The University of Minnesota Hospital and Clinic

Board of Governors

July 22, 1987

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** OTHER ATTACHMENTS **

"U Regents Reject 'Focus' Closings", St. Paul Pioneer Press Dispatch, July 11, 1987

"Med Product Makers Feel Pressure of Rules", St. Paul Pioneer Press Dispatch, July 12, 1987

"Regents Opose Closing Colleges", Minnesota Daily, July 13, 1987

"Dickler Responds to University's Call to be Director of Hospital and Clinic, Minneapolis Star & Tribune, July 15, 1987

"Abbott Northwestern to Cut Jobs", Minneapolis Star & Tribune, July 15, 1987

"2 Hospitals Will Merge Under Wing of HealthOne", Minneapolis Star & Tribune, July 15, 1987

"Perpich Questions Will of "U" to Change" and "Text of Perpich Letter", Minneapolis Star & Tribune, July 15, 1987

The University of Minnesota Hospital and Clinic
Board of Governors

July 22, 1987
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of June 24, 1987 Minutes	Approval
II.	Chairman's Report - Mr. Robert Latz	Information
III.	Hospital Director's Report - Mr. Greg Hart	Information
IV.	Special Presentation: Cardiovascular Care - Dr. Stuart Jamieson - Dr. Carl White	Information
V.	Committee Reports	
	A. Planning and Development Committee - Ms. Kris Johnson	
	B. Joint Conference Committee - Mr. George Heenan	
	1. Appointment of Medical Staff Hospital Council Chairmen	Approval
	C. Finance Committee - Mr. Robert Nickoloff	
	The Finance Committee will not meet in July	
VI.	Other Business	
VII.	Adjournment	

Minutes

Board of Governors

The University of Minnesota Hospital and Clinic

June 24, 1987

CALL TO ORDER:

Chairman Robert Latz called the June 24, 1987 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias
	David Brown, M.D.
	Shelley Chou, M.D.
	Phyllis Ellis
	Donald Gilmore
	Al Hanser
	Greg Hart
	George Heenan
	Robert Latz
	Jerry Meilahn
	James Moller, M.D.
	Robert Nickoloff
	Barbara O'Grady
	Neal Vanselow, M.D.
Absent:	Kris Johnson
	David Lilly

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the May 27, 1987 meeting as written.

CHAIRMAN'S REPORT:

Chairman Latz reviewed his June 12, 1987 Quarterly Report to the Regents. In addition to the material included in the written report, Mr. Latz briefly discussed indigent care and bioethics with the Regents.

The Strategic Planning Committee is currently reviewing its structure and composition. The Committee continues to consider how best to relate to the Planning and Development Committee.

Mr. Latz reminded the Board members of the annual retreat to be held September 17 and 18, 1987 at the Riverwood Conference Center. Plans are being formulated now. Mr. Latz requested that members suggesting themes for the retreat should contact either he or Ms. Nancy Janda.

Lastly, Mr. Latz reported that Dr. James Moller has been selected by the Honors and Awards Committee of the Minnesota Medical Foundation as the Outstanding Medical School Teacher of 1987. He was chosen from a group of outstanding educators nominated by faculty and other members of the medical community.

HOSPITAL DIRECTOR'S REPORT:

Mr. Greg Hart introduced Ms. Michelle Johnson, a Masters student in Hospital Administration Student who is completing an internship at UMHC this summer.

Mr. Hart reported that Health East had announced the closing of Mounds Park Hospital. An additional Health East hospital may be closed. Health East has apparently also been in negotiations with Divine Redeemer Hospital as a potential addition to the Health East group.

The University of Minnesota hosted the "Big 10" Regents meeting on June 1, 1987, Mr. Hart reported. A breakfast was held in the Hospital and the group discussed several issues related to university hospitals.

Mr. Hart reported that UMHC is celebrating June as employee recognition month. The last of these events, a luncheon to honor the recipient of the Donna Ahlgren Award and other Distinguished Service Award winners, will be held June 29, 1987.

Vice President Vanselow reviewed the recommendations of the Advisory Task Force on Planning for the Plan for Focus, commenting on each. The Board of Governors expressed serious concern about the recommendations as they affect several of the Health Sciences units. Dr. Vanselow emphasized that the recommendations are very preliminary. The report will be scrutinized this summer by the Central Administrative Officers and discussed by the Regents this fall.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Ms. Kris Johnson reported that the Committee had reviewed the suggested process for approving changes in the Purchasing Policy and Procedure manual. The Committee had endorsed the proposed change, which effectively delegates responsibility for clarifications, corrections of errors and minor changes in purchasing procedure to the Hospital Director. The Board of Governors seconded and passed a motion approving the change to the purchasing policy on Purchasing Authority as submitted.

The Committee also reviewed and endorsed the Quarterly Purchasing Report as presented to the Board. The Board of Governors seconded and passed a motion approving the Quarterly Purchasing Report as submitted.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. George Heenan reported that the Committee had reviewed in detail a number of items from the Credentials Committee of the Medical Staff-Hospital Council. Each item was briefly discussed. The Board noted that Dr. Roby Thompson should be listed as the Interim Head of Physical Medicine and Rehabilitation rather than Head. The Board of Governors seconded and passed individual motions approving the April 9, 1987 Credentials Committee of the Medical Staff-Hospital Council Credentials Committee Report and Recommendations, the Biennial Medical Staff-Hospital Council Credentials Committee Recommendations, the Chief of Staff Appointment, and the Reappointment of Chiefs of Clinical Services.

Lastly, Mr. Heenan reported that Jan Halverson had made a presentation to the Joint Conference Committee on informed consent. Mr. Halverson will be asked to present the same information at a future Board meeting.

FINANCE COMMITTEE:

Mr. Robert Nickoloff reported that the Hospital continues to be in a positive financial position.

Mr. Al Dees reviewed the 1987-88 Compensation Plan with the Board. The plan provides for: 1) an increase in salaries and salary ranges by 2% effective July 1, 1987; 2) defer implementation of additional across-the-board increases and performance based in-range increases until final information regarding State of Minnesota and the University pay plans become available; 3) implement the comparable worth increases for year three of the four-year plan effective July 1, 1987; 4) continue in-range progression increases based on accumulated hours worked for employees in general staff nurse, pharmacist, radiology technologist and nurse anesthetist classifications; 5) and implement salary and salary range adjustments for employees in the laboratory medical technologist classification series required to match current community market levels. Salary increases for hospital employees in University-dominated classifications, students and those covered by union contracts will be settled as additional information becomes available.

The Board of Governors seconded and passed a motion approving the 1987-88 Compensation Plan for non-student, non-union represented employees in hospital dominated classifications.

Mr. Greg Hart reported that Board members will be receiving a report on the current PCN status in the mail shortly.

ADJOURNMENT:

There being no further business, the June 24, 1987 meeting of the Board of Governors was adjourned at 3:55 P.M.

Respectfully submitted,

Kay F. Fuecker
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

July 15, 1987

TO: Members of the Board of Governors

FROM: Nancy C. Janda
Assistant Director and
Secretary to the Board of Governors

Drs. Stuart Jamieson and Carl White have agreed to speak to the Board of Governors on July 22, 1987 about recent developments in cardiovascular care at our hospital. Curriculum vitaes for both Dr. Jamieson and Dr. White are attached.

This presentation on cardiovascular care is one among a series of presentations that have been scheduled per the January, 1987 Board request that speakers who can broaden or enhance familiarity with current issues be engaged.

I will see you on Wednesday, July 22nd at 2:30 P.M.

NCJ/kff

Attachments

Stuart W. Jamieson

CURRICULUM VITAE

Present Position: Professor of Surgery
Head, Division of Cardiovascular and Thoracic Surgery
Director, Minnesota Heart and Lung Institute
University of Minnesota

Business Address: Minnesota Heart and Lung Institute
University of Minnesota Hospitals
425 East River Road
Minneapolis, MN 55455

Birthdate: 30 July 1947

Medical School: University of London (St. Mary's Hospital)

Qualifications: M.R.C.S. (London), L.R.C.P. (England) 1971
M.B., B.S. (London) 1971
F.R.C.S. (England) 1976
E.C.F.M.G. examination (U.S.A.) 1971
Federal Licensing Examination (U.S.A.) 1979

Licensure: General Medical Council, Great Britain and Ireland
State of California, License # A 035080
State of Minnesota, License # 29964

PROFESSIONAL AFFILIATIONS

American Association for Thoracic Surgery

American Heart Association
(Council on Cardiovascular Surgery)

American Medical Association

American Society of Transplant Surgeons
(Advisory Committee on Cardiac Transplantation)

California Medical Society

International Cardiac Transplantation Society
(Executive Committee and President)

Royal College of Physicians (Licenciate)

Fellow, American College of Angiology

Fellow, American College of Cardiology

Fellow, American College of Chest Physicians

Fellow, American College of Surgeons

Fellow, Royal College of Surgeons

Fellow, Royal Society of Medicine

Pan American Medical Association
(Council,Section on Transplantation)

Lyman Brewer Society (Faculty Member)

Santa Clara County Medical Association

Society of Thoracic Surgeons

Southern California Transplant Society

Thoracic Surgery Director's Association

Transplantation Society

Twin City Thoracic & Cardiovascular Surgical Society

Variety Club of the Northwest

POSITIONS HELD

May - December 1971: House Surgeon, St. Mary's Hospital, London (Mr. H.H.G. Eastcott and Mr. J.R. Kenyon)

January - July 1972: House Physician, Royal Lancaster Infirmary, Lancaster (Dr. A.R. Adamson and Dr. D. Barrett)

August 1972 - March 1974: Research Fellow, Department of Experimental Pathology, St. Mary's Hospital Medical School (Professor K. Porter)

Demonstrator in Anatomy, St. Mary's Hospital Medical School (Professor K. Goldby)

Honorary Registrar, Renal and Transplantation Units, St. Mary's Hospital, London

April - September 1974: Casualty Surgeon, St. Mary's Hospital, London

October 1974 - September 1975: Senior House Officer, General Surgery, Northwick Park Hospital, Harrow (Mr. J. Lewis, Mr. A. Elton, Mr. A. Cox)

October 1975 - March 1976: Resident Surgical Officer, Brompton Hospital, London (Mr. M. Paneth, Mr. J. Lincoln)

April 1976 - December 1976: Registrar, Surgical Unit, St. Mary's Hospital, London (Professor H. Dudley)

January 1977 - December 1977: Surgical Registrar, Brompton Hospital, London (Mr. M. Paneth, Mr. C. Lincoln, Mr. S. Lennox, Mr. W. Cleland)

October 1977: Appointed Senior Surgical Registrar, National Heart and Chest Hospitals, London

January 1978 - June 1979: Postdoctoral Fellow, Cardiovascular Surgery and Transplantation Service, Stanford University Medical Center

July 1979 - June 1980: Chief Resident, Cardiovascular Surgery, Chief Resident, Cardiac Transplantation Service, Stanford University Medical Center

POSITIONS HELD, CONT.

July 1980 - Assistant Clinical Professor, Cardiovascular Surgery, Stanford University Medical Center

August 1981-1983: Assistant Professor, Cardiovascular Surgery, Stanford University Medical Center

July 1980-December 1983: Assistant Chief and Co-Director of Cardiac Surgery, Veterans Administration Hospital, Palo Alto

September 1983-March 1986: Associate Professor of Cardiovascular Surgery, Stanford University Medical Center

July 1982-March 1986: Director, Heart-Lung Transplantation Program Director, Cardiac Surgery Experimental Laboratories, Stanford University Hospital Consultant Surgeon, Veterans Administration Hospital. Palo Alto

HONORS AND AWARDS

Medical School prizes in Surgery, Physiology and Pathology

Max Bonn Memorial Medal (St. Mary's Hospital - University of London)

Warren Low Prize in Surgery (St. Mary's Hospital) 1974

"Young Investigator Award" by European Congress of Cardiology, 1976

British Heart Foundation - American Heart Association Fellowship Award, 1978

Irvine H. Page Atherosclerosis Research Prize by the American Heart Association, 1978.

J. Maxwell Chamberlain Memorial Paper, Society of Thoracic Surgeons, 1984.

President, International Society for Heart Transplantation, 1986.

Medal of the Danish Surgical Society, 1986.

CURRICULUM VITAE

February 1987

NAME: Carl W. White, M.D.

OFFICE: Cardiovascular Division
Box 508 Mayo Building
420 Delaware St. S.E.
Minneapolis, MN 55455
(612) 625-2454

HOME: 14 Timberglade Road S.
Bloomington, MN 55437
(612) 835-9723

CITIZENSHIP: U.S.A., Social Security No.

EDUCATION:

University of Nebraska, Lincoln, Nebraska, B.S., 1961
University of Nebraska, Omaha, Nebraska, M.D., 1964
University of Oregon, Portland, Oregon, Rotating Intern, 1964-65
University of Iowa, Iowa City, Iowa, Resident in Medicine, 1967-70
University of Iowa, Iowa City, Iowa, Fellow in Cardiology, 1970-72

ACADEMIC APPOINTMENTS:

1972-73	Associate in Cardiology, University of Iowa, Iowa City, Iowa
1973-78	Assistant Professor of Medicine, University of Iowa, Iowa City, Iowa
1978-86	Associate Professor of Medicine, University of Iowa, Iowa City, Iowa
July 1986	Professor of Medicine, University of Iowa, Iowa City, Iowa
7/15/86-Present	Professor of Medicine, University of Minnesota, Minneapolis, Minnesota

OTHER EMPLOYMENT PERTAINING TO CURRENT PROFESSIONAL APPOINTMENTS:

1974-84	Member, Continuing Education Section, Dean's Office, College of Medicine
1976-81	Director, Coronary Care Unit, Veterans Administration Hospital, Iowa City, Iowa
1978-86	Director, Cardiac Catheterization Laboratories, University Hospital and Veterans Administration Hospital, Iowa City, Iowa
April 1984-July 1984	Visiting Colleague, University of London, Royal Postgraduate Medical School, Hammersmith Hospital, London, England
7/15/86-Present	Director, Clinical Cardiology, University of Minnesota; Director, Cardiac Catheterization Laboratory, University of Minnesota; Co-Director, Minnesota Heart and Lung Institute

CERTIFICATION AND LICENSURE:

Certification: American Board of Internal Medicine, 1970
ABIM, Diplomat, 1971
ABIM, Cardiovascular Diseases, 1973

CERTIFICATION AND LICENSURE (cont'd):

Licensure: Nebraska, 1964, Permanent, No. 11166
Iowa, 1970, Permanent, No. 18708
Minnesota, 1986, Permanent, No. 30230

PROFESSIONAL AFFILIATIONS: 6 3c → 3c

American Heart Association, IOWA AFFILIATE

1973-78	Member, Professional Education Committee
1976-78	Chairman, Professional Education Committee
1974-77	Member, Research Committee
1974-77	Member, Public Education Committee
1976-78	Member, Program Committee
1976-84	Member, Board of Directors
1980-81	Member, Budget Committee
1981-84	Chairman, Extramural Program Subcommittee

American Heart Association, NATIONAL CENTER

1973-Present	Fellow, Council on Clinical Cardiology
1978-Present	Fellow, Council on Circulation
1981-83	Member, National Program Committee

American College of Cardiology

1975-Present	Fellow, American College of Cardiology
1982-Present	Ad Hoc Committee on Research in Continuing Medical Education, American College of Cardiology

Other

1976-Present	American Federation for Clinical Research
1980-Present	Fellow, American College of Physicians
1980-Present	Fellow, Society for Cardiac Angiography
1981-Present	Central Society for Clinical Research

AREAS OF RESEARCH INTEREST:

A. Studies on coronary blood flow in man
B. Interventions in acute myocardial infarction
C. PTCA
D. Neurogenic control of coronary circulation
E. Atrial fibrillation

CURRENT PROJECTS:

A. Coronary Doppler catheters - studies on selective coronary blood flow velocity
B. Physiologic significance of coronary stenoses
C. Efficacy of thrombolytic therapy in acute infarction
D. Studies of PTCA
E. Atrial fibrillation: Hemodynamic and metabolic effects

TEACHING ACTIVITIES (University of Iowa):

Classroom, Seminar, or Teaching Laboratory

1972-83	50:111 Introduction to Clinical Medicine, 200 registrants, 7 hours
'74,'76,'78 '80,'83,'86	50:111 Preceptor, Intro to Clinical Medicine, 4 registrants, 40 hours

Clinical Teaching (in ward, clinic, or operating room)

1978-79	Cardiology Clinics, 16 wks/year, 6 hrs/week
1978-79	Coronary Care Unit and Cardiology Wards, 30 wks/year, 21 hrs/week
1978-86	Catheterization Laboratory, 52 wks/year, 20 hrs/week
1979-86	Coronary Care Unit and Cardiology Wards, 12 wks/year, 21 hrs/week
1980-86	Cardiology Clinics, 26 wks/year, 7 hrs/week

TEACHING ACTIVITIES OTHER THAN CLASSROOM OR CLINICAL (University of Iowa):

Grand Rounds

1978	Aortic Stenosis, Internal Medicine Grand Rounds
1978	Treatment of Congestive Heart Failure, Internal Medicine Grand Rounds
1979	Can Coronary Artery Bypass Surgery Prolong Life? Internal Medicine Grand Rounds
1980	Coronary Artery Spasm, Internal Medicine Grand Rounds
1981	Percutaneous Transluminal Coronary Angioplasty, Internal Medicine Grand Rounds
1981	Cardiac Radiology, Cardiovascular Conferences
1981	Thoracic Surgery, PTCA
1983	Coronary Spasm, Internal Medicine Grand Rounds
1984	PTCA Update, Internal Medicine Grand Rounds
1986	PTCA, Internal Medicine Grand Rounds, University of Minnesota

Conferences

1972	Attend Weekly Cardiology Conference, 45 wks/year, 2 hrs/week

Teaching Committees

1974-80	Continuing Medical Education Committee, 20 hrs/year, Chairman, 1977
1976-77	House Staff Evaluation Committee
1977-86	Educational Development Committee
1979-81	Chairman, Learning Resources Unit Advisory Committee

Student Counseling.

1974-75	Senior Student Advisor, 5 students, 10 hrs/year
1974-75	Freshman Student Advisor, 4 students, 5 hrs/year

TEACHING ACTIVITIES OTHER THAN CLASSROOM OR CLINICAL (continued):

Formal Study to Improve Teaching Abilities

1975-76 Improve Your Teaching Skills, Continuing Medical Education

Current Research

Effect of continuing medical education on physician behavior

Bibliography Concerning Teaching

1. Cardiology Today Course Syllabus (1973-1979)
2. "The Chest X-ray in Cardiovascular Disease: A Programmed Slide-Tape Learning Set," with Donald D. Brown, M.D.
   a. Spatial Relationships as demonstrated by the four views of the heart.
   b. The pulmonary vasculature - Pulmonary venous hypertension.
   c. The pulmonary vasculature - Pulmonary arterial hypertension, shunt flow.
3. "Trifasicular Block-A simulated Patient Management Problem," developed first in written form and subsequently computerized.
4. "Aortic Stenosis and Syncope" - A written clinical simulation.
5. "Diagnosis and Management of the Patient with Myocardial Infarction" - A Complex Multibranching Computerized Simulation.
6. An Evaluation of the Effectiveness of a Program of Cardiovascular Health Education in the Primary Schools.
7. "Diagnosis of Supraventricular and Ventricular Tachyarrhythmias" - A Complex Computerized Simulation Using Visual Aids.
8. See also Sections XX(1), 10, 13; XX(3), 10, 17, 18, 23, 24, 26; and XX(6), 1.

Continuing Education

Administration

1972-83	Program Director, Cardiovascular Division Continuing Educ.
1972-83	Organizer and Course Coordinator, Cardiology Today - Continuing Coronary Care for Physicians
1972-73	6 four day courses, 45 registrants
1973-74	5 four day courses, 42 registrants
1974-75	5 four day courses, 68 registrants
1975-76	4 four day courses, 54 registrants
1976-77	4 four day courses, 58 registrants
1977-78	4 four day courses, 67 registrants
1978-79	3 four day courses, 49 registrants
1979-80	4 four day courses, 65 registrants
1980-81	4 four day courses, 78 registrants
1981-82	2 four day courses, 46 registrants
1982-83	4 four day courses, 60 registrants
1973 - Present	Organizer and Course Coordinator, Specialized Training Workshops in Cardiovascular Disease
1973-74	13 workshops of one week's duration
1974-75	35 workshops of one week's duration
1975-76	26 workshops of one week's duration

TEACHING ACTIVITIES OTHER THAN CLASSROOM OR CLINICAL (continued):

Continuing Education (continued)

Administration (continued)

1976-77	26 workshops of one week's duration
1977-78	18 workshops of one week's duration
1978-79	20 workshops of one week's duration
1979-80	54 workshops of one week's duration
1980-81	37 workshops of one week's duration
1981-82	33 workshops of one week's duration
1982-83	31 workshops of one week's duration
1974	Assistant Director, Education Section, Cardiovascular Center
1974-Present	Member, Continuing Education Section, Dean's Office, College of Medicine, 1 day/week
1973-75	Organized Symposium in Basic Cardiology in Association with Minowa Area Health Planning Council
1974	Organized Symposium on Exercise Testing and Cardiac Rehabilitation - Iowa Heart Association, Des Moines
1975	Organized Symposium 75 - A Pharmacologic Approach to Ischemic Heart Disease, Iowa Heart Association, Des Moines
1975	Co-Organizer, Review Course for Vietnamese Physicians
1976-77	Organized Symposium 76 - Cardiac Emergencies, Iowa Heart Association, Iowa City
1976-78	Program Committee, Great Plans Regional Heart Association Conference on School Health Education
1981	Director, Cardiovascular Educational Programs - Cardiovascular Center
1981	Coordinated NHLBI Educational Program Project Grant Application

Lectures in Continuing Medical Education (1978 to present)

1978	Arrhythmias and Antiarrhythmic Drugs, Minowa Cardiology Services, Calmar
1978	Cardiac Arrhythmias and Their Diagnoses, Minowa Area Health Group, Calmar
1978	Acute Myocardial Infarction, Refresher Course for the Family Physician, Iowa City
1978	Six Pitfalls in the Management of Acute Myocardial Infarction, Refresher Course for the Family Physician, Iowa City
1978	Exercise Testing for CV Diagnosis, Physical Therapy Department, Iowa City
1978	Six Pitfalls in the Management of Myocardial Infarction, Department of Family Practice, Iowa City
1978	Dysrhythmic Dilemmas, Emergency Medicine Conference, Lake Okoboji
1978	Interpretation of Cardiac Radiology, Winter Meeting of Iowa Cardiologists, Iowa City

TEACHING ACTIVITES OTHER THAN CLASSROOM OR CLINICAL (continued):

Lectures in Continuing Medical Education (continued)

1979	Computers in Medical Education, Department of Internal Medicine Staff Meeting, Iowa City
1979	Emergency Procedures in Cardiology, EMSLRC, Iowa City
1979	Six Pitfalls in the Management of Acute Infarction, Interpretation of Cardiac Radiology, Visiting Professor Family Practice Residency Program, Mason City
1979	Safe Use of 5 Common Cardiac Drugs, Refresher Course for the Family Physician, Iowa City
1979	Dysrhythmic Dilemmas, EMSLRC CME Course, Sioux City, Iowa
1979	Community Based Cardiology Consultant, Lake City, Iowa
1980	Cardiovascular Radiology, Radiology Residents Board Review Course, Iowa City
1980	Does Coronary Artery Bypass Surgery Prolong Life? Family Practice Residents Conference, Davenport, Iowa
1980	Pitfalls in the Management of Myocardial Infarction, Family Practice Residents Conference, Iowa City, Iowa
1980	Case Studies in Emergency Cardiac Care, EMSLRC, Iowa City
1980	Cardiac Auscultation: Shall I Throw Away My Stethoscope? Refresher Course for the Family Physician, Iowa City
1980	Interpretation of Coronary Angiograms: Radiology Residents Board Review Course, Iowa City
1981	Hemodynamic Monitoring in the CCU, Critical Care Medicine Lecture Series, Iowa City
1981	Cardiovascular Case Studies: Advanced Emergency Medicine Course, EMSLRC, Iowa City
1981	Pitfalls in the Management of Myocardial Infarction, Emergency Medicine Conference, Iowa City
1981	Ten Questions in Your Management of Acute Infarctions, Burlington, Ottumwa, Oskaloosa, Boone, Clinton, Ames, Newton, Fort Madison, Marshalltown
1981	Special Cardiologic Faculty, Reading Retreat, Galena, Illinois
1981	Visiting Professor, Family Practice Residency Program, Mason City, Iowa
1981	Management of Acute Infarction, Refresher Course for the Family Physician, Iowa City
1981	Percutaneous Transluminal Angioplasty, Iowa Society of Internal Medicine, Iowa City
1982	Streptokinase in Acute Infarction - American College of Physicians - Regional Meeting, Iowa City
1982	Management of Acute Infarction, St. Luke's Hospital Medical Staff Meeting, Cedar Rapids, Iowa
1982	Streptokinase Update - Iowa Cardiology Meeting, Iowa City
1982	Angioplasty - Refresher Course for the Family Physician, Iowa City
1982	Update Acute Infarction Management, North Iowa Medical Center, Mason City, Iowa
1982	Streptokinase in Acute Infarction, Iowa Medical Society Meeting, Iowa City
1982	Thrombolytic Therapy in Acute Myocardial Infarction, EMSLRC

TEACHING ACTIVITIES OTHER THAN CLASSROOM OR CLINICAL (continued):

Lectures in Continuing Medical Education (continued)

1982	Streptokinase in Acute Myocardial Infarction, EMSLRC, 5th Annual Emergency Medical Conference
1982	Hemodynamic Monitoring in Acute Infarction and Thrombolytic Therapy in Acute Infarction, Wesley Medical Center, Wichita, Kansas
1982	Present Concepts in Management of Acute Infarction, Davis County Hospital, County Medical Society, Bloomfield
1982	Refresher Course for the Family Physician, Workshop in Cardiac Auscultation, Iowa City
1982	Coronary Artery Disease and Coronary Artery Surgery, Iowa Lutheran Hospital, Des Moines, Iowa
1982	Current Issues in Acute Myocardial Infarction, Iowa State
1982	Coronary Artery Disease and Coronary Artery Surgery, Iowa Lutheran Hospital, Des Moines, Iowa
1982	Current Issues in Acute Myocardial Infarction, Iowa State
1982	International Therapy in Acute Infarction, Physicians Assistants Tenth Anniversary Course, Iowa City
1982	Streptokinase Therapy, 5th Annual Emergency Medical Conference, Cedar Rapids, Iowa
1983	Streptokinase Therapy in Acute Infarction, Allen Memorial Hospital, Waterloo, Iowa
1983	Thrombolytic Therapy in Acute Infarction, Indiana Heart Association and Fort Wayne, Indiana Medical Society, Fort Wayne, Indiana
1983	Intervention in Acute Infarction, Refresher Course for the Family Physician, Iowa City
1983	PTCA, Iowa Medical Society Annual Meeting, Des Moines, Iowa
1983	Update Coronary Angioplasty, Regional Meeting, American College of Physicians, Iowa City
1983	Management of Acute MI, Ottumwa Medical Society, Ottumwa
1983	Neurogenic Control of the Coronary Circulation, Seminars in Cardiology, Portland, Oregon
1983	Workshops on Cardiac Auscultation - Selection of Patients for Coronary Artery Surgery, Refresher Course for the Family Physician, Iowa City
1984	Debate, Coronary Angiography, Update in Internal Medicine Course, Iowa City
1984	Streptokinase in Acute MI, PTCA in 1984, Cardiology Today, Iowa City
1985	Therapy of Acute MI, Broadlawns Hospital, Des Moines, Iowa
1985	PTCA and Streptokinase, Methodist Medical Center, Des Moines, Iowa
1985	PTCA, Cardiac Dilemmas, Iowa City
1985	Management of Acute MI, Refresher Course for the Family Physician, Iowa City, Iowa
1985	Is Coronary Arteriography the Gold Standard, Mercy Medical Center, Des Moines, Iowa
1985	Current Treatment of Acute Infarction, Henry County Medical Society, Mount Pleasant, Iowa
1985	Streptokinase and PTCA, Emergency Medical Services, Vanning Resource Center

TEACHING ACTIVITIES OTHER THAN CLASSROOM OR CLINICAL (continued):

Lectures in Continuing Medical Education (continued)

1985	Acute Infarction, Postville, Iowa
1986	Thrombolytus Therapy, Update 1986, Refresher Course for the Family Physician, Iowa City, Iowa
1986	Doppler Flow Measurements in Angioplasty, Des Moines Mercy Hospital Regional PTCA Conference, Des Moines, Iowa
1986	Selection of Patients for Coronary Reperfusion, Internal Medicine Course, University of Minnesota, Minneapolis

OTHER PROFESSIONAL ACTIVITIES:

Reviewer for Chest
Reviewer for Circulation
Reviewer for American Heart Journal
Reviewer for American Journal of Cardiology
Reviewer for American Journal of Physiology
Reviewer for Circulation Research
Reviewer for New England Journal of Medicine
Member Special Ad Hoc Committee for American College of Cardiology, Evaluation of the Effectiveness of Continuing Education
Special Study Section NHLBI

CLINICAL ACTIVITIES:

Inpatient - See Teaching Activities
Outpatient - See Teaching Activities

COLLEGIATE, UNIVERSITY, UNIVERSITY HOSPITALS, AND NATIONAL COMMITTEES:

1974-79	Continuing Medical Education Committee, College of Medicine, Chairperson, 1977
1976-80	Committee on Scientific and Moral Aspects of Death and Dying
1976-84	Chairman, Postgraduate Medical Education Committee, Department of Internal Medicine
1977-81	Educational Development Committee
1977	Member, Search Committee, Learning Resources Unit Director
1979-81	Learning Resources Unit Advisory Committee, Chairman, 1980
1984	Ad Hoc Committee on Laboratory Animal Experimentation - University Hospitals

HONORS AND AWARDS:

1961	Phi Beta Kappa
1964	Alpha Omega Alpha
1976-80	Teaching Scholar, American Heart Association
1979	Winegard CV Research Award, Iowa Heart Association
1984	University of Iowa Faculty Development Award

FINANCIAL RESOURCES (Grants and Contracts):

Federal (pending)

1986-91	Neural Control of the Coronary Circulation (C. White, P.I.) (20% effort)	$98,021 (first year)
12/1/86-9/30/89	Validation of Noninvasive Diagnostic Procedures for Detecting Coronary Disease with Direct Measurements of Coronary Flow Reserve in Humans - Subproject of Ischemic SCOR Supplement, University of Iowa (M.L. Marcus, P.I.) (10% effort)	$ 52,351 (first year)
4/1/87-10/31/95	Post CABG (Coronary Artery Bypass Graft) Study - Clinical Centers (D.B. Hunninghake, P.I.) (C. White) (20% effort)	

Other

1983-87	Efficacy of Ticlopidine Hydrochloride in Preventing Restenosis after Angioplasty: A Randomized Controlled Trial Syntex Research (C. White PI)	$1,300,000
7/15/86-2/30/87	Evaluation of Selective Intracoronary Doppler Flow-Probe Catheters - Medtronic, Inc.	$ 15,000

PHYSICAL FACILITIES:

Office:	237 KE Building Minnesota Heart and Lung Institute

MASTERS' AND Ph.D. THESES DIRECTED AND POSTDOCTORAL FELLOWS SUPERVISED:

1981	Ph.D. Thesis Committee, Lisa Ehrlich, College of Education, Evaluation of Assisted Simulations
1983	Masters Thesis Committee, Mark Coppess, College of Engineering, Iowa State University, An Ultrasonic Pulsed Doppler Balloon Catheter for Use in Cardiovascular Diagnosis
1982-85	Robert F. Wilson, M.D., Fellow, Cardiovascular Division
1983-86	Douglas Salmon, M.D., Fellow, Cardiovascular Division

MINUTES
Planning and Development Committee
July 8, 1987

CALL TO ORDER
Committee Chairman, Ms. B. Kristine Johnson, called the July 8, 1987 meeting of the Planning and Development Committee to order at 12:05 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Leonard Bienias Greg Hart Clint Hewitt Geoff Kaufmann Peter Lynch, M.D. Ted Thompson, M.D.
	Absent	S. Albert Hanser William Jacott, M.D.
	Staff	Cliff Fearing Nancy Janda Michele Johnson John LaBree, M.D. Lisa McDonald
	Guest:	Bruce Work, M.D.

APPROVAL OF MINUTES
The minutes of the June 11, 1987 meeting were approved as distributed.

UMCA UPDATE
Dr. Peter Lynch briefed the committee on UMCA's activities which have centered around the reorganization and addition of staff. UMCA recently signed a contract with MedCenters. Finally, the Ambulatory Management Council has turned their clinic management report over to UMCA.

OBSTETRICS PROGRAM
Mr. Hart reviewed current merger trends and their potential impact on UMHC's perinatal and neonatal programs.

Dr. Work discussed the obstetrics program and what is needed for a balanced residency program. In order to maintain its residency program, UMHC needs an in-house obstetrical program which means deliveries need to be increased from 500 to 1,500 per year. Potential ways to increase deliveries are through 1) expansion of maternal/fetal staff and unique services, 2) attracting more tertiary referrals through the development and expansion of outreach efforts, and 3) a concentrated marketing effort aimed at UM students and staff. Dr. Work concluded that the relocation and remodeling of OB is necessary in order to attract the above targets.

UNIVERSITY HOSPITAL CONSORTIUM (UHC) UPDATE
Mr. Hart provided some background on UHC which was founded at UMHC. Last year UMHC had $300,000 in savings from purchasing through UHC. Other councils are investigating areas of medical liability coverage, alternative delivery systems, affiliate programs, and marketing.

Mr. Kaufmann discussed the activities of the Marketing Council. The mission of the Council is to promote the UHC identity among member institutions, recruit new members and to provide individual support to members. Last year a full-time staff member was hired. Currently they are in the process of developing a clearinghouse of marketing material, research results, advertising, and other materials. The group is also looking at compiling a market consultant list, job bank, etc. UMHC may be participating in a study which will investigate how academic centers can better differentiate themselves.

OTHER BUSINESS
Mr. Bienias suggested that he would like to see UMCA explore the promotion of second opinions because he feels it is an untapped market. Mr. Kaufmann discussed the types of second opinions that have been explored by UMHC which are phone consultations, chart reviews, and patient exams. Preliminary discussions have been held with several local HMOs. Mr. Kaufmann will provide additional information regarding second opinions at the next meeting.

Ms. Johnson said there will be an August meeting given the issues at hand but no September meeting due to the Board retreat.

ADJOURNMENT
The Planning and Development Committee adjourned at 1:40 p.m.

Respectfully submitted,

Lisa G. McDonald

Lisa G. McDonald
Assistant Director
Planning and Marketing

MINUTES
Joint Conference Committee
Board of Governors
July 8, 1987

ATTENDANCE: Present: George Heenan, Chair
Phyllis Ellis
Patricia Ferrieri, M.D.
Donald Gilmore
Greg Hart
James Moller, M.D.
Michael Popkin, M.D.
Bruce Work, M.D.

Staff: Jan Halverson
Nancy Janda
Barbara Tebbitt

Guests: Marjorie Carey
Nancy Green
Michelle Johnson
Ted Yank

APPROVAL OF MINUTES

The minutes of the June 10, 1987 meeting were approved as submitted.

MEDICAL STAFF HOSPITAL COUNCIL REPORT

Dr. James Moller presented his recommendations for chairman appointments for the Medical Staff Hospital Council committees. He particularly noted four new candidates: for the Disaster Committee - Dr. Chuck Andres; for the Emergency Department Committee - Dr. Randall Moore; for the Product Evaluation and Standardization Committee - Dr. John F. Berlauk; and for the Medical Record and Patient Care Information Committee - Dr. Marvin Goldberg. Dr. Moller asked for the endorsement of these individuals so he could take the total list as presented to the Board on July 22.

Mr. Heenan moved that the Committee endorse Dr. Moller's recommendations for the committee chairmen. The motion was seconded and the Committee unanimously endorsed the candidates.

PATIENTS RIGHTS AND RESPONSIBILITIES

Nancy Green, Director of Patient Relations, presented information on the Hospital's role in explaining patients' rights and responsibilities. She presented two handouts, one the old University Hospital handbook on patients' rights and responsibilities and the latest edition based on current legislation, distributed by the Minnesota Hospital Association. Nancy informed the Committee about the history of patients' rights and responsibilities and the law pertaining to it. Ms. Green explained that all patients, when they come to the University of Minnesota Hospital are given the Patients' Bill of Rights and that they are specifically asked if they have received the Patients' Bill of Rights and if they understand it or not. If they are confused, a patient representative is sent to the person to talk to them about the bill of rights so that they can understand it or their family members can understand it.

The Committee asked Ms. Green questions pertaining to types, frequency and reporting of complaints, as well as responses to those complaints. Ms. Green said that her department received about 200 complaints per month, ranging from parking and food to waits and delays, to issues of physician communication.

Discussion ensued about the impact of the Patients First presentation of Dr. Fink from the Einstein Medical Center to the medical staff at the Semiannual Medical Staff Meeting. It was mentioned by Dr. Work and Greg Hart that physicians generally have reacted favorably to the presentation.

CLINICAL CHIEFS REPORT

Dr. Bruce Work conveyed to the Committee that the Chiefs have been consumed in many of the things that have been going on within the University lately. He mentioned that the Clinical Chiefs unanimously agreed to sign a response to the Commitment to Focus working paper that had been delivered last week. He mentioned that next week all the clinical department heads are going to put together a response to that report and also will review the entire report to send back to Vice President Benjamin.

Dr. Work also mentioned that the Chiefs have been spending a significant amount of time considering proposals from Health East and Health One. Discussions are currently taking place, and Dr. Work mentioned that he was personally interested in the discussions.

PRIMARY CARE NETWORK

Mr. Greg Hart gave an update on the Primary Care Network situation.

ADJOURNMENT

There being no further business the meeting adjourned at approximately 5:30.

Respectfully submitted,

Ted Yank

Ted Yank

TY/kj

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Box 707
Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-1945

July 16, 1987

TO: Board of Governors

FROM: James H. Moller, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council

SUBJECT: Appointment of Medical Staff-Hospital Council Committee Chairmen

The Medical Staff-Hospital Council reviewed the attached list of committee chairmen for 1987/1988 on July 14 and are forwarding their recommendations to you for your approval on July 22.

The Bylaws of the Medical and Dental Staff, Article VI, Part A, Section 1, (s), sets forth the requirement that the appointment of all Medical Staff-Hospital Council committee chairmen be made by the Board of Governors after receiving recommendations from the Medical Staff-Hospital Council.

Thank you.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL STAFF-HOSPITAL COUNCIL COMMITTEE CHAIRMEN APPOINTMENTS

1987/1988

1. **Bed Allocation Committee.**

   Seymour Levitt, M.D.

2. **Bylaws Committee**

   Glenn Gullickson, M.D.

3. **Biomedical Ethics Committee**

   Theodore Thompson, M.D.
   Susan Pappas-Varco RN, Co-Chair

4. **Cardiorespiratory Advisory Committee**

   Russell H. Larsen, M.D.

5. **Cardiovascular Advisory Committee**

   Michael W. Steffes

6. **Credentials Committee**

   Henry Buchwald, M.D.

7. **Disaster Committee**

   Charles Andres, M.D.

8. **Emergency Department Committee**

   Randall Moore, M.D.

9. **Infection Control Committee**

   Frank Rhame, M.D.

10. **Operating Room Committee**

    Roby Thompson, M.D.

11. **Outpatient Committee**

    Amos Deinard, M.D.

12. **Pharmacy & Therapeutics Committee**

    Russell Lucas, M.D.

13. **Product Evaluation & Standardization Committee**

    Jon F. Berlauk, M.D.

14. **Quality Assurance Steering Committee**

    James H. Moller, M.D.

15. **Tissue & Procedure Review Committee**

    Robert Maxwell, M.D.

16. **Transfusion Therapeutics Committee**

    Jeffrey McCullough, M.D.

17. **Medical Record and Patient Care Information Committee**

    Marvin Goldberg, M.D.

Minutes
Meeting of the
Board of Governors Finance Committee
The University of Minnesota Hospital and Clinic
June 24, 1987

MEMBERS PRESENT:
Carol Campbell
Edward Ciriacy, M.D.
Clifford Fearing
Gregory Hart
William Krivit, M.D.
J.E. Meilahn
Robert Nickoloff
Barbara O'Grady
Vic Vikmanis

STAFF:
Kay Fuecker
Nancy Janda
Michelle Johnson
Nels Larson
Dan Rode
Barbara Tebbitt

CALL TO ORDER: The meeting of the Finance Committee was called to order by Mr. Robert Nickoloff at 1:15 P.M. in the Board Room (8-106 University Hospital).

Mr. Nickoloff introduced Ms. Michelle Johnson, a Health Administration Student, who is an intern at UMHC this summer.

MINUTES: A motion was seconded and passed to approve the minutes of the May 27, 1987 meeting of the Finance Committee as written.

5/30/87 FINANCIAL STATEMENTS: Mr. Cliff Fearing reported that admissions for May totaled 1,653 or 239 above budgeted admissions of 1,414. The average lenth of stay was 7.6 days. The overall average year-to-date daily census is 422. The increase in admission levels was primarily in the areas of Medicine, Pediatrics, and Surgery. Outpatient census was 4.1% above budget with the largest increases occurring in Medicine, Family Practice and Urology.

The Hospital shows total revenus over expense of $2,760,769 for a favorable variance of $13,425,342. Ancillary revenue

was 22.4% above budget. Operating expenditures were 7.6% above budgeted levels.

Accounts Receivable represented 103.8 days of revenue outstanding on May 31, 1987. The increase occurred primarily in the commercial insurance, Blue Cross, and older accounts.

Mr. Fearing reported that UMHC has been approached by several national insurance companies to do organ transplantation for their consumers. Locally, Daytons and Honeywell have shown an interest. UMHC will be pursuing these proposals, taking into consideration our capacity constraints in staff, medical staff, and physical plant.

1987-88 COMPENSATION PLAN:

Mr. Greg Hart reported that the Hospital will implement the 1987-88 Compensation Plan on July 1, 1987 for non-student, non-union represented employees in Hospital dominated classifications. Increases for union employees and employees in University-dominated classes are awaiting final union settlements and the University pay plan to be finalized.

Mr. Al Dees presented the following recommendations regarding the 1987-88 Compensation Plan for non-student, non-union represented employees in Hospital dominated classifications: A) Increase salaries and salary ranges 2%, effective July 1, 1987; B) Defer implementation of any additional across the board increase and defer implementation of performance based in-range increases for eligible employees until final information regarding State of Minnesota and University pay plans becomes available. C) Implement the comparable worth increases scheduled for year three of the previously approved four-year plan, effective July 1, 1987; D) Continue in-range progression (step) increases based on accumulated hours worked for employees in general staff nurse, pharmacist, radiology technologist and nurse anesthetist classifications; E) Implement salary and salary range adjustments for employees in thhe laboratory medical technologist classification series required to match current community market levels.

A motion to endorse the 1987-88 Compensation Plan as submitted was seconded and passed by the Finance Committee.

PRIMARY CARE NETWORK UPDATE: Mr. Greg Hart reported that new financial projections were presented to the Primary Care Network Management Company Board on June 10, 1987. The new projections incorporate the elimination of the proposed Medicare Capitation Program. The Primary Care Management Company Board is presently reviewing various operation and funding alternatives before any further decisions are made. More specific informationn is being provided under separate cover for the Board of Governors information.

ADJOURNMENT: There being no further business, the Finance Committee adjourned at 2:10 P.M.

Respectfully submitted,

Kay F. Fuecker
Recording Secretary

Medical Oncology: Coming of Ago

ASCO chief B.J. Kennedy nurtures his special field

The American Cancer Society celebrates its 74th birthday this year, the National Cancer Institute its 50th.

Medical oncology? Its 15th.

Despite the attention cancer has received for so many years, it wasn't until 1972 that medical oncology was formally recognized as a sub-specialty of internal medicine—thanks, in large part, to Dr. B.J. Kennedy, the new president of the American Society of Clinical Oncology. Says Dr. John Durant, the head of the Fox Chase Cancer Center and a former ASCO president: "People identify B.J. Kennedy as one of the fathers of medical oncology. They recognize that he provided a great deal of leadership in legitimizing it as a specialty, and electing him as president is how we are honoring him for that."

It seems to be a well-deserved honor.

MITCH KEZAR COPE

B.J. Kennedy: *One of the fathers of medical oncology.*

Kennedy, director of the oncology division in the department of medicine at his alma mater, the University of Minnesota, "adopted" medical oncology during his postgraduate work at the Harvard Medical School and Massachusetts General Hospital in the late 1940s.

"I was training in endocrinology because there was no formal program in oncology. Oncology was where my interests were, though," says Kennedy.

His early research included hormonal studies that later became the basis for developing effective therapies for breast and endometrial cancer.

Apparently, there were others with the same interests in the stepchild field, and in 1956, the American College of Physicians established a cancer committee—the only such panel the college ever created for a single disease. It was while serving on that committee that Kennedy challenged his colleagues to establ[illegible] ASCO.

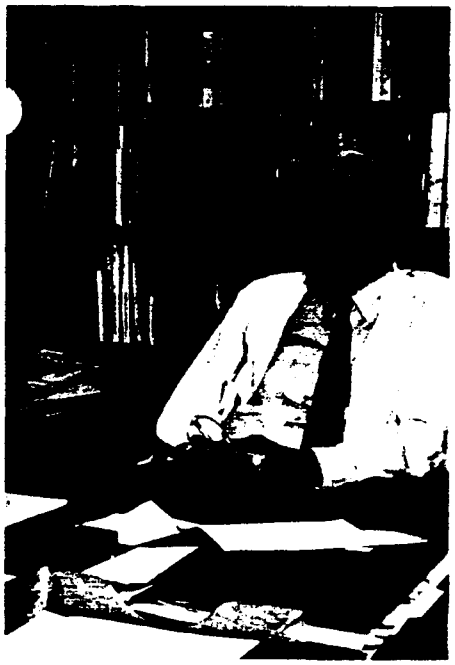
Formal sub-specialty: The asso[illegible] was formed in 1964, but it didn't give medical oncology the credibility and weight Kennedy thought it deserved. So he and his colleagues proposed that the field be recognized as a formal sub-specialty of internal medicine.

Kennedy and Dr. Emil Frei III, now director of the Dana-Farber Cancer Institute in Boston, pitched the idea to the American Board of Internal Medicine and the American Board of Medical Specialties in 1971. They accepted the proposal the following year and gave the first certifying exam for medical oncology in 1973.

"We have given the exam every two years since then," says Kennedy, who helped develop the test. "ASCO was a real catalyst. Oncology obviously warranted the recognition; it was just a complicated process that took a long time and a lot of jawboning."

Kennedy says he coined the term *medical oncology* "because I didn't want us to just say that we were oncologists and make it sound like we did everything. I wanted everyone to recognize that [illegible]ar internists.

"Now, medical oncologists probably play the largest role in cancer management. Some 40% of the oncologists o



In his office: *No politician.*

tumor boards are medical oncologists and many directors of cancer centers are medical oncologists," he points out.

"I believe this expanded role is a result of our efforts to improve oncology education and as a result of the progress that has been made in chemotherapy."

Internists used to play a limited role, says Kennedy.

"We were called in to make sure the patient was in good enough condition for surgery or radiation. The surgeons were the real giants in cancer management 25 years ago.

"But the development of chemotherapy really stressed the need for internists in the field. Radiotherapists and surgeons used to do chemo when there were only a few drugs that were used. Now, there are so many agents that even medical oncologists are specializing further by studying specific tumor systems."

Kennedy stresses that he doesn't want cancer specialists competing for control or recognition. He simply wants the best team working on one of medicine's toughest challenges.

Making medical oncology a recognized sub-specialty was one major way to give cancer more of the concentrated attention it required.

Kennedy succeeds Dr. Samuel Hellman, last year's ASCO president and physician-in-chief at New York's Memorial Sloan-Kettering Cancer Center.

Says the new leader: "The Society of Surgical Oncologists joined ASCO last year and the gynecologic oncologists have joined this year. Now, there are these in addition to the radiotherapists, so this is

Oncology research is like an ocean: *Some waves move faster than others.*

MITCH KEZAR / COPE

With a patient: *A firm believer that cancer* can *be managed.*

really a multi-disciplinary society and I find that very exciting. "Even though it is still the voice of medical oncologists, ASCO is attempting to bring oncologists together as a team and the spirit is good for understanding each other's skills."

Moreover, the relatively young sub-specialty of oncology has set something of an example for the eight other sub-specialties of internal medicine: cardiology, rheumatology, nephrology, allergy, hematology, endocrinology, pulmonary medicine, and infectious disease.

When medical oncology first was established "we specifically described what we thought the contents of our sub-specialty were," Kennedy recalls. "Secondly, we established formal guidelines for training programs, and then we developed the accreditation process."

Soon, the other sub-specialties adopted their own definitions, guidelines and accreditation processes. "It's good to be young sometimes," Kennedy boasts. "Oncology has been looked at as a leader because it was a new sub-specialty, and it could, did and still does ask questions."

The major question that oncologists are asking today is: Who should pay for research?

Short-changing: According to Kennedy, the federal government is already spending plenty of money on research. And academia is contributing a fair share, as well. But it's the insurance industry that's short-changing the system by refusing to pay for a patient's care during experimental treatment.

Most of the money raised for research barely covers the actual investigatory work, Kennedy explains; the patient or insurer is rarely charged for the drugs or technology being tested. The question arises as to who will pay for other related medical costs.

"Now, when we treat a patient with chemotherapy, the computers from the hospital not only tell the insurance company 'chemotherapy,' but what kind of chemotherapy," Kennedy says. "So when the bill arrives at the insurance company and they see that a patient's getting some investigative agent like carboplatinum, they say, 'Oh! That's research! We must disallow that hospitalization cost.' "

In the past, Kennedy says, insurers unwittingly reimbursed patients for those care-related costs incurred during experimental treatment. But everyone, he asserts, benefited from the advances researchers achieved.

Now that insurers have cracked down, Kennedy wants to know why patients enrolled in experimental treatment programs differ from patients just as sick but who aren't involved in those trials.

Insurance covers their costs, Kennedy argues, so why shouldn't it cover those incurred by test subjects?

"The issue was never really raised until now," says Kennedy, adding that today society is "getting down to economics and trying to save dollars. But I think everybody has to share the cost."

And this includes insurance companies who "ought to pay for patient care required during research therapy, providing it's legitimate and that it's done under some sort of proven-therapy protocol, not just anybody's fly-by-night research."

Discussing the controversial, patient-funded research conducted by Biotherapeutics, Inc., of Franklin, Tenn., Kennedy says the company's chairman, Dr Robert Oldham is "just trying to ge around the same hurdle. All Ol done is gone public. He says, 'I research; you pay for it.' I can't fault hin for doing what he's done because there i no system to pay for patient care and it' crippling progress in research.

"I don't find that inappropriate in sense that someone has to pay for it. I the patient has the money, fine. But tha approach doesn't work for everyone an so another solution must be found."

Kennedy—who notes that he has n solutions at hand for the problem— say ASCO's public affairs committee wi study the issue: "This is a tough one. Wh knows? Maybe it will require some kin of federal legislation."

MITCH KEZAR / COPE

Getting together the best team: *Impromptu meeting with an associate.*

He says medical oncologists are individually battling the reimbursement system, as well.

"Medicare does not recognize medical oncology as a sub-specialty, so ASCO will also work to get medical oncologists recognized as the highly trained specialists they are," Kennedy declares.

"We are currently reimbursed at a non-specialist rate, yet other sub-specialists of internal medicine, such as nephrologists, are recognized and appropriately reimbursed."

He then adds with a chuckle that he doesn't know the process for getting official recognition: "I'm not that much of a politician. But that's what I have committees for."

Noting that more formally trained clinical oncologists are setting up shop in more communities across the country, Kennedy also wants to see the old-fashioned town-and-gown conflicts disappear.

For years, general practitioners admitted that they were ill-prepared to deal with malignancies. It didn't help that community-based oncologists were hard to find.

Those factors—coupled with news that most advances in treatment were being made at academic medical centers—meant that local physicians lost patients to teaching institutions.

Now "in terms of care available, the doctors in the community clinics are doing a fine job, largely because oncology education has improved considerably, as have the treatments," Kennedy observes.

"You no longer have to go hundreds of miles to the university to get expert care. There are enough oncologists now that almost every community has pretty convenient access to a good one."

It used to be, he says, that community doctors would send patients who had cancer to the University of Minnesota's Masonic Cancer Center just so the physicians there could tell the patients they had cancer.

Five years ago, that wasn't an uncommon referral. The doctor knew, but he hadn't told the patient yet. He wanted us to tell the patient because that doctor thought we knew how."

Now these doctors have learned that they can tell patients themselves.

Efforts to debunk many of the myths and fears about cancer also have made it so that "patients now *want* to know if they have cancer," Kennedy adds.

"Cancer is no longer known as a 'terminal' disease; people are beginning to realize it *can* be managed."

In discussing progress made in the war against cancer beyond ASCO's reach, Kennedy likens oncology to an ocean:

"We need to appreciate that there are waves and some areas are going to move ahead faster than others and others are then going to catch up."

Those waves in research, teaching and patient care are always rising, falling and making way for the next surge, which will result from what's been building on the horizon, he explains.

"We do it all equally well, but in one year, you have an extra emphasis on teaching because you see new ways of teaching. You find an extra special way," Kennedy explains. "Next, there may be a research adjustment—some new people in the field—and research becomes important. Then, you become concerned about patient care."

Tidal wave: Like the sea, only rarely does a tidal wave, or singularly significant "breakthrough," come crashing in, Kennedy says: "I do not like the word 'breakthrough.' I think it is an old term, like 'terminal,' that doesn't apply."

The process, he explains, is incremental, but that doesn't lessen those waves' ultimate impact: "Always, it is progress and I do not think you can ever go backwards."

Kennedy sees the current wave as one that "focuses on augmenting clinical investigational programs, both in terms of training clinical investigators and stressing the value of high-quality clinical research."

That may not sound very exciting, but perhaps the wave is just beginning to build. And if it's like any of the other waves Kennedy has been behind, it could be well worth watching.

Women Switching From RNs to MDs

If Florence Nightengale was in college today, she'd probably switch majors.

This year, for the first time ever, there were more freshman women at four-year colleges aiming for careers as doctors than as nurses, a cause for deep concern among health professionals worried about nursing's future.

According to a study of 270,000 students by the Higher Education Research Institute at the University of California-Los Angeles, there were three prospective women nurses for every one prospective female physician at four-year colleges in 1968.

Last fall, there were 10 women looking into careers as physicians for every eight women interested in nursing.

If current projections hold, Kenneth C. Green of the institute says 60% of those women will earn medical degrees:

"By 1990, there will be more women doctors [graduating] than there will be baccalaureate nurses."

Green attributes the career shift to several social factors: "Freshmen in the '80's are far more interested in financial security than their peers two decades ago. They are more oriented toward high-stature professions and less interested in altruistic careers than the students who entered college 20 years ago.

"It's not that they are more materialistic. I think it is that they are just plain more scared. The recession of the '80's struck broader than any since the depression. Students saw it up close and personal. Right now, we are seeing both the effect of the women's movement and what I call 'portfolio building.' "

The American Association of Colleges and Nursing is all too aware of what many now refer to as the "crisis" in nursing education and nursing-program enrollment.

A recent AACN survey found that the number of nursing students enrolled full-time in four-year college programs fell by almost 10,000 to 66,654 this year—a 12.6% drop from 1986. And part-time nursing enrollments were down 2% to just over 34,000.

"We're very concerned about the implications of these trends," says Jeannette Spero, the AACN's president. With an aging population, "our need for highly skilled nurses is growing dramatically."

Adds Polly Bednash, the association's director of government relations: "If something doesn't happen, the situation is going to get pretty ugly. The number of nurses to fill hospital needs is already a problem.

"And enrollment at nursing schools is diminishing every year. Many, many nursing schools are in jeopardy of closing—even Boston University and American University have announced they may close" their nursing schools.

Why?

"Women are changing careers because nursing just isn't perceived very well," Bednash explains.

"One magazine listed it among the 10 *worst* careers for women. Women today are concerned that nursing doesn't allow career growth.

"We simply have got to start talking more about assets of nursing. We've got to let people know that nursing isn't just being stuck in a hospital at a bed."

The Minnesota Daily - Monday, June 29, 1987

Benjamin 'surprised' by task force report

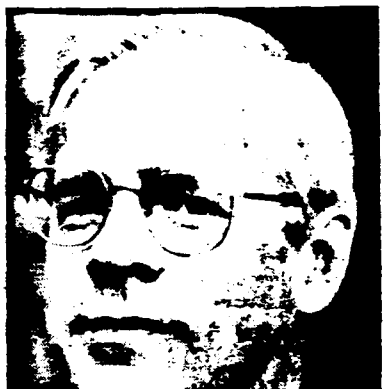
By **John R. Engen**
Staff Writer

While Vice President for Academic Affairs Roger Benjamin said the ax might have to fall on some University colleges, he expressed "surprise" at last week's recommendations to close the College of Veterinary Medicine and the School of Dentistry.

But, "if we take away those two major recommendations, the rest of the report really isn't that controversial," Benjamin said in a F[illegible] v interview.

T[illegible] dvisory Task Force on Planning released a report last week that recommends closing more than a dozen University units as part of President Ken Keller's Commitment to Focus plan to improve the quality of the University.

"A report like this always gets the affected groups deeply upset," Benjamin said.



Roger Benjamin

"But the painful truth is we've got this necessity of choice that must be confronted," he explained.

That "necessity" is based on the belief that the University must consolidate its resources by eliminating some departments and colleges.

What Benjamin thinks about the report is important because he will make the final recommendations on what programs should and should not be cut.

His recommendations are scheduled to be presented to Keller and the Board of Regents in late November. Between now and then, the task force proposals will move on to the Academic Affairs Planning Committee, which is scheduled to have its own recommendations prepared by July 31.

During fall quarter, members of the University community will be given ample opportunity to throw in their two cents' worth through a series of public forums, he said.

Benjamin repeatedly dodged questions concerning his thoughts on the proposed closings.

"Like (Keller), I find it a very dramatic step to go around closing collegiate units," Benjamin said. "But it is also true that University of Minnesota is underfunded."

Regardless of what happens, Benjamin acknowledged the task force recommendations have already hurt recruitment efforts and morale in the veterinary and dental programs. "There's no question serious damage has been done by this report," he said.

"We'll have to make dramatic steps to counteract that damage (if the programs stay)," he said. Those steps might include increased funding and public relations efforts.

Benjamin said he is aware of the alienation many part[illegible] University and state [illegible]ing as a result of report.

"I'm quite aware of the concern — especially in Health Sciences and in the rural areas of the state," he said. "They have to l

See **Benjamin** *page*

Benjamin *from 1*

reassured about their valuable role in our land grant university."

Benjamin also said he likes much of what the task force report says. In particular, he's impressed with the report's emphasis on undergraduate education, the strengthening of which Benjamin has always believed to be the key to CTF's success.

The task force proposed the creation of an Academy of Literature, Sciences and Arts, into which all incoming freshmen would enter. The academy would consist of four colleges and would bring the University back to the basics with a strong emphasis on the arts and science core.

Benjamin dismissed allegations that the task force recommendations are a political ploy, engineered by the administration to garner more University funding from the Legislature.

"What we've been charged with by the Legislature is to come back in two years with a better sense of our own priorities," Benjamin said. "There is no hidden agenda."

Vanselow says report endangers dental, vet schools

By Delores Lutz
Staff Writer

University officials must act quickly to save the School of Dentistry and the College of Veterinary Medicine, according to the University vice president for health sciences.

Both professional schools, targeted for elimination in a University task force report last week, already are threatened even if the recommendation is rejected, Dr. Neal Vanselow said in an interview Friday.

"We do not have a lot of time. These things can become self-fulfilling prophecies," he said.

Students accepted for the classes entering this fall have been calling the University to ask if they should bother coming here, he said, and some faculty members last week received job offers from other institutions.

Neal Vanselow

The two schools' uncertain futures also could jeopardize their faculties' abilities to garner federal research grants, which usually are given for projects that are spread over a number of years, Vanselow said.

Vanselow, who opposes the task force's proposal to close the dental and veterinary schools, wants the decision-making process for those schools speeded up to minimize the damage.

The University administration will study the task force report over the summer, and the Board of Regents is expected to act on the administration's recommendations in the fall.

"These schools are in a very, very difficult position," Vanselow said. "It's essential that we try to come to a resolution very quickly, hopefully before the summer is over."

The task force report is part of Strategy for Focus, the process of implementing President Ken Keller's Commitment to Focus.

The report said the dental school, which has a strong national reputation, should be closed because it is costly to operate, and there is a surplus of dentists.

Vanselow agrees that the supply of dentists currently exceeds demand, but he does not expect that situation to continue.

"There's going to be a shortage by the year 2000," he said.

The dentist surplus is similar to the surplus of engineers the country faced in the early 1970s, when Vanselow was on the medical school faculty at the University of Michigan.

"Engineers could not get jobs," he said. "But we didn't close our engineering schools, and thank heavens."

The prudent way to deal with a surplus is to cut back on class size, not to shut down the dental school, he said, because if the school had to be started up again a decade from now, it would never regain its present quality.

The dental school's Strategy for Focus plan, which was not available when the task force made its deliberations, has what Vanselow called "a very fine plan for the future."

The task force also justified its proposal to eliminate the College of Veterinary Medicine by citing a surplus of veterinarians, but Vanselow said that the surplus is limited by specialty and geography.

"Right now, I think that people would say that there is a surplus in small animal practice in the larger (metropolitan) areas," he said, but veterinarians still are important to Minnesota's agriculture and industries, particularly in research on poultry and livestock.

The veterinary school already has cut enrollment, he said.

Task force recommendations for U of M colleges

Here is a synopsis of college-by-college recommendations of the University of Minnesota's Advisory Task Force on Planning:

Agricultural Experiment Station: About $23 million in income from the station pays for salaries and research in the Institute of Agriculture, Forestry and Home Economics. Some of that money should go to others in related work. More should go for research, less for salaries.

Agriculture: Enrollment decreasing, but the college is important to the state economy. Move rhetoric department to the College of Liberal Arts and College of Forestry into the Agriculture College. Reduce budget, after adjustment for transferred programs, by $650,000.

Forestry: Enrollment has dropped for nine years. Graduate programs are good. Should be renamed School of Natural Resources and become part of the College of Agriculture, saving ,000 in administrative costs.

Home Economics: Importance of graduate study and research should be stressed and a core of undergraduate courses developed. Cut budget $250,000.

Minnesota Extension Service: Outreach arm of university is funded by federal, state and county money. Has expanded beyond agricultural services, including technology transfer from university to communities. Mission not clearly defined and should be reviewed.

Pharmacy: Only pharmacy program in state, with strong program and clear direction. Federal research funding down, but school is reemphasizing research to get it back, which should be supported. Cut overall budget $200,000.

Veterinary Medicine: One of three regional veterinary schools. Surplus of veterinarians led to sharp drop in applicants. Heavy on clinical education, light on research but with good reputation, an expensive program that costs $17,400 to teach each student. Needs several million dollars in , but unavailable, funding to function properly, so should be closed.

Mortuary Science: One of three in the country, program is high quality but devoted to training, not research. Work preparing bodies used in laboratories is essential. Should be eliminated and perhaps transferred to state or community college, and $175,000 budget for laboratory body preparation transferred to Medical School. Total savings: $66,000.

Medicine: State's primary site for medical research and physician training, although demand for doctors declining. Should increase graduate students and postdoctoral fellows. Family practice budget should be reduced $4 million and made up in outside funds. Shift the $4 million to basic biology and interdisciplinary programs in neurosciences, human genetics and biomedical ethics. It should get $175,000 from Mortuary Science.

Dentistry: Good national reputation for training dentists, but research record undistinguished. Enrollment plunged with declining need for dentists and too many dental schools. Received $8 million in 1986 from state and $1.6 million in federal research funds. Close school. Students could go to other schools in the region.

Nursing: Doctoral program approved in 1981 has awarded no degrees, but has significant research potential; should get another $120,000. Master's program should shift from professional enhancement to research. Enrollment in bachelor's program declining and should be strengthened by cutting size and requiring a bachelor's in another field, saving $250,000. Cut administration by $200,000.

Public Health: Has improved in recent reorganization, but needs more work. Organized Teaching Unit and graduate major in public health nursing don't teach nursing and should be eliminated, using $300,000 budget for program improvements in aging, health promotion and disease prevention, health care delivery and hazardous chemicals and health.

Management: Dramatically better in past decade under new leadership. It has reorganized, revised curricula and cut students. Too much spent on administration; should shift $200,000 to undergraduate teaching.

Biological Sciences: Provides focus for fundamental biology, of increasing importance to society. Excellent facilities in St. Paul, but not Minneapolis. Academic quality uneven and needs strengthening. Ecology and behavioral biology high quality, botany low in productivity and outside funding, and biochemistry, cell biology and genetics are widely dispersed. Should be restructured. Ecology and behavioral biology needs to provide new faculty to keep quality high. The college should receive $3 million more.

Education: Severely cut back since 1971. Educational psychology and Institute of Child Development high quality, but others mixed. Educational administration has questionable quality and should be improved or closed. Close vocational and technical education and recreation, park and leisure studies, saving $1.2 million. College should take over English as a second language, gaining $142,000, plus cognitive science ($550,000) and research on undergraduate education ($500,000).

Liberal Arts: Huge college strong in social and behavioral science, with six nationally distinguished departments. Arts and humanities alarmingly weak without a strong faculty, good facilities or coherent training in basic humanities, and is scandalously underfunded. Without improvement plan, university will be disgracefully deficient.

The college has too many small Ph.D. programs, which should be strengthened or eliminated, and too many small departments, which should be combined. Linguistics and South and Southwest Asian studies low quality and should be closed, saving $559,000. English as a second language should move out, taking $142,000. Broadcasting should go from communications to journalism, taking $100,000.

College should be divided into the College of Social and Behavioral Sciences and the College of Humanities and Arts. To keep social and behavioral sciences strong, more faculty and better facilities vital. New college should get $1.7 million. The Humphrey Institute should move to that college, bringing $1.1 million. Top priority should be given to finding humanities a building near its library. It should get $4 million to rebuild programs.

OVER

U.S. to Propose Ending Reimbursement To Hospitals of Unpaid Medicare Debts

By Joe Davidson
Staff Reporter of The Wall Street Journal

WASHINGTON—The Reagan administration plans to propose soon a regulation ending the federal practice of reimbursing hospitals for unpaid Medicare debts.

The $780 million, five-year savings would be used to finance the government's stepped-up fight against acquired immune deficiency syndrome, or AIDS.

Under current procedures, Medicare, the federal health program for the elderly, pays hospitals the amount they would otherwise lose from covered patients who don't pay the deductible or copayment fees. The proposed regulation, which could become final after a 60-day comment period, would leave those uncollected debts with the hospitals.

Fred Graefe, counsel to American Protestant Hospital Association, called the plan "utterly outrageous." If put into effect, he added, the rule would raise charity expenses for hospitals, increase pressure on poor people to pay for health care they need but can't afford, and shift more bad-debt costs to private insurers.

Mr. Graefe said the hospital-industry lobby will urge congressional action to stop the rule before it takes effect.

According to a federal health official, the White House Office of Management and Budget told the Department of Health and Human Services that increased funding for AIDS programs would have to come from other department programs.

Stephen Beck, executive director of the National Association of People with AIDS, said the proposal was "absolutely an attempt by the OMB and the Reagan administration to force two desperate situations to compete." AIDS programs should be allocated much more new money that isn't taken from other health or domestic programs, he added.

President Reagan is seeking $304 million in additional AIDS funding for the current and coming fiscal years. That money would come from the savings on bad debts, which occur when Medicare beneficiaries don't pay the $520 deductible on hospital stays, or the $130-a-day fee required between the 60th and 90th days of hospitalization.

A memo from William Roper, the Medicare administrator, to HHS Secretary Otis Bowen, said the proposed rule would have "the most severe effect" on rural and large urban hospitals with higher-than-average caseloads of poor people, government-controlled hospitals, and hospitals with large graduate medical-education programs.

Federal officials considered recouping the uncollected payments by reducing Social Security payments to those who incurred the debts, but rejected that option "because it would shift the responsibility for collecting bad-debt payments from hospitals to the government," the memo said.

July 6, 1987
Minnesota Daily

Patrick Dillree dies; tested new AIDS drug

By Delores Lutz
Staff Writer

Patrick Dillree, the first University Hospital and Clinic patient to receive the antiviral drug AZT, died of AIDS at University Hospital Friday morning. He was 26.

He swallowed his first dose of azidothymidine, a drug shown to be somewhat effective against AIDS, at a news conference last October. He recently had to stop taking the drug after being hospitalized for pneumonia one month ago.

The drug prolonged his life and improved its quality for a while, according to his mother, Lois Dillree.

"It was a lot better for him, definitely," she said Sunday. "He gained weight and it gave him the appearance of being well. He looked forward to Christmas and the holidays. It was easier for him to do things he could not do before."

Before he started taking AZT, Dillree was so weak that he had to crawl to the kitchen for a bowl of cereal, she said. With the drug, however, he was able to go shopping, drive a car and prepare simple foods, such as macaroni salad or bacon and eggs.

In an interview last week, Patrick Dillree said doctors sometimes asked him to answer questions from other patients who were considering taking the drug. He recalled giving candid appraisals of both the benefits and the side effects.

"I don't lead them on at all."

Dillree *from 1*

he said.

He did not like to talk about how he became infected with the AIDS virus, however.

"He had a drug problem, and he's certain he contracted AIDS by the use of bad needles," his mother said.

But he also was gay, although he was not an activist, and his mother said she was perplexed when he recently expressed the wish that he had married.

"In my mind, there are some questions whether he was outgrowing the homosexual life," she said, "but he could never talk about it."

In his last days, when the AIDS virus had attacked his nervous system, he was immobilized by pain and talked only with difficulty.

His mother, his brother and two of his friends were with him when he died at 10:05 a.m., just hours before he was to have met Sen. Rudy Boschwitz (R-Minn). The senator came to the hospital Friday afternoon to discuss AIDS issues with Dr. Frank Rhame, Dillree's physician.

Visitation will be from 5 p.m. to 9 p.m. today at the McDivitt Hauge Funeral Home, 3131 Minnehaha Ave. Funeral services will be at 10 a.m. Tuesday at Holy Name Catholic Church, 3637 11th Ave. S., Minneapolis.

Tuesday, July 7, 1987
The New York Times

Sudden Nurse Shortage Threatens Hospital Care

By TAMAR LEWIN

Over the last year a sudden — and dangerous — nursing shortage has begun to hamper hospitals all over the country.

According to the American Hospital Association, vacancies rate in hospital staff nursing jobs more than doubled to 13.5 percent from late 1985 to late 1986, and the problem is getting worse every day.

Health experts say the longterm prospects for nursing are bleak. Nursing school enrollments are plummeting, schools are closing their doors, and every year, a smaller pool of college students show interest in nursing careers. What is at stake, they say, is the quality of hospital care, for it is the nurses on the wards, and not the doctors making their rounds, who provide the bulk of patient care.

Vacancies in All Fields

To some extent, nursing shortages are a cyclical phenomenon. The last major one was in 1980, and the one before that in the late 1960's. But most health policy experts and nursing officials say the current shortage is different, and far more ominous.

"Never before have there been nurse shortages in every single state, in every kind of clinical area," said Connie Curran, the American Hospital Association's vice president for health ices. "It's not just bedside nurses, it's head nurses' jobs that aren't getting filled. And there's no quick solution, since the nursing schools don't have as many people in the pipeline as they used to."

Critical Care Is Affected

The shortage is especially apparent on the unpopular night shifts and in critical care units. At Children's Hospital in Oakland, Calif., for example, the 48-bed intensive care unit for newborn infants is short about 20 nurses, or one-eighth of its staff.

The unit gets the very sickest infants in the East Bay area. Most are connected to machines that aid in breathing and monitor heart rates, and most must have their vital signs checked every hour. Some get up to 12 different medications, and all need feeding and diapering. Both the staff nurses and their supervisors are working extra shifts to keep up with the mounting workload.

"We haven't had anything scary happen yet, but if two babies got into trouble — we call it 'crumping' — at the same time, there might not be enough bodies to get everything done," said Beryl Epstein, assistant director of the unit.

"We had a wave of resignations last fall, people who were leaving hospital work because they wanted better hours, and people who were going to medical school. We're trying to hire, but there are not a lot of applications. I don't see the light at the end of the tunnel."

More and More Overtime

But compared to other neonatal wards, Ms. Epstein's unit is relatively well-staffed, with each nurse usually assigned to only one or two infants. A similar unit in Jackson, Miss., now uses less-trained licensed practical nurses and "nursery care technicians" to feed and hold the babies, while each registered nurse looks after an average of 4 babies.

Hospitals, which employ about two-thirds of the nation's 1.5 million registered nurses, are responding in different ways. Some are relying more on temporary help, either hired through an outside agency, or from the hospital's own roster of substitutes. Some are recruiting overseas. Some, unable to maintain adequate staffs, have been forced to close beds. And almost all are asking their nurses, and their supervi-

Continued on Page 11, Column 1

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sors, to work more and more overtime.

"Hospitals are just beginning to feel the decline in nursing school enrollments that began in 1983," said Pamela Moraldo, executive director of the National League of Nursing. "I think the crisis is going to come soon, and the quality of care will deteriorate."

A Lack of Status And a Limit to Salaries

There are a host of reasons for the shortage. For one thing, nursing is not a lucrative profession. Although beginning nurses earn competitive salaries, averaging about $21,000, there is little room for growth, and even the most experienced bedside nurses usually reach a plateau at about $30,000. Many nurses believe that as long as the profession remains a province of women — only 3 percent are men — it will be underpaid and undervalued.

"It's a cultural problem," said Ms. Epstein. "Nursing is seen as women's work, like day care. It's caretaking, and women in the 1980's don't see caretaking as a necessary part of their identity. And since it's not highly respected, it won't attract men."

And since women are now free to go into the higher-paid, higher-status professions that once were dominated by men, nursing is no longer an obvious choice for young women choosing a career. Last month Boston University reflected a national trend when, citing falling enrollment, it announced that it would close its 41-year-old nursing school next year.

'Why Not Be a Doctor?'

Even trained nurses are leaving the field, turning instead to real estate, medicine, business or law.

"When I was a nurse, I felt I was presumed to be stupid and I resented that terribly," said Pat Permakoff, a 38-year-old lawyer in New York City. "Back in high school, I thought my only choices were to be a nurse, a secretary or a stewardess. But women aren't funneled into those categories anymore, and at this point, I don't know what the attraction of nursing would be. If you're going to be in a hospital setting, why not be a doctor?"

Most young women seem to share that view. This year, for the first time, more freshman women at four-year colleges said they were interested in becoming doctors than in becoming nurses, according to the annual survey by Kenneth C. Green, associate director of the Higher Education Research Institute at the University of California, Los Angeles.

The Growing Ills Of an Aging Population

Demographics compound the problem. The pool of college-age students that generates new nurses is shrinking, while the rising number of elderly people requires more and more nursing care, and not just in hospitals. The demand is growing in clinics, insurance companies, and home health care.

In addition, recent Federal cost-control policies have forced hospitals to discharge patients sooner, so that wards are filled with only the most acutely ill patients, who need the most intensive nursing care. In fact, the ratio of patients to nurses in hospitals is now about one to one as against two patients for every nurse in 1975.

To complete the circle, those same policies make hospitals reluctant to increase nursing salaries, the largest single item in hospital budgets.

The Department of Health and Human Services predicts that by the year 2000, there will be only slightly more than half the number of registered nurses with bachelor's degrees that are needed.

The problem has just begun to attract legislative attention. Last month, Senator Edward M. Kennedy, Democrat of Massachusetts, introduced a plan to create nursing recruitment centers, an advisory committee on retaining nurses, and grants to support innovative nursing models. And some members of Congress want to restore Federal funds for nurse training, which have been cut from a high of $150 million in 1974 to $53 million this year.

Concern Over Downgraded Role

But some health economists say the real cause of the shortage is that hospitals are depending on comparatively cheap nursing staffs to perform too many nonnursing roles.

"Patients in hospitals are sicker than they used to be, but that alone can't account for the dramatic increase in the ratio of nurses to patients," said Linda Aiken, vice president of the Robert Wood Johnson Foundation in Princeton, N.J. "Since nursing salaries have gone up only 14 percent since 1983, while other hospital employees' salaries are up 20 percent, I can only conclude that hospitals are cutting costs by using nurses as substitutes for respiratory therapists, pharmacists, secretaries, and maintenance people. That is not efficient when the nursing pool is dwindling."

While registered nurses with bachelor degrees are in short supply, there is a good supply of nurses with less training, those with one or two years of college education. Some hospital administrators and nursing executives say the imbalance may prompt a downgrading of the nursing function into a more technical and less professional role, at a time when sophisticated medical technology requires more-educated nurses.

"As the pool of registered nurses decreases, hospitals are going to resort to other kinds of nurses," said one nursing supervisor in California. "The question is, as a patient, do you want somebody who can carry your bedpan, or a professional who can act as your advocate with doctor, assess your condition, and work with you on your treatment."

Where Nurses Are Seen As Professionals

Indeed, many nurses believe that the only way to resolve the hospital nursing shortage for the long term is to make nursing more clearly a professional job.

"Nurses have to be able to aspire to real money, just like other professionals, but money alone won't do it," said Dr. Moraldo of the National League for Nursing. "The way to get nurses into hospital jobs is to give them more responsibility, more status, more autonofield is when they think they can no longer do a good professional job."

The experience at Boston's Beth Israel Hospital, where turnover is low and the nursing shortage has hardly been felt, seems to bear that out. Beth Israel has an unusually strong nursing director, whose title and role in the hospital are on a par with the chief of medicine, a salary scale that pays staff nurses nearly $40,000, and a system under which each nurse is assigned the primary responsibility for a few patients, with whom she stays on every subsequent readmission to the hospital.

A Waiting List for Jobs

For many years, Beth Israel had a waiting list for nurses who wanted jobs. Of the seven staff nurses on the day shift at the hospital's cancer unit, four had to wait and work elsewhere before getting hired. All seem enormously pleased with the responsibility and room for growth in their jobs.

"Nursing here is really the best of both worlds," said Mary Johnson, an oncology nurse who helped develop the charts used to track the progress of the unit's bone marrow transplant patients.

"We're involved in science, but what we do is also an art. We get very involved in our patient's lives, and often their family's lives too. Especially in oncology, a big issue is how aggressively the patient wants to fight the cancer. We help them work that through, and try to respect their decisions."

Across town, at Boston City Hospital, where a 28-bed surgical unit was closed for lack of nurses in February, nurses say they are stretched too thin and cannot imagine staying in their jobs for years to come.

Kerry Kineavy, 24 years old, had been on the job only five months when she found that she was the only staff nurse scheduled for the evening shift on her ward of patients with AIDS, asthma and problems related to alcoholism and drug abuse. And although she got help from other nurses, some hired from a temporary agency and some working overtime to help out, Ms. Kineavy described it as a nightmare.

'Cried My Eyes Out'

"One guy admitted with lice immediately traded his clothes with another patient," she said. "A patient escaped

down the back stairs, tried to jump over the fence, got a spike caught in his buttock and had to be treated in the emergency room. And then one guy punched a blind patient in the face. We had just been talking to the blind patient, and he couldn't see who hit him, so he began yelling, 'The nurse hit me, the nurse hit me.'

"I closed the door and cried my eyes out."

Ms. Kineavy said that about a third of her duties each day are not really nursing tasks: mixing medications, cleaning beds, answering the phone and transporting patients.

Temporary Measures And Long-Term Goals

Tom Smith, Boston City's nursing director, says he realizes that some of his nurses have too much to do. "We're trying to recruit nursing assistants, but you can earn more working at McDonald's," he said. "And the number of inquiries about R.N. jobs has dropped off."

So he, like the nursing directors of many other hospitals, depends on temporary nurses supplied by employment agencies, an expensive solution since the hospital must pay the daily, or per diem, rate for the nurses as well as a commission to the agency.

The presence of outsiders can be a burden for staff nurses.

"It takes about a half hour to get a per diem oriented to our charting system, where we keep supplies, how we contact a doctor, and what the background on the patient is," said Deborah Blomstrand, a nurse at Evanston Hospital in Evanston, Ill., where temporary nurses have become increasingly common in recent months.

New York Hospital, which has about 160 vacancies and uses a large number of temporary nurses, was criticized for its nursing care after the death there of Andy Warhol last February. Last month, Linda Pfingsten, the director of nursing administration, went to Dublin, Ireland, to recruit nurses.

"We've never recruited foreign nurses before," Ms. Pfingsten said, "and I think it's very degrading to the profession. But everyone said there were scads of nurses in Ireland, so I thought I better go see."

At the same time, 14 other American hospitals paid $6,000 each to send representatives to nursing job fairs in London and Dublin, hoping to lure nurses with salaries much higher than they earned there.

"There were probably 1,500 nurses at the fair, and the three of us from University of Texas talked to about 200 of them," said Marie Bean, the nursing recruiter at the University of Texas Hospital in Galveston. "We hope to get 12 to 15 nurses out of it, but it will be months before we know how well we did."

Both in this country and abroad, newspapers' classified sections are filled with advertisements for nurses. Many hospitals offer bonuses and bounties: $2,000 for signing up, $1,000 for staying six months or $500 for recruiting a friend.

Lure of Normal Working Hours

A few hospitals faced with serious nurse shortages have reopened contract negotiations with their unions to give raises of up to 20 percent, and most nursing recruiters expect large increases in the next round of salary negotiations. But even if salaries for registered nurses rise substantially, the drain of nurses from hospital jobs is likely to continue.

Unhappy about working night hours and taking orders from dozens of different physicians, nurses are increasingly turning to jobs in corporate health departments, insurance companies or health maintenance organizations, where they can earn just as much money and have regular working hours. According to the American Nurses Association, 68 percent of all nurses work in hospitals as against 75 percent a few years ago.

And as more nurses leave hospitals, with no replacements in sight, the job gets harder for those who stay, with extra pressure to work overtime and less opportunity for the personal contact that drew most of them into nursing.

"I was trained at a time when talking to patients, and caring, was a basic part of the job, and that was important to me," said Donna Lentsch, a night nurse at the Marian Health Center in Sioux City, Iowa. "But as a nurse, you have to set priorities, and that means doing the technical part of the job, like the medications, even when it doesn't leave any time to sit down and talk to the patient who's afraid.

"That," she added, "can be very frustrating."

Decline in area's hospital use hits bottom

Key indicators change slightly

By Gordon Slovut
Staff Writer

The decade-long decline in hospital use in the Twin Cities area appears to be bottoming out, according to a study released Tuesday by the Metropolitan Council.

There was little or no change from 1985 to 1986 in two indicators of hospital use. Admissions to the region's private hospitals were down less than 1 percent. The average length of stay for what the council calls "acute services" remained at about 6.5 days

Overall, hospital use has plunged more than 20 percent over the past 10 years as the result of public and private programs designed to shorten hospital stays and curtail admissions. Medicare has shortened hospital stays of the elderly by paying hospitals a flat fee based on a patient's diagnosis. Some health maintenance organizations (HMOs) have been pressuring doctors to keep their patients out of hospitals and to discharge them quickly.

Malcolm Mitchell, head of the council's health planning staff, said he expects hospital use to drop slightly this year. But he said he thinks the era of major decreases is over.

For the most part, hospitals are now caring only for "complex cases," he said. Much surgery has been shifted to one-day surgical centers run by hospitals and private corporations. And many doctors are doing in their offices minor surgery and diagnostic tests once done in hospitals.

Mitchell said he expects that trend to continue. One major need is for improved care of patients after they are well enough to leave the hospital, but not quite well enough to care for themselves.

The Council of Hospital Corporations, a trade association for 31 hospitals in the Twin Cities area, has challenged the Metropolitan Council's findings. Victor Ellison, vice president for public affairs, said his organization's preliminary figures show the average length of stay dropped 2.2 percent last year, from 5.98 days in 1985 to 5.85 in 1986.

Ellison said the council's figures from individual hospitals will be ready late this month. Preliminary figures indicate that the number of admissions dropped 1.7 percent last year and the number of days patients spent in hospitals decreased 3.7 percent, he said.

He said he believes his figures are more accurate, because the Met Council uses hospital census figures while his organization uses information taken from patients' charts.

Mitchell said that if the Metropolitan Council's figures are inaccurate, which he doubts, then the fault lies with the hospitals. "They gave those figures to us and we gave them a chance to recheck them and suggest any corrections," Mitchell said. "We made any corrections they suggested."

Mitchell said hospitals have made some beneficial adjustments as the result of declining admissions. They have been consolidating "expertise in just a few locations for the more difficult procedures," he said. An example is the decision by Mount Sinai Hospital, which has been plagued in recent years by a low occupancy rate, to create the Phillips Eye Institute for eye surgery. The institute could become a regional and even national center for eye surgery, he said.

Two hospitals have folded in recent years, two have merged and many have joined groups to share functions such as management and marketing, Mitchell said.

He said the major hospital groups admitted 62 percent of the region's patients last year, up from 47 percent in 1982. The number of metropolitan hospitals involved in groups rose from 16 to 22 last year and some of the remaining independents are discussing affiliations, he said.

Area hospital comparisons

	1985			1986		
	Admissions	Average Stay	Occupancy Rate	Admissions	Average Stay	Occupancy Rate
Abbott Northwestern	22,509	7.4	56.3	24,876	7.3	54.6
Anoka State	1,272	87.6	99.0	1,210	91.8	92.0
Bethesda	6,867	5.8	37.2	6,490	5.7	34.2
District Memorial	1,399	3.6	30.8	1,323	3.4	27.8
Divine Redeemer	2,138	4.6	21.3	2,154	5.3	23.8
Fairview Ridges	5,826	3.2	34.0	6,014	3.4	36.9
Fairview Riverside	14,292	7.9	61.3	* Did not file report		
Fairview Southdale	16,039	4.8	54.5	16,736	4.9	57.3
Gillette Childrens	958	9.9	43.4	872	8.5	34.0
Golden Valley Hlth	2,390	25.0	43.6	1,957	27.8	41.1
Henn Med Center	15,867	6.5	58.3	16,686	6.3	59.4
Lakeview Memorial	3,704	3.4	35.6	3,647	3.3	34.4
Mercy	11,141	5.0	53.2	11,907	4.9	55.9
Methodist	18,331	4.5	53.2	18,097	4.6	53.5
Metro Medical Center	15,814	6.0	37.9	14,550	6.0	34.3
Midway	7,748	4.6	38.5	7,405	4.9	40.4
Mounds Park	4,199	6.4	32.8	2,303	9.7	27.4
Mount Sinai	8,441	4.0	33.9	8,542	5.4	31.9
Mpls Childrens	4,636	6.0	62.3	4,874	6.5	73.6
North Memorial	18,729	5.3	48.9	19,068	4.8	51.3
Queen of Peace	1,464	4.3	30.8	1,449	4.2	29.5
Regina Memorial	2,262	3.4	26.4	2,019	3.5	24.6
Samaritan	1,942	4.5	15.3	1,102	7.5	14.9
Sanford	609	4.0	14.1	511	3.2	11.7
St. Francis	4,105	3.2	28.2	3,606	3.1	24.7
St. John's	8,765	5.5	36.9	10,095	4.7	45.7
St. Joseph's	8,462	6.5	39.2	8,235	6.8	42.4
St. Mary's	10,533	6.6	41.0	9,542	6.6	37.0
St. Paul Childrens	4,220	5.3	52.3	4,055	5.5	51.9
St. Paul-Ramsey	13,681	6.2	53.6	13,391	6.0	51.0
United	14,815	6.5	48.5	14,790	6.1	45.9
Unity	10,860	4.6	49.0	10,922	4.2	45.9
University of Minn.	16,748	8.4	46.1	17,803	8.3	56.1
Veterans Adm	23,512	7.9	76.4	22,816	7.7	74.2
Waconia Ridgeview	4,720	4.0	47.6	4,569	3.8	43.8
Metropolitan Totals	307,881	6.5	48.4	292,411	6.5	48.5

* Metropolitan Council used Fairview Riverside's 1985 figures to make overall calculations for 1986 because the hospital, which has merged with St. Mary's, did not file a report for 1986.
Note—Admissions, lengths of stay and occupancies are for acute services such as medical-surgical units, pediatrics and intensive care. Totals from hospitals do not quite match metropolitan totals because of adjustments in calculations.
Source—Metropolitan Council.

Wednesday, July 8, 1987
St. Paul Pioneer Dispatch

Better use rates for Twin Cities hospitals shown

By Walter Parker
Staff Writer

The long downward spiral of the beleaguered Twin Cities hospital industry may have begun to level off, at least temporarily, according to figures released Tuesday for 1986.

Total patient admissions and the average length of time patients stayed in the hospital — six days — were virtually the same last year as they were in 1985, according to the Metropolitan Health Planning Board. Board staff members estimated there were 282,000 admissions in 1986, less than half a percent below 1985.

That result follows years of steep annual declines of between 5 and 10 percent in the major indicators of hospital activity. The industry subsequently has been swept up by a whirlwind of mergers, consolidations and closings in efforts to achieve economic stability in an era when people who pay medical bills are slashing hospital expenditures.

"We may be bottoming out," said Malcolm Mitchell, executive director of the board, which is part of the Metropolitan Council. "We'll have to wait for the 1987 data to see what happens."

Preliminary calculations show acute care hospital use rates of 667 days in the hospital per 1,000 population in 1986, compared with 691 the previous year, he said.

In 1975, by contrast, the use rate was 1,170 days per 1,000 population in the Twin Cities. In the long run, Mitchell predicted, Twin Cities hospitals' usage rates will ultimately stabilize at a rate of between 500 and 550 days per 1,000 population.

"But the major quick reduction has already occurred," Mitchell said. "Now it's going to be in specialty areas such as low-income populations and higher-risk groups that we'll see the reductions in coming years."

If experiments in Hennepin and Dakota counties are successful in using prepaid plans to care for low-income Medicaid patients, the expanded use of that approach will chip away even further at hospitals, he said.

> **"We may be bottoming out."**
>
> **Malcolm Mitchell**
> Health planning board

The leveling off does not alter the fact that Twin Cities hospitals, which have roughly 9,000 beds, still have far too much capacity and that more shrinkage can be expected, Mitchell and other observers said.

Hospital leaders greeted Tuesday's report with a mixture of pleasure and caution.

"It's nice to have it changing," said David Slone, vice president of United Hospital in St. Paul, which had the same use rate in 1986 as the previous year. "I think we've reached a point where patients who are sick have to be admitted. Literally there's a bottom point to it. There's only so much you can do on the outpatient side before people have to be brought into the hospital."

Slone said that United's average daily census in the first six months of this year was up 3.5 percent over the previous six-month period and that admissions are up 7.6 percent. The hospital has 271 beds.

The Council of Hospital Corporations, a Twin Cities association of 31 hospitals, said its own use figures — scheduled for release later this month — show patient-days down 3.7 percent in 1986, a somewhat less optimistic view of the picture than the health board's numbers suggest. But the trend is consistent: patient days fell 6.4 percent the previous year, said spokesman Vic Ellison.

John Reiling, president of operations for the five-hospital HealthEast group in St. Paul, said he expects the pace of hospital use decline to slow down but not to stop. Factors such as technological innovation and pressure to cut costs will not abate, he said.

JUL 9 1987
Wall Street Journal

The Computer Is Now More Doctors Use High-Tech Help for Diagnoses

By Richard Gibson
Staff Reporter of The Wall Street Journal

A teen-age girl suffering severe stomach pains is admitted to an emergency room. A doctor begins to treat her but makes the wrong diagnosis, and the girl dies.

The doctor's computer sounds "Taps."

"The Case of Lower Abdominal Pain in a Young Girl" is a computer simulation—one of dozens being written to help physicians diagnose real illnesses and keep up with rapid changes in medicine. For years, hospitals and medical laboratories have used computers to analyze blood and run other routine tests, but only recently have computers found their way into the doctor's bag.

"The computer will have the same impact on medicine that the microscope did in the 19th century," predicts Marsden Blois, president of the American College of Medical Informatics, which tracks biomedical information management.

Among other uses, existing desktop programs help doctors evaluate coughs, detect early signs of heart failure, treat diabetes, determine proper drug dosages, suggest diets to reduce hypertension and calculate the odds on how much longer a person who stops smoking will live.

A Shortage of Software

Using computers for diagnosis is still limited by a shortage of proven software, by legal and ethical questions, and by a bad case of computer illiteracy among physicians. Moreover, doctors may lack the patience to learn to use computers. "We tend to be oriented toward doing things in a time-efficient manner, so a literature search of 10 minutes is just too large an investment," says John Sandness, a physician at the University of Minnesota's medical school. Calling a specialist on the phone still may be faster.

A recent American Medical Association survey found that while 45% of the doctors who responded have computers in their offices, less than 9% are using the devices to help make diagnostic decisions. Still, nearly a fourth say they eventually intend to do so.

Younger doctors are the best candidates, partly because medical schools are increasingly employing computers as teaching tools. In one experiment, Harvard Medical School has been substituting computer terminals for large lecture-oriented classes. Some universities even offer graduate studies in medical computing. University of Minnesota medical students who spend their third year in the field, training with physicians, take computers along.

One such student, Joseph Stanford, uses his terminal at a group practice in Hutchinson, Minn., to tap into various medical data banks, including the library in Minneapolis 70 miles away and to stay abreast of health developments through a nationwide news service. He also wrote a program to plot female patients' fertility for contraceptive purposes.

While some older doctors in the clinic avoid his computer, Mr. Stanford says others like George Gordon embrace it. A 39-year-old family practitioner, Dr. Gordon uses a personal computer at home as a way of continuing his medical education. Several companies and universities produce continuing medical education courses on floppy disks.

Such programs typically pose hypothetical situations, then ask doctors to indicate the proper examination procedure, what tests to order and the appropriate treatment. "For me it's been very valuable," says Dr. Gordon. "It gives you intensive feedback on how you did."

But he is disappointed that there isn't more software to help him quickly diagnose a real patient. "Say I have a 38-year-old guy with stomach pains. A computer could play doctor and ask logical questions," he says, rather than "for me to sit down and dig through a medical book and look at every possible kind of abdominal pain."

> 'WE'VE long since exceeded the point where any human doctor will remember' thousands of case histories, says one medical school spokesman. 'But the computer can.'

Big medical institutions and private companies are taking on that challenge. Huge data bases are being assembled that, when finished, will allow doctors anywhere to tap in and get expert advice on all manner of disease. Others are confined to one ailment. Oncocin, for example, a data base being developed at Stanford University, recommends drug therapies for certain types of cancers and keeps track of patients' progress.

DXplain, a data base that is part of a nationwide AMA-sponsored computerized information network, can advise the inquiring physician why his or her suggested diagnosis isn't supported by the evidence given the computer. Its creators, all of whom are medical doctors, say DXplain is intended to help clinicians rather than replace them.

Crammed with thousands of case histories, such systems take advantage of the computer's superior memory. "We've long since exceeded the point where any human doctor will remember all this, but the computer can," says a Stanford spokesman.

Floppy disks that doctors can load into their own microcomputers aren't as elaborate, but still offer quick analysis as well as a teaching format perhaps more entertaining than a textbook.

In a program called The Case of the Confused Housewife, a woman comes into an emergency room complaining of dizziness. The software, made by Cardinal Systems Inc. in Minneapolis, not only includes standard textbook data but also has a simple graphic of the sympathetic nervous system. Physicians can plug in characteristics of an actual patient and test a hypothesis. The program also indicates appropriate therapeutic drugs, by brand name and cost, with this caveat: "Suggested drugs shouldn't be prescribed without your careful assessment of the individual patient."

To help doctors and medical students sort through the thousands of pills and potions on the market, another computer program called McDope, written at McMaster University in Ontario, allows the user to administer drugs to a variety of patients and immediately witness the likely results. Until it was revised, the program included this line: "Your patient just died; do you have a good lawyer?"

Indeed, numerous legal and ethical questions need to be considered before the medical community accepts computerized diagnosis. For instance, can software designers and their users be held liable for a glitch in a computer diagnosis?

Malpractice Suits

So far, no significant cases have come before the courts. But Edward Shortliffe, a leading medical programmer, argues in the current Journal of the American Medical Association that: "It is unrealistic to require that decision-support programs make correct assessments under all circumstances." The Food and Drug Administration is still reviewing whether diagnostic programs come under its jurisdiction as medical devices. One dilemma underlying such issues is the probable nature of medical diagnoses; they're often couched in phrases like "seem to have" and "the tests indicate." Some legal specialists believe doctors eventually might risk malpractice suits for *not* consulting computer programs.

Other intriguing possibilities are raised because the programs presumably would be available to the public. Might insurance company clerks run diagnostic programs to second-guess a physician's therapy and fees?

Translating how doctors think into computer code also remains a major challenge. "A lot of things we do in medicine are hard to write down in rules," says David Olson, a professor at the University of Nebraska medical school. Doctors quickly determine a great deal about a patient in a single glance, while a computer would have to be told whether the person is a man or woman, young or old, bedridden or not.

But M. Rex Wheeler, a California physician who is working on a uniform medical code for software, says such issues will dissipate in the need for rapid, better data in an extremely complex profession. "The physician must review old charts and get information from patients who don't remember, and as a result may make diagnoses from inadequate information," he says. "He shoots from the hip and has no choice because that's what a paper-based system presents him."

St. Paul Pioneer Press Dis[illegible] Thursday, July 9, 1987

Mayo to merge Florida hospital, branch clinic

Associated Press

JACKSONVILLE, Fla. — The Mayo Clinic has agreed to take over the assets and liabilities of a troubled 289-bed Jacksonville hospital in an agreement to merge the hospital and a Mayo branch clinic.

St. Luke's Hospital's board of directors agreed Monday to the merger that calls for Mayo Medical Resources to take over St. Luke's Health Systems Inc., the parent company for the hospital and for other real estate and medical-related firms.

St. Luke's patient admissions have lagged since 1984 when it moved to a new $57 million building. St. Luke's had a $951,000 deficit in 1986 on gross patient revenues of $44.6 million, according to the Florida Hospital Cost Containment Board.

Furthermore, its 57 percent occupancy rate is less than the Duval County hospital average of 65 percent, and nearly 30 percent of St. Luke's patients are admitted by Mayo Clinic doctors.

No money will change hands in the merger, said Dr. Robert Waller, vice president of the Mayo Foundation of Rochester, which owns the buildings and properties of Mayo's satellite clinics in Jacksonville and Arizona.

St. Luke's 22-member board of directors will be dissolved, however, and replaced by a board with fewer members, Waller said.

Joe Adams, chairman of St. Luke's Health Systems Inc., predicted the merger would strengthen the financial resources of the hospital, which is about eight miles from the Jacksonville Mayo Clinic.

Some St. Luke doctors said the merger came as a surprise.

"I'm disappointed that the board did not consult the medical staff to make a decision of this magnitude," Dr. John Lovejoy Jr., an orthopedic surgeon, said. "I'm just a little confused by it all.

"Why was all this necessary if the previous situation was working? A lot of doctors made a big commitment to the hospital when it moved to its present location three years ago by buying offices in their buildings.

"There's a great feeling of confusion and concern that we're losing control of the hospital."

Pediatricians' trouble: Too many of them, fewer young patients

By Patrick Young
Newhouse News Service

The bust in the baby boom has left the nation's baby doctors with a troubled future.

Medical schools have turned out too many pediatricians, and these physicians now face significant competition from each other as well as problems with reimbursement and medical malpractice, according to a report published today in the Journal of the American Medical Association (AMA).

"Between 1970 and 1985, the number of pediatricians practicing in the United States (including pediatric subspecialists) grew by 89.3 percent to a total of 35,617; the number of all physicians grew by only 65.5 percent during this period," said the report by the AMA's Council on Long Range Planning and Development.

In the same period, the number of children under age 19 dropped from 77 million to 70.3 million, and the number of children per pediatrician in the year 2000 is projected to be less than half what it was in 1970, the council said.

Although the number of children is projected to grow slightly during the rest of this century, it is then "expected to stabilize at 72 to 73 million children until the year 2050."

The report was prepared in cooperation with the American Academy of Pediatrics. It said other factors will further put the squeeze on pediatricians:

■ A large part of their time is spent in "cognitive" services that insurance companies don't readily pay for, such as patient reassurance and support, family education and counseling about growth, development, social adjustment and sexual concerns.

U.S. medical schools have turned out too many pediatricians, who now face competing for a declining number of patients, as well as the problems of medical malpractice suits and of getting reimbursed for services, said an American Medical Association report.

If insurance plans and other third-party payers continue to favor reimbursement for technological procedures over cognitive services, pediatricians will have to face decreasing incomes, the report suggested.

■ Reduced Medicaid payments will adversely affect pediatricians, particularly if the proportion of poor children continues to rise, the AMA council warned. It cited figures from the Congressional Budget Office that the number of children living below the federal government's official poverty level rose 38 percent between 1980 and 1985. The council noted that poor children are far more likely to require medical care.

Unless Medicaid payments are increased to meet the rising costs of care, pediatricians will face a higher demand for care with a lower financial return, the report said.

Samuel Flint, the pediatrics academy's director of child health finance and organization, said this issue is particularly disturbing to his group because it adversely affects both the health of children and medical economics. "Our concern is that kids get care," he said. "What there really is is an undersupply of kids with insurance."

■ Malpractice suits and insurance costs generally have affected pediatrics less than many other specialties because pediatricians perform fewer high-risk procedures. In many states, however, malpractice suits can be filed at any time until a child reaches age 18. "Thus, pediatricians may face liability claims for many years after the alleged occurrence of malpractice," the AMA council said.

The report offered some general recommendations for improving the situation, but these were criticized in an accompanying editorial in the AMA journal as "passive" and inadequate.

Dr. Vincent A. Fulginiti of the University of Arizona Medical College said what is needed are tactics "to reach our goals, goals that should include reducing poverty, adjusting the number of pediatricians who will enter the profession, redistributing the excess number of pediatricians to underserved areas, and insisting on adequate compensation for ambulatory-cognitive services, which save patient costs and spare morbidity."

July 12, 1987
St. Paul Pioneer Press Dispatch

Med product makers feel pressure of rules

By Dave Peters
Staff Writer

Minnesota's medical device makers say they fear that innovations in technology, for which they have developed a solid reputation, are being endangered by the process that determines who pays for them.

The state's multibillion-dollar medical products industry, led by 3M Co. and Medtronic Inc. and including dozens of smaller companies, is used to having to prove to the federal Food and Drug Administration that new products are safe and effective.

But industry officials say that in the past several years pressure to reduce health care costs has resulted in a lengthy second round of examination to determine whether Medicare will pay for new procedures. If there is little or no reimbursement to doctors and hospitals for a new therapy, there's little incentive for companies to develop it, they say.

B. Kristine Johnson
New concerns

"In looking at new technology, one of the things we will look at is whether that technology is covered (by Medicare)," said B. Kristine Johnson, vice president of corporate affairs for Medtronic, the world's leading supplier of heart pacemakers and the maker of a variety of other medical products. "If you went back five years I don't think that would have been a concern."

Medicare's reimbursement policy is important for the number of patients it includes and because other insurers watch it.

Pam Effertz, spokeswoman for Group Health, said FDA and Medicare decisions on new technology are very important in that health maintenance organization's decisions to pay. "We have to ask, 'Are the benefits of the development clearly going to outweigh the costs?' " Effertz said.

The question means that the payback for a new product can take longer and that some development efforts get dropped.

Robert Buuck, president of American Medical Systems in Minnetonka, said his company has declined to pursue the development of some products because of uncertainty over reimbursement. "It has clearly been a factor and is becoming a larger one," said Buuck, who also directs the nation-

Please see Minnesota/2H

Medicare/ Issue of what will be covered draws criticism

Continued from Page 1H

tor of technology management of Blue Cross-Blue Shield, explained that "there was a time in this country when health-care costs were not a predominant concern. New techniques were adopted and paid for by insurers without much critical review. Now health-care costs are a major issue. And insurers are finding that the costs associated with new medical technology are significant."

Health Care Financing Administration officials say their coverage rules do not deny Medicare recipients access to new technology.

"I don't think it's a fair charge that Medicare beneficiaries are denied access to new technology," said Kathleen Buto, deputy director of the Health Care Financing Administration's Bureau of Eligibility, Reimbursement and Coverage. "If it's an effective technology, we cover it; it's just a matter of time. But we have to always be aware of the opposite concern — that the minute you approve something, you run the risk of making an instant market for medicine that may not be proven and effective."

Some experts, including the physician who treated Jameson, agree.

"I think you have to be fairly careful and cautious with new technology," said John Simpson, a widely respected staff surgeon at Sequoia Hospital in Redwood City who has done pioneering work in the field of catheter technology.

Increased scrutiny

Though viewed variously as the propellant or retardant of medical inflation, technology is drawing increased scrutiny these days. That is because, after three years of relative stability, medical costs are threatening to explode again despite efforts to economize such as shortening hospital stays and trimming medical payments, said Rita Ricardo Campbell, an expert on health-care economics and a fellow at the Hoover Institution at Stanford University.

Patient groups complain that decisions on Medicare coverage are often based on the potential cost of the technology.

Campbell cited three main culprits: expensive new technology that can run as much as $75,000 for a liver transplant, as well as the aging of baby boomers and the escalating costs of treating new diseases such as acquired immune deficiency syndrome and Alzheimer's disease.

Health Care Financing Administration's review of comments from physicians, patient advocacy groups and equipment manufacturers will result this summer in the agency publishing its rules for Medicare coverage of such new and sometimes controversial technology and procedures as catheters to clear clogged arteries, liver transplants and artificial ears to restore hearing, said William Roper, who heads the health care administration.

Under federal law, the agency has the authority to withhold payment for devices or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

But patient groups say decisions on Medicare coverage are often based on the potential cost of the technology. They also say decisions can vary from region to region because Health Care Financing Administration's procedural rules are buried in 1,800-page manuals that are not available to those outside the agency.

Blue Shield example

The Medicare review comes a[s] some other health insurers have [al] technology coverage issues.

For example, after a federal judge in 1985 ordered Illinois' Medicaid program to pay for a liver transplant for then 19-year-old Maritza Rivera, Illinois changed its policy and began paying for such operations. More recently, Illinois stopped making blanket prohibitions of new procedures and now reviews them on a case-by-case basis, said Daniel Pittmen, a spokesman for the Illinois Department of Public Aid in Springfield.

Blue Shield of California has become more aggressive in paying for promising new technology. Its technology assessment committee, which holds open meetings throughout California about four times a year to solicit public and scientific comment, has been cited as a model by patient groups and equipment makers.

Last month, Blue Shield's board approved an unusual plan aimed at making promising new technology more quickly available to patients. Blue Shield said it has decided to pay for some experimental procedures "when the clinical outcome (is) successful." If not successful, the doctor "and the hospital would absorb the cost and charge neither Blue Shield nor the subscriber for any of the services related to the procedure."

"We want to ensure that Blue Shield subscribers have access to valuable services and technologies as quickly as possible," explained Ralph Schaffarzick, medical director of Blue Shield of California. "Let's face it, there are some new technologies that promote the quality of care and there are others that contribute nothing except money to the pockets of its promoters."

Citing recalls of some products, some argue that it may be prudent [t]' [t]he Health Care Financing Ad[m]inistration is taking its time and [l]ooking over the shoulder of the [F]DA, which reviews products, and make recommendations on the effectiveness of medical techniques and procedures.

But others believe the lengthy Health Care Financing Administration review process can be as flawed as the FDA's.

"We delegate authority to the Health Care Financing Administration and the FDA to make some of these decisions," said Rep. Henry Waxman, D-Calif., chairman of the health and environment subcommittee of the House Energy and Commerce Committee. "It's one source of constant frustration to us ... that the decisions (by the health care administration) are so slow and so clearly biased."

Displeasure on the Hill

Others on Capitol Hill have also expressed displeasure with the Health Care Financing Administration.

In its 1986 budget bill, the Senate chided HCFA for continuing to classify liver transplants as experimental.

Noting that the National Institutes of Health and several other groups had endorsed the procedure, "it is the sense of the Senate that ... (HCFA) immediately reconsider the Medicare liver transplant coverage decision and implement a policy under which a liver transplant shall not be considered to be an experimental procedure for Medicare beneficiaries."

More than a year after that directive, the Health Care Financing Administration is still in the process of reviewing liver transplants along with 21 other procedures that the agency has declined to pay for, including bone marrow transplants and some kinds of heart monitors, said Robert Wren, director of the Health Care Financing Administration's office of coverage policy.

Wren argues that the industry complains about the administration's lengthy review process only because manufacturers "want to make a quick profit to cover their research costs."

But some companies argue that it is not just manufacturers' profits that administration policy may be hurting. The agency may be slowing the development of new medical technology.

In a study of venture capital financing for health-care technology, the yearly amount of such funds was found to have declined to $467 million in 1985 from $567 million in 1983. During that time overall venture financing remained stable at $2.8 billion, said the author of the study, Vincent Bucci, vice president of government and regulatory affairs for Shiley-Infusaid Inc., a Boston-based manufacturer of pharmaceutical delivery systems.

Although Bucci said he cannot draw any firm conclusions until 1986 data is available later this year, he said: "I believe technology assessment tends to inhibit the dissemination of new technology."

For his part, catheter recipient Jameson said he is a believer in the benefits of new technology. As long as a device has been approved by the FDA, he believes that patients and competent doctors can best decide what is the most effective treatment.

"It's not like I went to some quack somewhere," Jameson said. "This was not ... medicine that had never been done before. It was incomprehensible to me that a bunch of government bureaucrats could decide that my doctor and I weren't doing the right thing."

But experts say the power of bureaucrats will continue to grow as they attempt to employ medical technology assessment to slow rising health-care costs.

Regents oppose closing colleges

By **Chris Niskanen**
and **Greta Guest**
Staff Writers

After three weeks of public outcry over the proposed closings of the School of Dentistry and the College of Veterinary Medicine, the University Board of Regents faced a difficult dilemma during Friday's monthly meeting.

The regents had to decide whether to allow the task force recommendation process to continue, or to step in to allay public concern and spare the schools more negative publicity.

In fact, they did both.

The regents unanimously passed a resolution "to convey our strong disposition against the closing" of the two schools, as well as of the Department of Vocational and Technical Education.

The resolution, however, does not halt further examination of the Advisory Task Force on Planning's proposals over the next three months.

While the resolution's wording doesn't clearly reject the closings, all the regents said they would [illegible] closing dentistry and veterinary medicine if such proposals came before them in the future.

Wally Hilke

"I think there is absolutely no danger that those schools will be closed," said Regent Wally Hilke, who wrote the resolution.

During the meeting, all the regents expressed their hesitation to close the schools.

"I'm not so sure the (resolution) is as strong as many of us would like," said Regent David Roe, "but I think it sends a signal to the people of the state of Minnesota that [illegible] what the mission of this University is."

After Friday's meeting, both administrators and deans of the targeted colleges were satisfied, though the deans felt the resolution came too late.

"I was pleased with what (the regents) said," said Richard Elzay, dean of the School of Dentistry. "But it was not hard enough to take care of the negative impact."

In the past three weeks, the uncertainty facing the two schools has caused problems in recruiting and retaining students and faculty. Both schools are nationally recognized, but that distinction has suffered in light of the proposed closings.

College of Veterinary Medicine Dean Robert Dunlop said, "It was nice to hear that almost every individual regent opposed the closing.

"But we'll have to wait to see greatest concern to the administration was that a definitive rejection of proposals by the regents would undermine the next three months of discussion and make any further recommendations meaningless.

But the task force chairman, Charles Campbell, whose com

See Resolution page

July 13, 1987
Minnesota Daily

Regents applaud aspects of task force report

Resolution *from 1*

mittee spent three months drawing up the report, was satisfied with Friday's resolution.

"I think the process is preserved," he said.

The resolution comes three weeks after the 22-member Advisory Task Force on Planning released controversial proposals designed to implement University President Ken Keller's Commitment to Focus plan to improve the University's quality.

The task force recommended several school closings to help raise $25 million needed to make improvements in undergraduate education, with an emphasis on strengthening the arts and sciences.

The Department of Vocational and Technical Education, which trains teachers and administrators for vocational and technical schools, also has been recommended for closing but had received little public attention until Friday.

The regents wrote: "We also note our strong disposition against closing such units as vocational and technical education that uniquely serve an important state need."

George Copa, director of the vocational and technical education, said he was "pleased" with the vote of confidence, but his department will continue to deal with the negative publicity "until we have a clean bill of health."

The report also recommends closing the Department of Mortuary Science, radio station KUOM, the Department of Linguistics, the Department of South and Southwest Asian studies and the University Art Museum.

These proposed closings were not discussed by the regents.

As public criticism mounted against closing the dental and veterinary schools, the regents were swamped with phone calls and letters from their constituencies.

"There are tremendous feelings of abandonment on the part of the public by this University," said Regent Stanley Sahlstrom.

According to Friday's resolution, a message is being sent to the public to reaffirm that the task force recommendations are not final.

"We remind all friends of the University that the task force document is preliminary," the resolution states. "Its authors assume that significant changes will be made before and after it reaches the board and this is surely true."

Under the original planning process, regents were not to make decisions until late this year after the University's Academic Affairs Planning Committee and Keller had analyzed and revised those proposals.

But Keller requested in his July 6 resolution that the board decide on the school closings at its September meeting to halt further damage to the schools' reputations and recruiting efforts.

Keller's resolution was never voted on Friday. The regents decided from the beginning to take a stronger stance, with Keller's support.

"I don't think it's different in substance," Keller said of the regents' resolution. "I think, in fact, it's a better resolution than the one I proposed."

While the regents said they disapproved of the college closings, they applauded other aspects of the task force's report, especially those that would directly improve the undergraduate experience.

"There are many, many recommendations that would increase the educational undergraduate experience," said Regent Mary Schertler.

The task force recommendations now go to the Academic Affairs Planning Committee, where they will be reviewed with input from the deans of all colleges.

Regent Wally Hilke said the Academic Affairs Planning Committee should "know our feelings on these issues now.

"(The committee) should know that we aren't looking strongly at recouping or reallocating resources from closing those collegiate units so that they can make better decisions" on the other task force recommendations, Hilke said.

July 15, 1987
Minneapolis Star & Tribune

Dickler responds to university's call to be director of hospital and clinic

By Gordon Slovut
Staff Writer

The University of Minnesota is bringing back Robert Dickler, the senior assistant administrator who headed its successful drive for financing to build the new $113 million main hospital, to be general director of University Hospital and Clinic.

Dickler persuaded the legislature to let the hospital use the state's credit to borrow money to build and equip the hospital, which has replaced outdated facilities in the Mayo building on the health science campus.

Dickler, 41, who has been director of the University of Colorado Hospital in Denver since leaving here in 1981, returns to run a hospital facing the same problems confronting other hospitals in the Twin Cities metropolitan area: declining use, increasing competition and pressure from Medicare and insurers to hold down the cost of health care.

■ Two hospitals will merge under wing of HealthOne. 5B
■ Abbott Northwestern will cut 5 percent of its staff. 11D

Despite advertising publicly for patients and starting new programs, the hospital has experienced an overall downward trend in inpatient use in the 1980s, with the exception of a small increase in 1986.

"There are going to be a lot of strategic decisions facing us," Dickler said from his Denver office Tuesday.

Dr. Neal Vanselow, University of Minnesota vice president for health sciences, said Dickler, who also will be assistant to the vice president for health sciences, will take over the hospital in September if the Board of Regents approves. He succeeds C. Edward Schwartz, who resigned in February to become director of the University of Pennsylvania Hospital. Dickler joined the University of Minnesota Hospital administrative staff in 1971 after receiving a master's degree in hospital administration from the university. He was senior assistant administrator at Minnesota in 1981 when he resigned to head the Colorado hospital.

University Hospital, like most hospitals in the Twin Cities metropolitan area, has been losing patients as health maintenance organizations (HMOs) have diverted patients to outpatient clinics, one-day surgical centers, doctors' offices and, in some cases, to less sophisticated hospitals.

Other hospitals, such as Abbott Northwestern and its heart transplantation program, are competing with University Hospital by offering some of the specialized services formerly provided almost exclusively by University.

July 15, 1987
Minneapolis Star & Tribune

Abbott Northwestern to cut jobs

Abbott Northwestern Hospital will cut 5 percent of its staff, or the equivalent of 200 full-time jobs, on Aug. 1 because of what it calls "cost pressures" from government and private insurers.

The south Minneapolis hospital, which has 3,900 employees, said the cutbacks will affect mostly support services, such as marketing, lab, X-ray and food-service workers, among others. "It will not affect patients directly," a hospital spokeswoman said.

Megan O'Hara, manager of media relations, said the layoffs will include part-time and full-time workers, as well as a reduction in hours for other employees. But she said it's uncertain exactly how many employees will be affected.

The hospital said the cutbacks are needed despite the fact that business is growing. With 27,000 admissions a year, it claims a higher market share than any other Twin Cities area hospital. It also has a relatively high occupancy rate, 73 percent, for its 740 beds.

In a statement released Tuesday, the hospital said, "The reductions are a response to cost pressures from third-party payers," such as Medicare, which sets limits on hospital payments. "Medicare, which accounts for 35 percent of Abbott Northwestern's patients, only allowed a 0.5 percent increase in ... rates, while the hospital's average salary increase was 3 percent."

O'Hara said the hospital also is under pressure from health maintenance organizations, which demand discounted rates for their patients. "We have, to date, been able to absorb discounts, but at this point it means streamlining, too," she said.

July 15, 1987
Minneapolis Star & Tribune

2 hospitals will merge under wing of HealthOne

By Gordon Slovut
Staff Writer

The boards of directors of Mount Sinai Hospital and Metropolitan Medical Center (MMC) approved preliminary proposals Tuesday to merge the two hospitals.

The boards voted to sign letters of intent to consolidate the Minneapolis hospitals and place them under the management of HealthOne, the metropolitan area's largest multi-hospital organization.

Its hospitals had 20 percent of the area's admissions in 1986.

The boards of Sinai and MMC are creating committees to work out arrangements for the merger, tentatively scheduled to occur between Oct. 1 and Dec. 31.

MMC has been a HealthOne affiliate and Mount Sinai, which in recent years has had affiliation talks with several hospital organizations, has been an independent.

Warren Green, the outgoing administrator of Mount Sinai who will become director of HealthOne's operations in St. Paul, including United Hospital of St. Paul, said the HealthOne board of directors will vote on the preliminary merger agreement on Monday. He said the merger won't become final until both hospital boards and HealthOne approve the final merger agreement probably in the fall.

Mount Sinai, which has a strong doctor-training and research program in collaboration with the University of Minnesota, and MMC have different specialty programs. Mount Sinai, for example, has the area's largest eye surgery program but does not offer open-heart surgery, pediatrics, obstetrics and chemical dependency programs, all of which are major programs at MMC.

Both hospitals have had low occupancy rates in recent years and the administrations of both hospitals believe the alliance should help strengthen their financial position. Additional patients could come from HealthOne's growing health insurance program, PreferredOne, and by referral from doctors at the HealthOne hospitals. Those hospitals besides MMC and United are Mercy of Coon Rapids, Unity of Fridley, Golden Valley Health Center and St. Paul Children's.

Green said the merger plan provides that the new institution will have Mount Sinai in its name. Green said his hospital board approved the letter of intent unanimously. The vote from MMC's board was unavailable.

Mount Sinai has 273 licensed beds, 450 physicians and 800 employees. MMC has 749 licensed beds, 800 doctors and about 2,000 employees.

St. Paul Pioneer Press Dispatch

Saturday, July 11, 1987

U regents reject 'Focus' closings

Yield to storm of letters, calls

By Lucy Dalglish
Staff Writer

University of Minnesota regents, reacting to hundreds of phone calls and letters, indicated Friday they will not close the College of Veterinary Medicine, the School of Dentistry and the department of vocational and technical education.

While a resolution they passed says a formal decision on closing the programs will not be made until September, it was clear as each of the 12 regents spoke during a standing-room-only meeting that none supports a task force recommendation to cut the programs.

■ A 5 percent tuition increase is approved. Page 4A

The resolution "sends a signal to the people of this state that we know what the mission of this university is," said Regent David Roe of Medicine Lake.

The 22 faculty and student task force members were appointed by university officials to recommend ways to implement the university's "Commitment to Focus" plan, which is designed to improve the quality of the institution. The task force worked for three months and were told to make recommendations assuming there would be no additional funding from the Legislature or private sources.

The report was the first step in a

Please see Regents/4A

Continued from Page 1A

nine-month process to identify ways to streamline university operations and to focus more resources on undergraduate and research programs.

Several other programs and departments also were set for elimination, including mortuary science, the university's art museum and the linguistics department. Those programs will be evaluated by university officials over the next few months.

It was mostly the recommendation to close dentistry and veterinary medicine, two nationally recognized colleges, that outraged the public. The $13 million saved by closing the schools was to be used to improve undergraduate programs.

As word of the recommendation spread across the state the past two weeks, regents were inundated with calls and letters.

"I can hardly stay home at night," said Regent Stanley Sahlstrom of Crookston. "My phone is always ringing and my wife is about to leave me."

Sahlstrom said rural Minnesotans feel "a deep sense of betrayal. Because of the enormous anger out there, we would never have gotten any more support from them."

Perhaps the angriest regent was Charles McGuiggan, a dentist from Marshall, who called the task force recommendations an "anti-health sciences report." His suggestion to vote immediately to protect dentistry, veterinary medicine and vocational-technical education was rejected.

Although university President Kenneth Keller had suggested a resolution earlier in the week urging early action on dentistry and veterinary medicine, regents ultimately adopted a stronger one from Regent Wally Hilke, St. Paul.

Hilke's resolution said the wish to convey their "strong disposition against closing" the two colleges and programs such as vocational-technical education that "uniquely serve an important state need."

Regents praised the task force's efforts to redesign the undergraduate structure by creating an "Academy of Literature, Sciences and Arts," that would admit freshmen who would advance into one of four colleges when they become juniors.

Regent Mary Schertler, St. Paul, said while the task force did an admirable job on academic recommendations, it should not have been charged with making funding decisions.

"It's unfortunate that the parameters of the group exceeded what I perceived the parameters to be," she said. "The expanded charge of finding $24 million (the recommendation's total cost) was not appropriate for this group.

"It's the budgetary and political questions that got us into trouble," Schertler said. "The budgetary and political questions are (the regents') problems."

Charles Campbell, a physics professor and chairman of the task force, said he sympathized with the regents' dilemma. "They serve as the voice of the people of the state," Campbell said.

He said he was pleased that regents seemed satisfied with the "positive parts" of the report, such as the redesigned lower division for undergraduates.

Campbell said if they task force was given the same charge again, it would have made the same recommendations.

Robert Dunlop, dean of the veterinary school, said he believes the regents' resolution "saves the college," but the report has caused great internal problems at the university.

In Dunlop's view, the report says some colleges are more important than others, a notion he rejects.

Citizens League executive director Curt Johnson, who supports the process of identifying areas to cut, watched the debate and said tough choices will still have to be made in implementing Commitment to Focus.

"I think what (the regents) reflected was the reactions they were getting politically," Johnson said. "I hope they have no illusions that lists like this won't turn up in the future. Something will ultimately have to go."

41.

July 15, 1987
Minneapolis Star & Tribune

Perpich questions will of 'U' to change

He threatens budget freeze

By Jim Dawson
Staff Writer

Gov. Rudy Perpich, in a sharply worded open letter Tuesday to the University of Minnesota, questioned the courage of its officials to make the changes necessary to improve quality, and threatened to freeze the university's budget unless a substantial reorganization plan is completed by the end of the year.

The letter was triggered by the Board of Regents' less-than-enthusiastic reception last week of a task force recommendation calling for closing the dental and veterinary medicine colleges at the university. The recommendation was part of a larger report proposing a blueprint to implement university President Kenneth Keller's Commitment to Focus plan to improve quality at the university.

"After the events of the past few weeks," Perpich said in the letter, "I, along with many legislators, doubt whether the university has sufficient courage to undertake this fundamental, necessary reform."

In an interview, he accused the regents of "from the top of their heads kind of rejecting" the report. Perpich, a former dentist, also indicated that he supports one of the most controversial recommendations in the report, to close the School of Dentistry.

In the letter, which was delivered to the news media, not university officials, Perpich said the state has been very generous with the university. Then he threatened future funding. "My message today to the university is the same as it was in 1984: Either present, by January 1988, a reorganizational plan untainted by waste, duplication and the dead hand of time past, or prepare for a budget freeze."

In 1984 the governor told the regents he wanted a plan to improve quality or he would freeze the budget. The result of his demand was Commitment to Focus.

Neither Keller, the author of Commitment to Focus, nor Regents Chairman David Lebedoff were aware of the letter until it was read to them by a reporter, and both said they were surprised by its contents.

Keller called the governor's concern "misplaced," and said, "I don't think the process is going badly. There has been enormous change (at the university) in the last three years. We've changed the preparation standard. Last Friday the regents passed a motion reducing the number of students by 8,000 over the next half-dozen years. We've restructured General College. We've reduced enrollment in the dental school, in veterinary medicine, in (the school of) management."

He said he is being accused by legislators of moving too fast, not too slow.

Keller also noted that while the governor might be frustrated by the slowness of change, "We're frustrated by the slowness of support."

In his letter Perpich said that during the past four years the university has received about $151.8 million for new buildings and building improvements, and $1.3 billion in direct appropriations from the state. "Continued state support, however, will be contingent on the university's ability to continually refashion itself to meet the needs of the future," Perpich said.

Keller disagreed with the governor's assessment of support. "We had the second-worst appropriation this session of any in the last 20 years," he said.

Perpich concluded his letter with a threat that could translate into the university's loss of a chance to get $20 million for Commitment to Focus next year. Last week, when he learned that the state will have a substantial, and unexpected, budget surplus, he said he planned to recommend $20 million of the money for Commitment to Focus.

"Focus is, in 1988, right on the top of my list," Perpich said yesterday. But if he doesn't see major changes, such as closing unneeded programs, "Then we'll take those resources elsewhere," he said.

Perpich was most concerned about sentiment among university officials to keep the School of Dentistry. The regents unanimously passed a resolution last Friday expressing their "strong disposition against closing the College of Veterinary Medicine or the School of Dentistry," the two most dramatic recommendations of the task force report.

Perpich, a graduate of the dental school at Marquette University in Milwaukee, said that while he knows little about veterinary medicine, he does know about dentistry. The demand for dentists is declining, he said, and the need for the university to train new dentists is less important than the need for new engineers. He said he's talking to the heads of other dental schools in Nebraska, Iowa, Wisconsin and the rest of the Midwest, urging them to consider a regional dental school.

Lebedoff said, "Just because the regents indicated they weren't disposed toward shutting down the vet med or the dental school doesn't mean they are not going to make tough choices."

He said that if, by the governor's deadline of the end of the year, the regents are not making the tough choices needed to streamline and improve the university, "Then we'll be deserving of scorn. But the jury is still out."

Text of Perpich letter

An open letter to the University of Minnesota:

When I took office in 1983, with the state nearly bankrupt and a recession in full-swing, I assumed with relief that the University of Minnesota was one institution about which I did not have to worry. I could not have been more mistaken.

In pursuit of jobs to pull Minnesota out of recession, we bid for the Microelectronics Computer Consortium, a prestigious research institute which wanted to be located near a major research university. Our bid relied heavily on the presumed excellence of the U of M, so we were shocked when Admiral Bobby Inman, director of the consortium, dismissed the U as a mediocre institution.

I have long maintained that even when Minnesota loses an economic development competition, we profit because of the knowledge we gain, and this case was no exception. Informed of the university's shortcomings and cognizant of its importance to economic development, I requested a study of the U by the commissioner of finance, Gus Donhowe.

Commissioner Donhowe confirmed that the U of M was an institution striving for comprehensive mediocrity. We concluded that the U had to cease duplicating offerings of the vo-tech, state university and community college systems and focus instead on becoming a major research university. In February 1984, Commissioner Donhowe and I met with the Board of Regents of the university and delivered an ultimatum: Either focus or face a budget freeze.

Remarkably nimble when faced with a hanging, the Board of Regents quickly charged Ken Keller, then interim president, to develop a plan to reorganize the university. The general plan, now known as Commitment to Focus, was accepted by the regents. On the plan's strength Ken Keller became president of the university, charged with the implementation of widespread reform.

Three years have since passed and the university has now reached the critical stage in which it must decide which programs to eliminate. After the events of the last few weeks, I, along with many legislators, doubt whether the university has sufficient courage to undertake this fundamental, necessary reform.

The state has been very generous to the university. Over the past 4 years we have provided $151,880,300 for new buildings and building improvements and $1,320,177,500, a 42 percent increase, for direct appropriations. Continued state support, however, will be contingent on the university's ability to continually refashion itself to meet the needs of the future.

In 1977 I first requested that the university take steps to beautify its unattractive campus, and I even offered to raise private funds to pay for the beautification. I have made the same offer and request every year of my three terms as governor, yet the university has not improved its campus in any substantial way. I do not intend to wait as long for organizational reform. My message today to the university is the same as it was in 1984: Either present by January 1988 a reorganizational plan untainted by waste, duplication and the dead hand of time past, or prepare for a budget freeze.

— Rudy Perpich

Handout at 7/22/87
BOG Mtg.

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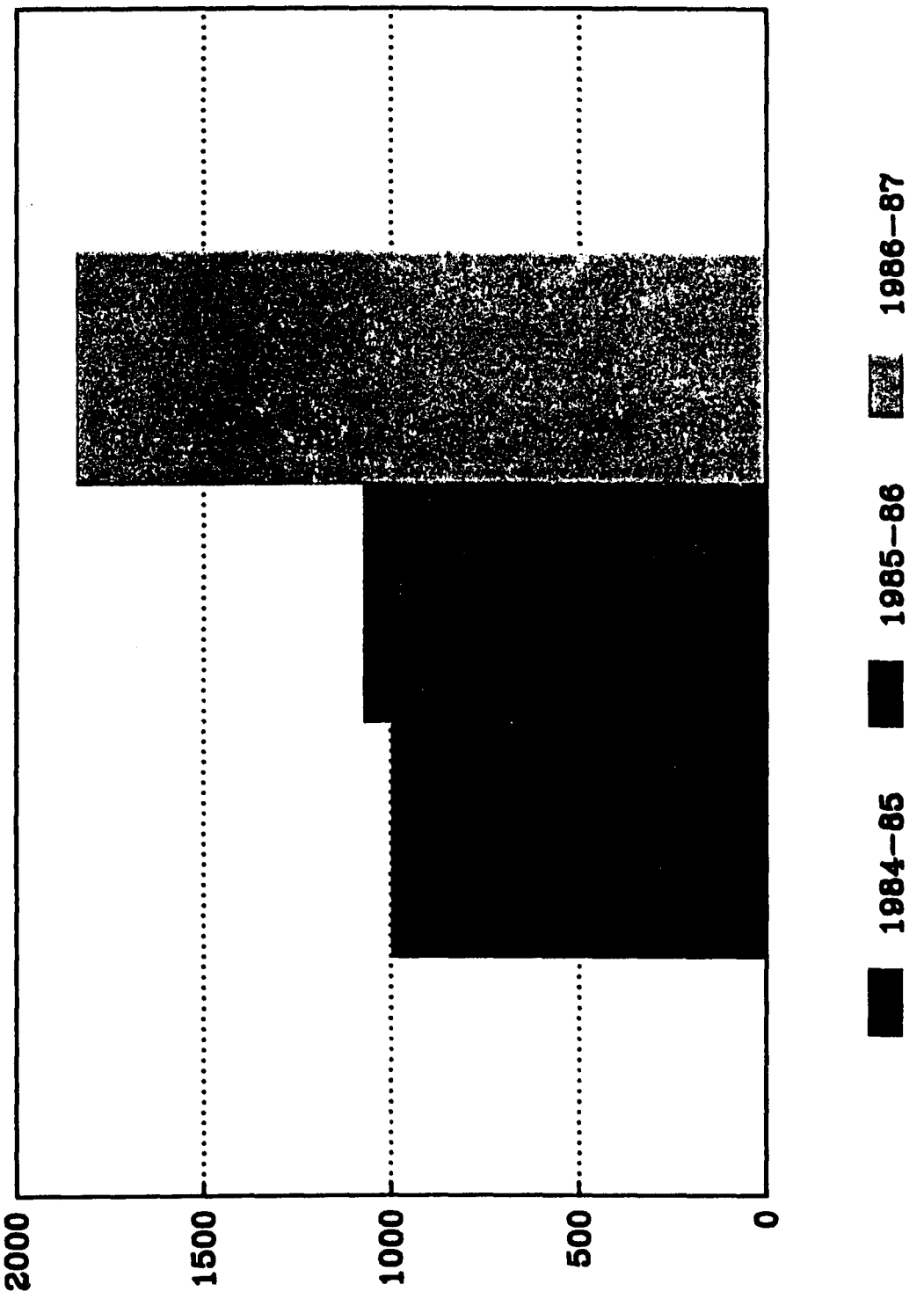

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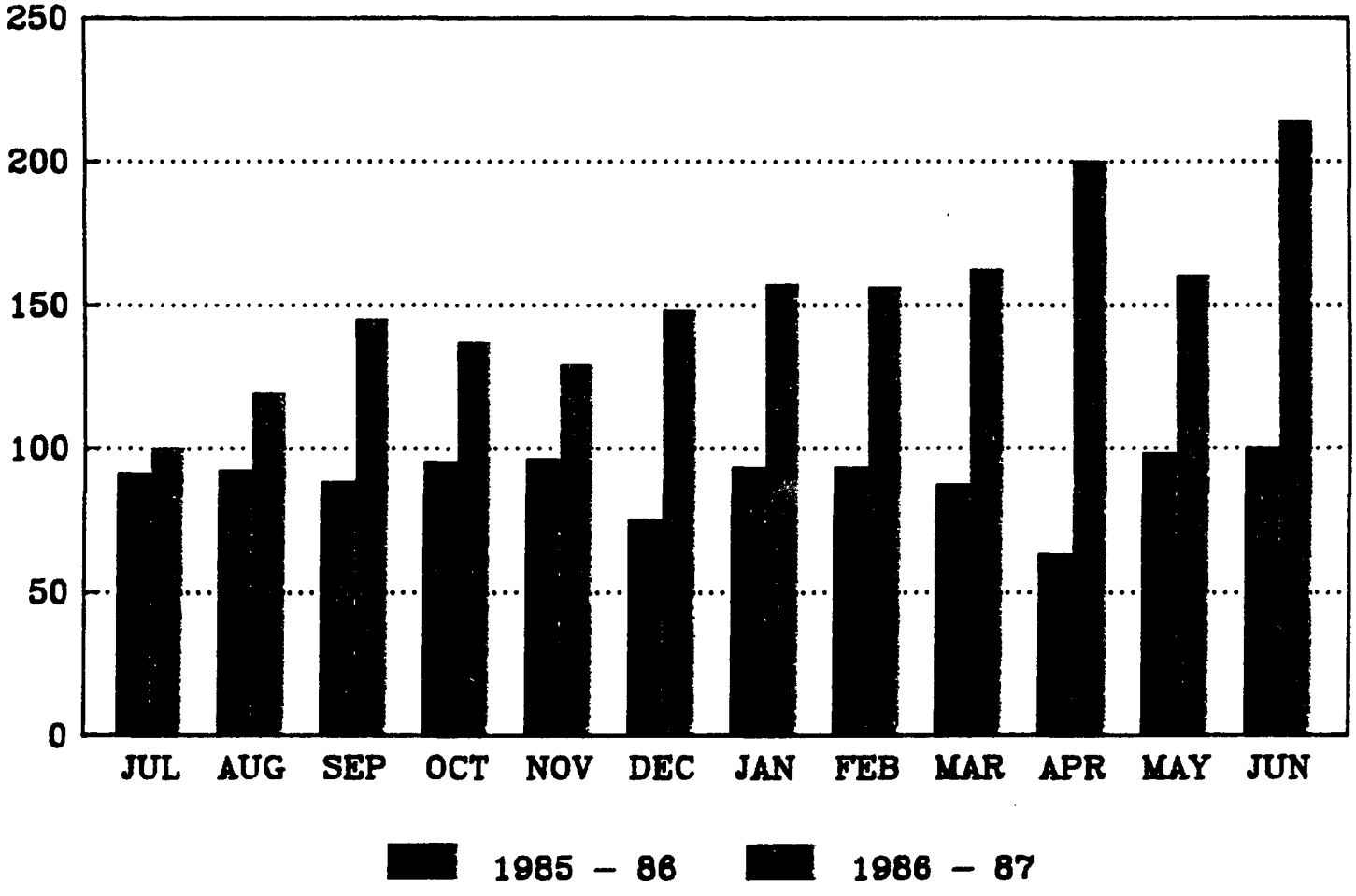

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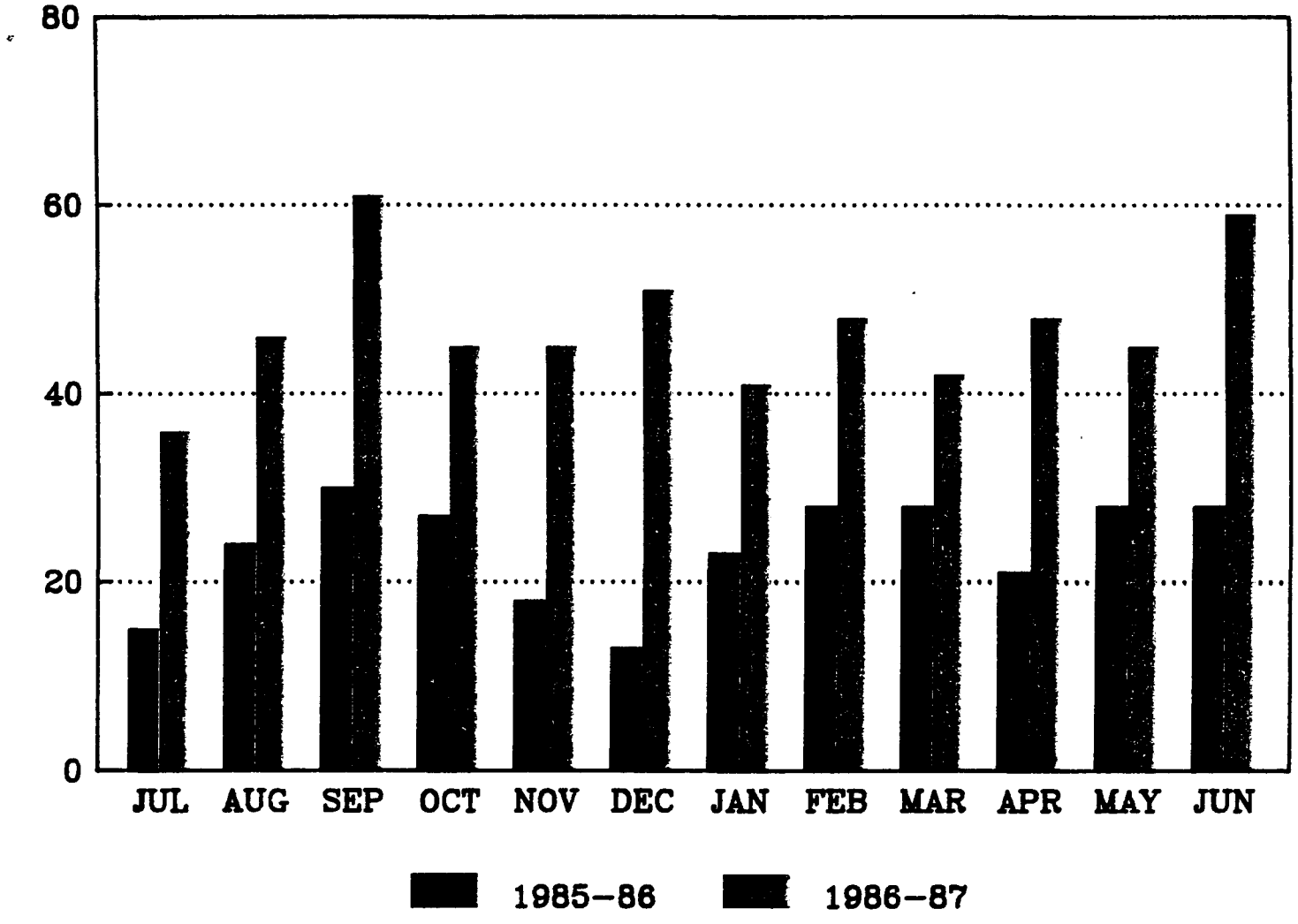

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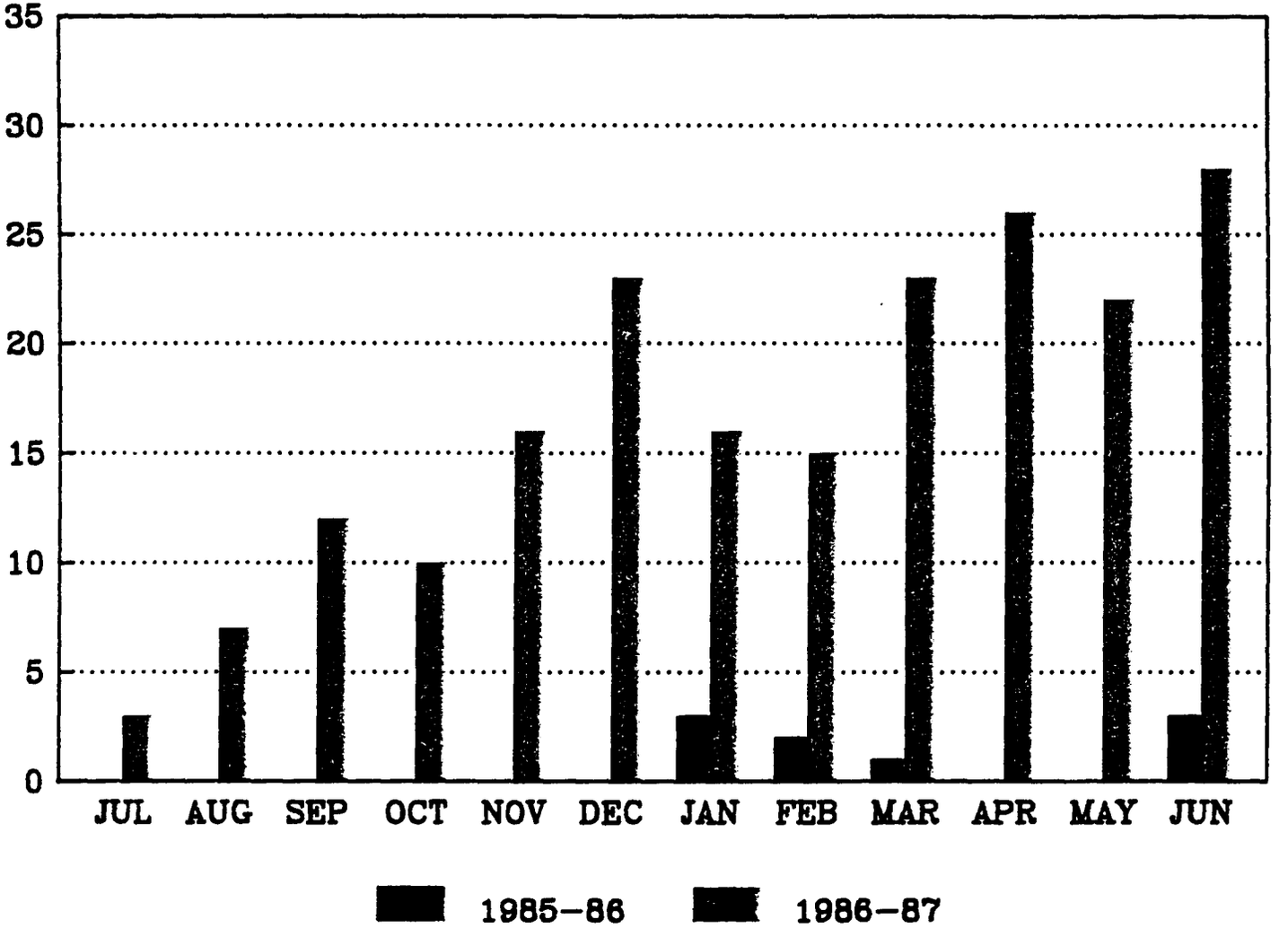
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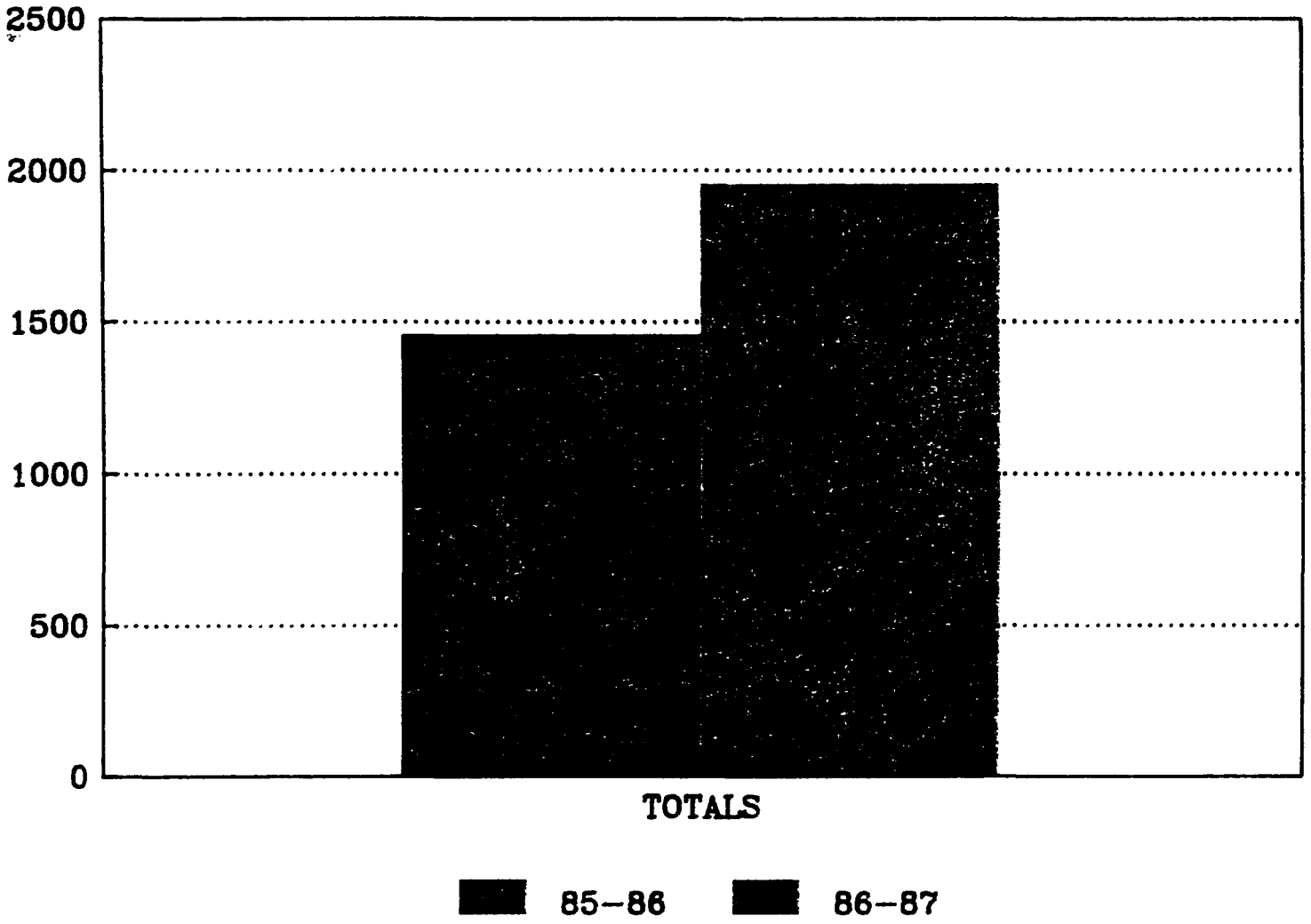

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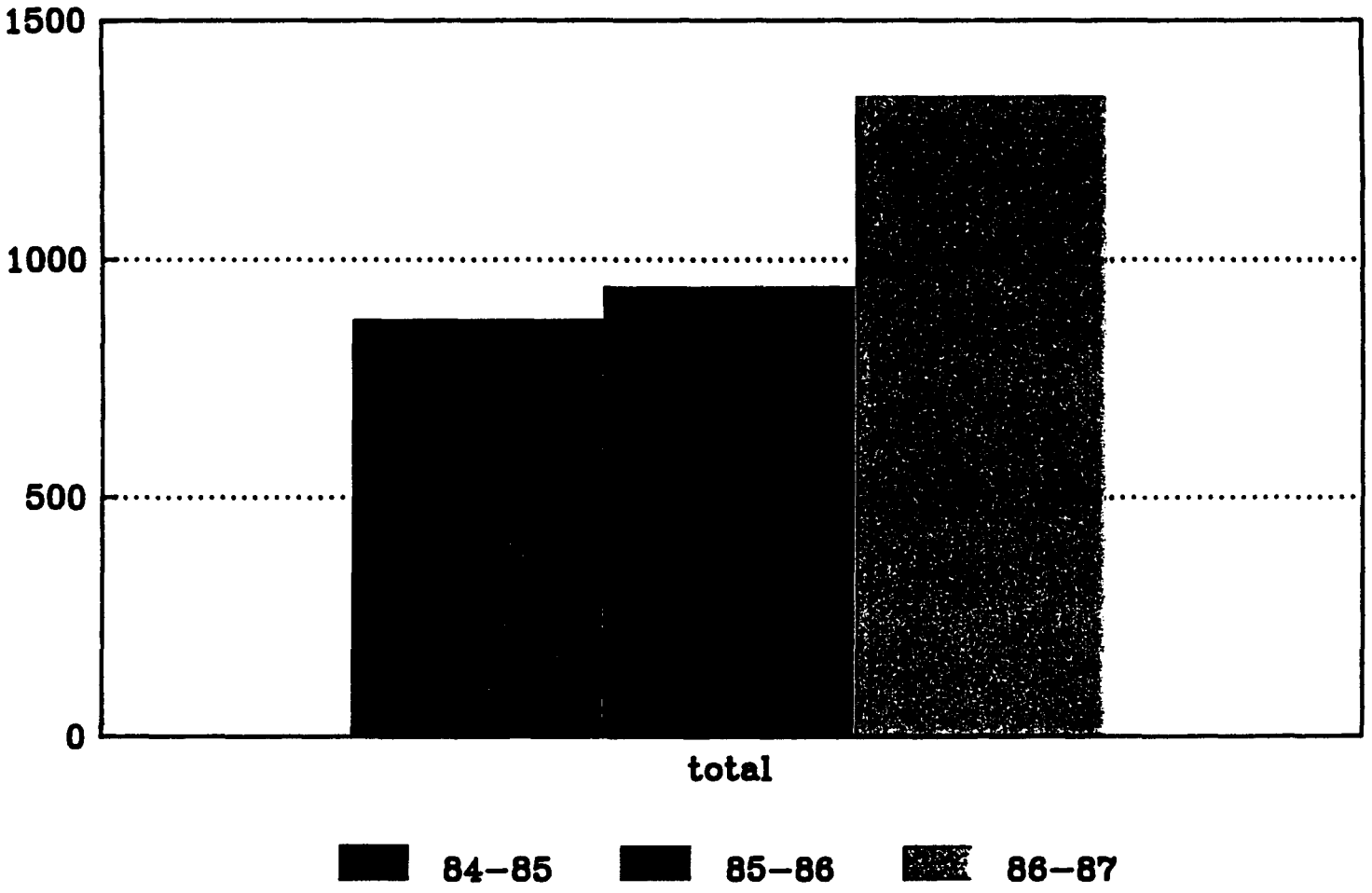

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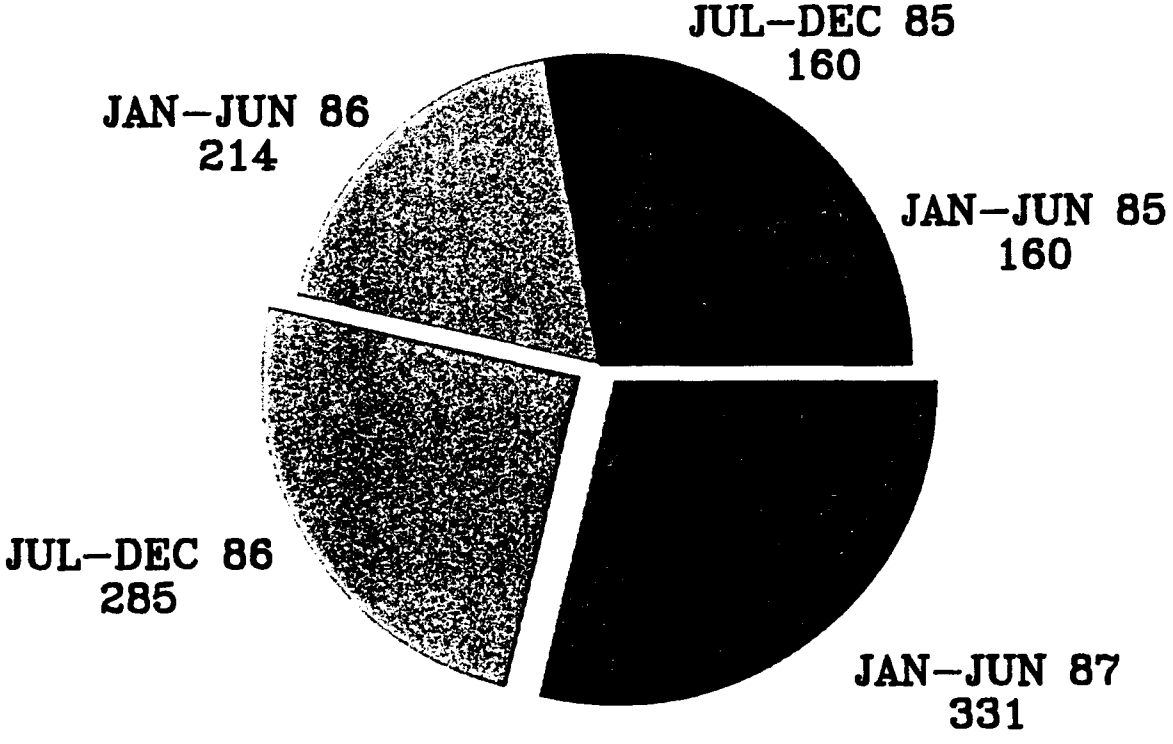
1985 – 1987



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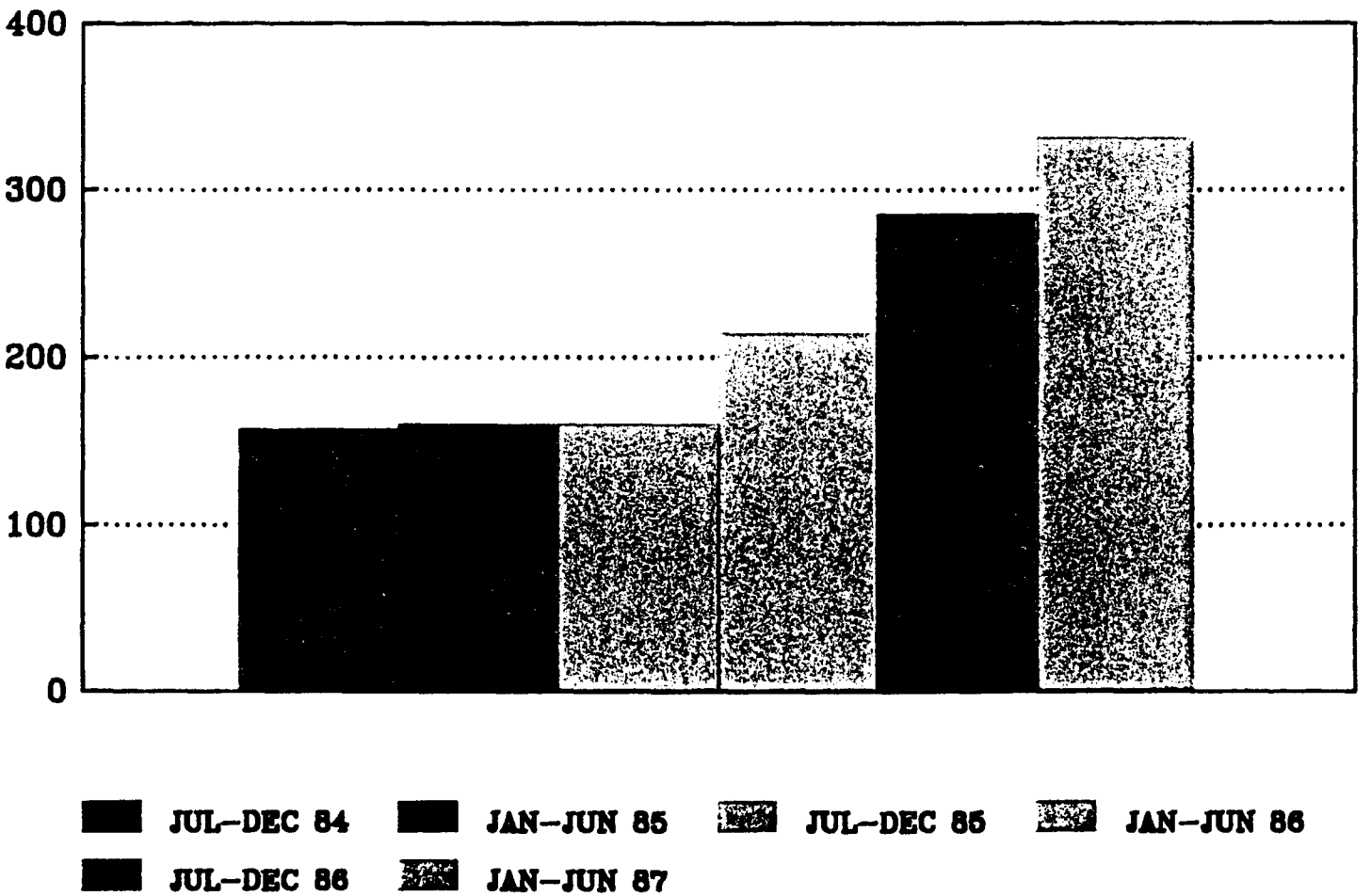
1985 – 1987



The University of Minnesota Hospital and Clinic

Board of Governors

August 26, 1987

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U Selected for Medicare Heart Transplants, St. Paul Pioneer Press Dispatch, August 7, 1987
University Hospital Chosen to Help Test Alzheimer's Drug, Minneapolis Star & Tribune, August 7, 1987
Toddler Who Got Artificial Heart Valves Leaves Hospital, Minneapolis Star & Tribune, August 19, 1987

The University of Minnesota Hospital and Clinic
Board of Governors

August 26, 1987
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of July 22, 1987 Minutes	Approval
II.	Chairman's Report - Mr. Robert Latz	Information
III.	Hospital Director's Report - Mr. Greg Hart	Information
IV.	Special Presentation: Biomedical Ethics - Dr. Arthur L. Caplan	Discussion
V.	Committee Reports	
	A. Planning and Development Committee - Mr. Leonard Bienias	
	1. Quarterly Purchasing Report	Approval
	2. Results of the Image Study	Information
	3. Community University Health Care Center	Information
	B. Joint Conference Committee - Mr. George Heenan	
	The Joint Conference Committee did not meet in August.	
	C. Finance Committee - Mr. Robert Nickoloff	
	1. Bad Debts	Approval
	2. Compensation Plan	Approval
VI.	Other Business	
VII.	Adjournment	

Minutes

Board of Governors

The University of Minnesota Hospital and Clinic

July 22, 1987

CALL TO ORDER:

Chairman Robert Latz called the July 22, 1987 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	David Brown, M.D. Shelley Chou, M.D. Donald Gilmore Al Hanser Greg Hart George Heenan Kris Johnson Robert Latz James Moller, M.D. Neal Vanselow, M.D.
Absent:	Leonard Bienias Phyllis Ellis David Lilly Jerry Meilahn Robert Nickoloff Barbara O'Grady

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the June 24, 1987 meeting as written.

CHAIRMAN'S REPORT:

Chairman Latz introduced Ms. Barbara Muesing, Secretary to the Board of Regents, and Ms. Dee Lutz, from the Minnesota Daily.

Chairman Latz noted that several retreat topics are under development. They include: conditions under which UMHC should seek affiliation with another hospital; structuring hospital programs in a way that encourages positive

metro and outstate physician interface with UMHC; and an evaluation of how contracting for specific patient populations fit with our teaching and research mission.

Lastly, Chairman Latz reported that the September 23, 1987 meeting of the Board of Governors is cancelled.

HOSPITAL DIRECTOR'S REPORT:

Mr. Greg Hart introduced Mr. Ted Yank, the Administrative Fellow at UMHC. Mr. Yank is a graduate of the Minnesota Hospital Administration Program and will be attending the Board of Governors meetings as part of his duties.

Mr. Hart reported that the Board of Regents had approved the Hospital's 1987-88 budget. There were two primary points discussed as part of that approval; the case mix of UMHC patients and the 1987-88 price increase. The price increase for 1987-88 is 2.9%. Information on price increases at other metro area hospitals is still preliminary.

On July 7, 1987, Mr. Hart reported, the Metropolitan Council released a report comparing 1985 and 1986 hospital occupancy rates. There was little change from 1985 to 1986 either in the number of admissions or the average length of stay community-wide. This plateau is the first seen in several years. According to the study, overall hospital use plunged more than 20% over the past ten years.

Lastly, Mr. Hart reported that he would be forwarding information to all Board members on the Primary Care Network in the next couple of days.

Dr. Vanselow updated the members of the Board on responses to the Strategy for Focus Task Force Report. On July 10, 1987 the Board of Regents passed a resolution recognizing the Task Force for its efforts but emphasizing that the recommendations are preliminary. A statement was included in the resolution that indicated the Regents view the closing of an entire collegiate unit as being unlikely. Dr. Vanselow indicated that a review of the entire report will be undertaken by the Provost Planning Committee in the coming months. Two Health Sciences representatives, Ms. Cheri Perlmutter and Dr. Gilbert Banker, will sit on that committee.

Mr. Latz reported that the Hospital's Strategic Planning Committee will be meeting frequently in coming months. The Board representatives will be Robert Latz and Kris Johnson, with George Heenan and Robert Nickoloff as alternates.

SPECIAL PRESENTATION: CARDIOVASCULAR CARE

Drs. Stuart Jamieson and Carl White reviewed the historical development of cardiovascular care at The University of Minnesota Hospital and Clinic. That review included a significant number of breakthroughs in cardiovascular care and included a number of world renown physicians who built the program at Minnesota.

Drs. Jamieson and White also reviewed more recent events, which mark a rejuvination of the service here at Minnesota. On April 10, 1987 the Minnesota Heart and Lung Institute celebrated an official opening. Significant increases in the number of cardiology admissions, cardiac catheterizations and cardiovascular surgery cases have occurred in the recent past.

In conclusion, Drs. Jamieson and White emphasized a need to proceed aggressively with the development of this program.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Ms. Kris Johnson reported that there were not action items coming from the Planning and Development Committee for the Board to consider in July.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. George Heenan briefly described the process undertaken for the annual appointments of the Clinical Chiefs. He presented the list of Clinical Chiefs as endorsed by the Medical Staff-Hospital Council and the Joint Conference Committee. The Board passed and seconded a motion to approve the appointments of the Clinical Chiefs as submitted.

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing reported that the committee did not meet in July. He also noted that the year-end financial statement will be available for the August meeting. Lastly, Mr. Fearing noted that there was a slight decrease in the account receivables during July.

ADJOURNMENT:

There being no further business, the June 22, 1987 meeting of the Board of Governors was adjourned at 4:25 P.M.

Respectfully submitted,

Kay F. Fuecker
Secretary
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

August 18, 1987

TO: Members of the Board of Governors

FROM: Nancy C. Janda
Assistant Director and
Secretary to the Board of Governors

Dr. Arthur Caplan, Director of the Biomedical Ethics Center, has agreed to speak to the Board of Governors on August 26, 1987. A biographical sketch of Dr. Caplan is attached.

This presentation is another in a series of presentations that have been scheduled per the January, 1987 Board request that speakers who can broaden or enhance familiarity with current issues be engaged.

I will see you on Wednesday, August 26th at 2:30 P.M.

NCJ/kff

Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

Biomedical Ethics Center
3-113 Owre Hall
Box 33 UMHC
420 Delaware Street S.E.
Minneapolis, Minnesota 55455
(612) 625-4917

ARTHUR L. CAPLAN, Ph.D.

Arthur Caplan received his Ph.D. in philosophy from Columbia University. He is currently Director, Center for Biomedical Ethics and Professor of Philosophy and Surgery at the University of Minnesota in Minneapolis.

Dr. Caplan was formerly Associate Director of The Hastings Center. He has also taught at Columbia University's College of Physicians and Surgeons at the University of Pittsburgh.

He is the author or editor of eleven books, including Scientific Controversy, Which Babies Shall Live?, The Sociobiology Debate, Concepts of Health and Disease, and In Search of Equity. He has contributed more than 100 articles to professional journals in the fields of philosophy, medicine, and the biological sciences.

In addition, he has written for many newspapers including the Washington Post, New York Times, Philadelphia Inquirer, Los Angeles Times, and Newsday on subjects in medical ethics. He is also a frequent guest on such programs as Nightline, ABC's World News Tonight, the CBS Evening News, National Public Radio's All Things Considered, and Morning Edition.

Dr. Caplan has served as a consultant to the New York Academy of Sciences, New Jersey Department of Health, the Office of Technology Assessment of the U.S. Congress, the National Institutes of Health, the National Endowment for the Humanities, and the Institute of Medicine of the National Academy of Sciences.

He is a member of the Committee on Philosophy and Medicine of the American Philosophical Association, the Committee on Professional Medical Conduct/New York State Department of Health, the Advisory Boards of the Poynter Center for Media Studies, the Bioethics Institute at St. Francis Hospital (Miami, Florida), the Professional Ethics and Conduct Committee of the American Psychological Association, the National Bone Marrow Donor Registry of the American Red Cross, and the Task Force on Organ Transplantation of the State of New Jersey.

MINUTES
Planning and Development Committee
August 12, 1987

CALL TO ORDER
Committee Chairman, Ms. B. Kristine Johnson, called the August 12, 1987 meeting of the Planning and Development Committee to order at 12:05 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Leonard Bienias Clint Hewitt Geoff Kaufmann Peter Lynch, M.D. Ted Thompson, M.D.
	Absent	Greg Hart S. Albert Hanser William Jacott, M.D.
	Staff	Cliff Fearing Marge Carey Mark Koenig Michelle Johnson John LaBree, M.D. Lisa McDonald Mary Ellen Wells
	Guests	David Coombes Amos Deinard, M.D. Sally Howard Sue Webber

APPROVAL OF MINUTES
The minutes of the July 8, 1987 meeting were approved as distributed.

MAY/JUNE PURCHASING REPORT
Mr. Koenig reported that there was $11,964,940 in purchasing activity for May/June 1987 which is higher than prior periods due to the purchase of the computer system for $3,736,748. Purchase awards to other than low bidder were reviewed as well as sole source awards of $4,006,267. Mr. Koenig also reported on 86/87 savings resulting from the University Hospital Consortium of $342,075, with $310,000 coming from IV and solutions.

The committee approved the report.

UMCA UPDATE
Dr. Lynch briefed the committee on UMCA's activities. UMCA is interested in going ahead with the Alliance, however they will not be providing financial support. The Clinic Management Report is being reviewed. Finally, interviews

have been concluded and a chief operating officer has been identified. UMCA cannot make a financial commitment of hiring a chief operating officer until there is some resolution of their financial problems resulting from Primary Care Network's (PCN) bankruptcy. UMCA had loan guarantees for their share of PCN pledged to UMHC. Mr. Fearing stated that the hospital is working with UMCA.

SECOND OPINION SERVICE

Mr. Kaufmann provided the committee with background from the previous P & D meeting regarding second opinions.

Mr. Coombes discussed UMCA's plans for a second opinion service with PCN which has been canceled because of PCN's termination. Other HMOs have indicated some interest.

Mr. Bienias stated that UMHC should be promoting second opinion services directly to the public. Dr. LaBree responded that UMHC does quite a few second opinions without advertising. He said that the Medicine Clinic, given personnel and space constraints, could not handle any large increases that would be generated from an ad campaign. Dr. Lynch felt that an ad campaign directed at consumers would alienate referring physicians which UMHC relies on because it is a tertiary center. He also felt that single visits do not benefit the teaching mission.

It was concluded that the second opinion service is an UMCA issue. Mr. Coombes suggested that a pilot program be done with an HMO or self-insured group before any large program is launched to measure the impact on the system. Once a plan has been developed Mr. Coombes will inform the P & D committee.

UMHC IMAGE STUDY

Mr. Kaufmann reviewed the results of UMHC's Image Study conducted in June 1987 among 1,000 Twin Cities residents. General conclusions from the study were:

1) Public perceives UMHC to excel in oncology, cardiology, intensive care, and comprehensive eye care.
2) Areas where there are opportunities because of no clear market leader are geriatrics, PM&R, and orthopaedics.
3) Overall UMHC has the strongest reputation and most modern technology. UMHC provides the greatest range of services as well as specialized care with top ranked physicians.

Mr. Kaufmann concluded that the gap is closing in the areas in which UMHC has previously excelled. A follow-up study is scheduled for the same time next year.

COMMUNITY UNIVERSITY HEALTH CARE CENTER (CUHCC)

Dr. Deinard discussed the mission of CUHCC and how it has evolved into a multi-disciplined clinic that serves the corridor poor. Currently CUHCC needs a replacement facility because their current facility is inadequate and does not comply with several codes and ordinances. After reviewing slides and

discussing CUHCC's problems, Dr. Deinard asked the committees' opinion on their mission and site considerations.

The cost of the new building is estimated to cost between $850,000 - $1,200,000 depending on the site.

Ms. Johnson asked that the long-term plans for the Franklin/Chicago area be incorporated into the site selection decision. Mr. Fearing discussed the financial issues.

Ms. Johnson summarized that it's difficult to comment until more substantial financial numbers and projections are available as well as our legal obligations, and the city's plans for the current area.

OTHER

The Public Relations and Strategic Planning Coordinating Committee agenda items were postponed due to lack of time.

ADJOURNMENT

The Planning and Development Committee adjourned at 1:45 p.m.

Respectfully submitted,

Lisa G. McDonald
Assistant Director
Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

August 18, 1987

TO: Members of the Board of Governors

FROM: Greg Hart
Interim Hospital Director

SUBJECT: Purchasing Report

Attached is a copy of the Hospital's Purchasing Activity report for the period of May and June, 1987.

Please note that this report is for a period of only two months. This shorter than normal reporting period will allow us to prepare future reports using the same three month period as financial reporting.

This report is being submitted for your approval at the August 26, 1987 Board of Governors meeting.

If you have any questions regarding the report before our meeting, please feel free to call me.

/kff

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF MAY-JUNE 1987

I. PURCHASE ORDER ANALYSIS

RANGE	NUMBER OF P.O.'S	TOTAL DOLLAR VALUE
$ 0 - $ 499	3745	$599,696.53
$ 500 - $1,999	1304	$1,299,146.05
$ 2,000 - $4,999	386	$1,174,359.21
$ 5,000 - $9,999	176	$1,223,173.49
$10,000 - OVER	169	$7,459,816.68
TOTAL PURCHASE ORDER	5780	$11,756,191.96

II. CONFIRMING ORDERS

$ 0 - $ 99	87	$4,224.77
$ 100 - $ 499	119	$28,570.57
$ 500 - $ 999	55	$38,834.29
$1,000 - $1,999	32	$45,856.86
$2,000 - OVER	22	$91,267.40
CONFIRMING ORDERS	315	$208,753.89
TOTAL	6095	$11,964,945.85

III. SET ASIDE AWARDS

(Attachment C)

IV. PURCHASE AWARDS TO OTHER THAN APPARENT LOW BIDDER

(Attachment A)

V. SOLE SOURCE

(Attachment B)

VI. VENDOR APPEALS

(Attachment D)

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

(Attachment E)

ATTACHMENT A

IV. Purchase Award to Other Than Low Bidder, $5,000.00 or More

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
1.	87-412	Deseret/Central Venous Catheter	6,993.00	6,174.00	Materials
		Reason: Catheter is too stiff and end of catheter is not sufficiently tapered, making insertion difficult.			
		Cook, Inc./Central Venous Catheter	6,993.00	6,650.00	Materials
		Reason: Catheter is too stiff and does not have side ports as specified.			
2.	87-232 Line 8	American Bentley/Arterial Filter	10,000.00	9,200.00	Cardio
		Reason: Filter is not compatible with existing bypass loop/tubing pack.			
	Line 8	Shiley/Arterial Filter	10,000.00	9,500.00	Cardio
		Reason: Filter is not heparin bonded.			
3.	87-235 Line 24	Electromedics/Haemonetics Bowl Assembly	13,200.00	11,040.00	Cardio
		Reason: Product is not compatible with existing cell saver hardware.			
	Line 41	Shiley/Bypass Loop with Filter	9,120.00	8,320.00	Cardio
		Reason: Product does not contain a herapin bonded filter.			
4.	87-283 Line 26	American Bentley/Custom Pack	7,200.00	5,760.00	Cardio
		Reason: Pack did not contain specified components.			
		Surgikos/Custom Packs	9,600.00	2,406.00	Cardio
	Lines 27 & 29	Reason: Packs did not contain specified components.			

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
5.	87-268	Medix/Br. Neutralon Gloves	96,102.00	77,942.00	Materials
		Reason: Cuffs roll down, causing exposure of contaminated sleeve edge; gloves do not fit well, and holes/tears were frequently noted.			
6.	H072116	Colonial/Hematology Analyzer	17,500.00	12,950.00	CUHCC
		Reason: Equipment offered requires more technician time, would increase the risk of exposure to contagious diseases; cost per test was higher, and test accuracy not as good.			
		Baker Instrument/Hematology Analyzer	17,500.00	14,500.00	CUHCC
		Reason: Equipment offered requires a larger test sample, which is less advantageous for pediatric patients. Results are less accurate and costlier per test.			
		American Scientific/Hematology Analyzer	17,500.00	15,500.00	CUHCC
		Reason: Equipment offered requires more technician time, increases the risk of exposure to contagious diseases, is less accurate and is more space consuming.			
7.	H071169	EPS/Tablet Counter	5,385.00	4,635.00	Pharmacy
		Reason: Machine offered did not meet the specifications to be micro-processor controlled, resulting in less speed and accuracy.			
8.	H071627	Fisher Scientific/Incubator	5,352.00	4,367.00	Nursing
		Reason: Equipment did not meet specifications for vertical laminar flow design to reduce contamination, disposable blower wheels, and local repair service.			
9.	87-432	Key Medical/Administration Set	29,700.00	16,800.00	Materials
		Reason: The low bidder was not an authorized distributor for the product.			

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
10.	H072117	Hewlett Packard/Protocol Analyzer	14,842.50	10,010.00	ISD
		Reason: Product offered did not have two disk drives; maximum data rate was 64 kbps vs. 128 kbps as requested.			
11.	H068669	Pentax/Bronchoscope	7,990.00	6,392.00	Endoscopy
		Reason: Eyepiece is separate from working channel making it difficult to obtain biopsies; also more difficult to inject saline, inject anesthetic and perform lavage.			
12.	H073031	American Scientific/Analyzer	11,620.00	8,500.00 & 11,550.00	Labs
		Reason: Both instruments offered require a 350ml sample for each determination, exceeding the maximum 125ml specified.			
13.	H072614	Carmac Corp./Chest Freezer	6,123.57	4,780.00	Labs
		Reason: Capacity was only 7.5 cubic feet compared to the specified 20.5 cubic feet.			
		Fisher/Chest Freezer	6,123.57	4,158.40	Labs
		Reason: Capacity was only 12 cubic feet compared to the specified 20.5 cubic feet.			
14.	H070835	Contract Furnishings/Systems Furniture	11,316.00	10,952.20	Materials
		Reason: Rejected vendor--Rebco. System furniture offered did not offer as much work surface space and was not as aesthetically pleasing.			
15.	87-463	Medline/Isolation Gowns	39,963.00	35,568.80	Materials
		Reason: Gown does not meet specifications for thread count, sweep, sleeve length, cuff length, or full-back coverage.			
	87-473	Mars White Knight/Isolation Gowns	39,963.00	37,783.00	Materials
		Reason: Gown does not meet specifications for length, sleeve length, sweep, or full-back coverage.			

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
15.	87-473	American Institutional Textile/Isolation Gowns	39,963.00	38,060.00	Materials
		Reason: Fabric has insufficient thread count; neck opening is too large and neck edge is poorly stitched with raw edges exposed.			
		Charm-Tex/Isolation Gowns	39,963.00	38,060.00	Materials
		Reason: Neck opening is too large and four inch overlap at waist does not provide sufficient coverage.			
		Angelica Uniform/Isolation Gowns	39,963.00	39,444.00	Materials
		Reason: Gown does not meet specifications for sweep and length.			
16.	H071632	International Medical/Spirometers	9,855.00	9,177.00	Anesthes.
		Reason: Vendor bid item which did not meet all the specifications. Components of item offered were not compatible with each other, and therefore, unusable; adapter is required for tubing posing a risk for loss and requiring more set up time.			
17.	87-454	Medline/Tray Surgical Skin Prep	35,481.60	19,238.40	Materials
		Reason: The tray is not adequately supplied with cotton balls and other components.			
		Kendall/Prep Tray	35,481.60	26,726.40	Materials
		Reason: The prep sponges are not woven tightly enough to apply prep solution without dripping.			
		Kendall/Prep Tray	35,481.60	20,851.20	Materials
		Reason: The prep sponges were not large enough for adequate painting.			
		Sterile Design/Prep Tray	35,481.60	28,800.00	Materials
		Reason: Tray components were poorly arranged and the prep sponges are not large enough.			

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
17.	87-454	Sterile Design/Prep Tray UMH03AMM	35,481.60	26,496.00	Materials
		Reason: No samples were received.			
		Medical Concepts/Prep Tray S0083	35,481.60	29,952.00	Materials
		Reason: The prep sponges were not large enough.			
		AHS/Prep Tray	35,481.60	28,224.00	Materials
		Reason: Components in the tray are not adequate to do a proper prep procedure.			
		Medix/Prep Tray 37-242-1	35,481.60	30,182.40	Materials
		Reason: Poor arrangement of tray components compromises sterility and the prep sponges cannot provide proper painting in the prep.			
		Medix/Prep Tray 37-240-1	35,481.60	29,260.00	Materials
		Reason: Poor arrangement of tray components compromises sterility and the prep sponges are absent.			
		Medix/Prep Tray 37-184-1	35,481.60	29,260.00	Materials
		Reason: Poor arrangement of tray components compromises sterility and there is not enough prep sponges.			

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ATTACHMENT B

V. SOLE SOURCE

VENDOR	CONTRACT/ P.O. NUMBER	VALUE	DEPARTMENT	PRODUCT
Allegheny Intern'l	H333606	$10,525.00	Cardio.	Maint. Agreement
Diasonics	H072101	$10,000.00	Cardio.	Transesophageal Echo Probe
Narco	H071705	$18,000.00	Cardio.	Equipment Rental
D.L. Phillips	H071709	$9,462.03	Facilities	Pneumatic Tube Installation
UNISYS	H336201	$11,250.00	I.S.D.	Software Installation
Technisoft	H071650	$5,495.00	I.S.D.	Spinal Instr.
Hewlett-Packard	H072625	$3,990.00	I.S.D.	Disk Packs
DSI	H072860	$57,700.00	I.S.D.	DSI Printer
UNISYS	H072855	$3,736,748.00	I.S.D.	A15-F Computer
Organon Teknika	H334160	$5,760.00	Labs	Oxisensors
Scientific Assoc.	H071181	$3,130.25	Labs	CliniScribe Sys.
Abbott Labs	H069795	$4,000.00	Labs	Antigen EIA
Quinton Instruments	H072114	$26,195.00	Labs	Stress Test Sys.
Professional Mktg.	H072140	$3,672.00	Labs	EP Data Equip.
Microfilm Comm.	H069820	OPEN	Labs	Microfilming
Anaerobe Systems	H072861	$8,000.00	Labs	Anaerobic Chamber
Diatech Corp.	H072613	$3,110.00	Labs	Diamond Knives
Minn. Dept.of Health	H073032	$3,600.00	Labs	Lab Tests
Delmed	H072530	$1,500.00	M.S./CSP	PD Cycler Repair
AMSCO	H072600	$5,584.50	Maint/Oper	Sterilizer Parts
NBI	H073027	$38,541.00	Med. Rec.	Shared Logic Sys
Tri-Med	H072529	$4,261.00	Nursing	Oximeter
Concept, Inc.	H071641	$10,000.00	O.R.	Camera
Minnesota Scientific	H073020	$3,319.00	O.R.	Retractors
Animal Fair	H072109	$22,424.00	Vol. Serv.	U-Bear Costumes
TOTAL		$4,006,266.78		

ATTACHMENT C

VII. SET ASIDE AWARDS

A. AWARDED BIDS

CATEGORY	VENDOR	TOTAL DOLLAR VALUE
Sequential Compression Sleeves	Halcon	$41,253.00
	TOTAL AWARDED BIDS	$41,253.00

B. DEPARTMENTAL PURCHASES

MAY 1987

	P.O. NUMBER	VENDOR	TOTAL DOLLAR VALUE
1.	H070836	Contract Furnishings	$2,193.73
2.	H069490	Quality Medical	$915.75
3.	H070602	Quality Medical	$313.20
4.	H068939	Trophy Craft	$163.80
5.	H334141	Audio Visual Wholesalers	$374.10
6.	H334271	Audio Visual Wholesalers	$408.70
7.	H334270	Audio Visual Wholesalers	$408.70
8.	H334268	Audio Visual Wholesalers	$408.70
9.	H069498	Quality Medical	$118.60
10.	H334892	Audio Visual Wholesalers	$408.70
11.	H335013	Budget Paper	$88.60
12.	H335008	Audio Visual Wholesalers	$408.70
13.	H335007	Audio Visual Wholesalers	$408.70
14.	H335006	Audio Visual Wholesalers	$408.70
15.	H335000	Audio Visual Wholesalers	$408.70
16.	H068943	Trophy Craft	$96.85
17.	H071656	Quality Medical	$545.86
18.	H071653	Quality Medical	$261.05
19.	H068945	Trophy Craft	$161.45
20.	H333646	Halcon	$418.32
21.	H334026	Halcon	$504.96
22.	H334305	Halcon	$172.80
23.	H334391	Halcon	$30.00
24.	H334653	Halcon	$179.28
25.	H335094	Halcon	$537.84
26.	H335081	Halcon	$2,596.75
27.	H335077	Halcon	$312.00
28.	H333563	Home Hospital Equipment	$388.08
29.	H334255	Home Hospital Equipment	$656.64
30.	H334751	Home Hospital Equipment	$635.04
31.	H333669	Sexton Data	$1,173.00
32.	H334230	Art Materials	$356.40
33.	H334444	Art Materials	$356.40
34.	H334903	Office Machine Sales	$844.20
35.	H334020	Quality Medical	$85.56
36.	H334801	Quality Medical	$50.70
		MAY TOTAL	$17,800.56

III. SET ASIDE AWARDS (cont'd)

JUNE 1987

1.	H335929	Home Hospital Supply	$802.56
2.	H335923	Home Hospital Supply	$28.50
3.	H337077	Home Hospital Supply	$635.04
4.	H335250	Halcon	$83.76
5.	H335429	Halcon	$541.20
6.	H335799	Halcon	$537.84
7.	H336440	Halcon	$2,996.25
8.	H336338	Halcon	$179.28
9.	H336533	Halcon	$59.76
10.	H336715	Halcon	$149.70
11.	H335664	Quality Medical	$138.25
12.	H336232	Quality Medical	$64.17
13.	H071659	Quality Medical	$331.75
14.	H335540	Sexton Data	$119.20
15.	H071665	Quality Medical	$55.65
16.	H070633	Quality Medical	$381.80
17.	H068948	Trophy Craft	$150.55
18.	H071674	Quality Medical	$137.20
19.	H072702	Quality Medical	$208.45
20.	H336752	Audio Visual Wholesalers	$129.94
21.	H071813	Quality Medical	$49.95
22.	H068950	Trophy Craft	$136.90
23.	H072704	Quality Medical	$143.78
24.	H072828	Trophy Craft	$273.90
		JUNE TOTAL	$8,335.38

C. QUARTERLY GRAND TOTAL

Awarded Bids	$41,253.00
May Purchases	$17,800.56
June Purchases	$8,335.38
GRAND TOTAL	$67,388.94

ATTACHMENT D

VI. VENDOR APPEALS

1. VENDOR NAME: Softserv Business Systems, Inc.

   NATURE OF PURCHASE: Programming Consulting Services

   AMOUNT OF AWARD: $20,000.00

   REASON FOR APPEAL: The vendor is of the opinion that his company can provide an adequate level of service, comparable to the current vendor. The Clinic is re-considering the low bidder.

2. VENDOR NAME: Burton Equipment (rejected vendor)
   Lift Star & Store (awarded vendor)

   NATURE OF PURCHASE: Cabinets, Metal

   AMOUNT OF AWARD: $2,981.13

   REASON FOR APPEAL: Vendor was rejected for offering two cabinets instead of three. Burton felt the two cabinets offered more storage than the three specified. Three cabinets, however, were needed since they would be in three locations.

govl2d

ATTACHMENT E

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

1.	Nature of Purchase:	Membership to Health Care Advisory Board
	Consortium Vendor Name:	Health Care Advisory Board
	Purchase Order #:	H072581
	Value of Purchase:	$7,500.00
	Value of Next Lowest Bidder:	N/A
	Savings:	Discount amount not available.
2.	Nature of Purchase:	Overbed Tables
	Consortium Vendor Name:	Hill Rom
	Purchase Order #:	H335804
	Value of Purchase:	$2,388.00
	Value of Next Lowest Bidder:	Not bid
	Savings:	$00
3.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	6 P.O.'s (month of May)
	Value of Purchase:	$7,894.25
	Value of Next Lowest Bidder:	Not bid
	Savings:	$1,412.00
4.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	3 P.O.'s (month of June)
	Value of Purchase:	$4,491.30
	Value of Next Lowest Bidder:	Not bid
	Savings:	$ 404.50
5.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	P.O.'s issued from January 1, 1987 - March 31, 1987
	Savings:	Additional 2% rebate received in June based on volume - $725.72
6.	Nature of Purchase:	Supply Parts from Castle/ Sybron
	Consortium Vendor Name:	Castle/Sybron
	Purchase Order #:	H072540
	Value of Purchase:	$ 986.59
	Value of Next Lowest Bidder:	Not bid
	Savings:	$ 271.81

TOTAL SAVINGS THIS QUARTER: $2,814.03

TOTAL SAVINGS FISCAL YEAR 1986 - 1987: $342,075.67

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Planning and Marketing
The University of Minnesota Hospital and Clinic
Box 200, Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-3330

Date: August 17, 1987

To: Board of Governors

From: Geoff Kaufmann GK

Subject: **RESULTS OF OUR MOST RECENT IMAGE SURVEY**

UMHC completed its third image study in June of this year. A market research firm made 1,000 calls to residents of the seven-county metro area proportionately by population. Over half of the respondents belonged to an HMO.

UMHC unaided awareness remains high at 27 percent. Recall of our advertising was second only to Abbott-Northwestern. UMHC was viewed by respondents to be one of the best hospitals for critical care and rehabilitation. UMHC was rated tops for eye care, cancer, cardiovascular care, and orthopaedics. UMHC had the highest overall reputation of any metro area hospital although we ranked lower, but still above average, for convenience and friendliness. We also ranked number one for modern technology, range of services, specialized care, and quality of physicians.

In summary, UMHC can be very proud of its image in the metro area. I believe there is a correct perception of our specialty orientation and commitment to modern, high-quality care.

A summary of the image study follows.

GLK:asf

Attachment

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
HEALTH CARE TRACKING STUDY

Background

A joint health care tracking study was conducted in Spring of 1987 in the seven county metro area among adults 18 years or older who make the health care provider decisions for their families. This was the third year UMHC had conducted the survey, but it was the first time we participated in a joint study with other metro area hospitals.

Objectives

The purpose of the study was to measure the awareness, perception and usage of Twin Cities area hospitals as well as, consumer perception of hospital specialties, advertising awareness, and overall satisfaction of hospital care by past patients.

Methodology

One thousand telephone interviews were completed by adults in St. Paul and its suburbs (44%) and Minneapolis and its suburbs (56%) between May 22 and June 1, 1987.

Summary of Findings

A. Demographics
   1. The majority of the respondents were female (64%) and 80% were between the ages of 18-54, living in a household of 2 or less people (46%).
   2. Fifty two percent of the respondents belonged to an HMO with PHP accounting for 28% of the HMO while 44% carried traditional coverage. Between 18% - 21% of the respondents had both traditional and HMO coverage. These numbers may be high due to confusion by the general public of insurance classifications.

Unaided Awareness

Total unaided awareness of The University of Minnesota Hospital and Clinic of 27% was fourth behind Abbott Northwestern (44%) St. Paul Ramsey (41%), and Fairview Southdale 28%.

Unaided Advertising Awareness (Hospital Advertising Recall)

UMHC had the second highest hospital advertising recall (13%) among respondents who were asked what hospitals they had seen advertising for in the last year. Abbott Northwestern was first at 31%.

Those individuals who saw UMHC advertising (n = 134) saw it on television (65%), newspaper (43%) outdoor (13%) radio (13%) magazines (7%) direct mail (3%) and other (2%).

UMHC's advertising expenditures were down from past years. We feel that the consumers are probably confusing the news coverage on television, newspapers and radio. We did not begin using radio (Metro Traffic Control) until after the survey was conducted.

Past Hospital Usage

52% of the respondents or members of their family had been treated at a hospital in the last year. UMHC treated (2%) or 18 of those individuals.

Image Ratings

1. UMHC had the highest image rating for overall reputation 9.0 out of a 10 point scale. This is up 1.05 points from last year.

2. Past UMHC patients gave UMHC the highest image rating among the hospitals rated by the group 9.0.

3. Factors contributing to UMHC's image based on a 10 point scale where: 1 means poor and 10 means excellent were:

	Total	Past UMHC Patients
*Modern Technology	9.2	9.3
*Range of Services	8.9	9.1
*Specialized Care	8.8	9.0
*Physicians	8.6	8.8
Quality of Service	8.4	8.5
Friendliness	7.7	7.6
Convenient to Use	6.7	6.8

*Indicates those areas where UMHC received the highest ranking.

Hospitals Used For Specific Services

1. Respondents were most likely to use UMHC for Comprehensive Eye Care (9%), Cancer Care (22%), Special Cardiac Care (20%), Orthopedic Specialities (7%).

2. A large percentage (29% - 52%) of respondents said they didn't know which hospital they would use for Geriatric Care, Gynecology Care, Maternity/Birthing Care, Physician Therapy and Rehabilitation, Cancer Care Comprehensive Eye Care, Mental Health and Orthopedic Specialities.

3. The number of respondents who selected UMHC for the various hospital services did not change significantly from 1985 to 1986. However the gap is narrowing between other area hospitals, most notably Abbott Northwestern, MMC, United and North Memorial.

Decision Maker For Hospital Coverage

1. Forty-five percent stated they decide which hospital to use, 29% rely on their physician and 24% are limited by their health plan.

8/19/87(14)

Hospital Perceptual Map
Expanded Interpretation

The most important factors in interpreting the perceptual map are the dimensions: Specific Medical Services and General/Social Services on the horizontal dimension, and Planned Visit and Crisis Visit on the vertical dimension.

The dimensions are the most important factors because they are the basis or framework on which all hospitals and vectors are charted. All placements are based on the dimensions, including the quadrants.

The dimensions define the hospitals, and the hospitals define the vectors. The vectors, in turn, merely reflect the averages of the nearby or distant hospitals. This is to say that, when interpreting the map, the whole of the map is much more important than the sum of its parts.

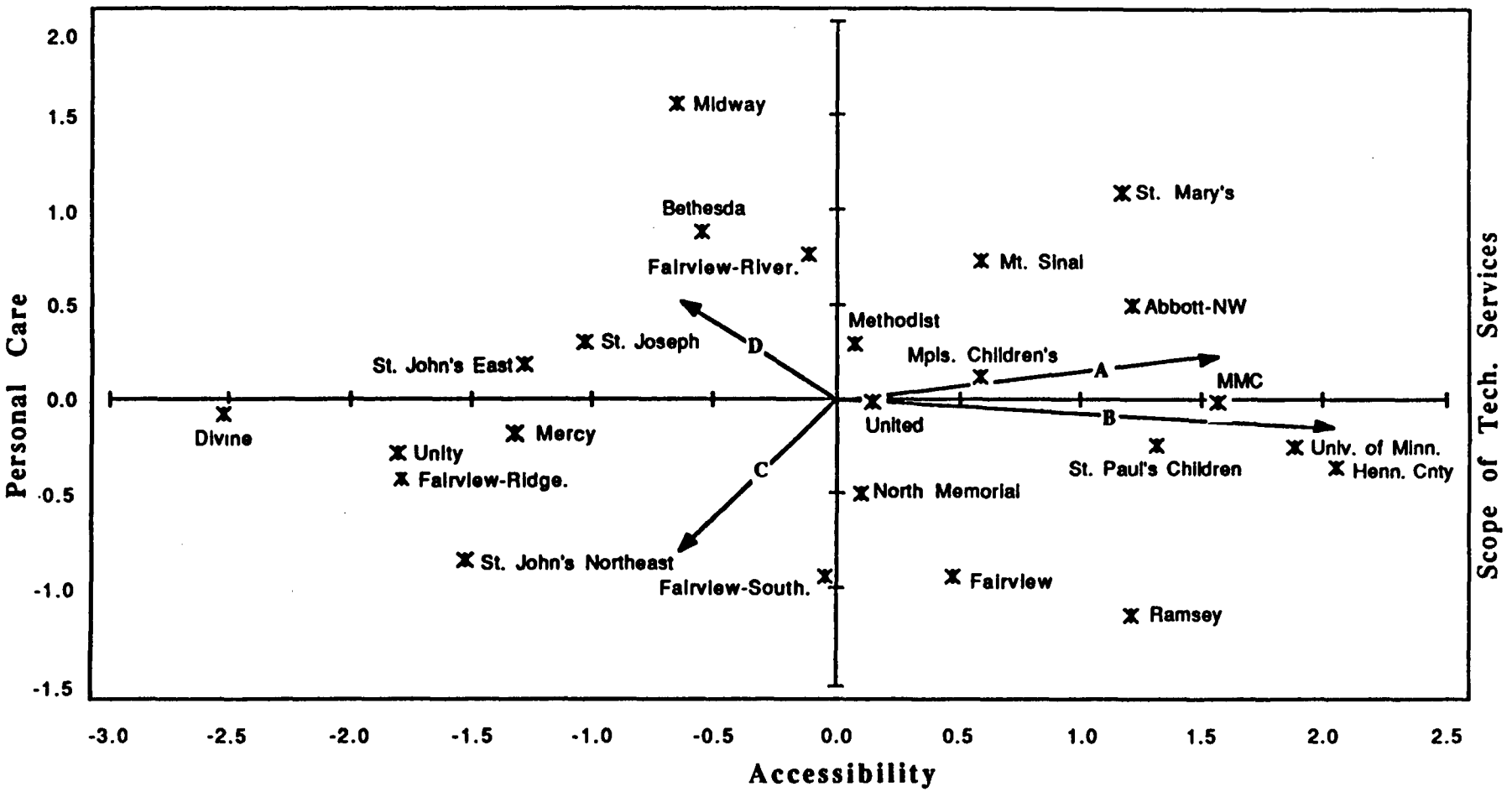
For example, the University of Minnesota, Gillette Hospital, Minneapolis Children's, St. Paul Children's, and St. John's Hospital are similar in that they are perceived to be more Planned than Crisis, as well as more General/Social than Specific Medical. The vectors indicate that these hospitals are perceived to be more associated with Pediatrics, Vector A. Also, those hospitals as a whole are less associated with Emergency and I.C.U., Vectors D and E, because hospitals are, directionally speaking, roughly 180 degrees from Vectors D and E.

A common mistake when interpreting a perceptual map is to strongly associate and define a hospital by nearby vectors. While this may, to a limited degree, be correct, it can be erroneous because there are many factors other than the closest vector that eventually define a hospital's location on the map.

Relationship of Perceptual Map to Data Tables

A common misconception regarding perceptual maps is that they are merely a plot of the frequencies outlined in the data tables. This is false. The perceptual map begins with the same "raw" data that is used to produce crosstabulations. This data is then subjected to a statistical process which equally weights each hospital on the basis of frequency but differentiates them on the basis of patterns in which consumers answered all parts of the questions being mapped. In the case of question five, the 37 hospitals mentioned are compared with the 13 hospital specialties to identify patterns of similarity/dissimilarity which are plotted on a two-dimensional graph.

Hospital Perceptual Map by Characteristics



Legend:

A = Modern Technology B = Range of Service C = Convenient D = Friendly

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

August 17, 1987

TO: Members of the Board of Governors

FROM: Greg Hart
Interim Hospital Director

SUBJECT: CUHCC Replacement Facility

On May 27, 1987 Dr. Amos Deinard and Ms. Mary Ellen Wells provided the Board with general background information on the Community University Health Care Center (CUHCC). Earlier this month, the Planning and Development Committee reviewed the highlights of a feasibility study done to evaluate options for replacing the CUHCC facility. That same information will be presented for informational purposes at the August 26, 1987 Finance Committee and Board of Governors meeting.

In October we anticipate asking the Board of Governors for approval to proceed with the replacement of the CUHCC facility. Amos Deinard, MD and Mary Ellen Wells will be joining us at the Board meeting next Wednesday should you have questions about the information included in your packet.

/sk

COMMUNITY UNIVERSITY HEALTH CARE CENTER
FACILITY REPLACEMENT

Introduction

The Community University Health Care Center (CUHCC), established by the University of Minnesota in 1966, became a satellite clinic of The University of Minnesota Hospital and Clinic in June 1984. CUHCC provides primary medical, dental and mental health services to a low income population in South Minneapolis.

CUHCC carries the University's mission of service to the neighborhood level, and is also active in furthering the University's other missions of education and research. There were approximately 48,000 patient visits in 1986-87. 30 students received education and training opportunities, and staff are presently engaged in 12 research projects. CUHCC's annual operating budget is approximately $2,000,000.

The relationship between CUHCC and UMHC has always been strong. Since CUHCC's pre-paid plan began in 1975, the Hospital has supported CUHCC by writing off those charges for patients who are hospitalized or referred to a specialty clinic on campus and who are not covered by insurance or Medical Assistance. In turn, CUHCC is UMHC's representative in the Minneapolis community for provision of services to the corridor poor.

CUHCC's physical plant, site, and programs have been assessed to determine the need for a new clinic facility. Following is a summary of these studies.

Space Program Analysis

A Functional Space/Program analysis of CUHCC has been conducted by Hans Tronnes Associates. The study concludes that the present building does not adequately meet CUHCC's current space needs. The following table compares square footage in the building by program area with Tronnes' recommended square footage:

CUHCC Space Requirements

Program/Area	Current Square Footage	Recommended Square Footage
Administrative	2,264	3,545
Medical	1,273	2,710
Laboratory	149	380
Dental	356	1,200
Mental Health & Social Services	3,354	4,240
Janitorial & Supply	169	146
Total	7,565	12,221

The study also found that the building is not handicapped accessible, and that expansion or renovation of the facility is not feasible.

Market Research

Focus Groups, a telephone survey, and a survey of current CUHCC patients were conducted in early 1987. The purpose of this research was to assess the potential of attracting a new paying patient population, to identify what patients would like in a community clinic, as well as to assist in determining the best location for a replacement facility.

Results of these surveys show that a majority of near-south Minneapolis residents are interested in the concept of a neighborhood health center such as CUHCC and that current patients will continue to use CUHCC if it remains in a convenient location. It is unclear, however, to what extent CUHCC can attract patients who are able to pay full charges.

Facility Options

A thorough review of near-south Minneapolis revealed no clinic facility available for purchase or lease. However, possible locations for new construction and commercial buildings for renovation are available.

The architectural firm of Ankeny, Kell, Richter and Associates analyzed two options -- new construction and renovation of an existing structure. Their preliminary estimates indicate that a replacement facility can be obtained for a cost of approximately $1,500,000. Through further study by staff and the possibility of donated land, the estimate has been reduced to between $850,000 and $1,200,000.

Conclusion

In October of 1987, the Board of Governors will be asked to formally recognize continued support for CUHCC's mission of providing service to the corridor poor, to recognize the need for a replacement facility and to authorize staff to expend up to $1,200,000 for a replacement facility.

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

August 14, 1987

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Bad Debts - Fourth Quarter, 1986-87

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the fourth quarter of 1986-87 is $806,128.34, represented by 1667 accounts. Bad debt recoveries during the period amounted to $14,232.70, leaving a net charge-off of $791,895.64.

The third quarter bad debt of $806,128.34 was 1.3% of gross charges. This compares to a budgeted level of bad debts of 1.33% ($665,561.00).

A statistical summary is attached along with a detailed description of losses over $2,000 and recoveries over $200 for each of the months in the fourth quarter. We have likewise continued additional reports with a break down of the bad debts by residence and by admitting clinical service for the quarter and the fiscal year.

Total fiscal year bad debts have amounted to $2,600,851.38, represented by 5,607 accounts. Recoveries during the fiscal year amounted to $49,147.96, leaving a net charge-off of $2,551,703.42.

The fiscal year bad debt of $2,600,851.38 was 1.1% of gross charges. This compares to a budgeted level of bad debts of 1.33% ($2,644,099.00).

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

APRIL 1987 THROUGH JUNE 1987

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	85,347.62	232	215,043.41	43	300,391.03	275
Total	85,347.62	232	215,043.41	43	300,391.03	275
Recoveries	(2,748.73)	20	(000.00)	0	(2,748.73)	20
Net Total	$ 82,598.89	232*	$ 215,043.41	43*	$ 297,642.30	275*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 4,360.37	15	$ 304,571.67	7	$ 308,932.04	22
Bad Debt (701) Write-Offs	165,541.30	1354	28,804.23	6	194,345.53	1360
Total	169,901.67	1369	333,375.90	13	503,277.57	1382
Recoveries	(11,187.05)	90	(000.00)	0	(11,187.05)	90
Net Total	$ 158,714.62	1369*	$ 333,375.90	13*	$ 492,090.52	1382*
INPATIENT AND OUTPATIENT TOTAL	$ 241,313.51	1601*	$ 548,419.31	56*	$ 789,732.82	1657*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 1,840.55	4	$ 0.00	0	$ 1,840.55	4
Outpatient (710)	619.19	6	.00	0	619.19	6
Total	2,459.74	10	0.00	0	2,459.74	10
Recoveries	(296.92)	1	(000.00)	0	(296.92)	1
Net Total	$ 2,162.82	10*	$ 000.00	0	$ 2,162.82	10*
TOTAL NET BAD DEBT	$ 243,476.33	1611*	$ 548,419.31	56*	$ 791,895.64	1667*

NOTE: More than $2,000 amount includes legal settlements totaling $11,502.78

DOLLARS BUDGETED $ 665,561.00

UNIVERSITY OF MINNESTOA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

APRIL 1987 THROUGH JUNE 1987

	LESS THAN $100	# OF ACCOUNTS	$100 - $199	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Medicare (610) Non-Recoverable	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Bad Debt (701) Write-Offs	$2,731.10	75	$58,774.42	140	$23,842.10	17	$139,197.83	38	$75,845.58	5	$300,391.03	275
Total	$2,731.10	75	$58,774.42	140	$23,842.10	17	$139,197.83	38	$75,845.58	5	$300,391.03	275
Recoveries	($324.88)	17	($900.00)	2	($1,443.85)	1	0.00	0	0.00	0	($2,748.73)	20
Net Total	$2,406.22	75 *	$57,794.42	140 *	$22,398.25	17 *	$139,197.83	38 *	$75,845.58	5 *	$297,642.30	275 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$323.88	6	$2,608.21	8	$1,428.28	1	$25,664.26	5	$278,907.41	2	$308,932.04	22
Bad Debt (710) Write-Offs	$32,714.79	948	$116,503.34	394	$16,323.17	12	$16,822.69	5	$11,981.54	1	$194,345.53	1360
Total	$33,038.67	954	$119,111.55	402	$17,751.45	13	$42,486.95	10	$290,888.95	3	$503,277.57	1382
Recoveries	($1,734.64)	64	($6,787.41)	25	($2,665.00)	1	$0.00	0	$0.00	0	($11,187.05)	90
Net Total	$31,304.03	954 *	$112,324.14	402 *	$15,086.45	13 *	$42,486.95	10 *	$290,888.95	3 *	$492,090.52	1382 *
INPATIENT AND OUTPATIENT TOTAL	$33,710.25	1029 *	$170,118.56	542 *	$37,484.70	30 *	$181,684.78	48 *	$366,734.53	8 *	$789,732.82	1657 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$1,840.55	4	$0.00	0	$0.00	0	$0.00	0	$1,840.55	4
Outpatient (710)	$295.41	5	$323.78	1	$0.00	0	$0.00	0	$0.00	0	$619.19	6
Total	$295.41	5	$2,164.33	5	$0.00	0	$0.00	0	$0.00	0	$2,459.74	10
Recoveries	$0.00	0	($296.92)	1	$0.00	0	$0.00	0	$0.00	0	($296.92)	1
Net Total	$295.41	5 *	$1,867.41	5 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$2,162.82	10 *
TOTAL NET BAD DEBT	$34,005.66	1034 *	$171,985.97	547 *	$37,484.70	30 *	$181,684.78	48 *	$366,734.53	8 *	$791,895.64	1667 *
DOLLARS BUDGETED											$665,561.00	

* Net total of accounts do no include recoveries.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1986 THROUGH JUNE 1987

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	237,275.47	626	836,887.08	112	1,074,162.55	738
Total	237,275.47	626	836,887.08	112	1,074,162.55	738
Recoveries	(9,822.93)	60	(6,765.64)	2	(16,588.57)	62
Net Total	$ 227,452.54	626*	$ 830,121.44	112*	$1,057,573.98	738*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 19,218.78	60	$ 863,812.70	22	$ 883,031.48	82
Bad Debt (701) Write-Offs	494,030.25	4724	133,228.65	26	627,258.90	4750
Total	513,249.03	4784	997,041.35	48	1,510,290.38	4832
Recoveries	(23,822.16)	415	(8,440.31)	2	(32,262.47)	417
Net Total	$ 489,426.87	4784*	$ 988,601.04	48*	$1,510,290.38	4832*
INPATIENT AND OUTPATIENT TOTAL	$ 716,879.41	5410*	$1,818,722.48	160*	$2,535.601.89	5570*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 10,345.77	20	$ 4,187.27	1	$ 14,533.04	21
Outpatient (710)	1,865.41	16	.00	0	1,865.41	16
Total	12,211.18	36	4,187.27	1	16,398.45	37
Recoveries	(296.92)	1	(000.00)	0	(296.92)	1
Net Total	$ 11,914.26	36*	$ 4,187.27	1	$ 16,101.53	37*
TOTAL NET BAD DEBT	$ 728,793.67	5446*	$1,822,909.75	161*	$2,551,703.42	5607*

NOTE: More than $2,000 amount includes legal settlements totaling $55,530.40

DOLLARS BUDGETED **$2,644,099.00**

*Net total of accounts do not include recoveries.

UNIVERSITY OF MINNESTOA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1986 THROUGH JUNE 1987

	LESS THAN $100	# OF ACCOUNTS	$100 - $199	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Medicare (610) Non-Recoverable	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Bad Debt (701) Write-Offs	$7,185.14	204	$151,339.01	366	$78,751.32	56	$344,365.33	90	$492,521.75	22	$1,074,162.55	738
Total	$7,185.14	204	$151,339.01	366	$78,751.32	56	$344,365.33	90	$492,521.75	22	$1,074,162.55	738
Recoveries	($972.34)	44	($6,406.24)	14	($2,444.35)	2	($6,765.64)	2	$0.00	0	($16,588.57)	62
Net Total	$6,212.80	204 *	$144,932.77	366 *	$76,306.97	56 *	$337,599.69	90 *	$492,521.75	22 *	$1,057,573.98	738 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$975.60	23	$8,549.96	30	$9,693.22	7	$61,774.96	13	$802,037.74	9	$883,031.48	82
Bad Debt (710) Write-Offs	$116,004.91	3466	$324,563.21	1221	$53,462.13	37	$71,701.11	21	$61,527.54	5	$627,258.90	4750
Total	$116,980.51	3489	$333,113.17	1251	$63,155.35	44	$133,476.07	34	$863,565.28	14	$1,510,290.38	4832
Recoveries	($5,624.59)	236	($15,532.57)	178	($2,665.00)	1	($8,440.31)	2	$0.00	0	($32,262.47)	417
Net Total	$111,355.92	3489 *	$317,580.60	1251 *	$60,490.35	44 *	$125,035.76	34 *	$863,565.28	14 *	$1,478,027.91	4832 *
INPATIENT AND OUTPATIENT TOTAL	$117,568.72	3693 *	$462,513.37	1617 *	$136,797.32	100 *	$462,635.45	124 *	$1,356,087.03	36 *	$2,535,601.89	5570 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$8,545.77	19	$1,800.00	1	$4,187.27	1	$0.00	0	$14,533.04	21
Outpatient (710)	$577.13	10	$1,288.28	6	$0.00	0	$0.00	0	$0.00	0	$1,865.41	16
Total	$577.13	10	$9,834.05	25	$1,800.00	1	$4,187.27	1	$0.00	0	$16,398.45	37
Recoveries	$0.00	0	($296.92)	1	$0.00	0	$0.00	0	$0.00	0	($296.92)	1
Net Total	$577.13	10 *	$9,537.13	25 *	$1,800.00	1 *	$4,187.27	1 *	$0.00	0 *	$16,101.53	37 *
TOTAL NET BAD DEBT	$118,145.85	3703 *	$472,050.50	1642 *	$138,597.32	101 *	$466,822.72	125 *	$1,356,087.03	36 *	$2,551,703.42	5607 *
DOLLARS BUDGETED											$2,644,099.00	

* Net total of accounts do no include recoveries.

FOURTH QUARTER FISCAL YEAR - 1987
and YEAR-TO-DATE BAD DEBTS
BY STATE

STATE	FOURTH QUARTER NUMBER	FOURTH QUARTER AMOUNT[1]	TOTAL FSY NUMBER	TOTAL FSY AMOUNT[1]
Alabama	1	14.30	8	414.22
Alaska			3	67.87
Arizona	3	12,000.87	28	29,889.94
Arkansas	1	279.90	4	923.17
California	35	10,302.87	71	16,221.70
Colorado			23	2,163.09
Connecticut	1	470.00	2	485.23
Delaware				
Dist. of Columbia			2	37.70
Florida	12	7,829.28	30	25,698.37
Georgia	1	180.00	7	5,146.44
Hawaii				
Idaho			2	237.33
Illinois	5	20,317.78	23	21,865.59
Indiana	2	74.00	13	54,672.05
Iowa	8	5,995.48	28	11,529.91
Kansas			3	739.00
Kentucky			1	75.00
Louisiana			4	1,480.91
Maine	2	1,050.10	4	1,397.60
Maryland	20	2,676.50	28	4,885.88
Massachusetts	1	13.16	6	272.13
Michigan	6	962.02	14	2,778.60
Minnesota	1378	632,435.26	4,730	1,994,979.10
Mississippi			2	301.50
Missouri	2	20.78	6	1,914.37
Montana	1	269.45	7	1,157.26
Nebraska	7	12,547.14	11	53,094.61
Nevada	11	550.94	12	573.16
New Hampshire				
New Jersey	3	1,151.11	3	1,151.11
New Mexico	1	0.02	2	123.22
New York	6	2,746.33	27	5,500.64
North Carolina	1	37.50	3	1,135.50
North Dakota	38	26,710.45	103	64,623.29
Ohio	1	14.50	10	5,007.41
Oklahoma	4	363.83	6	571.63
Oregon			2	1,147.65
Pennsylvania	2	553.31	3	625.81
Puerto Rico				
Rhode Island			2	20,432.19
South Carolina			2	302.46
South Dakota	63	35,236.20	7	105,816.52
Tennessee			7	628.27
Texas	3	5,812.60	18	105,652.50
Utah			1	120.38
Vermont	3	102.58	3	102.58
Virginia	5	1,412.50	6	1,472.50
Washington	1	23.60	3	92.40
West Virginia				
Wisconsin	39	23,973.75	167	52,018.23
Wyoming			1	1,037.36
Total	1,667	806,128.34	5,607	2,600,851.38

FOURTH QUARTER FISCAL YEAR - 1987
and YEAR-TO-DATE BAD DEBTS
BY SERVICE

ADMITTING SERVICE	FOURTH QUARTER NUMBER	FOURTH QUARTER NUMBER	TOTAL FSY 87 AMOUNT	TOTAL FSY 87 AMOUNT
Anesthesiology				
Clinical Research	4	5,215.62	7	5,452.44
Dentistry			2	29.61
Dermatology			2	714.81
Family Practice			1	517.88
GYN	2	180.95	11	12,564.67
GYN-Oncology	7	4,473.95	40	57,163.89
Lab Medicine & Pathology				
Medicine-Blue	3	478.97	10	5,172.39
Green	4	1,587.41	17	12,475.50
Masonic(onc)	15	21,356.19	33	28,379.19
Purple			3	25,846.43
Red A	8	13,512.55	18	26,919.82
Red B	5	18,088.83	7	18,339.33
Rose A	3	5,012.25	7	5,845.05
Rose B				
White A	10	12,588.32	25	17,765.24
White B	10	5,190.74	27	16,975.13
Yellow A	3	792.77	13	3,459.21
Yellow B	2	702.69	5	8,967.78
Neurology	10	7,462.43	24	42,455.79
Neuro-epilepsy	1	399.74	4	2,120.63
Neurosurgery	9	9,174.71	33	26,249.28
New Born-General	6	2,403.16	12	9,809.01
Obstetrics-General	11	6,015.38	19	9,056.60
-Midwife	1	404.81	2	1,399.34
Opthalmology	4	3,564.00	16	10,551.64
Orthopaedic Surgery	7	2,336.84	38	17,941.75
Otolaryngology	5	3,613.66	21	14,634.24
Pediatrics-General	24	28,243.30	55	123,493.06
Neurology	1	371.92	8	2,847.85
Neurosurgery	1	0.03	1	125.03
Opthalmology	1	614.61	3	6,269.69
Orthopaedics	1	0.41	3	4,225.32
Otolaryngology	1	825.00	2	2,312.58
Surgery Green	1	382.18	4	1,261.92
Surgery Orange	1	736.00	4	2,599.17
Surg. Transplant			2	85,548.47
Urology	1	290.94	2	302.55
Physical Med. & Rehab.	1	0.76	4	209.00
Psychiatry-Child	2	22,499.72	3	24,233.77
Adult	8	11,795.68	30	43,442.32
Radiology				
Surgery-Blue	17	7,468.10	41	68,503.72
Orange	3	1,924.06	13	9,484.51
Purple	3	290.90	14	58,665.00
Red	8	4,967.91	20	21,243.41
White	9	4,694.79	20	24,145.08
Therapeutic Radiology				
Urology	4	1,751.05	18	19,765.20
Unknown	61	90,818.27	114	209,211.30
Outpatient	1,388	503,896.27	4,849	1,512,155.79
Total	1667	806,128.34	5,607	2,600,851.38

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

TO: Members, Board of Governors

FROM: Greg Hart
Interim Hospital Director

DATE: August 19, 1987

SUBJECT: Compensation Plan

The Board of Governors approved an initial set of recommendations for the 1987-88 employee compensation plan in June. We indicated at that time that we would return to the Board in August with the remainder of our recommendations for the compensation plan.

The two primary elements of the pay plan approved earlier by the Board were(a) a 2% across-the-board increase in salaries and salary ranges, and (b) implementation of the third year of our four year plan for comparable worth. These actions applied to non-unionized employees in Hospital dominated classifications. We recommended deferral of a decision on additional adjustments given that the total State and University pay plans were not known in June.

We are now prepared to recommend the following additional elements of the pay plan:

1. For employees in non-union, Hospital dominated classes:

   In addition to the 2% increase in salary range adjustments already provided, that in-range adjustments (progression increases) be provided on a merit basis to eligible employees, in an amount equivalent to 1.8% of the applicable salaries. This results in a 3.8% weighted average salary increase for this group of employees.

2. For employees in non-union, University dominated classes:

   That the 2.5% pay plan set by the University be distributed to the applicable employees in the form of a 1% across-the-board increase (already implemented) and a 1.5% merit-based progression increase and in addition, that lump sum merit increases be provided to highly rated employees in an amount totaling $80,000. This results in a weighted average increase for this group of 3.3%.

   Both of the above actions are recommended to be made effective retroactive to July 1.

The Hospital's budget for across-the-board salary range changes and progression increases allows for an average increase of 4.5%. The two recommendations outlined above can be accomplished with less than the budgeted amounts, given that they result in an average increase of 3.8% and 3.3%, respectively, for the two groups.

It should be noted that both of the above recommendations involve distribution of the progression component of the pay plan on a merit basis. This is consistent with the Board's action last fall, which authorized inclusion of a merit-based system as part of the 1987-88 compensation plan. Employees whose performance "exceeds expectations" will, with approval of the prior two recommendations, receive 2%-2.5% more than those whose performance "meets expectations". Those whose performance has been rated as less than "meets expectations" will not receive any progression increase; this third group involves only 1% of our employees.

One of our objectives in developing a compensation plan is to keep the increases for unionized and non-unionized employees in reasonable parity. Though as of the writing of this memo the AFSCME and Teamsters negotiations have not been finalized, we are confident that the recommendations outlined earlier and the eventual contract settlements will result in the objective of reasonable parity being achieved. Additional union contract negotiating sessions are scheduled for the next few days.

We are requesting Finance Committee and Board of Governors approval to proceed with the two pay plan elements and expenditures described earlier at the August meetings. This will allow us to provide our employees with their additional salary increases in September.

We will be happy to answer your questions next week. Thank you for your attention to this matter.

GWH/jmp

July 23, 1987
Minnesota Daily

Area competitors may be hurting U hospital

By **Delores Lutz**
Staff Writer

Dr. Stuart Jamieson came to the University — where open-heart surgery was invented — to transplant hearts and lungs.

But his Twin Cities real estate agent was surprised about his job. She didn't know the University was in the heart transplant business.

That's a good example of why, when it comes to cardiac care, the University Hospital and Clinic is losing the competition wars to Abbott-Northwestern Hospital in Minneapolis and the Mayo Clinic in Rochester, Jamieson told the University Hospital Board of Governors Wednesday.

"The University of Minnesota is being eaten alive by competition in the private sector," said Jamieson, who heads the University's division of cardiovascular and thoracic surgery.

Although the University is a world leader in heart transplants, it has fallen behind in open-heart operations. In the last six months, University Hospital has done 330 such operations, compared with 1,200 performed annually at Abbott-Northwestern, he said.

Abbott-Northwestern Hospital

See **Hospital** *page 3*

and the Mayo Clinic are the University's main competitors in heart surgery — not because of expertise, but because of publicity, more physician referrals and appealing amenities for patients, he said.

The University must fight back with sophisticated marketing and attention to detail, said Jamieson, adding that walking into Abbott-Northwestern is "like walking into the Ritz.

"It's the little things that are going to get you — like the color of the carpet, whether you're nice to patients and whether you answer the phones," he said.

Jamieson, who is director of the Minnesota Heart and Lung Institute at the University, came here from Stanford University last year. The board invited him and Dr. Carl White, director of clinical cardiology at the University, to speak at its monthly meeting.

The doctors' remarks about competition surprised board members. They had expected a briefing on cardiac care and organ transplantation. Instead, they received an hour-long lecture with several pointed messages.

"Clinic facilities at the University of Minnesota, especially the cardiology clinic, are abominable," said White, who came here last year from the University of Iowa.

Heart transplantation is the "flagship" of cardiac care at the University, but Abbott-Northwestern makes the headlines, Jamieson said.

Abbott-Northwestern has performed four highly publicized heart transplants, but the University has done 70 during the past year alone, he said.

On the publicity front, Jamieson said, "We're just getting killed."

In the discussion following Jamieson's and White's talk, University Hospital's acting director Gregory Hart said University officials have good reason to call news conferences sparingly.

"Organ transplants are virtually a daily event; the media would get tired of us calling them every day," Hart said. "What is indeed exceptional at Abbott-Northwestern is quite routine here."

July 28, 1987
Minneapolis Star & Tribune

Doctor says he left AIDS off death certificate

He cites wishes of ex-Dayton chief

By Lewis Cope
Staff Writer

A noted AIDS expert at the University of Minnesota acknowledged Monday that he had withheld from a death certificate the fact that a well-known patient had died from an AIDS-related disease.

Dr. Frank Rhame said he did so at the request of his patient and he defended his action.

Rhame filed an amended death certificate for Carl R. Erickson, former president of Dayton's department stores, indicating he died from an AIDS-related cancer. The editor of a gay newspaper had charged last week that the AIDS aspect was being covered up.

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"There were two secrets involved — gayness and AIDS," Campbell added, saying that Erickson was not "terribly secretive about his gayness" as a part of his bisexual life. Most cases of AIDS have been in homosexual or bisexual men.

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He also had been vice president of the Minneapolis Downtown Council, a senior vice president of the Dayton Hudson Corp., Dayton's parent company, and one of the founders of the Downtown Development Corp. in 1976.

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Text of Rhame's letter

July 24, 1987
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There is one good thing which could come from this episode. Death certificates do not need to be public documents. In the majority of states, they are not. Death certificates do provide an important statistical base. But that end can be achieved without them being public documents. The current state law puts physicians in a difficult bind when their patients wish to maintain their privacy about medical diagnoses of all sorts. The integrity of death certificates is a valid goal — it would be better served by keeping them private.

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I have received the family's permission to issue this statement. But they and I deeply resent being forced to violate Carl's desire for privacy.
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August 1, 1987
Minneapolis Star and Tribune

2nd HMO in state declared insolvent

By Maura Lerner
Staff Writer

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"For the moment, they're safe," Hatch said, because their contracts guarantee coverage for another 90 days. "Our only concern is making sure that the health care continues to be delivered."

The HMO, which was associated with the University of Minnesota, was the first of what was to be a national chain of HMOs linked to university hospitals. But the organizers ran into difficulty breaking into the state's highly competitive market. About a third of its enrollees are in Brainerd, with the rest scattered in parts of central and southwestern

HMO continued on page 2B

HMO Continued from page 1B

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Health Partners lost $497,000 since it began operating in March 1986. Last week, its board of directors asked the state to intercede, saying it was running out of money and had exhausted all efforts to raise cash.

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It was the second HMO in Minnesota to fold in three months. The first, More HMO of Virginia, Minn., was declared insolvent in May. In June, after negotiations with Hatch's office, Blue Cross and Blue Shield of Minnesota agreed to assume coverage of More's 8,500 members.

The HMO was run by a for-profit company, Primary Care Network Management Company, which was cofounded by Connecticut industrialist Edward C. Whitehead of Technicon, a developer of medical laboratory equipment.

Filiatrault said Whitehead had hoped to create a national network of HMOs in association with university hospitals. The management company was cosponsored by the university and a group of local physicians.

U selected for Medicare heart transplants

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The decision is expected to have its primary effect not on the over-65 population, but on persons receiving disability payments from Medicare, the federal health insurance program for the aged and disabled. In 1986, about 3 million of the 32 million Medicare recipients were on disability.

Singling out centers to perform major procedures newly covered by Medicare is a "significant turnaround" in federal health policy and is aimed at channeling money to hospitals with the best performances, said Helen Darling, an aide to U.S. Sen. Dave Durenburger, who announced the university's selection.

In the past, once a procedure was approved, such as kidney transplants, all institutions licensed to perform them were eligible to receive Medicare reimbursements. Hand-picking only a few hospitals is also a way of controlling costs by limiting the number of operations done, which are already limited by a shortage of organ donors.

"This is a nice thing," said Dr. John Najarian, a transplant surgeon and chairman of the surgery department at the university. "It's prestigious from the point of view of the others selected. To be the third following those two is quite a distinction."

The other two centers, announced July 13, are Stanford University in Palo Alto, Calif., and the Medical College of Virginia, in Richmond. Both were pioneering centers in heart transplant surgery, which is now performed at more than 70 institutions around the country. About 10 to 12 centers eventually are expected to be approved by Medicare.

Of about 2,500 heart transplant operations so far worldwide, only nine recipients have been over 65, said Najarian. Patients in that age group are generally considered at higher risk for the operation. Given the small supply of donor organs relative to demand for them, most centers give preference to younger recipients, all else being equal.

The oldest heart transplant recipient at the university was a woman, who was 64 at the time of

Please see Transplants/4B

Transplants

Continued from Page 1B

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He said the selection by the Health Care Financing Administration, which runs Medicare, is a tribute to the U of M heart transplant program, which is led by surgeons W. Steves Ring and Stuart Jamieson. The heart transplant survival rate at the university is now 96 percent for one year and 94 percent for two years, Najarian said.

Survival rate was one of several quality and cost criteria listed by Medicare officials last fall when they announced expansion of benefits to include heart transplants. Others included volume, population base and commitment to the program.

Darling and Najarian noted that Medicare administrators have for years resisted extending coverage to heart transplants, partly to contain costs. The 1972 decision to cover kidney transplants — the only other organ transplant included in Medicare benefits — mushroomed into a $2 billion a year program because so many people disabled by kidney disease became eligible.

The heart transplant category is expanding rapidly as well. Last year there were about 1,000 in the United States, compared to 300 four years ago, said Najarian.

Approving only a handful of transplant centers for hearts will be a way of "easing in, of testing the waters to see how it's going to work before they go too far," said John Kralewski, director of the division of health science research and policy at the university.

August 7, 1987
St. Paul Pioneer Press Dispatch

August 7, 1987
Minneapolis Star & Tribune

University Hospital chosen to help test Alzheimer's drug

By Lewis Cope
Staff Writer

The University of Minnesota Hospital is one of 17 medical centers across the nation that will test a drug that researchers hope can delay or possibly reverse some of the memory loss of Alzheimer's disease, federal health officials said Thursday.

But Dr. David Knopman, who will direct the university study in which 18 patients will get the drug called THA (tetrahydroaminoacridine), warned against too much optimism.

"This is an experimental study — we don't know if the drug is going to work," he said. Although a California doctor reported last November that 16 of 17 Alzheimer's patients appeared to be helped without major side effects, Knopman noted that other drugs had shown early promise but failed to work in larger, carefully controlled trials with Alzheimer's patients.

If it does help, "it's highly unlikely that is going to produce dramatic results," he said, even though any help would be an encouraging lead. "It won't be a cure," he said.

Plans call for 300 Alzheimer's patients to be given THA at the 17 centers participating in the two-year study. Alzheimer's is a major, but not the only cause, of severe senility and confusion in many elderly and some younger people. In later stages, it severely limits physical activity. As many as 3 million Americans are thought to have Alzheimer's.

The theory is that THA helps by blocking the brain's normal breakdown of acetylcholine, a chemical messenger that may be involved in sending memory-related messages between nerve cells in the brain. But other brain chemicals also are affected by Alzheimer's, and some brain cells may be so damaged by the disease that the drug can't help, said Knopman, an associate professor of neurology.

He said that the trial is limited to patients with mild to moderate Alzheimer's, and that so many people already have asked about the drug that the chances are slim that anyone applying now will be selected. More information can be obtained by calling 626-3004.

The $5 million cost of the two-year test is being paid by the federal National Institute on Aging, the nonprofit Alzheimer's Disease and Related Disorders Association, and Warner-Lambert Co., which is supplying the drug. Knopman said at least two other drugs have been tested against the disease at other Twin Cities hospitals recently, with no results yet available.

Toddler who got artificial heart valves leaves hospital

Sixteen-month-old Allegria Nocho — probably the youngest person in the world to get two artificial heart valves — went home from the University of Minnesota Hospital Tuesday.

When the girl from Grand Forks, N.D., arrived at the hospital June 15,she was in "extreme cardiac failure" and so weak "that there was not even talk about surgery for two weeks," recalled Dr. John Foker.

Marfan's syndrome, an unusual problem in adults and a rare occurrence in infants, had so badly damaged two of her heart's four valves that her heart was severely strained to pump enough blood to keep her alive.

The valves are one-way doors that keep blood flowing in the right direction. When they leak, not enough blood is pumped out to the body to deliver oxygen and nutrients.

In an effort to compensate for its overload, Allegria's heart had expanded so much that it spread nearly across her chest, Foker said, which pressed on her lungs and seriously impaired her breathing, doctors said.

Allegria gained enough strength by July 7 that a team was able to operate. In the 4½-hour surgery, Foker opened Allegria's tiny chest and cut open her heart.

A heart-lung machine took over the job of pumping blood through her body as Foker cut out the two defective valves and sewed in artificial ones made of carbon, each about an inch in diameter.

Allegria, the daughter of Audrey Nocho, has made slow but steady progress since surgery, and her heart is nearly normal size, allowing for good breathing, Foker said.

But she is still weak as her body adapts to the repaired heart, he said. She went home by ambulance.

Looking ahead, Foker said that "she should now have a reasonably active childhood — although she's not going to be a marathon swimmer."

He said Allegrio probably will need more surgery as a teen-ager to get at least one larger valve as her heart grows.

He noted that Marfan's syndrome in adulthood can cause life-threatening problems in the aorta, the main blood vessel that carries blood from the heart.

But he said Allegria will be watched closely in an effort to keep any such problem from becoming serious.

August 19, 1987
Minneapolis Star & Tribune

July 23, 1987
Minnesota Daily

Area competitors may be hurting U hospital

By Delores Lutz
Staff Writer

Dr. Stuart Jamieson came to the University — where open-heart surgery was invented — to transplant hearts and lungs.

But his Twin Cities real estate agent was surprised about his job. She didn't know the University was in the heart transplant business.

That's a good example of why, when it comes to cardiac care, the University Hospital and Clinic is losing the competition wars to Abbott-Northwestern Hospital in Minneapolis and the Mayo Clinic in Rochester, Jamieson told the University Hospital Board of Governors Wednesday.

"The University of Minnesota is being eaten alive by competition in the private sector," said Jamieson, who heads the University's division of cardiovascular and thoracic surgery.

Although the University is a world leader in heart transplants, it has fallen behind in open-heart operations. In the last six months, University Hospital has done 330 such operations, compared with 1,200 performed annually at Abbott-Northwestern, he said.

Abbott-Northwestern Hospital

See Hospital *page 3*

and the Mayo Clinic are the University's main competitors in heart surgery — not because of expertise, but because of publicity, more physician referrals and appealing amenities for patients, he said.

The University must fight back with sophisticated marketing and attention to detail, said Jamieson, adding that walking into Abbott-Northwestern is "like walking into the Ritz.

"It's the little things that are going to get you — like the color of the carpet, whether you're nice to patients and whether you answer the phones," he said.

Jamieson, who is director of the Minnesota Heart and Lung Institute at the University, came here from Stanford University last year. The board invited him and Dr. Carl White, director of clinical cardiology at the University, to speak at its monthly meeting.

The doctors' remarks about competition surprised board members. They had expected a briefing on cardiac care and organ transplantation. Instead, they received an hour-long lecture with several pointed messages.

"Clinic facilities at the University of Minnesota, especially the cardiology clinic, are abominable," said White, who came here last year from the University of Iowa.

Heart transplantation is the "flagship" of cardiac care at the University, but Abbott-Northwestern makes the headlines, Jamieson said.

Abbott-Northwestern has performed four highly publicized heart transplants, but the University has done 70 during the past year alone, he said.

On the publicity front, Jamieson said, "We're just getting killed."

In the discussion following Jamieson's and White's talk, University Hospital's acting director Gregory Hart said University officials have good reason to call news conferences sparingly.

"Organ transplants are virtually a daily event; the media would get tired of us calling them every day," Hart said. "What is indeed exceptional at Abbott-Northwestern is quite routine here."

July 28, 1987
Minneapolis Star & Tribune

Doctor says he left AIDS off death certificate

He cites wishes of ex-Dayton chief

By Lewis Cope
Staff Writer

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Dr. Frank Rhame said he did so at the request of his patient and he defended his action.

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August 1, 1987
Minneapolis Star and Tribune

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HMO continued on page 2B

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Please see Transplants/4B

Transplants

Continued from Page 1B

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The theory is that THA helps by blocking the brain's normal breakdown of acetylcholine, a chemical messenger that may be involved in sending memory-related messages between nerve cells in the brain. But other brain chemicals also are affected by Alzheimer's, and some brain cells may be so damaged by the disease that the drug can't help, said Knopman, an associate professor of neurology.

He said that the trial is limited to patients with mild to moderate Alzheimer's, and that so many people already have asked about the drug that the chances are slim that anyone applying now will be selected. More information can be obtained by calling 626-3004.

The $5 million cost of the two-year test is being paid by the federal National Institute on Aging, the nonprofit Alzheimer's Disease and Related Disorders Association, and Warner-Lambert Co., which is supplying the drug. Knopman said at least two other drugs have been tested against the disease at other Twin Cities hospitals recently, with no results yet available.

Toddler who got artificial heart valves leaves hospital

Sixteen-month-old Allegria Nocho — probably the youngest person in the world to get two artificial heart valves — went home from the University of Minnesota Hospital Tuesday.

When the girl from Grand Forks, N.D., arrived at the hospital June 15,she was in "extreme cardiac failure" and so weak "that there was not even talk about surgery for two weeks," recalled Dr. John Foker.

Marfan's syndrome, an unusual problem in adults and a rare occurrence in infants, had so badly damaged two of her heart's four valves that her heart was severely strained to pump enough blood to keep her alive.

The valves are one-way doors that keep blood flowing in the right direction. When they leak, not enough blood is pumped out to the body to deliver oxygen and nutrients.

In an effort to compensate for its overload, Allegria's heart had expanded so much that it spread nearly across her chest, Foker said, which pressed on her lungs and seriously impaired her breathing, doctors said.

Allegria gained enough strength by July 7 that a team was able to operate. In the 4½-hour surgery, Foker opened Allegria's tiny chest and cut open her heart.

A heart-lung machine took over the job of pumping blood through her body as Foker cut out the two defective valves and sewed in artificial ones made of carbon, each about an inch in diameter.

Allegria, the daughter of Audrey Nocho, has made slow but steady progress since surgery, and her heart is nearly normal size, allowing for good breathing, Foker said.

But she is still weak as her body adapts to the repaired heart, he said. She went home by ambulance.

Looking ahead, Foker said that "she should now have a reasonably active childhood — although she's not going to be a marathon swimmer."

He said Allegrio probably will need more surgery as a teen-ager to get at least one larger valve as her heart grows.

He noted that Marfan's syndrome in adulthood can cause life-threatening problems in the aorta, the main blood vessel that carries blood from the heart.

But he said Allegria will be watched closely in an effort to keep any such problem from becoming serious.

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