	Accomplished	In Process	Future
1. Communication System			
2. Organization of Work			X
3. Administrative and orientation hours		X	X
4. Leadership responsibilities		X	X
5. Education		X	X
6. Nursing Utilization Management Information System		X	X
7. Assignment of Nursing Personnel		X	
8. Linen and Nutrition services	X	X	
2. Develop plan to delete two assistant directors and eight head nurse positions	X	X	
3. Review and determine future role of Clinical nurse specialist positions	X		
4. Review number of office staff following installation of computer terminal		X	
5. Explore computerized scheduling to decrease planning time		X	
6. Evaluate workload of assistants and administrators following establishment of autonomous purchasing practices	X		
7. Evaluate role of Resource office to explore streamlining in scheduling to reduce hours worked	X		
8. Cease transportation of research materials to physicians' private labs	X		
III. Program and Patient Schedules			
1. Address annual losses in patient care cost centers such as Obstetrics, Physical Medicine, Psychiatry		X	X
2. Renegotiate Indian Health Service program reimbursement rate.	X	X	
3. Continue discussions with City of Minneapolis regarding future of Community University Health Care Center		X	

4. The task force strongly urges that in the future, prior to implementation of any university wide policies affecting UMH&C, the hospital administration analyze and inform the Board of Regents and Central Administration of the immediate financial effect of such policies on UMH&C as well as the potential effect on its future ability to remain competitive in the market place of health care delivery.

Hospital Administration will employ this perspective before those considering institutional wide policies

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

May 23, 1984

TO: Board of Governors Finance Committee

FROM: Clifford Fearing
Senior Associate Director

SUBJECT: Report of Operations for the period July 1, 1983 through April 30, 1984.

The Hospitals' operating position for the month of April continues to reflect lower than anticipated inpatient census levels and further reductions in the average inpatient ancillary service revenue per admission. To highlight our position:

Inpatient Census: During the month of April, admissions totaled 1,696 or 22 below projected admissions of 1,718. Admissions this month were at or above budgeted levels in all areas except Surgery, Obstetrics and the Intensive Care Units. Due to a lower overall length of stay for the month, the patient day total of 14,099 was 2,059 days below the budgeted level of of 16,158. The overall length of stay for the month of April was 8.7 days compared to the year-to-date average through March of 9.2 days.

To recap our year-to-date inpatient census:

	1982-83 Actual	Budget	Actual	Variance	% Variance
Admissions	17,414	16,966	16,549	(417)	(2.5)
Avg. Length of Stay	9.5	9.6	9.1	(0.5)	(5.2)
Patient Days	165,902	163,010	152,383	(10,627)	(6.5)
Percent Occupancy	74.1	72.5	67.9	(4.6)	(6.3)
Avg. Daily Census	545.7	534.5	499.6	(34.9)	(6.5)

Outpatient Census: April clinic census totaled 18,523 compared to projected visits of 18,585. Our year-to-date clinic census total of 172,779 visits is 686 visits, or 0.4% above projected visits of 172,093. However, the clinic census through April of this fiscal year is 157 visits below our total of a year ago.

Financial Operations: The Hospitals' Statement of Operations shows total revenues over expense of $8,104,094, a favorable variance of $525,392. This favorable variance continues to be due to our investment income being higher than projected by approximately $2,265,000. The net revenue from operations through April shows a net loss of $7,840,500 which is nearly $1,742,000 greater than the budgeted loss of $6,098,655.

Patient care charges through April totaled $150,314,837 and are $6,216,000 (4.0%) below budgeted levels. Routine revenue is 6.0% below budget and reflects the overall patient day variance. Ancillary revenue levels declined during the month of April reflecting a lower average acuity level. Inpatient ancillary charges per admission declined from the March year-to-date average of $4,806 to an average of $4,299 for the month of April.

Operating expenditures through April totaled $132,419,546 and are approximately $2,866,000 (2.1%) below budget. Overall spending levels during April continue to reflect reduced personnel costs, and supply and expense costs associated with our lower census levels and with the actions taken by management in November.

Accounts Receivable: The balance in patient accounts receivable as of April 30, 1984 totaled $41,832,356 and represents 84.9 days of revenue outstanding. Total receivables increased nearly $872,000 during the month of April with the increase occurring primarily in the Medical Assistance, commercial insurance, and HMO categories. Minnesota Medical Assistance receivables showed the largest increase and reflects their continued back-log of claims following a conversion in their payment system last fall. We have also experienced an increase in claims audits by insurance companies which results in delay of the payment.

Conclusion: The Hospitals overall financial position through the end of April continues to remain within the fiscal plan implemented in November. Operational changes that are necessary and appropriate continue to be made in relation to changes in acuity level and ancillary service utilization.

/jem

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1983 TO APRIL 30, 1984

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$156,531,095	$150,314,837	$-6,216,258	-4.0%
Deductions from Charges	30,014,949	28,652,334	-1,362,615	-4.5
Other Operating Revenue	2,670,568	2,916,543	245,975	9.2
TOTAL REVENUE FROM OPERATIONS	$129,186,714	$124,579,046	$-4,607,668	-3.6%
Expenditures				
Salaries	$ 65,157,149	$ 63,952,809	$-1,204,340	-1.8%
Fringe Benefits	12,102,330	12,808,474	706,144	5.8
Contract Compensation	6,228,200	6,664,706	436,506	7.0
Medical Supplies, Drugs, Blood	21,275,443	20,298,374	-977,069	-4.6
Campus Administration Expense	4,355,000	4,355,000	0	0.0
Depreciation	5,377,627	5,069,878	-307,749	-5.7
General Supplies & Expense	20,789,620	19,270,305	-1,519,315	-7.3
Total Expenditures	$135,285,369	$132,419,546	$-2,865,823	-2.1%
Net Revenue from Operations	$ -6,098,655	$ -7,840,500	$-1,741,845	-28.6%
Non-Operating Revenue				
Appropriations	$ 10,350,375	$ 10,350,375	0	
Interest Income on Reserves	1,532,161	3,797,054	$ 2,264,893	
Shared Service	307,688	310,032	2,344	0.8%
Investment Income on Trustee Held Assets	1,487,133	1,487,133	0	
Total Non-Operating Revenue	$ 13,677,357	$ 15,944,594	$ 2,267,237	16.6%
Revenue Over / -Under Expenses	$ 7,578,702	$ 8,104,094	$ 525,392	(1)

(1) Variance equals 0.4% of total budgeted revenue.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S E
Minneapolis Minnesota 55455

May 23, 1984

TO: Board of Governors

FROM: C. Edward Schwartz C.E. Schwartz
Hospital Director

SUBJECT: 1984-85 Operating Budget for University of Minnesota Hospitals and Clinics.

Enclosed for your review are the Operating Budget Schedules for 1984-85. (The volatility inherent in the current 1983-84 census and revenue levels has necessitated that we develop a contingency budget for 1984-85, as well as the base budget that has been in development since February of 1984.) The budget schedules for 1984-85 have been designed around two different sets of assumptions regarding utilization levels and therefore represent a base budget, i.e. that budget which has been developed as in the past through a budget process incolving all levels of management preparing forecasts of revenue, expenses, revenue deductions and capital needs. The second budget is a contingency budget based on assumptions of admissions, patient days, clinic visits, and revenue and expense levels that may occur should the recent declines in utilization continue into 1984-85.

The schedules which you have before you outline the base budget which we will operate within should the higher levels of utilization occur, and provide you with the levels of operations we expect should the current trend in utilization occur throughout the next fiscal year.

The annual Equipment and Renovation Budget is also included for review with the Planning and Development Committee at a joint luncheon today. Levels of capital expenditures for the 1984-85 fiscal year are not expected to vary based on the different levels of volume assumptions. The amount of the Capital Budget for 1984-85 is $5,103,000.

In constructing the base budget and contingency budgets for 1984-85, planning assumptions, requirements and covenants related to the 1982 Series Bonds have been incorporated as required.

Beginning July 1, 1984, University of Minnesota Hospitals & Clinics will begin receiving reimbursement for Medicare patients under the new Diagnostic Related Groups (DRGs) prospective payment system. Medicare contract

deduction calculations have been based on this new payment system. Also for 1984-85, new Medicaid reimbursement policies which pay University of Minnesota Hospitals & Clinics $7,209.00 per admission, and the Blue Cross Blue Shield of Minnesota AWARE payment schedule have been incorporated in calculating the revenue deductions for 1984-85.

Rate increase requirements for the 1984-85 base operating budget and the contingency budget are consistent at 7%.

/jem

University of Minnesota Hospitals & Clinics

Budget Letter
Fiscal Year 1984-85

Introduction

The volatility in patient census and patient revenue levels during the 1983-84 fiscal year have dictated that management take a substantially different approach to the operating budget for 1984-85 from that in previous years. Declines in census levels in September (primarily created by reductions in the average length of stays in most clinical services) dictated that a minimum of eight months of patient activity be used as a base for projecting 1983-84 activity levels. Major declines in ancillary utilization in January 1984 provided a further need to defer the budget process from its normal January through April development to a March through June development.

As the budget was under development in March 1984 at the detail department level, further declines in the average length of stay occurred along with declines in average revenues per admission. With the month of April showing a recovery of approximately 25% of the March declines, management decided to complete the 1984-85 budget based on its original projection using July through February data, and to develop a contingency budget for 1984-85 based on experience levels existing in March and April of 1984.

The budget schedules included for your review today incorporate both the base and contingency budgets and outline the FTE reductions management must make to achieve the contingency budget levels of expenditures should the activity remain at March and April 1984 levels.

In addition, management has initiated several efforts to offset the decline in patient census and reduce the need to adjust its work force by 190 FTEs. Schedule XII is a summary of these initial efforts.

The 1984-85 Budget

As in the past, the 1984-85 budget (both the base and the contingency budgets) have been developed by management consistent with the following budget objectives:

1. To provide the capital and operating resources that are necessary and essential to fulfill the Hospitals' mission.

2. To reinforce the need for cost containment among the management and medical staff at the Hospitals, by communicating through the limitations imposed by the approved budget, the need for fiscal restraint and budgetary accountability.

3. To restrict the price increases necessary from the effects of cost shifting to the levels identified in the financial feasibility study. More specifically, to operate the Hospitals within the financial limitations imposed by new federal, state, and other third party payor payment systems.

4. To provide the cash flow necessary to fund the financial obligations resulting from the Renewal Project bonding, consistent with the targets established in the financial feasibility study and the legal obligations contained within the Bond Indenture.

5. To incorporate the Cost Containment Task Force recommendations.

In addition to these broad budget objectives, several key variables have been introduced into the 1984-85 budget projections. These include:

- Medicare Prospective Payment System

  The Social Security Amendments of 1965 (Pub. L. 89-97) established Title XVIII of the Social Security Act (the Act), which authorized the establishment of the Medicare program to pay part of the costs of health care services furnished to eligible beneficiaries. Part A of the program (Hospital Insurance) provides basic health insurance protection against the costs of inpatient hospital care and other inpatient or home health care. Part B of the program (Supplementary Medical Insurance) provides voluntary supplementary insurance covering most physicians' services and certain other items and services not covered under Part A.

  Generally, there are two bases for payment under the Medicare program. The first is "reasonable cost" and the second is "reasonable charge". Essentially, reasonable costs include all direct and indirect costs that are necessary and proper for the efficient delivery of needed health services to beneficiaries. Within this general framework, there are numerous rules regarding the reasonableness of certain categories of cost, how they are to be calculated, and how they are to be reported and how they are paid.

  Because actual reasonable costs cannot be determined until the end of the provider's cost reporting period, interim reimbursement amounts, approximating actual costs are determined by the fiscal intermediary serving each provider and paid to the provider throughout the year.

  Providers are required to maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Cost reports must be submitted to the intermediary on an annual basis. Final settlement is made following further review and/or audit of the cost report and records.

The second basis of payment, "reasonable charge", is for physicians' services and other medical and health services that are not furnished directly by a provider of services or by others under an arrangement with the provider. The principles of reasonable charge reimbursement are primarily limited to the usual and customary charge in a given geographical area.

The Social Security Amendments of 1972 (Pub. L. 92-603) contained numerous provisions affecting the Medicare program. Two sections, however, are particularly relevant to changes in Medicare reimbursement.

Section 222 of the 1972 Amendments authorized the Secretary to engage in experiments and demonstration projects in order to determine the advantages and disadvantages of making payments to Medicare providers on a prospective basis.

Section 223 of the Social Security Amendments of 1972 amended section 1861(v)(1) of the Act to authorize the Secretary to set prospective limits on the costs that are recognized as reasonable under Medicare. Section 223 authorized the Secretary to apply limits to direct and indirect overall costs or to costs incurred for specific items or services furnished by a Medicare provider and to base these limits on estimates of the cost necessary for the efficient delivery of needed health services.

On September 3, 1982, the President signed into law the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97-248. Section 101(a) of that legislation added section 1886 to the Act. This new section included two provisions that limited Medicare reimbursement for costs of inpatient hospital services. Section 1886(a) of the Act provided for the extension of the section 223 hospital cost limits, which had previously been applied only to inpatient general routine operating costs, to the total operating costs of inpatient hospital services. The expanded limits were to apply on a per discharge or per admission basis, and were to take into account the mix of types of Medicare cases treated by the hospital. Section 1886(b) of the Act provided for a new three-year limitation on payment for hospital costs and provided for incentive payments to hospitals that keep their costs below a target amount.

On April 20, 1983, the President signed Pub. L. 98-21, the Social Security Amendments of 1983. Title VI of Pub. L. 98-21 provides for Medicare payment for hospital inpatient services under a prospective payment system, rather than on a reasonable cost basis. Essentially, Medicare payment will be made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). This list contains 470 specific categories. The prospective payment rate will not include capital-related costs (e.g., depreciation, taxes, rent, etc.) or direct medical education costs, which will temporarily continue to be reimbursed under a reasonable cost-based system.

The statute provides for a 3-year transition period during which a declining portion of the total prospective payment will be based on hospitals' historical costs in a given base year and a gradually increasing portion will be based on a regional and/or national federal rate per discharge. Beginning with the fourth year and continuing thereafter (i.e., cost reporting periods beginning on or after October 1, 1986), Medicare payment for hospital inpatient services will be determined fully under a national DRG payment methodology.

The federal payment rates are determined based on the mean urban or rural standard amount per discharge. This amount is then adjusted to account for area differences in hospital wages. The standard amounts per discharge will be updated annually. For FY 84 and FY 85, the prospective payment system must be "budget neutral". That is, payments may not be greater than nor less than the payments that would have been paid under the law previously in effect. Beginning with FY 86, the Secretary will determine the update factor taking into consideration recommendations made by a commission of independent experts appointed by the Director of the Office of Technology Assessment.

Additional payments will be made to hospitals for discharges meeting specified criteria as "outliers". Outliers are cases that have an extremely long length of stay or unusually high cost when compared to most discharges classified in the same DRG. Additional payments will also be made for indirect costs of approved graduate medical education programs.

Beneficiaries may be charged only for deductibles, coinsurance amounts, and non-covered services (e.g., phone, television, etc.). They may not be charged for differences between the hospital's cost of providing covered care and the Medicare payment amount.

Under the prospective payment system, payment will be made to the hospital on a per discharge basis. Therefore, hospitals may have incentives to increase admissions or reduce services. To safeguard against such practices, the statute requires the establishment of a monitoring system to review admission practices and quality of care. If an abuse of the prospective payment system is discovered (e.g., unnecessary multiple admissions of the same beneficiary or inappropriate medical practices), payment may be partially or totally denied to the hosptial.

All the relevant elements of this new law have been incorporated in UMH&C's forecasts for fiscal year 1984-85.

- Blue Cross Blue Shield of Minnesota "AWARE" Program

Blue Cross and Blue Shield of Minnesota (BCBSM) introduced a new preferred provider organization program called AWARE on April 1, 1983. As of this date, all 27 hospitals in the metropolitam area have

agreed to provide services to patients who choose this health care coverage. Currently, BCBSM is only marketing the AWARE program in the metropolitan area.

The AWARE program is an insurance coverage where hospitals agree to provide services to patients at the fifty-fifth percentile (55%) of the average metropolitan area hospital charge in five general areas, i.e., Medical, Surgical, Obstetrics, Mental Disorders and Chemical Dependency and other limited speciality areas. UMH&C chose to participate in this program as of January 1, 1984. Through March 31, 1984 the discounts provided to Blue Cross under this program have been averaging 7% of Blue Cross charges. For 1984-85 budget purposes, we have included discounts at a 8.5%level to insure against a change in patient mix within this payor group. Discounts are provided on all Blue Cross Blue Shield of Minnesota policies except those companies who have inter-state policies. All out of state Blue Cross contracts are paid on a full charge basis.

- Demand Assessment

Numerous assessments of UMH&C's future demand have been performed over the last six years. Each of these assessments has forecast a decline in average length of stay and admissions for UMH&C through 1988. For fiscal year 1983-84 UMH&C used the forecast decline in census produced by Touche Ross and Company for their 1982 financial feasibility study. As a result of this forecast, the 1983-84 budget was set at 20,475 admissions, 196,000 patient days and 208,950 clinic visits.

As a result of the occupancy declines in September of 1983 and experience through February of 1984, management revised the 1983-84 forecasts to 183,500 patient days, 19,500 admissions and clinic visits were projected at 208,000. With these 1983-84 revised forecasts as a base, management established the following demand budgets for 1984-85:

Patient Days	181,215
Admissions	19,331
Clinic Visits	208,000

These levels of volume were used to develop the 1983-84 departmental budgets.

With the decline in occupancy experienced in March and April of 1984, further reductions in forecast volumes became necessary. Based on April 1984 year to date volumes with projections for May and June 1984 based on April levels of activity, the following revised volume levels have been established for 1983-84:

Patient Days	181,060
Admissions	19,850
Clinic Visits	208,000

Using these revised volume estimates as a base and adjusting the admissions and average length of stay to reflect the forecast declines in the feasibility study, the following volume forecasts have been established as the [redacted] base budget for 1984-85:

Patient Days	178,861
Admissions	19,676
Clinic Visits	208,000

This base budget assumes that the declines in occupancy experienced in March and April of 1984 will not continue. In order to prepare for the probability that these levels do continue, management developed a contingency budget for 1984-85 based on this recent experience. If the March and April 1984 utilization levels continue, the following will be the demand budget for 1984-85.

Patient Days	163,465
Admissions	18,923
Clinic Visits	208,000

Schedules I, II, and III summarize the demand forecasts for 1983-84 and 1984-85.

- The Series 1982 Bonds

Under the Indenture of the Series 1982 Bonds, UMH&C is required to contribute $4 million in equity to the Renewal Project, provide cash to amortize $2.8 million of abandoned planning costs and generate sufficient cash to cover $5.103 million in capital needs expected during the fiscal year. These factors have all been included in the projection for 1984-85.

- New Programs

New program requests for 1984-85 have been minimal. For 1984-85, 16.4 new full time equivalents have been added to the budget base. 11.4 of these positions have been justified by reduced operating expense in non-salary areas, and 5 of the positions have been justified through increases in outpatient revenues. Schedule V provides the detail of these new positions.

- Cost Containment Task Force

Another critical internal effort has been the work of the Cost Containment Task Force. You have all recieved a summary of this report. Its essential message is that management and the medical staff must work together in controlling costs and in responding to the constraints of the environment. Our budget for next year reflects the recommendations of the Task Force, including much of what has already been accomplished to date relative to the recommendations in the Task Force Report. In addition, the advice we have received more recently from the Medical Staff Budget Advisory Committee is reflected in our budgeting guidelines.

- 1983-84 Budget Base

In conjunction with each of the above elements, the primary basis for the fiscal year 1984-85 budget is the current year 1983-84 experience. In forecasting the 1984-85 fiscal year budget elements, the current experience in each category was used as the starting point to determine expected 1984-85 results. As described below and shown in the attached detail schedules, forecast admissions, patient days, clinic visits, expenses, revenues, and revenue deductions have been made based on current year experience adjusted for changes predicted in the feasibility study, requirements of the Indenture and new federal reimbursement regulations. The following are general descriptions of how the major elements in the 1984-85 budget forecast were projected:

- Full Time Equivalent Analysis

Budgeted full time equivalents for 1983-84 were 3626.8. Due to activity levels in excess of budgeted levels for the first quarter of 1983-84, FTEs in use as of October were 3653.3. In order to achieve the 1983-84 financial objectives 161.6 full time equivalents were eliminated from the current year budget as of 12-15-83. The result was an adjusted operating budget of 3491.7 FTEs.

Reductions in March and April volumes required most departments to leave vacated positions open. These new vacancies have produced a current FTE count of 3460.

In developing the base budget for 1984-85 a target of 3425 FTEs was established based on our long range planning model productivity forecasting assessment. This, in addition to the 16.4 new program FTEs, brought our base budget for 1984-85 to 3441.4 FTEs.

In analyzing the volume forecasted in our contingency budget, a full time equivalent requirement of 3286.4 is forecast including the 16.4 new FTEs.

Based on our current position it will require a reduction of 35 FTEs to reduce our FTEs to the base budget and it will require a total reduction of 190 FTEs to achieve our contingency budget FTE levels.

Schedule IV summarizes the FTE status for current operating levels, the base budget and the contingency budget.

- Ancillary Service Utilization

This is an area of particular focus, given that over 50% of our admissions will be paid for on a fixed cost per stay or fixed cost per day basis next year. The Cost Containment Task Force report also identified the need to control the use of ancillary services, and several departments and committees are already working on this important issue.

The use of ancillary services has two key variables - the number of admissions/patient days, and the number of tests, procedures, etc. per admission/patient day. As noted earlier, we are budgeting for a decline in admissions/patient days, and ancillary service areas have been budgeted accordingly. In addition we have budgeted to achieve decreases in the use of such services per admission or per patient day ranging from 0% - 5%. This is a relatively moderate decline in ancillary service use; it is also one that with the mutual support and cooperation of our management staff and medical staff should be realistically achievable.

- Expenditure Summary

Schedules VI & VII are comparative summaries of expenditures for fiscal 1983-84 and for the base budget and contingency budgets for 1984-85. These expenditures have been determined using the number of full time equivalents shown on Schedule IV as a basis for salaries and the April year to date actual experience as the basis for the other categories of expense. Decreases in supply and expense categories apparant over the January - April time period have been incorporated in all forecasts. The following inflationary assumptions were used in forecasting 1984-85:

		Inflation %
Salaries		
- July 1, 1984 increase	4.5 %	
- Carry forward of 1/1/84 increase	.5 %	
- 1/1/85 increase	.5 %	
- Comparable worth increase	1.83%	
		7.33%
Fringe Benefits		
Interest Expense (Short-term Notes)		7.0 %
Academic/Resident Contract		5.9 %
Physician Compensation		5.5 %
Other Contract		5.5 %
Utilities		10.0 %
Insurance		(1.0)%
Campus G/A		8.0 %
Drugs		8.0 %
Blood		4.0 %
Food		4.5 %
Laundry/Linen		5.0 %
Rental		4.8 %
Maintenance		5.3 %
Communications		4.6 %
General Supplies/Expense		5.3 %

Depreciation has been calculated using the capital equipment budget as the base for new purchases.

- Series 1982 Bond Indenture Requirements

  Schedule VIII is a summary of the $15,308,000 in cash needs required under the Series 1982 Bond Indenture.

- Deductions From Revenue

  Schedule IX is a summary of the expected deductions from revenue for fiscal years 1984 and 1985. The fiscal 1985 forecast is based on the new prospective payment system and Medicaid regulations.

- Non-Operating and Other Operating Revenue

  Schedule X is a summary of expected appropriations and other non-patient revenues for fiscal years 1984 and 1985. Inflationary increases on the appropriation are forecast based on known allocated appropriations from the University.

- Fiscal Year 1984-85 Cost, Price and Revenue Increases

  To finance the expected increases in costs, revenue deductions and Renewal Project cash flow needs for 1984-85 will require an increase of 7.0% in price increases which increases gross revenues 2.48% in the base budget and represents a 2.72% decrease in gross revenues in the contingency budget. Gross patient charges will increase $4,433,700 under the base budget and will decrease $4,855,600 under the contingency budget. The Comparative Statement of Operations and Projected Cash Flow Statements on Schedule XI summarizes our expected position for fiscal year 1984-85.

Schedule I

UNIVERSITY OF MINNESOTA HOSPITAL & CLINICS
BUDGET YEAR 1984-85
COMPARATIVE DEMAND ANALYSIS
INPATIENT ADMISSIONS

ADMISSIONS	1983-84 PLANNED BUDGET	1983-84 PROJECTION	1984-85 BASE BUDGET	1984-85 CONTINGENCY BUDGET
Clinical Research	363	420	420	380
Dentistry	189	172	172	127
Dermatology	114	107	109	106
Family Practice	42	61	61	64
Gynecology	1,573	1,333	1,333	1,227
Medicine	3,810	3,542	3,492	3,469
Neurology	847	778	778	726
Neurosurgery	1,053	1,062	1,062	909
Newborn	818	800	796	819
Obstetrics	1,104	1,102	1,096	1,105
Ophthalmology	887	841	829	733
Orthopaedics	932	991	991	996
Otolaryngology	912	939	945	1,048
Pediatrics	3,325	3,337	3,299	2,943
PM & R	272	257	257	253
Psychiatry - Adult	434	613	660	564
Psychiatry - Child	136	86	91	79
Surgery	2,877	2,614	2,490	2,540
Urology	787	795	795	835
TOTAL	20,475	19,850	19,676	18,923

Schedule II

UNIVERSITY OF MINNESOTA HOSPITAL & CLINICS
BUDGET YEAR 1984-85
COMPARATIVE DEMAND ANALYSIS
PATIENT DAYS

ADMISSIONS	1983-84 PLANNED BUDGET	1983-84 PROJECTION	1984-85 BASE BUDGET	1984-85 CONTINGENCY BUDGET
Clinical Research	1,631	1,940	1,940	1,919
Dentistry	665	530	530	555
Dermatology	1,479	1,424	1,438	1,653
Family Practice	142	389	389	204
Gynecology	9,427	7,691	7,691	6,037
Medicine	36,153	32,982	32,640	31,587
Neurology	9,193	8,340	8,340	7,311
Neurosurgery	9,341	8,507	8,507	7,699
Newborn	3,881	3,184	3,166	2,876
Obstetrics	4,424	4,474	4,091	3,779
Ophthalmology	3,990	3,633	3,413	2,946
Orthopaedics	8,143	7,769	7,769	7,062
Otolaryngology	3,467	3,531	3,507	3,301
Pediatrics	39,987	39,310	39,058	33,129
PM & R	9,723	7,199	7,199	6,621
Psychiatry - Adult	11,748	14,780	14,809	13,997
Psychiatry - Child	6,895	3,313	3,467	3,629
Surgery	29,725	25,879	24,722	23,507
Urology	5,986	6,185	6,185	5,653
TOTAL	196,000	181,060	178,861	163,465

UNIVERSITY OF MINNESOTA HOSPITAL & CLINICS
BUDGET YEAR 1984-85
COMPARATIVE DEMAND ANALYSIS
CLINIC VISITS

Schedule III

AMBULATORY CARE	1983-84 PLANNED BUDGET	1983-84 PROJECTION	1984-85 BASE BUDGET	1984-85 CONTINGENCY BUDGET
Clinic visits	174,758	175,197	176,246	176,246
E.R. Visits	16,064	14,550	13,684	13,684
Therapeutic Rad. Visits	15,265	15,351	15,197	15,197
Ambulatory Surgery Visits	2,863	2,902	2,873	2,873
TOTAL	208,950	208,000	208,000	208,000

Schedule IV

University of Minnesota Hospitals & Clinics
Budget Year 1984-85
Full Time Equivalent (FTE) Summary

• 1983-84 Planned Budget		3,626.8
1983-84 Experience		
July - October Increase		26.5
October YTD Actual		3,653.3
December 1984 Reduction		(161.6)
December 31, 1983 FTE Position		3,491.7
March & April Reductions		(31.7)
April 30, 1984 FTE Position		3,460.0
• Budget year FTE additions based on direct supply and expense cost reductions or supported by additional non-patient revenues (see schedule)		16.4
• 1983-84 FTE Budget Base		3,476.4
1984-85 Base Budget Target FTEs	3,425.0	
1984-85 New Program FTE Additions	16.4	
		3,441.4
FTE Reductions Necessary to Achieve Base Budget for 1984-85		35.0
• 1983-84 FTE Budget Base		3,476.4
1984-85 Contingency Budget Target FTEs	3,270.0	
1984-85 New Program FTE Additions	16.4	
		3,286.4
FTE Reductions Necessary to Achieve Contingency Budget for 1984-85		190.0

Schedule V

Position Increases with Offsetting Income Statement Effects

FTE	
.4	Personnel "CARES Project - Non-Patient Revenue
1.0	Medical Records State Contract - Non-Patient Revenue
1.0	OAD In-House Maintenance - Cost Offset
1.0	Biomedical Engineering - Non-Patient Revenue
.6	Pharmacy - Research - Non-Patient Revenue
.25	Pharmacy - Investigational Drugs - Non-Patient Revenue
1.0	Patient Monitoring - MOA Expense Decrease
1.0	Labs - Outreach - Non-Patient Revenue
1.9	Outpatient - Hemophelia Grant - Non-Patient Revenue
.75	Radiology - MOA Expense Decrease
2.5	Quality Assurance - Revenue Deduction Decrease
11.4	FTE

New Program Revenue Justified

Sports Medicine	1.5 FTE
NMR	1.5 FTE
Outpatient Pharmacy	.5 FTE
CAPD	.5 FTE
Miscellaneous OPD	1.0 FTE
	5.0 FTE

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

EXPENDITURE SUMMARY -- 1983-84 PROJECTION VS 1984-85 BASE BUDGET

Schedule VI

FOR FISCAL YEARS 1983-84 AND 1984-85

	1983-84 Planned Budget	1983-84 Projection	Variance	Percent Variance	1984-85 Base Budget	Increase/ -Decrease	Percent Change
Expenditures							
Salaries	$ 78,110,219	76,195,000	-1,915,219	-2.5%	$ 80,011,200	3,816,200	5.0%
Fringe Benefits	14,508,242	15,292,800	784,558	5.4%	16,298,900	1,006,100	6.6%
Academic Contracts	1,737,061	1,626,500	-110,561	-6.4%	1,722,200	95,700	5.9%
Resident Contracts	4,239,404	4,220,900	-18,504	-0.4%	4,466,000	245,100	5.8%
Physician Compensation	1,497,382	2,183,500	686,118	45.8%	2,303,600	120,100	5.5%
Total Salary, F.B. & Fees	$ 100,092,308	99,518,700	-573,608	-0.6%	$ 104,801,900	5,283,200	5.3%
Laundry & Linen	$ 2,464,962	2,130,700	-334,262	-13.6%	$ 2,210,100	79,400	3.7%
Raw Food	1,398,406	1,371,800	-26,606	-1.9%	1,403,100	31,300	2.3%
Drugs	9,594,859	10,261,500	666,641	6.9%	11,348,300	1,086,800	10.6%
Blood & Blood Derivatives	4,920,772	4,371,100	-549,672	-11.2%	4,206,000	-165,100	-3.8%
Medical Supplies	11,014,901	9,515,200	-1,499,701	-13.6%	9,634,400	119,200	1.3%
Utilities	1,918,629	1,988,600	69,971	3.6%	2,190,000	201,400	10.1%
Insurance	897,388	842,600	-54,788	-6.1%	834,000	-8,600	-1.0%
Rental	1,428,482	1,381,000	-47,482	-3.3%	1,921,700	540,700	39.2%
Maintenance & Repair	2,827,575	2,837,900	10,325	0.4%	2,968,700	130,800	4.6%
Communications	1,103,117	1,078,900	-24,217	-2.2%	1,140,300	61,400	5.7%
Campus Administration Expense	5,226,000	5,226,000	0	0.0%	5,644,000	418,000	8.0%
Depreciation	6,504,726	6,147,900	-356,826	-5.5%	6,824,200	676,300	11.0%
General Supplies & Expense	12,987,449	11,882,700	-1,104,749	-8.5%	13,237,500	1,354,800	11.4%
Total Supplies & Expense	$ 62,287,266	59,035,900	-3,251,366	-5.2%	$ 63,562,300	4,526,400	7.7%
Total Expenditures	$ 162,379,574	158,554,600	-3,824,974	-2.4%	$ 168,364,200	9,809,600	6.2%

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

EXPENDITURE SUMMARY -- 1983-84 PROJECTION VS 1984-85 CONTINGENCY BUDGET

FOR FISCAL YEARS 1983-84 AND 1984-85

Schedule VII

	1983-84 Planned Budget	1983-84 Projection	Variance	Percent Variance	1984-85 Contingency Budget	Increase/ -Decrease	Percent Change
Expenditures							
Salaries	$ 78,110,219	76,195,000	-1,915,219	-2.5%	$ 76,347,300	152,300	0.2%
Fringe Benefits	14,508,242	15,292,800	784,5[illegible]	5.4%	15,552,200	259,400	1.7%
Academic Contracts	1,737,061	1,626,500	-110,561	-6.4%	1,722,200	95,700	5.9%
Resident Contracts	4,239,404	4,220,900	-18,504	-0.4%	4,466,000	245,100	5.8%
Physician Compensation	1,497,382	2,183,500	686,118	45.8%	2,303,600	120,100	5.5%
Total Salary, F.B. & Fees	$ 100,092,308	99,518,700	-573,608	-0.6%	$ 100,391,300	872,600	0.9%
Laundry & Linen	$ 2,464,962	2,130,700	-334,262	-13.6%	$ 2,070,400	-60,300	-2.8%
Raw Food	1,398,406	1,371,800	-26,606	-1.9%	1,324,600	-47,200	-3.4%
Drugs	9,594,859	10,261,500	666,641	6.9%	11,008,100	746,600	7.3%
Blood & Blood Derivatives	4,920,772	4,371,100	-549,672	-11.2%	4,089,800	-281,300	-6.4%
Medical Supplies	11,014,901	9,515,200	-1,499,701	-13.6%	9,346,500	-168,700	-1.8%
Utilities	1,918,629	1,988,600	69,971	3.6%	2,190,000	201,400	10.1%
Insurance	897,388	842,600	-54,788	-6.1%	834,000	-8,600	-1.0%
Rental	1,428,482	1,381,000	-47,482	-3.3%	1,910,700	529,700	38.4%
Maintenance & Repair	2,827,575	2,837,900	10,325	0.4%	2,968,700	130,800	4.6%
Communications	1,103,117	1,078,900	-24,217	-2.2%	1,140,300	61,400	5.7%
Campus Administration Expense	5,226,000	5,226,000	0	0.0%	5,644,000	418,000	8.0%
Depreciation	6,504,726	6,147,900	-356,826	-5.5%	6,824,200	676,300	11.0%
General Supplies & Expense	12,987,449	11,882,700	-1,104,749	-8.5%	13,160,100	1,277,400	10.8%
Total Supplies & Expense	$ 62,287,266	59,035,900	-3,251,366	-5.2%	$ 62,511,400	3,475,500	5.9%
Total Expenditures	$ 162,379,574	158,554,600	-3,824,974	-2.4%	$ 162,902,700	4,348,100	2.7%

Schedule VIII

University of Minnesota Hospitals & Clinics
Series 1982 Indenture Requirements
1984-85 Budget Year

Reoccurring Capital		$ 5,103,000
Short Term Support Projects:		
- Lipid Clinic Buy-Out	350,000	
- NMR	1,000,000	
- Urologic Kidney Stone Lithotriptor	600,000	
- Completion of BC Shell Space	539,000	
- Linear Accelerator	400,000	
		2,889,000
Existing Computer Lease		516,000
Renewal Project Equity Contribution		4,000,000
Retirement of Short-Term Debt		2,800,000
Total Feasibility Study Requirements		$15,308,000

Schedule IX

University of Minnesota Hospitals & Clinics
Deductions From Charges
Budget Year 1984-85

	1983-84 Planned Budget	1983-84 Projection	1984-85 Base Budget	1984-85 Contingency Budget
Medicare/Medical Assistance	$21,955,959	$20,166,000	$17,923,000	$16,317,000
Medicare/Med. Assis. - Screen Limits	72,875	380,000	390,000	369,000
Blue Cross AWARE	944,000	634,500	1,356,100	1,277,100
GAMC Rateable Reduction	755,844	644,000	676,200	640,000
Billing Adjustments:				
Laboratory Medicine	2,419,878	2,579,200	2,643,200	2,509,200
Cancer Detection/ Colon Cancer	40,588	36,300	31,100	29,500
Late Charges	280,588	80,500	82,500	78,300
All Other	1,129,320	1,635,900	1,707,600	1,620,900
Employee Benefits	59,193	28,800	29,500	28,000
Provision for Uncollectables	4,091,294	3,045,100	2,434,600	2,051,500
Other:				
Clinical Research Center	434,400	469,000	475,000	450,000
Charitable Care	250,000	290,000	270,000	256,300
Kidney Acquisition	1,647,675	1,488,500	1,525,400	1,448,000
Negotiated Contract	1,909,906	1,007,000	760,000	744,900
O.B. Specials/Group Health	392,135	215,200	63,500	61,600
All Other Contract Adj.	19,151	52,500	53,800	51,100
Totals	$36,402,806	$32,752,500	$30,421,500	$27,932,400

Schedule X

University of Minnesota Hospitals & Clinics
Budget Year 1984-85
Non-Operating Revenue Analysis

	1983-84 Budget	1983-84 Projection	1984-85 Budget Base	1984-85 Budget Contingency
Appropriations	$12,420,450	$12,420,700	$13,041,700	$13,041,700
Interest Income	1,838,596	4,559,000	3,022,000	3,053,000
Shared Services	369,224	387,400	406,800	406,800
Investment Income on Trustee Held Funds	1,725,000	1,746,000	1,860,000	1,860,000
Total	$16,353,270	$19,113,100	$18,330,500	$18,361,500

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS
SUMMARY STATEMENT OF OPERATIONS AND OPERATING CASH FLOW
FOR FISCAL YEARS 1983-84 AND 1984-85

Schedule XI

	1983-84 PLANNED BUDGET	1983-84 PROJECTION	1984-85 BASE BUDGET	1984-85 CONTINGENCY BUDGET
GROSS PATIENT CHARGES	188,871,500	178,687,700	183,121,400	173,832,100
DEDUCTIONS FROM CHARGES	36,402,806	32,752,500	30,421,500	27,932,400
OTHER OPERATING REVENUE	3,210,457	3,517,200	3,430,300	3,374,700
TOTAL REVENUE FROM OPERATIONS	155,679,151	149,452,400	156,130,200	149,274,400
EXPENDITURES				
SALARIES	78,110,219	76,195,000	80,011,200	76,347,300
FRINGE BENEFITS	14,508,242	15,292,800	16,298,900	15,552,200
CONTRACT COMPENSATION	7,473,847	8,030,900	8,491,800	8,491,800
MEDICAL SUPPLIES, DRUGS, BLOOD	25,530,532	24,147,800	25,188,700	24,444,400
CAMPUS ADMIN. EXPENSE	5,226,000	5,226,000	5,644,000	5,644,000
DEPRECIATION	6,504,726	6,147,900	6,824,200	6,824,200
GENERAL SUPPLIES & EXPENSE	25,026,008	23,514,200	25,905,400	25,598,800
TOTAL EXPENDITURES	162,379,574	158,554,600	168,364,200	162,902,700
NET REVENUE FROM OPERATIONS	-6,700,423	-9,102,200	-12,234,000	-13,628,300
TOTAL NON-OPERATING REVENUE	16,353,270	19,113,100	18,330,500	18,361,500
REVENUE OVER/(UNDER) EXPENSES	9,652,847	10,010,900	6,096,500	4,733,200
ADD NON-CASH OUTLAYS:				
DEPRECIATION	6,504,726	6,147,900	6,824,200	6,824,200
CAMPUS ADMIN. EXPENSE	5,226,000	5,226,000	5,644,000	5,644,000
K.E. UTILITIES	163,456	137,900	149,000	149,000
INCREASE IN ACCRUED EXPENSE	490,669	461,900	867,300	503,300
INCREASE IN 3RD PARTY PAYABLE	12,486,538	11,404,000	500,000	500,000
DECREASE IN PREPAID EXPENSE	179,854	-127,700	136,000	136,000
INVESTMENT INCOME HELD BY TRUSTEE	-1,725,000	-1,746,000	-1,860,000	-1,860,000
TOTAL FUNDS PROVIDED	32,979,090	31,514,900	18,357,000	16,629,700
FUNDS APPLIED:				
INCREASE IN ACCOUNTS RECEIVABLE	3,303,620	4,033,000	925,600	-933,700
INCREASE IN ACCRUED REVENUE	7,398	274,300	28,000	28,000
INCREASE IN INVENTORIES	815,400	240,400	272,100	163,800
TRANSFER TO RESERVES - 3RD PARTY	12,486,538	11,404,000	500,000	500,000
TOTAL FUNDS APPLIED	16,612,956	15,951,700	1,725,700	-241,900
TOTAL CASH AVAILABLE FROM OPERATIONS	16,366,134	15,563,200	16,631,300	16,871,600

Schedule XII

University of Minnesota Hospitals & Clinics
Budget Year 1984-85
Contingency Budget Plans Initiated as of 5/15/84

1. Initiate discussions with physicians to "bring back" to University patients being cared for by University physicians at other hospitals.

2. Initiate Obstetrics program review.

3. Initiated contacts with Physicians Health Plan regarding renal transplantation and Gynocology - Oncology services.

4. Proceeding with contract negotiations with Group Health on cardiac surgery and heart catherization.

5. Proceeding with plans to review preferred provider organization in California and the University of Wisconsin Health Maintenance Organization.

6. Developed bed reconfiguration plan to close beds and reduce 23.41 FTEs in process of the bed allocation change.

PROPOSED CAPITAL EQUIPMENT & REMODELING/RENOVATION BUDGET FOR FISCAL YEAR 1984-85

- CONTENTS -

1984-85 CAPITAL BUDGET

FIVE YEAR CAPITAL BUDGET PROJECTIONS

	84/85	85/86	UNIT J	86/87	87/88	88/89
NON-RECURRING CAPITAL EXPENSE						
Lipid Clinic Buyout	$ 350,000					
N M R Radiology	1,000,000					
Kidney Stone Machine	600,000	600,000				
Computer Upgrade	250,000	250,000		250,000	250,000	250,000
4 MEV Linear Accelerator	400,000					
RECURRING CAPITAL & UNIT J REQUESTS						
Departmental Not to Exceed Allotments		2,092,000	6,650,000	2,872,000	5,192,000	5,942,000
Detailed Departmental Requests	3,875,808					
Endoscopy (Unit J Enhancements)		360,000				
Heart Cath (Unit J Enhancements)		1,695,000				
Diagnostic Radiology (Unit J Enhancements)		505,000				
Diagnostic Radiology (Unit J Replacements)		2,000,000	508,000			
OAD	648,130	715,000		787,000	865,000	951,000
Unit J Furniture			1,960,000			
Miscellaneous Unit J Equipment			1,680,000			
Unit J Move Costs			775,000			
Unit J Equipment Inflation			1,671,000			
Mayo Remodeling Furniture & Equipment				250,000	250,000	
Remodeling	578,427	300,000		200,000	410,000	410,000
TOTAL RECURRING & UNIT J REQUESTS	5,102,365	7,667,000	13,244,000	4,109,000	6,717,000	7,303,000
FUNDS AVAILABLE	5,500,000	8,064,000	13,250,000	4,629,000	7,251,000	7,935,000
SUBTRACTIONS FROM FUNDS						
CT Scanner	277,000	277,000		277,000	277,000	277,000
ET-1100 Terminals	120,000	120,000		120,000		
A9F Computer				123,000	257,000	355,000
NET FUNDS AVAILABLE	5,103,000	7,667,000	13,250,000	4,109,000	6,717,000	7,303,000

1984-85 CAPITAL BUDGET
EQUIPMENT BUDGET BY DEPARTMENT

DEPARTMENT	EQUIPMENT BUDGETED AMOUNT
ANESTHESIOLOGY	$ 75,489
BIOMEDICAL ENGINEERING	17,000
COMMUNITY SERVICES	500
CO-OP LIAISON OFFICE	795
CYSTOSCOPY	98,814
DIAGNOSTIC RADIOLOGY	918,125
LABS	1,176,621
MATERIALS MANAGEMENT	198,225
NEUROLOGICAL LAB	37,000
NURSING SERVICES	161,373
NUTRITION	5,200
OPERATING ROOMS	287,774
OUTPATIENT	168,084
PATIENT MONITORING	328,154
PATIENT RELATIONS	2,175
PERSONNEL	2,600
PHARMACY	17,125
PHYSICAL MEDICINE & REHABILITATION	17,632
PUBLIC RELATIONS	13,114
RADIO PAGING	10,000
RESPIRATORY THERAPY	246,943
THERAPEUTIC RADIOLOGY	62,805
WORD PROCESSING	30,260
	$ 3,875,808

1984-85 CAPITAL BUDGET

EQUIPMENT ITEMS OF $100,000 OR MORE

DEPARTMENT	ITEM	COST
Laboratories	Replacement Computer	$ 778,710
	Random Access Analyzer	125,000
Patient Monitoring	Monitoring System CCU/201	120,000
Diagnostic Radiology	Video Tape Recorders (3 @ $35,000)	105,000
	Skull Unit	185,000
	Total Body Scanner	145,000
	Cleon Whole Body Scanner	150,000
Computer Services	Cost Accounting Software	100,000
	Nursing Station Management System	150,000
	Data Communications Equipment	229,000

1984-85 CAPITAL BUDGET
REMODELING/RENOVATION BUDGET BY DEPARTMENT

DEPARTMENT		REMODELING BUDGET AMOUNT
Biomedical Engineering		$ 5,000
Computer Services		27,050
Labs		29,400
Maintenance & Operations		80,000
Materials Management		29,500
Nursing Services		232,680
Nutrition		1,750
Operating Rooms		5,000
Outpatient		158,300
Patient Accounting		1,447
Pharmacy		2,300
Physical Medicine & Rehabilitation		6,000
	TOTAL	$ 578,427

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

May 15, 1984

TO: Board of Governors

FROM: C. Edward Schwartz
Hospital Director

SUBJECT: Annual Employee Compensation Plan

The Hospital Personnel Policies and Procedures require that the Board of Governors approve the employee compensation plan each year. The purpose of this memo is to provide recommendations in this regard for fiscal year 1984-85.

The basic compensation plan increases follow those of the University very closely. With the recent delegation of authority, and with the job evaluation study currently underway, our recommendation is that 1984-85 not be a year for major salary plan restructuring. The plan that is presented here is thus relatively straightforward.

The major recommendation is for a 4.5% (or 30¢ per hour, whichever is greater) increase in salary scales and individual employee salaries effective July 1, 1984. This is the same percentage increase which the University is providing, and the same increase called for under our union contracts.

Effective January 1, 1985, an additional 1% increase would be provided. This also reflects past practice and the University's plan for 1984-85.

This will be the second year of implementation of the comparable worth adjustments initiated in 1983-84. It is projected that the additional cost of the comparable worth adjustments will be $475,000, to be provided to employees in 35 job classifications, with the comparable worth adjustments ranging from 2.7% to 7.7%. Approximately 561 FTEs and 750 employees will benefit from these additional salary increases.

During fiscal year 1984-85 we also anticipate the need to make market-place related salary adjustments for a number of classifications. The bulk of these are in Nursing related classes, where the salary administration structure at the University has caused a large number of our nursing staff to fall behind their counterparts in the community. The details of this component of the salary plan will be developed following the community MNA settlement. At this point there is $600,000

budgeted for the nursing related adjustments. We have also budgeted approximately $300,000 for other classification or salary adjustments for non-nursing personnel.

Each of these components of the compensation plan has been incorporated into the 1984-85 budget projections, and thus can be financed within the recommended price increase.

In summary, in addition to a .5% salary increase carry forward from January of 1984, we have budgeted an average increase of 5% for salaries in fiscal 1984-85 and have an additional $1,375,000 incorporated for salary adjustments associated with comparable worth.

We would be happy to provide additional details or answer any questions which the Board of Governors may have.

/kj

May 23, 1984

ALLOCATION OF UNIT "J" SHELL SPACE

RESOLUTION

1. The allocation of Unit J shell space be accomplished in accordance with the schematic drawing dated May 8, 1984. Approximate assignments of space are as follows:

. Endoscopy	2930 NSF
. Cardiopulmonary Labs	6750 NSF
. Nutrition	1900 NSF
. Materials Management	500 NSF
. Therapeutic Radiology	200 NSF
. Pediatric Dialysis	1200 NSF

2. Detailed planning, departmental review and construction shall commence on all spaces listed, total planning and construction costs not to exceed $2.4 million.

Office of the Chief of Staff

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
Box 707 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

May 8, 1984

TO: Board of Governors

FROM: Paul G. Quie, M.D.
Chief of Staff

SUBJECT: Appointment of Chief of Staff

The Bylaws of the Medical and Dental Staff, Article V, Part A:, Section 3. (a) states "Election: The Chief of Staff shall be elected by the voting members of the medical staff by a plurality vote of the staff voting by mail ballot. His or her election shall become effective as soon as approved by the Board. The Chief of Staff shall serve a three year term and is eligible for a second two year term but in any event shall serve until a successor has been elected and his or her election approved by the Board. If the office of Chief of Staff becomes vacant the Vice Chief of Staff shall serve as acting Chief of Staff for the remainder of the term or until a successor is elected."

My last term of office as Chief of Staff will come to an end on June 30, 1984. The Nominating Committee appointed by the Medical Staff-Hospital Council selected Dr. James Moller to run for election for the office of Chief of Staff and the Council approved the recommendation. Elections were held in April and the tabulated results indicate that Dr. James Moller has won the election by plurality. I hereby request your approval of Dr. James Moller as Chief of Staff.

Thank you for your consideration of this request.

PGQ/lk

Minutes
Finance Committee
University of Minnesota Hospitals & Clinics
April 25, 1984

MEMBERS PRESENT:	Al France, Chair Carl Drake Cliff Fearing Richard Kronenberg, M.D. Jerry Meilahn C. Edward Schwartz
MEMBERS ABSENT:	Shelley Chou, M.D. Mary Des Roches
STAFF:	Greg Hart Nancy Janda Nels Larson Jane Morris Barbara Tebbitt
GUESTS:	David Cost Steve Grygar Lynn Hornquist Barbara O'Grady

CALL TO ORDER: The meeting of the Finance Committee was chaired by Mr. Al France and was called to order at 9:40 a.m. in the Dale Shepard Room of the Campus Club.

MINUTES APPROVED: The minutes of the March 28, 1984 meeting of the Finance Committee were approved.

MARCH YTD FINANCIAL STATEMENTS (INFORMATION): Mr. Fearing reviewed the Report of Operations for the period July 1, 1983 through March 31, 1984. He stated that the month of March showed a downturn in census levels compared to the levels for September 1983 through February 1984. Inpatient admissions during March were 1,621 or 219 below the projected figure of 1,840. Outpatient clinic visits were also below the 18,659 projected visits at 17,002 for March. The YTD clinic census is still 0.5% above projected visits, although it is 833 visits below the total of a year ago.

Total revenues over expense are $7,565,932, a favorable variance of $1,043,443, and this variance continues to be due in most part to investment income. Net revenue from operations through March however, showed a net loss of $6,749,442 compared to the budgeted loss of $5,760,816.

Patient care charges and routine revenues through March are both below budget. Ancillary revenues declined reflecting the declines in admissions and in revenues per admission. Somewhat offsetting this is the decline in expenditures (1.8% below budget), continuing to reflect the cost reduction actions taken by management last fall.

Patient accounts receivable decreased from the February level of 83.4 days to 81.5 days of revenue outstanding as of March 31, 1984. The targeted goal for the end of the fiscal year is 78 days.

In addition, Mr. Fearing noted that there has been a change in geographic distribution of admissions. Metro area admissions have fallen off while admissions from outstate and out-of-state have remained relatively consistent. This drop in metro area admissions is consistent with other area hospitals and is partially due to more stringent screening and review procedures by third party payors.

In concluding the Report of Operations, Mr. Fearing stated that the drop in census levels will effect both 1983-84 year end projections and 1984-85 budget projections making expense reductions a necessary consideration to meet financial requirements.

Mr. Fearing gave a complete review of the detail Income Statement with explanations of areas showing major variations from the budget.

The Operating Cash Flow Statement shows negative total cash available of $72,147 after transfers to Renewal Project of $3,000,000, transfers to debt retirement of $2,100,000, and transfers to Plant of $3,079,137. Mr. Fearing further explained the negative cash flow by noting that March had the lowest number of outstanding payroll days. He stated that all committments for the Bond Indenture have now been met for this fiscal year.

Mr. Schwartz asked that a discussion and explanation of Medicare Part A and Part B be presented to the Committee at a future meeting.

1984-85 BUDGET (INFORMATION):

Mr. Fearing stated that the Budget process is on schedule for approval in June by the Board of Governors. The June date is two months behind the historic timetable for budget approval, but more time was required to accumulate data to make 1984-85 budget projections in light of the recent changes in census levels and the institution of the AWARE program at University Hospitals. The Finance Committee will possibly be scheduled for two meetings in June to review and recommend approval of a 1984-85 budget. The Hospital budget will be brought to the Board of Regents for information and approval at their July meeting.

1984-85 CENSUS PROJECTIONS (INFORMATION):

Mr. Fearing summarized a report of Inpatient Census Highlights comparing data from March 1983 and March 1984 for admissions, patient days and average daily census.

A discussion followed focusing on the declining activity levels, and that University Hospitals pursue both increasing its market share and decreasing costs. The issue of the Hospitals' marketing plan will be brought to the Board of Governors in June.

YEAR END PROJECTIONS (INFORMATION):

Mr. Fearing reviewed a Projected Comparative Income Statement and Operating Cash Flow for the fiscal year ending June 30, 1984. The revenue over expense projection for this period is $8,080,331 or $1,572,516 under the original 1983-84 target. The net cash bottom line was originally budgeted at $16,366,134, and is now projected at $15,047,232, assuming a goal of 78.0 days of revenue outstanding at 6/30/84. Mr. Fearing explained how the amount of revenue outstanding would effect the total cash available at the 75.0 day and 80.0 day levels.

LONG RANGE PLAN UPDATE (INFORMATION):

Mr. Fearing highlighted a collection of schedules that essentially updated all the assumptions of the feasibility study and explained how these revised assumptions were used to arrive at a new long range plan. These schedules show comparisons of the long range plan to the feasibility study, revenue and expense forecasts, and expense forecast assumptions. Mr. France added that the entire report is a valuable supporting document for the budget and should be reviewed in detail by the Committee members.

THIRD QUARTER BAD DEBTS (ENDORSEMENT):

Mr. Fearing reported that bad debts for the third quarter of 1983-84 amounted to $547,950.30, (represented by 1,497 accounts). Additional bad debts of $2,282.00 for Home Health Services were also reported. He stated that the year-to-date total for bad debts was $1,513,131.06, which was 1.1% of gross charges (compared to a budgeted level of 3.1%).

A motion was made and approved by the Committee to endorse the Bad Debt Report and recommend it to the full Board of Governors.

ADJOURNMENT:

There being no further business, the meeting of the Finance Committee was adjourned at 11:50 a.m.

Respectfully submitted,

Jane E. Morris
Recording Secretary

Minutes
Planning and Development Committee
Board of Governors
May 9, 1984

CALL TO ORDER: Committee Chairman Al Hanser called the meeting of the Planning and Development Committee to order at 10:45 a.m., Wednesday, May 9, 1984, in Hospital Dining Room III.

ATTENDANCE:

Present: Al Hanser, Committee Chair
Lynn Hornquist
William Krivit, M.D.
John LaBree, M.D.
Virgil Moline
C. Edward Schwartz
I. Dodd Wilson, M.D.

Absent: Clint Hewitt

Staff: Greg Hart
Ed Howell
Nancy Janda
Mark Koenig

Guests: David Cost, Board Chair
Ken Merwin
Ron Werft
Steve Young, Robert Douglass Assoc.

APPROVAL OF MINUTES: The committee seconded and passed a motion to approve the minutes of the April 11, 1984 meeting as written.

RENEWAL & RENOVATION STEERING COMMITTEE REPORT: Mr. Mark Koenig reviewed for the Committee the status of the bid packages, noting that 99% of all bid packages had been awarded. Only two packages, one for site work and one for final cleanup, are not yet awarded. Mr. Koenig also indicated that the new Radiation Therapy facility is scheduled for occupancy on August 1, 1984 and that the remainder of Unit "J" remains on schedule for substantial completion by March 1, 1986 and certified completion by December 1, 1986.

Mr. Hanser raised a current issue, for the Committee's information, as to whether the coaxial cable in Unit "J" would be most appropriately installed by the Northwestern Bell Telephone workers or by the Electrica Repair and Construction workers. Although the telephone workers bid was well below that of the electrical workers, the electrical workers, on the national level, have been disputing the issuance of coaxial cable contracts to telephone workers.

SHELL SPACE: Mr. Mark Koenig presented background information and a proposed resolution for the allocation of unfinished shell space in Unit "J". He noted that on February 28th the Medical Staff Coordinating Committee recommended that the programs of Endoscopy and Cardiopulmonary Laboratories have priority for occupancy for that unfinished space.

Hospital Administration and Unit "J" planners, he added, have assisted the departments of Endoscopy and Cardiopulmonary Laboratories in the development of operational and functional programs and that schematic drawings indicate that these programs can be accommodated in the available space on level 1 of Unit "J". A couple of smaller areas on that same level have been reviewed by the Hospital Staff Coordinating Committee and have been recommended for assignment to the Departments of Nutrition and Materials Management. With that background, Mr. Koenig presented the following resolution for Planning and Development Committee endorsement:

RESOLUTION:

RESOLUTION

1. The allocation of Unit J shell space be accomplished in accordance with the schematic drawing dated May 8, 1984. Approximate assignments of space are as follows:

. Endoscopy	2930 NSF
. Cardiopulmonary Labs	6750 NSF
. Nutrition	1900 NSF
. Materials Management	500 NSF
. Therapeutic Radiology	200 NSF
. Pediatric Dialysis	1200 NSF

2. Detailed planning, departmental review and construction shall commence on all spaces listed, total planning and construction costs not to exceed $2.4 million.

ENDORSEMENT: The Committee seconded and passed a motion to endorse the resolution as written and will forward the resolution to the full Board for approval at their May 23rd meeting.

INSTITUTIONAL OBJECTIVES: Mr. C. Edward Schwartz introduced the Institutional Objectives for 1984-85 by noting that they had been reviewed and revised by several different Management and Medical Staff groups and that all of the Board Committees would have the opportunity for input before the full Board considered these objectives at their May meeting. Mr. Schwartz reviewed each of the major headings under which the objectives are categorized. Committee discussion followed regarding the importance of defining ourselves as an institution in a way that meets the needs of our patient population and referring physicians. The Committee recommended that an objective be added, that in essence, would provide patient activity targets for th respective Medical Staff departments and an incentive system to reward those departments that meet or exceed target levels. Mr. Schwartz agreed to draft such an objective.

ENDORSEMENT: With that addition, the Planning and Development Committee seconded and passed the motion to endorse the 1984-85 Institutional Objectives.

FEASIBILITY STUDY: UNIT "J" CAMPAIGN: Mr. Ken Merwin distributed copies of final report developed by the Bentz, Whaley, Flessner Firm that assesses the University of Minnesota Hospitals and Clinics fundraising potential for Unit "J". In light of Mr. Flessner's inability to attend the Planning and Development Committee meeting, Mr. Merwin asked that the Committee members review the document before the June Committee meeting, at which time Mr. Flessner will make a formal presentation of findings.

EXTRACORPOREAL LITHOTHRIPTER STATUS REPORT:

Mr. Greg Hart relayed to the Committee the outcome of his meeting in New Orleans with representatives of Dornier Corporation, manufacturer of the extracorporeal lithothripter. He indicated that as FDA approval of the lithothripter is not expected until late 1984 or early 1985, that the Dornier Corporation is not prepared to develop agreements for acquisition of this technology at present. He did note that the Dornier representatives are well aware of the continued interest on the part of the University Hospitals in obtaining a lithothripter and that Dr. Fraley would continue to communicate closely with the corporation.

ADJOURNMENT:

Due to time constraints, the Committee tour of the new Radiation Therapy facility was postponed and the meeting was adjourned at 12:50 p.m.

Respectfully submitted,

Nancy C. Janda

Nancy C. Janda
Executive Assistant
to the Board of Governors

Minutes

Joint Conference Committee

Board of Governors

May 9, 1984

ATTENDANCE:

Present: Barbara O'Grady, Chair
Phyllis Ellis
Glenn Gullickson, M.D.
Robert Latz
Robert Maxwell, M.D.
Paul Quie, M.D.
C. Edward Schwartz

Absent: Paula Clayton, M.D.

Guest: Dianne Bartels

Staff: Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt

APPROVAL OF MINUTES:

The minutes of the March 14, 1984 meeting of the Joint Conference Committee were approved as submitted.

CASE STUDY - ETHICS:

Ms. Dianne Bartels, co-chair of the Biomedical Ethics Committee, reviewed for the Committee a case which raised several ethical issues. This was a case in which the Biomedical Ethics Committee was asked to play a consultative role, in particular to assist the involved medical staff. The case involved a judgment about transplantation of a child and the physician's judgment, that of several consulting physicians, and the wishes of the parents. The committee's involvement was as a consultative group for the attending physician and as a convener of a group discussion with the involved medical staff and the parents of the child. The Chief of Staff's role in the process was also an important one, and a satisfactory conclusion was reached in a very difficult case.

Ms. Bartels indicated that consultations in cases such as these will likely become more frequent in the future. The Biomedical Ethics Committee is currently in the process of developing guidelines for this role. The Joint Conference Committee asked that these guidelines be reviewed with the Committee following their development, and thanked Ms. Bartels for her informative presentation.

JCAH REVIEW:

Ms. Nancy Janda provided the Committee with an overview of the Joint Commission on Accreditation of Hospitals and their process for accreditation survey. She indicated that historically the JCAH has looked at three major areas - physical plant, quality of care, and the administrative and organizational process used in the Hospital. In recent history the Joint Commission has focused its efforts in particular at quality assurance and has also begun using outcome measures rather than looking for specific processes within the organization.

Ms. Janda indicated that University Hospitals will receive its site visit late in 1984. She described the process of this site visit, and indicated that we are currently doing an interim survey and self-assessment in preparation for the site visit. Further information will be provided to the Joint Conference Committee as the December date approaches.

MEDICAL STAFF/HOSPITAL COUNCIL REPORT:

Dr. Paul Quie reported on the most recent meeting of the Medical Staff Hospital Council. He indicated that the bulk of the Council's discussion revolved around a quality assurance study on histories and physicals. He described the findings and conclusions of this study.

Dr. Quie also indicated that the Council had appointed a task force on gender identification.

Dr. Quie also reported that Dr. James Moller has been elected as the new Chief of Staff, to become effective July 1, 1984, and that he will be joining the Joint Conference Committee at this time.

It was then noted that this is the last meeting of the Joint Conference Committee at which Dr. Quie will be present. In recognition of Dr. Quie's outstanding contributions over the past five years to the Joint Conference Committee and the Board of Governors in his role as Chief of Staff, Mr. Latz offered a formal motion expressing great appreciation to Dr. Quie for his years of service on the Committee and the Board. The Committee unanimously and strongly endorsed this motion.

CLINICAL CHIEFS REPORT:

Dr. Glenn Gullickson reported that the Clinical Chiefs are planning a second retreat scheduled for June 9, 1984. The focus of this retreat will be on program development, volume levels, and marketing. The assessment process which the Chiefs are currently going through in preparation for the retreat was described.

Dr. Gullickson also reported that the Hospitals and the Clinical Chiefs have engaged a consultant to review the organization and financin of ambulatory care at the Hospitals. This consulting study will be done over the next several months.

INSTITUTIONAL OBJECTIVES:

Mr. Schwartz went over a set of proposed institutional objectives for fiscal year 1984-85. The objectives are broadly divided into the areas of medical staff programmatic development, external market share objectives, financial objectives, operating and activity objectives, and construction and renovation objectives.
Mr. Schwartz indicated that at the Planning and Development Committee earlier that day the group suggested an additional objective under the medical staff and programmatic development section. This objective relates to the development of a fund for program enrichment and the development of incentives for the medical staff for clinical activities. The Joint Conference Committee also suggested an additional objective, related to delineation of the medical staff and Board's role in process in dealing with ethical issues, particularly those where resource allocation impinges on clinical decision making. The Committee discussed these objectives in some depth, with some reservation being expressed. It was agreed that these two items would not become part of the formal Joint Conference Committee endorsement of the institutional objectives, but would continue to be developed and examined.

The Joint Conference Committee amended objective #3 under construction and renovation, adding the phrase "directed at patient care delivery efficiency and cost". With this amendment, the Joint Conference Committee endorsed the objectives as proposed.

OTHER:

Ms. Tebbitt reported on the status of the potential nursing strike at the community hospitals and University Hospitals preparation should such a strike occur. Ms. Tebbitt also noted that the Hospitals is currently in the process of developing a major bed reallocation and station reconfiguration plan and reviewing this plan with the medical staff.

ADJOURNMENT:

There being no further business, the meeting adjourned at approximately 8:50 p.m.

Respectfully submitted,

Greg Hart/s

Greg Hart

Nurses authorize May 31 strike deadline

By Josephine Marcotty
Staff Writer

Registered nurses at 17 Twin Cities hospitals Wednesday rejected a contract offer by a decisive margin and authorized a strike for midnight May 31.

Bob Wiesner, labor relations representative for the Minnesota Nurses Association, said last night that he expected the Federal Mediation and Conciliation Service would arrange a meeting between the nurses and hospitals before a strike begins.

"The nurses appreciate the seriousness of the situation. They didn't make the decision lightly, but their status as employees is in jeopardy," he said.

The vote tally was completed about midnight. The totals were not released, but Wiesner said there was more than a two-to-one margin against the offer.

If the nurses and the 17 hospitals do not reach agreement by May 31, the nurses could strike.

The nurses' biggest concern is job security, they said at the meetings held yesterday. They said winning a contract that protects their job security is far more important than one that boosts their wages.

They said nurses are having the number of hours they work reduced involuntarily, and without warning. Then, hospitals frequently will call them on short notice and ask them to work extra shifts when extra nurses are needed.

"It's like a daily labor pool," said Lori Hanson, a nurse who used to work at St. Mary's Hospital. In February she had her hours reduced from 24 to 16 per week, and since has found a full-time job at Children's Hospital in Minneapolis.

Karen Patek, labor representative for the MNA, said that during the last four years the number of full-time nursing jobs at the hospitals has shrunk from 50 percent to 30 percent.

Mike Phillips, director of labor relations for Health Employers, Inc., which is representing the hospitals at the bargaining table, said that the hospitals need flexibility, particularly for weekend coverage.

In addition, Patricia Oatman, director of public relations for Metropolitan Medical Center, said that the hospital needs to be able to adjust its nursing staff to match the number of patients on a daily basis. It is easier to do that with a larger number of part-time nurses, she said.

The MNA has proposed that hospitals implement cutbacks in hours as well as layoffs according to seniority. In addition, they want nurses to be able to transfer between units, and between hospitals owned by the same corporation.

But Phillips said that the hospitals cannot transfer nurses to other units unless they are qualified for the work.

"You can't operate a hospital on the same model as an industrial setting where people are interchangeable and can go from one job to another. You have to take into account their ability to move from one service to another," he said.

Several nurses also worried that if the trend toward part-time work continues, nursing may lose status as a profession.

"Who's going to go through four years of college knowing they can't work full time when they get out?" said Barbara Bly, a nurse at Abbot-Northwestern Hospital.

Though job security was named as the most important issue on the table, the hospitals and the MNA must also agree on wages.

The nurses have asked for a 6 percent wage increase in each year, and the hospitals have offered 3.5 and 4 percent. Under the hospitals' offer, registered nurses with an associate degree would earn $1,714 per month, and $2,366 per month after 12 years.

Assistant head nurses with an associate degree would start at $1,849 per month and would earn $2,502 after 12 years. Nurses at each level earn more with higher educational degrees

The hospitals involved in the negotiations are Abbott Northwestern, Eitel, Fairview, Fairview Deaconess, Metropolitan Medical Center, Children's Medical Center, Mount Sinai, St. Mary's, St. Mary's Rehabilitation Center, all of Minneapolis; St. Joseph's, Samaritan, St. John's, Bethesda, all of St. Paul; Fairview Southdale, Edina; North Memorial Medical Center, Robbinsdale; Methodist, St. Louis Park, and Divine Redeemer, South St. Paul.

Nurses at United Hospital and Children's Hospital, both in St. Paul, on Tuesday overwhelmingly rejected a similar contract. The contracts covering those 740 registered nurses also expires May 31. Two years ago United and Children's withdrew from the hospital group that is negotiating contracts with the other Twin Cities nurses.

There has not been a strike by nurses in the Twin Cities, although there have been strikes in Red Wing, Winona, Hastings and Hibbing, Minn.

MINNEAPOLIS STAR & TRIBUNE, THURSDAY, MAY 17, 1984

and possibly viral-surface characteristics that preferentially enhance entry into lymphocytes or epithelium. Given the large and sophisticated genomes of these viruses, it seems certain that such biologic variants exist.

The solutions to these mysteries of pathogenesis have more than academic interest. EBV DNA is regularly found in the epithelial elements of nasopharyngeal carcinoma in which the virus returns to its latent state or, at best, undergoes abortive replication.[12,13] Does this mean that latency by the virus and growth stimulation of the host cell are inexorably linked? In nasopharyngeal carcinoma, stimulation of malignant growth of the epithelial cells may be consequent to failure of the virus to replicate. On the other hand, it is the replicative, not the immortalizing, mode of infection of normal epithelial cells that yields virus, which permits the infection to be transmitted from one person to another. Therefore, control of EBV infection and disease through either chemotherapy or vaccination must be directed not only at immortalization but at reducing or eliminating virus from the site of replication in the mouth and salivary glands.

Yale University
School of Medicine
New Haven, CT 06510 GEORGE MILLER, M.D.

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ARE TEACHING HOSPITALS WORTH THE EXTRA COST?

EVERYONE knows that teaching hospitals have greater expenses and charge more for their services than do nonteaching hospitals. In 1981, for example, the average cost of care, per adjusted admission, in the more than 300 major teaching hospitals belonging to the Council of Teaching Hospitals was approximately twice that in the nonteaching hospitals.[1] Several reasons are usually given for this striking difference. Teaching hospitals must bear the direct and indirect costs of their multiple teaching programs. They also do a certain amount of clinical research that is not fully reimbursed through outside grants and contracts. Their patients tend to be sicker, to have more complicated illnesses, and hence to require more sophisticated care. Teaching hospitals are usually the tertiary-care centers of last resort and must maintain relatively larger and more specialized staffs, use more technology, and have considerably greater standby capacity. Finally, they usually have a much higher fraction of nonpaying patients than do nonteaching hospitals. Although they constitute less than 6 per cent of all acute-care hospitals, the hospitals belonging to the Council of Teaching Hospitals provide almost half the charity care in the country.

In the days when hospitals were paid more or less whatever they charged, this difference in cost was no problem. The teaching hospitals provided the services that they deemed necessary for their teaching, research, and patient-care commitments, and like other hospitals, they simply billed the third-party payers for their total expenses. The third-party payers — Medicare and Medicaid, Blue Cross, and the private insurance companies — were in effect paying for *all* the costs of the teaching hospitals, even though they were obligated to pay only for clinical care. Of course, much of this extra payment was being returned to patients in the form of services provided by house staff and students, as well as more sophisticated clinical care. But at least some of the differential payment was simply a cross-subsidy — a transfer of the cost of education, research, and free care to the third parties.

Now those halcyon days are over. The third-party payers, particularly Medicare and Medicaid, are running out of funds and are relentlessly tightening the screws in an effort to reduce their expenses. Price competition has arrived, Medicare is switching to a prospective payment system based on fixed payments according to diagnosis-related groups (DRGs), and for the first time, teaching hospitals must face the need to cut their costs if they wish to survive.

The Medicare prospective payment system makes no distinction between a patient in a given DRG who is treated in a nonteaching hospital and one treated in a teaching hospital in the same region. It is assumed that the average complexity of cases in a given DRG, and hence the resources needed to treat them, are the same in all hospitals. The direct costs of house staff and fellows are separated from patient costs and are, for the moment, reimbursed separately and in full. The indirect costs of the house staff, and all the other direct and indirect costs of teaching and research, are dealt with through an added payment calculated by an arbitrary formula based on the number of house officers per bed. Under this system, there is no recognition of the costs of free care in the teaching hospitals.

The Medicare DRG payment system will be phased in over a period of three years (and possibly more). For the time being, the other third parties continue to reimburse charges or costs or some fraction thereof. But the handwriting is on the wall, and the message is plain: The special needs of teaching hospitals will no longer be automatically accommodated by a passive reimbursement system. The major teaching hospitals are now called on to convince the government and the other third-party payers that their unique and expensive blend of education, research, and sophisticated tertiary care for all comers, regardless of ability to pay, is worth supporting.

The study reported by Garber and his colleagues[2] in this issue is a timely and important contribution to this discussion. It compares costs and outcomes for 12 types of severe medical and surgical problems between the faculty and community services of a major teaching hospital (Stanford University). Patients on the faculty service were admitted by house staff or faculty physicians and cared for by the usual teams of house staff, students and faculty. Patients on the community service were admitted and attended by private physicians in the community. Students and house staff helped the private physicians care for one third of these patients (usually those who were sickest or of the greatest educational interest), but the other two thirds were in a completely nonteaching setting.

As expected, costs (i.e., charges) were *much* higher on the faculty service, but Garber and his colleagues found that adjustment for case mix eliminated most of the cost differential. Average costs per admission for all 12 medical and surgical problems studied were about 60 per cent higher on the faculty service; when adjusted for DRG mix, however, the difference was only 11 per cent, although still significant. Adjusted cost differences were largest (70 per cent) among the sickest patients — i.e., those judged on admission to have the least chance of survival. Outcomes were also different on the two services. The in-hospital mortality rate, adjusted for DRG mix and other patient characteristics, was about a third lower on the faculty service, with the differences again being largest among those who were judged to be the sickest on admission.

These fascinating results must be interpreted cautiously. They may underestimate the contrasts between teaching and nonteaching hospitals because they were obtained from two services in the same university hospital, which differed far less than the average teaching and nonteaching hospitals would. Furthermore, the data were derived from only one hospital and 12 diagnoses, and therefore may not be representative.

Despite these limitations, this report from Stanford deserves careful consideration. It tells us that an important part of the added costs of teaching hospitals is probably due to the increased intensity of workup and treatment of very sick patients. It also tells us that this increased care appears to produce measurably greater in-hospital survival. The message here seems to be that the relatively high costs of teaching hospitals will need to be weighed against the medical results achieved in such centers, as well as their educational and research outputs.

Before squeezing the teaching hospitals any harder, policy makers should be certain they understand what these institutions have been contributing to the public welfare. I suspect that in the end the third parties will decide that they must make special arrangements to ensure the survival and vitality of the teaching hospitals. Meanwhile, the academic medical centers are likely to be in for some difficult times. To survive, they will need astute leadership, cooperation from their medical staffs, and more evidence of the kind produced by the Stanford study.

ARNOLD S. RELMAN, M.D.

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CORRESPONDENCE

Letters to the Editor are considered for publication (subject to editing and abridgment), provided that they are submitted in duplicate, signed by all authors, typewritten in double spacing, and do not exceed 1½ pages of text (excluding references). They should not duplicate similar material being submitted or published elsewhere, and they should not contain abbreviations. Letters referring to a recent *Journal* article should be received within six weeks of the article's publication. We are unable to provide pre-publication proofs, and unpublished material will not be returned to authors unless a stamped, self-addressed envelope is enclosed.

CHRISTIAN SCIENCE AND THE CARE OF CHILDREN

To the Editor: My late husband, Phillip Signorini, was a member of the Christian Science church, and at various times he consulted a Christian Science practitioner.

When he was 40 years old, his glands enlarged and then increased gradually both in number and in size. In the beginning, he had been seen by a physician at work, who advised further studies. The Christian Science practitioner advised strongly against this, as well as other medical consultation. About four months before his death, when his physical condition had deteriorated and he had a cough and swelling of the glands in all parts of the body, I pleaded with him to see a medical doctor. He was almost ready to do this when the practitioner persuaded him to go to a sanitarium run by the Christian Science Benevolent Association.

The conditions at the sanitarium were deplorable. The "normal measures of cleanliness" that were applied during his stay were as follows: His personal care as administered by the personnel was minimal. The bed linen was changed but once weekly. He had weeping edema of his legs and ascites of great extent during the last weeks, and at times he was sitting on a wet bed sheet. I was not allowed to give him a gentle back rub with lotion. I was told: "We do not do this here."

During his stay there he had pain and difficulty in breathing. He was unable to stay in bed for any length of time and had difficulty in swallowing; his appetite was extremely poor. I spoke to them about the administration of oxygen, but they said they never did that.

During his stay at the facility he had two practitioners. Most of the time a lady from Marshfield administered the "treatment." She never visited him, but all the treatment was done in long phone

Harsh Medicine

Medicare's New Limits On Hospital Payments Force Wide Cost Cuts

Doctors Give Fewer Tests, Shorten Patient Stays; Institutions Trim Staffs

Suppliers Feel the Frugality

By Carolyn Phillips
Staff Reporter of The Wall Street Journal

After years of runaway inflation, the U.S. health-care industry is suddenly on a cost-cutting binge.

That sounds about as believable as "the check is in the mail," but it is true, basically because Uncle Sam grew weary of putting so many checks in the mail. The federal government has changed its Medicare payment system, forcing a far-reaching shakeup.

The elderly-care program has begun paying hospitals based on what it figures treatments should cost rather than on what hospitals actually spend. Thus, hospitals that have freely run up the tab, certain of hefty reimbursements, now must keep a close eye on expenses.

Coming in under the Medicare-set mark means a profit, and exceeding it means a loss. Because Medicare recipients account for about 40% of all patient-days in the nation's acute-care hospitals, some of these institutions no doubt will become terminal cases if they fail to adjust to the new system and to other expected changes in federal reimbursements.

Early Ramifications

Though only about 40% of hospitals have been phased in to the "prospective payment" system since it began last October, the shockwaves are already evident:

—Hospitals are laying off staff members, buying cost-calculating computers and driving hard bargains with medical-supply companies.

—Supply companies are changing their marketing tactics and lowering their growth expectations.

—Doctors are taking fewer tests, and patients are using more alternative facilities. And both are concerned about what this all means for the quality of care.

Patients may also find their hospital stays shortening. When 88-year-old Ada Fish broke her arm recently, she spent a week in a Lakeland, Fla., hospital, but was then "rushed out," as she sees it. "I think I should have stayed another week," says Mrs. Fish, "but my doctor told me Washington couldn't pay all that money."

That is the heart of the matter. With health-care costs rising at more than 15% a year and with Uncle Sam footing about 30% of the nation's total health-care bill, Congress in 1982 decreed a tightening of the Medicare purse strings. The decree didn't get much attention, buried in tax legislation, but it set federal bureaucrats to laboring on an overhaul.

Basis of System

The system they developed pays hospitals fixed amounts to treat specific ailments, based on categories called diagnosis-related groups, or DRGs. The amounts Medicare pays are adjusted to reflect regional average costs and whether hospitals are urban or rural.

Predictably, the changes haven't been universally acclaimed. Administratively, the new system imposes enormous burdens, and medically it runs counter to an ingrained hang-the-expense ethos. "Our fear is that if these rates are lowered too much, hospitals will have to hold back on using life-saving technology, on doing all the things they can do to save lives," says Michael D. Bromberg, the executive director of the Federation of American Hospitals, a trade group.

The real problem with the prospective-payment system, others fear, is that hospitals will become adept at getting around it. One possible tactic: arbitrarily assigning patients to DRGs that pay more than their ailments would warrant. That was a glitch in the system in New Jersey, which has had a state-run prospective-payment setup for several years. Another: shifting costs to non-Medicare patients. Some software companies are peddling computer programs they claim will show hospitals how to do just that.

Private insurers worry about that sort of thing. "Prospective payment should be instituted for all payments to hospitals," says Colin C. Hampton, the president of Union Mutual Life Insurance Co. of Portland, Maine. "As long as they apply only to Medicare, then the act of shifting costs to private payers is exacerbated."

Wider Application?

Federal health officials say they are also interested in wider use of the prospective-payment program and are currently studying its application to doctors' fees and nursing-home charges.

Hospitals are apprehensive because under the new system, "one or two very expensive cases could bankrupt a small hospital," says Jack Flaig, the finance vice president of Tuality Community Hospital in Hillsboro, Ore.

Some of the nation's 5,000 acute-care hospitals surely will go into bankruptcy, predicts Alex McMahon, the president of the American Hospital Association, another trade group. There is general agreement that small, not-for-profit institutions are most vulnerable. They have been much more oriented to community pride than the bottom line, and they aren't generally long on management.

Investor-owned facilities, which have always kept an eye on the bottom line and on cost controls, are expected to fare better. "Our costs are already lower than the DRG

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rates, so for us prospective payment is a great positive," says David Jones, the chairman of Humana Inc., a Louisville-based operator of 86 U.S. hospitals. "I see low-cost producers having a field day in this environment."

In the main, however, hospitals are scrambling to reach that point. The first step for many is slashing the payroll. In Evergreen Park, Ill., Little Company of Mary Hospital recently laid off 226 employees, or about 10% of its staff. In Lancaster, S.C., Elliott White Springs Memorial Hospital cut six of its 21 management positions, had other salaried employees take a temporary 10% pay cut and reduced the workweek for hourly employees. All over the country, hospitals are imposing hiring freezes.

They are, however, hiring legions of consultants to help streamline their operations and buying computers and software to help get a handle on their costs.

Administrators are lecturing their staffs about cost consciousness and urging doctors to reduce patient tests—or to have the tests done outside the hospital, where old reimbursement standards apply. They also are imploring doctors to think twice before admitting patients and to be quicker about discharging them.

At teaching hospitals, the new economics of health care are particularly hammered home. At the University of Alabama in Birmingham, residents and physicians discuss costs as well as treatments as they make their rounds. At the University of Chicago hospitals and clinics, staff members get pocket manuals listing laboratory-test costs.

Elsewhere in Chicago, Illinois Masonic Medical Center is making moves that reflect other national trends. It has set up a "self-care" unit, where patients with relatively minor ailments can recuperate with minimal nursing and at relatively minimal cost. It should thus come out nicely ahead on prospective-payment reimbursement. Other hospitals are starting low-overhead satellite businesses, such as emergency centers and home-health-care services, both to take advantage of the new Medicare payment policy and to find new sources of revenue.

Illinois Masonic also made a local splash by announcing a 25% reduction in its semi-private-room rates. It did that partly because it had trimmed its staff 7% and partly because it was applying a classic business principle: Increased volume compensates for reduced margins. In the same spirit, other hospitals have taken to renting billboards and running newspapers, radio and television ads.

As hospitals feel the heat, they pass it on to their suppliers. "Pricing pressure has been fierce," says Karl Bays, the chairman of American Hospital Supply Corp. in Evanston, Ill. That applies even to the little things. Northwestern Memorial Hospital of Chicago recently sought competing bids for surgical gloves, to see whether it could get a break on the price it was paying. It did, lowering its cost to 33 cents from 37 cents. At 281,000 pairs a year, that is a saving of $11,000.

This newly thrifty mind-set also applies to choice of products. No-frills urinary bags

cont:

are in; the fancy ones with access valves [illegible] hanging apparatuses are out. Generic [illegible] sterilants are in favor, the brand-name ones aren't. "Hospitals are definitely looking to buy Chevys instead of Cadillacs," says Art Spirakes, Northwestern Memorial's purchasing director. "And that's got companies very nervous. We're seeing more aggressiveness on the part of sales reps. They show up more frequently and are more insistent."

Medical-supply companies are also pushing some different products and doing some different sorts of marketing. They are selling cost-figuring software, in competition with the likes of Big Eight accounting firms. They are developing more products for home health care. They are holding prospective-payment education seminars for hospitals, the better to establish themselves as stalwart friends in the storm. They are locking in customers where possible by guaranteeing quick delivery on orders to enable hospitals to keep low inventories.

Suppliers are also taking steps to trim their own costs. Baxter Travenol Laboratories Inc. has automated much of its manufacturing. Several pharmaceutical companies are developing processes to make certain drugs for less. Philadelphia-based SmithKline Beckman Corp. has laid off hundreds of workers in its diagnostic-instru[illegible]'s business.

It has been a painful time for companies accustomed to galloping growth in sales profits. In the 1983 fourth quarter, when the prospective-payment system kicked into gear and hospitals turned cautious in purchasing, medical-supply concerns took it on the chin, reporting depressed results.

That was a harbinger of things to come. Industry executives don't see disaster in the offing but most see an age of diminished expectations. Baxter Travenol, a company accustomed to annual earnings gains exceeding [illegible]%, reported that first-quarter profit fell [illegible]%, although it does expect an earnings gain for the year. American Hospital Supply, which has enjoyed similar growth rates, sees its annual profit percentage rise slipping to the mid-teens. For others, the slippage could be more severe.

"Until now, everybody's done relatively well in the health business," says Charles Aschauer, executive vice president of Abbott Laboratories of North Chicago, Ill. "But I think these new constraints are going to bring out the differences in managerial skills. The good guys will look even better. The marginal guys won't look so good."

Red Cross will coordinate transplant network

By Delores Lutz

The St. Paul Red Cross and Minnesota's three organ transplant centers will cooperate in a unique network for recovering and distributing donor organs in the Upper Midwest, doctors announced Monday.

The arrangement, which uses 24-hour toll-free telephone numbers and Red Cross nurses acting as coordinators, is directed at increasing the number of organs available for transplant at University Hospitals, Hennepin County Medical Center and the Mayo Clinic in Rochester.

Physicians from the Red Cross and the state's three organ transplant centers announced the agreement at a press conference in St. Paul.

"The aim of our coordinated efforts is to make it as easy and convenient as possible to make organs available," said Dr. Jeffrey McCullough, director of St. Paul Red Cross Blood Services. "As the 'system' gets better and better, more transplants will be done and more lives will be saved."

National and regional networks already exist with computerized lists of patients awaiting transplants, but this program focuses on locating donors, most of whom are young and healthy people struck down in accidents that leave them brain-dead.

When the family of such a patient is interested in donating the patient's organs, a Red Cross coordinator is dispatched to the hospital to answer the family's questions and make the appropriate arrangements if they decide to donate.

The three Minnesota transplant centers combined have more than 600 people on transplant waiting lists at any one time, doctors said. All three institutions do kidney transplants, and the University also transplants hearts, livers and pancreases.

The new program is expected to use donors more efficiently because different organs from the same donor could go to different institutions, McCullough said.

The Red Cross chapters throughout the state are "in a way, the ideal network," and they probably will help transplant teams locate donors in small rural hospitals that might otherwise go undiscovered, said Dr. John Najarian, the University's chief of surgery.

Donors and organ recipients must be carefully matched to have compatible tissue types, so the chances of finding a match increase as the number of potential donors rises.

The Red Cross has been coordinating donors for the University since July, and "it's increased our effectiveness by a major amount," Najarian said.

Last month, the University transplant program was offered 48 livers, 14 hearts, nine pancreases and 14 kidneys, Najarian said, but only 15 to 20 percent of organs offered prove suitable for transplant.

Last year, University surgeons transplanted 16 livers, 12 hearts, 24 pancreases and 190 kidneys, he said. University Hospitals has 500 people waiting for organ transplants, and some experts estimate that 20,000 people are on transplant waiting lists nationwide, he said.

The new program "should improve the outcome" of organ donations because, with the three centers cooperating, the chances are better that one of them will have a patient who matches the donor, McCullough said. Finding a match quickly is important, because surgeons usually have only hours to retrieve an organ and transplant it.

Dr. Sylvester Sterioff of the Mayo Clinic said that only about 20 percent of families refuse to donate a loved one's organ when asked.

Donating organs often allows people to resolve their grief, said Gayl Rogers, the Red Cross's assistant director for transplant donor services. "Often a tragic accident is involved. Sometimes donating an organ gives a positiveness to a tragedy that otherwise seems senseless," she said.

McCullough predicted that organ procurement programs such as this may become common in the future, just as centralized blood banks have caught on during the past 20 years.

"I think this probably is the way organ programs will go," McCullough said. "It allows people to go to the public with one simple message and one simple way to access the system. We need to make it simple for everybody."

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Three transplant centers to coordinate efforts

By Lewis Cope
Staff Writer

Minnesota's three transplant centers — with more than 500 patients on their waiting lists — announced a pioneering program Monday designed to speed donor organs to recipients.

"This is a tremendous move forward for transplantation," said Dr. John Najarian, chief of surgery at the University of Minnesota Hospitals, which has the nation's largest kidney transplant program and also does heart, pancreas and liver transplants.

"We hope that as more organs are made available for use at all the transplant centers, more lives will be saved," said Dr. Jeffrey McCullough of the St. Paul Red Cross. The Red Cross chapter will serve as the clearinghouse for organs that will go to University Hospitals, Hennepin County Medical Center and the Mayo Clinic in Rochester, Minn.

Another aim is to get the best possible match of tissue and blood factors, so that the organ goes to the person whose body is least likely to reject it, McCullough said. Najarian said the program should help patients such as 3-year-old Cheryl Bjerke, who because of unusual factors in her blood has been waiting more than two years for a donor kidney.

She, like others awaiting kidney transplants, is being kept alive on a kidney dialysis machine that removes impurities form the blood. "But children like Cheryl don't grow much on dialysis," Najarian said. So it's vital to give children new kidneys as soon as possible.

There is no backup machine for those needing heart and liver transplants. "We average about one death every two weeks of patients waiting for liver transplants alone," Najarian said.

In the past, all three transplant centers have operated their own donor organ programs. They have maintained contacts with hospitals throughout the state and, through national registries, with some hospitals around the country. The organs come from people who die, and are used only with permission of the donor's family.

There have been some exchanges of organs between the three Minnesota programs, but there often have been delays, officials of the three institutions said. Sometimes organs have become too damaged to use because of delays.

The Red Cross now will contact hospitals regularly, promote donation of organs and offer toll-free phone numbers. This is designed to get the maximum number of donor organs, and get them to the right patients in time, McCullough said.

Najarian said this is the first time in the nation that an independent group has become the statewide clearinghouse for organ donations. He said this could be the model for other states, and then be linked to a nationwide network that experts long have wanted.

There are now 300 people on the waiting list at the University of Minnesota Hospitals for kidney transplants, Najarian said. Surgeons there did 190 kidney transplants last year. There are about 35 waiting for liver transplants, 35 for pancreas transplants and 12 for heart transplants at the hospital, he said. About 15 liver, 24 pancreas and 12 heart transplants were done there last year.

The Mayo Clinic has about 60 patients awaiting kidney transplants, and Hennepin County Medical Center has about 75. Each did about 55 kidney transplants a year.

Information on the donor program can be obtained by contacting the Red Cross at 291-4654 (from the Twin Cities area), toll-free (800) 3-DONATE (from elsewhere in Minnesota), or (800) 24-SHARE (from elsewhere in the nation).

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MINNEAPOLIS STAR & TRIBUNE
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Ethics review advised for 'Baby Doe' cases

By Delores Lutz

The American Academy of Pediatrics will recommend this week that hospital ethics committees review all decisions to withhold treatment from children who are "not imminently dying," according to an academy member.

Committee review is necessary because withholding treatment from a child who otherwise could have a long life raises ethical questions, said Dr. Norman Fost, a pediatrics professor at the University of Wisconsin.

"That doesn't imply that such decisions are unethical or that most are unethical," Fost said, but a review mechanism is wise because some past decisions have seemed "indefensible."

One of those indefensible decisions was made two years ago in Bloomington, Ind., in the case that provoked the Reagan administration's controversial "Baby Doe" rules, Fost said in a speech Friday to about 100 people in the Coffman Union Theater. Fost's visit was sponsored by the University's Student Committee on Biomedical Ethics.

In the Indiana case, a baby who had Down's syndrome and a correctable stomach defect was allowed to starve to death at the request of the parents.

Their decision was based on "misinformation" about the extent of the baby's retardation and the chances of surviving surgery, Fost said. Such a decision "is no longer permissible in this country," he added, particularly because many people are willing to adopt retarded children whose bio-

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logical parents don't want them.

"It is not optional for physicians or parents to collude in such a decision. It's wrong. It's morally wrong and it's legally wrong," Fost said.

Another example of a wrong decision is the case of Phillip Becker, who was 10 when his parents refused heart surgery for him because he was retarded; a court upheld the parents' right to make the decision. "The doctors were stunned. Phillip was condemned to die a slow, lingering death," Fost said.

There are situations in which it is ethical to withold life-sustaining care, however, Fost said. For example, doctors would not attempt to prolong the life of a child who had anencephaly (the absence of a brain) because trying to treat such a child would make no sense.

"Not only is it permissible, it's obligatory to withhold treatment when it does not serve the child's interest," Fost said.

Fost, who is a nationally recognized expert on issues in care of the handicapped newborn, helped make the film *Who Should Survive?*, which examines the case history of an infant much like the Indiana "Baby Doe."

The ethics committees should review all decisions in which life-saving treatment is being withheld, but they must play a "consultative" role that fosters consensus instead of making mandatory decisions, Fost said. The final decision still rests with the family and doctor.

Still, everyone involved will have to recognize that the committees will have the potential to force decision making through peer pressure and the threat of retribution against rebellious physicians, he said.

"The committees will inevitably be wolves in sheeps' clothing," Fost said.

The "infant care review committees," as the federal government calls them, are recognized by the current set of federal regulations, introduced last February. The original "Baby Doe" rules required hospitals to post signs advising the public of a hotline for reporting cases of alleged "discrimination" against handicapped infants. Those rules, which were supported by right-to-life groups and opposed by many health professionals, were struck down by a federal court.

Fost said he believes that fewer decisions similar to the Indiana case have been made during the past two years because "Baby Doe" issues have received so much public discussion.

Photo/Greta Pratt

Norman Fost

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