minutes after the scheduled time. If an unavoidable delay is anticipated by the attending surgeon, he should notify the operating suite personnel and relinquish his operating time to the succeeding surgeon.

c. In case of a cancellation, the operating schedule shall be advanced to fill the vacancy. Cancellation of one case and substitution by another at the same hour shall not be permitted.

d. Except in an emergency, patients shall be admitted not later than 2:00 p.m. on the day preceding a scheduled operation.

e. In cases of emergency situations, the elective surgery scheduled will be interrupted or cancelled in order to provide space and personnel to meet the emergency.

f. Priority will be on a "first scheduled, first served" basis for the active and associate staff. Courtesy staff will have second priority after the above-mentioned cases are performed (i.e., courtesy staff cases will be scheduled on a time available basis).

8. Responsibilities of the Attending Surgeon

a. A history, physical examination, and necessary laboratory tests shall be completed and recorded prior to surgery. This provision may be deferred in an emergency provided the surgeon states in writing that delay would constitute a hazard to the patient.

b. The attending surgeon shall see the patient within twenty-four hours of surgery and record a concise preoperative note indicating the diagnosis and plan of management on the progress sheet. The note may be written by the resident, but must be countersigned by the attending physician.

c. The scheduled surgeon shall perform the operation or be responsible for the performed operation. In either case, the scheduled surgeon's attendance in the immediate area is mandatory until the patient arrives in the recovery room.

d. The attending surgeon shall be responsible for and shall sign the operative note.

e. The postoperative note shall be written on the progress sheet immediately after surgery.

f. The surgeon shall be responsible for the patient's postoperative care.

g. Except in emergency, consultation with a member of the Active Medical Staff or otherwise qualified consultant shall be required in all major cases in which the patient is not a good risk. Consultation is also required in all major cases in which a second major operation is contemplated as a result of a serious complica-

tion or problem related to a previous operation performed during the same hospitalization.

h. In view of the resident training program in surgery, preceptoral training in surgery is not permitted. Physicians who desire to assist at operations shall not displace the surgical house staff from their assigned positions on the operating team.

i. On major abdominal, thoracic and vascular cases, a qualified assistant (a physician) is necessary.

9. Because of the considerable number of concommitant and inter-related problems to be encountered in various surgical procedures, it is recommended that there be formed a surgical suite committee, composed of representatives of different surgical specialties, anesthesia and nursing service, and hospital administration. This committee shall meet as needed to review the functions within the surgical area and to recommend additions or changes in policy or rules when indicated. The policies, regulations and rules for a surgical suite include:

   a. Surgical day care patients who require general anesthesia should be pre-registered prior to arrival at the hospital. Arrival at St. Marys Hospital Medical Center should occur between 7:00 A.M. and 7:30 A.M. on the day of surgery with the patient having had nothing by mouth after midnight. Basic laboratory tests are required, including a blood count and urinalysis.

   b. Scheduling, transporting patients, and maintaining an aseptic and otherwise safe environment is the responsibility of the Supervisor of the Operating Suite and the personnel responsible to her. The responsibilities are outlined in the section, "Operating Suite" in the Administrative Manual of St. Marys Hospital Medical Center.

10. A patient admitted for dental care is a dual responsibility involving the dentist and the physician member of the Medical Staff.

    a. Dentists' responsibilities:

       (1) A detailed dental history justifying hospital admission;

       (2) A detailed description of the examination of the oral cavity and a preoperative diagnosis;

       (3) A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the hospital pathologist for examination.

       (4) Progress notes as are pertinent to the oral condition;

       (5) Clinical resume (or summary statement).

b. Physicians' responsibilities:

(1) Medical history pertinent to the patient's general health;

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery;

(3) Supervision of the patient's general health status while hospitalized.

c. A licensed physician must be in attendance in the surgical suite while the dental surgical procedures are being performed.

d. The discharge for the patient shall be the dual responsibility of the attending dentist and physician.

11. Consent for operation:

a. Informed, written and signed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

b. Should a second operation be required during the patient's stay in the hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.

12. The Department of Surgery shall adopt these rules and regulations according to procedures described herein. The department may in the future adopt such other rules and regulations as may be necessary for the proper conduct of the work of the department. Rules and regulations shall be adopted by and may be amended by a two-thirds vote of the members of the department who are active members of the Medical Staff. Such rules and regulations shall become effective and supercede all previous departmental rules and regulations when approved by the Executive Committee of the Medical Staff and the Governing Board.

13. All questions of enforcement and interpretation of these rules and regulations shall be the responsibility of the departmental chairman subject to the approval of the Executive Committee and the Executive Director.

AMENDMENTS

ADDENDUM TO RULES AND REGULATIONS OF THE DEPARTMENT OF SURGERY PERTAINING TO PODIATRIC CARE.

14. A patient admitted for podiatric care is the dual responsibility involving the podiatrist and the physician member of the medical staff jointly admitting the patient.

    a. Podiatrists' responsibilities:

        (1) A detailed podiatric history justifying the hospital admission;

        (2) A detailed podiatric examination with a preoperative diagnosis;

        (3) A complete operative report, describing the finding and technique;

        (4) Medical orders within the scope of his license applicable directly to the podiatric care;

        (5) Progress notes pertinent to the podiatric condition;

        (6) Clinical resume (or summary statement).

    b. Physicians' responsibilities:

        (1) A medical history pertinent to the patient's general health;

        (2) A complete physical examination to determine the patient's condition prior to anesthesia and surgery;

        (3) Responsibility for the overall aspect of the patient's care throughout the hospital stay.

    c. A licensed physician must be in attendance in the Operating Suite while podiatric surgical procedures are being performed.

    d. The discharge of the podiatric patient shall be the dual responsibility of the attending podiatrist and physician.

12/15/75

These Departmental Rules and Regulations have been approved by greater than a two-thirds majority vote of the active staff members of the respective departments and by the Executive Committee of the medical staff of St. Marys Hospital Medical Center at their regular meeting May 21, 1973 and subsequently by the Governing Board of the Sisters of St. Mary.

ETHICAL AND RELIGIOUS DIRECTIVES
promulgated by USCC

PREAMBLE: Catholic health facilities witness to the saving presence of Christ and His Church in a variety of ways: by testifying to transcendent spiritual beliefs concerning life, suffering, and death; by humble service to humanity and especially to the poor; by medical competence and leadership; and by fidelity to the Church's teachings while ministering to the good of the whole person.--The total good of the patient, which includes his higher spiritual as well as his bodily welfare, is the primary concern of those entrusted with the management of a Catholic health facility. So important is this, in fact, that if an institution could not fulfill its basic mission in this regard, it would have no justification for continuing its existence as a Catholic health facility. Trustees and administrators of Catholic health facilities should understand that this responsibility affects their relationship with every patient, regardless of religion, and is seriously binding in conscience.--A Catholic-sponsored health facility, its board of trustees, and administration face today a serious difficulty as, with community support, the Catholic health facility exists side by side with other medical facilities not committed to the same moral code, or stands alone as the one facility serving the community. However, the health facility identified as Catholic exists today and serves the community in a large part because of the past dedication and sacrifice of countless individuals whose lives have been inspired by the Gospel and the teachings of the Catholic Church.--And just as it bears responsibility to the past, so does the Catholic health facility carry special responsibility for the present and future. Any facility identified as Catholic assumes with this identification the responsibility to reflect in its policies and practices the moral teachings of the Church, under the guidance of the local bishop. Within the community the Catholic health facility is needed as a courageous witness to the highest ethical and moral principles in its pursuit of excellence.--The Catholic-sponsored health facility and its board of trustees, acting through its chief executive officer, further, carry an overriding responsibility in conscience to prohibit those procedures which are morally and spiritually harmful. The basic norms delineating this moral responsibility are listed in these *Ethical and Religious Directives for Catholic Health Facilities*. It should be understood that patients and those who accept board membership, staff appointment or privileges, or employment in a Catholic health facility will respect and agree to abide by its policies and these *Directives*. Any attempt to use a Catholic health facility for procedures contrary to these norms would indeed compromise the board and administration in its responsibility to seek and protect the total good of its patients, under the guidance of the Church.--These *Directives* prohibit those procedures which, according to present knowledge, are recognized as clearly wrong. The basic moral absolutes which underlie these *Directives* are not subject to change, although particular applications might be modified as scientific investigation and theological development open up new problems or cast new light on old ones.--In addition to consultations among theologians, physicians, and other medical and scientific personnel in local areas, the Committee on Health Affairs of the United States Catholic Conference, with the widest consultation possible, should regularly receive suggestions and recommendations from the field, and should periodically discuss any possible need for an updated revision of these *Directives*.--The moral evaluation of new scientific developments and legitimately debated questions must be finally submitted to the teaching authority of the Church in the person of the local bishop, who has the ultimate responsibility for teaching Catholic doctrine.

GENERAL: Directive 1. The procedures listed in these *Directives* as permissible require the consent, at least implied or reasonably presumed, of the patient or his guardians. This condition is to be understood in all cases. 2.No person may be obliged to take part in a medical or surgical procedure which he judges in conscience to be immoral;nor may a health facility or any of its staff be obliged to provide a medical or surgical procedure which violates their conscience or these *Directives*. 3.Every patient, regardless of the extent of his physical or psychic disability, has a right to be treated with a respect consonant with his dignity as a person. 4.Man has the right and the duty to protect the integrity of his body together with all of its bodily functions. 5.Any procedure potentially harmful to the patient is morally justified only insofar as it is designed to produce a proportionate good. 6.Ordinarily the proportionate good that justifies a medical or surgical procedure should be the total good of the patient himself. 7.Adequate consultation is recommended, not only when there is doubt concerning the morality of some procedure, but also with regard to all procedures involving serious consequences, even though such procedures are listed here as permissible. The health facility has the right to insist on such consultations. 8.Everyone has the right and the duty to prepare for the solemn moment of death. Unless it is clear, therefore, that a dying patient is already well-prepared for death as regards both spiritual and temporal affairs, it is the physician's duty to inform him of his critical condition or to have some other responsible person impart this information. 9.The obligation of professional secrecy must be carefully fulfilled not only as regards the information on the patients' charts and records but also as regards confidential matters learned in the exercise of professional duties. Moreover, the charts and records must be duly safe-guarded against inspection by those who have no right to see them.

10.The directly intended termination of any patient's life, even at his own request, is always morally wrong. 11.From the moment of conception, life must be guarded with the greatest care. Any deliberate medical procedure, the *purpose* of which is to deprive a fetus or an embryo of its life, is immoral. 12.Abortion, that is, the directly intended termination of pregnancy before viability, is never permitted nor is the directly intended destruction of a viable fetus. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic hospitals are not to provide abortion services based upon the principle of material cooperation. 13.Operations, treatments, and medications, which do not directly intend termination of pregnancy but which have as their purpose the cure of a proportionately serious pathological condition of the mother, are permitted when they cannot be safely postponed until the fetus is viable, even though they may or will result in the death of the fetus. If the fetus is not certainly dead, it should be baptized. 14.Regarding the treatment of hemorrhage during pregnancy and before the fetus is viable: Procedures that are designed to empty the uterus of a living fetus still effectively attached to the mother are not permitted; procedures designed to stop hemorrhage (as distinguished from those designed precisely to expel the living and attached fetus) are permitted insofar as necessary, even if fetal death is inevitably a side effect. 15.Cesarean section for the removal of a viable fetus is permitted, even with risk to the life of the mother, when necessary for successful delivery. It is likewise permitted, even with risk for the child, when necessary for the safety of the mother. 16. In extrauterine pregnancy the dangerously affected part of the mother (e.g., cervix, ovary, or fallopian tube) may be removed, even though fetal death is foreseen, profided that: a. the affected part is presumed already to be so damaged and dangerously affected as to warrant its removal, and that b. the operation is not just a separation of the embryo or fetus from its site within the part (which would be a direct abortion from a uterine appendage); and that c. the operation cannot be postponed without notably increasing the danger to the mother. 17.Hysterectomy, in the presence of pregnancy and even before viability, is permitted when directed to the removal of a dangerous pathological condition of the uterus of such serious nature that the operation cannot be safely postponed until the fetus is viable.

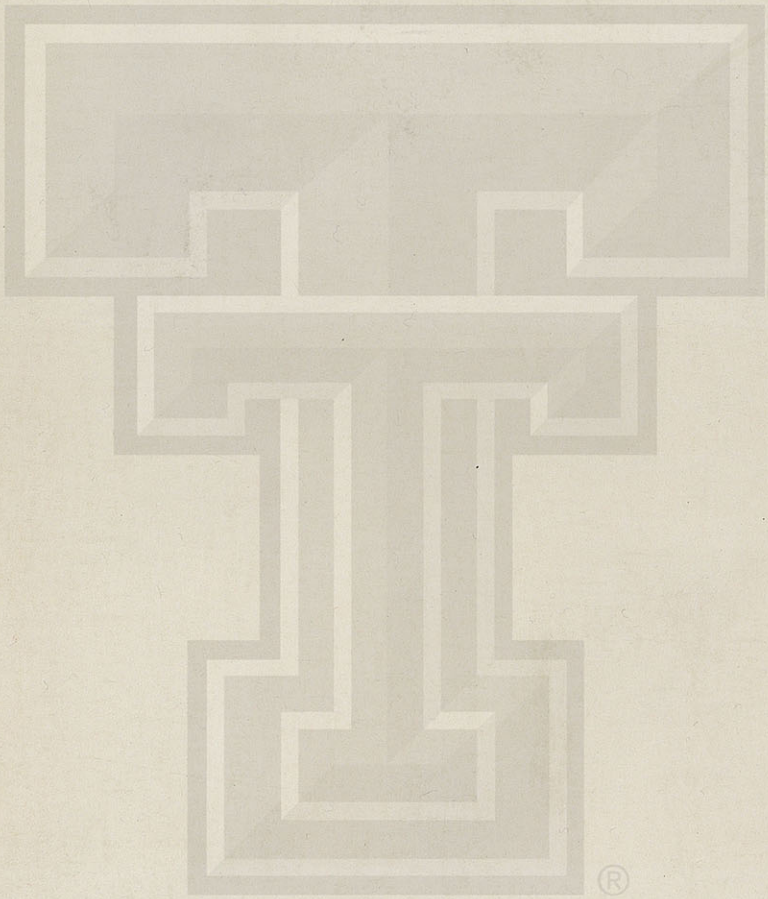
PROCEDURES Involving Reproductive Organs and Functions: Directive 18.Sterilization, whether permanent or temporary, for men or for women, may not be used as a means of contraception. 19.Similarly excluded is every action which, either in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an end or as a means, to render procreation impossible. 20.Procedures that induce sterility, whether permanent or temporary, are permitted when: a. They are immediately directed to the cure, diminution, or prevention of a serious pathological condition and are not directly contraceptive (that is, contraception is not the purpose); and b. a simpler treatment is not reasonably available. Hence, for example, oophorectomy or irradiation of the ovaries may be allowed in treating carcinoma of the breast and metastasis therefrom; and orchidectomy is permitted in the treatment of carcinoma of the prostate. 21.Because the ultimate personal expression of conjugal love in the martial act is viewed as the only fitting context for the human sharing of the divine act of creation, donor insemination and insemination that is totally artificial are morally objectionable. However, help may be given to a normally performed conjugal act to attain its purpose. The use of the sex faculty outside the legitimate use by married partners is never permitted even for medical or other laudable purpose, e.g., masturbation as a means of obtaining seminal specimens. 22.Hysterectomy is permitted when it is sincerely judged to be a necessary means of removing some serious uterine pathological condition. In these cases, the pathological condition of each patient must be considered individually and care must be taken that a hysterectomy is not performed merely as a contraceptive measure, or as a routine procedure after any definite number of Cesarean sections. 23.For a proportionate reason, labor may be induced after the fetus is viable. 24.In all cases in which the presence of pregnancy would render some procedure illicit (e.g. curettage), the physician must make use of such pregnancy tests and consultation as may be needed in order to be reasonably certain that the patient is not pregnant. It is to be noted that curettage of the endometrium after rape to prevent implantation of a possible embryo is morally equivalent to abortion. 25.Radiation therapy of the mother's reproductive organs is permitted during pregnancy only when necessary to suppress a dangerous pathological condition.

OTHER Procedures: Directive 26.Therapeutic procedures which are likely to be dangerous are morally justifiable for proportionate reasons. 27.Experimentation on patients without due consent is morally objectionable, and even the moral right of the patient to consent is limited by his duties of stewardship. 28.Euthanasia ("mercy killing") in all its forms is forbidden. The failure to supply the ordinary means of preserving life is equivalent to euthanasia. However, neither the physician nor the patient is obliged to the use of extraordinary means. 29.It is not euthanasia to give a dying person sedatives and analgesics for the alleviation of pain, when such a measure is judged necessary, even though they may deprive the patient of the use of reason, or shorten his life. 30.The transplantation of organs from living donors is morally permissible when the anticipated benefit to the recipient is proportionate to the harm done to the donor, provided that the loss of such

organ(s) does not deprive the donor of life itself nor of the functional integrity of his body. 31.Post-mortem examinations must not be begun until death is morally certain. Vital organs, that is, organs necessary to sustain life, may not be removed until death has taken place. The determination of the time of death must be made in accordance with responsible and commonly accepted scientific criteria. In accordance with current medical practice, to prevent any conflict of interest, the dying patient's doctor or doctors should ordinarily be distinct from the transplant team. 32.Ghost surgery, which implies the calculated deception of the patient as to identity of the operating surgeon, is morally objectionable. 33.Unnecessary procedures, whether diagnostic or therapeutic, are morally objectionable. A procedure is unnecessary when no proportionate reason justifies it. *A fortiori*, any procedure that is contra-indicated by sound medical standards is unnecessary.

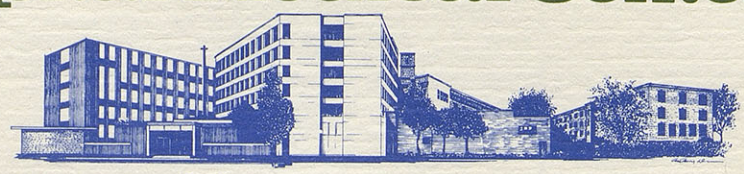
THE Religious Care of Patients: Directive 34.The administration should be certain that patients in a health facility receive appropriate spiritual care. 35.Except in cases of emergency (i.e., danger of death), all requests for baptism made by adults or for infants should be referred to the chaplain of the health facility. 36.If a priest is not available, anyone having the use of reason and proper intention can baptize. The ordinary method of conferring emergency baptism is as follows: The person baptizing pours water on the head in such a way that it will flow on the skin, and, while the water is being poured, must pronounce these words audibly: *I baptize you in the name of the Father, and of the Son, and of the Holy Spirit.* The same person who pours the water must pronounce the words. 37.When emergency baptism is conferred, the chaplain should be notified. 38.It is the mind of the Church that the sick should have the widest possible liberty to receive the sacraments frequently. The generous cooperation of the entire staff and personnel is requested for this purpose. 39.While providing the sick abundant opportunity to receive Holy Communion, there should be no interference with the freedom of the faithful to communicate or not to communicate. 40.In wards and semi-private rooms, every effort should be made to provide sufficient privacy for confession. 41.When possible, one who is seriously ill should be given the opportunity to receive the Sacraments of the Sick, while in full possession of his rational faculties. The chaplain must, therefore, be notified as soon as an illness is diagnosed as being so serious that some probability of death is recognized. 42.Personnel of a Catholic health facility should make every effort to satisfy the spiritual needs and desires of non-Catholics. Therefore, in hospitals and similar institutions conducted by Catholics, the authorities in charge should, with the consent of the patient, promptly advise ministers of other communions of the presence of their communicants and afford them every facility for visiting the sick and giving them spiritual and sacramental ministrations. 43.If there is a reasonable cause present for not burying a fetus or member of the human body, these may be cremated in a manner consonant with the dignity of the deceased human body.

11/71



St. Marys Hospital Medical Center

707 South Mills Street
Madison, Wisconsin 53715
Telephone (608) 251-6100



A Hospital of the Sisters of Saint Mary

October 18, 1978

Sherman P. Vinograd, M.D.
6529 Sothoron Road
McLean, VA 22101

Dear Sir:

I was most happy to hear that you might possibly be interested in the position of Medical Director at St. Marys Hospital Medical Center. Dr. Botham informed me of his telephone conversation with you.

I am sending to you a copy of the job description as developed and feel that this pretty well covers the areas of responsibility of the Medical Director.

I have served in this position for the past 10 years. The first six years were spent half time, the last four years full time. I have found the job most challenging and rewarding. What success I have had in the position has been mainly due to the wholehearted cooperation that I have had from members of the medical staff as well as hospital administration and the educational efforts that the members of the administrative staff to provide to me some of the necessary basics in hospital administration. I have found all of them just a great group to work with.

The Search Committee appointed by the medical staff would be most happy to receive your C.V. if you would be interested in considering the position at St. Marys Hospital Medical Center.

If there is any additional information which I can provide, please feel free to call me or write me or any other member of the committee which consists of myself, Dr. Botham, Dr. Max Smith, and Dr. David Noll, present Chief of Staff. Mr. Steve Barney serves as the administrative representative to the committee. If you would like to give me a phone call, you could reach me at 608/251-6100, extension 398.

I am working only part time now and will complete my commitment on November 30. I will be at St. Marys, however, Tuesday and Wednesday, October 24 and 25, and would be happy to receive a phone call from you if you wish.

It was sure good to hear both about you and from you again, Sherm, and I am looking forward to further exchange of information relative to the position of Medical Director.

Sincerely yours,

George C. Hank, M.D.
Medical Director

GCH:kr

Enclosure

Medical Director

Position Title: Assistant Executive Director

I. Identification

A. Shift: Week days ordinarily; on occasion, some evening, night and weekend.

B. Hours: geographical half or full time

C. Area: Administration

D. Reports To: Executive Director

II. Position Description

A. Summary: Under the general guidance of the Executive Director, the Medical Director performs the planning, organizing, actuating, controlling and evaluating functions necessary to administer the functions and projects delegated to him by the Executive Director. The majority of these activities relate to Medical Staff and Medical Education. He sees that projects are properly administered according to accepted norms in order to assure that the hospital medical center is organized in such a way that its overall purposes and objectives are attained and that where indicated innovative measures are incorporated to expand the hospital medical center's capacity to meet new and/or growing health needs.

B. Major Duties:

1. Responsible for administration of Medical Staff and Medical Education affairs which have hospital medical center ramifications while at all points and times being most careful and cautious to support, respect and enhance the self-governing aspects of the Medical Staff unless these at any point conflict with the hospital medical center by-laws, rules, and regulations.

2. Assumes administrative responsibility for:
   a. the quality of medical care at SMHMC,
   b. the proper functioning of the medical staff in the hospital medical center,
   c. the securing of observance of the hospital medical center by-laws, rules and regulations of the medical staff,
   d. the maintaining of up-to-date information on all assignments of house staff including their responsibility for patient care and ability and privilege to perform specific procedures.

3. Assumes such duties as are incidental to the management of the medical staff organization, viz., those too time-consuming for the chief of staff.

4. Represents SMHMC in negotiations and conferences with the university.

5. Acts as SMHMC's official liaison in the areas of the education program for undergraduate and graduate physicians at the hospital medical center unless and until it seems appropriate for these to be handled by a DME.

6. Helps coordinate research programs both within SMHMC and as they may relate to other institutions.

7. Acts as SMHMC's official liaison with the Emergency Physicians of Madison.

8. Assures that sufficient and appropriate physicians are appointed by the chief of staff to the necessary committees.

9. Analyzes and evaluates the functioning of medical staff departments and committees.

10. Promotes and maintains harmony and effective working relationships by appropriate meetings, conferences, etc. between physicians and hospital medical center departments.

11. Assists Executive Director in interpreting policies and objectives of the hospital medical center organization to the medical staff.

12. Assists in formulating policies for hospital medical center and for medical staff.

13. Directs compilation of budgetary needs for his activities and for most of the areas of Medical Education in the hospital medical center.

14. Keeps Executive Director and the Chief of Staff informed of activities and problems in relation to the medical staff and medical education.
(Meets weekly in a joint meeting of Chief Executive Officer, Executive Director, Chief of Staff & Vice Chief of Staff).

15. Initiates or directs revisions to Medical Staff By-Laws in conjunction with appropriate Medical Staff officers.

16. Assures that medical staff departments are carrying out surveillance of new staff members and on-going education for staff members.

17. Keeps abreast of new developments and initiates the process toward change where indicated.

18. Attends and participates in professional meetings and activities.

19. Responsible for the initial review of all new applicants and their request for privileges.

20. Assures that all personnel records of the medical staff are complete and up-to-date.

21. Prepares monthly a summary of the patient review activities by the medical staff for forwarding to the Governing Board.

C. Minor Duties: As required by the position.

III. Performance Requirements

A. Responsibilities:	Is responsible for people, policies, methods procedures, expenditures, confidential information, legal aspects, safety, public relations, training and selection of personnel as these relate to his function.
B. Knowledge:	Sufficient to carry out responsibilities (knowing where to obtain such knowledge if and when needed).
C. Skill:	Needed in analyzing situations, in knowing and applying remedies and in handling professional people. Should possess skill in oral and written communications and conference techniques.
D. Mental Application:	Flexibility, ability to concentrate and integrate, to plan and do creative work.
E. Dexterity:	N/A
F. Accuracy:	In the areas of perception of content and implication of situation.
G. Experience:	Prerequisite is progressive experience in handling Medical Staff affairs,
H. Education:	Minimum of Doctorate in Medicine.

I. Physical:

1. Sedentary
2. Indoor environment.

IV. Non-Performance Conditions

A. Position Relationships: Reports to Executive Director. Responsible for direction of education function and for much of liaison with medical staff officers and committees.

B. Policy Responsibilities: Must carry out hospital policies relating to items of confidentiality, public relations, and/or having legal implications.

C. Certification Requirements: Licensed to practice medicine in the State of Wisconsin.

D. Promotion Possibilities: Associate Executive Director

Date: March, 1969

Revised: February, 1971

Updated: December, 1971

Updated: May, 1972

Updated: August, 1978

MEMORANDUM OF CALL

TO: Jim Lewis

☐ YOU WERE CALLED BY— ☐ YOU WERE VISITED BY—

Paul Story

OF (*Organization*)

☐ PLEASE CALL → PHONE NO. CODE/EXT. 54224

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

☐ RETURNED YOUR CALL ☐ WISHES AN APPOINTMENT

MESSAGE

Mr. Lowe

554 9066
3455

RECEIVED BY	DATE	TIME
	12/14	10

STANDARD FORM 63
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-11.6

GPO : 1969—o48—16—80341-1 382-389

63-108

National Aeronautics and
Space Administration

Washington, D.C.
20546

Reply to Attn of: SBR-3

May 1, 1979

Sister Rebecca
Chief Executive Officer
St. Marys Hospital
Medical Center
707 South Mills Street
Madison, WI 53715

Dear Sister:

Thank you for your formal offer of the position of Medical Director of St. Marys Hospital Medical Center. As an expression of confidence in me by the Administration and medical staff I am both deeply honored and personally warmed by it, and truly so.

To recount our verbal exchanges on the subject before and since your letter, as I am sure you will recall I expressed three reservations. In no particular order they are, first, I noted that Dr. Botham's estimates of 50-65 hours a week are an excessive requirement in my view. Whereas I normally do not count hours and, in retrospect, have rarely limited myself to a 40 hour week, in fact have all too often far exceeded it, I cannot agree to a commitment of that magnitude. I believe that you and I have resolved this in mutual fairness with the general understanding that the position be defined on a professional rather than a wage per hour basis; that I will allot and spend whatever time it takes (40 hours a week or more) to meet fully the responsibilities of the position, and St. Marys, in turn, will be as considerate as possible of excessive time demands and help to ease them to the extent it can.

Secondly, I was concerned whether or not the annual salary would be adjusted to compensate for inflationary losses, a major problem these days. Your reply was that the matter of salary would be reevaluated each year and that inflation would be considered. I appreciate that you cannot make firm future commitments at this time and have no trouble accepting this in good faith.

Finally, the important issue of organizational location. I expressed the view that the Medical Director should report to the highest hospital authority, your position; that considering its critical role in the interrelationship between administration and medical staff, a Medical Directorship that is organizationally concieved as one of three or so boxes one

step removed from your authority is unacceptable to me, both in principle and personally. This was Greg's description and it is essentially reflected in your latest organizational chart which shows no connection between the Medical Director and the Chief Executive Officer, although the chart does convey a relatively unique location in the shceme of things. All of this, as I sincerely hope I made clear, is entirely independent of any consideration of personalities. Greg, Steve and all of the members of your administrative staff whom I've met are all first rate, highly competent people. I'm sure it would be a pleasure to work with them.

Our conversation about this was quite lengthy but my understanding of your response was fundamentally that the organizational chart really doesn't convey a true picture of the actual day to day working relationships among the Chief Executive Officer, Executive Director and Medical Director; that in reality the three work together as peers without recourse to levels of authority, and you offered your assurance that they will continue to do so. I do feel that the organizational chart should be altered to reflect this, but I assume there are delicate "biopolitical" balances involved that I know nothing about and, therefore, did not press the point. On the strength of your assurance of this, in essence an honorable handshake, I bypassed this reservation and agreed verbally to accept the position.

Lastly, a question has recently arisen which we have not discussed before. Just within the past two weeks or so I have been asked if I would be willing to serve as a consultant to a few organizations, NASA included, from time to time. Of course, I do want to do this. There is nothing firm at this time, but by way of ball park estimate my best guess is that this would occur no more than six or eight times a year at maximum. I can't see that this would pose a problem for you and will assume that it doesn't unless I hear from you to the contrary.

Assuming that my understanding of all I have outlined above is correct, I do indeed intend to make good by handshake and accept your offer of the Medical Directorship. Since this is really a letter to you, you may wish me to write an uncomplicated letter of acceptance for the record. If so, or if I have erred, please let me know and I will be happy to respond accordingly, this time without delay.

With all best wishes.

Sincerely yours,

S. P. Vinograd, M.D.
Director, Medical Sciences

Please send mail to my home: 6529 Sothoron Road, McLean, Virginia 22101. I did extend for two weeks but my final date here at NASA will be May 4, 1979.

St. Marys Hospital Medical Center

707 South Mills Street
Madison, Wisconsin 53715
Telephone (608) 251-6100

A Hospital of the Sisters of Saint Mary

May 9, 1979

Sherman P. Vinograd, M.D.
6529 Sothoron Road
McLean, VA 22101

Dear Dr. Vinograd:

I received your letter of May 1, 1979. Sherman, it very accurately portrays our conversations and the contents are quite acceptable to me as you have worded them. I do think for the record's purpose it would be desirable to have a brief letter of acceptance from you alluding to our previous discussions and correspondence, but not necessarily itemizing anything. This letter can then be more freely distributed.

Regarding the question of serving as a consultant to a few organizations from time to time, this is not only acceptable, but I think desirable. We have always encouraged administrative persons to be as involved as possible in things that are professionally stimulating to them as long as this does not interfere with their performance of their primary function at the hospital. The way you have described such activity, I do not envision it in any way presenting a problem.

We look forward with enthusiasm to your joining us on July 2, 1979. I am starting to firm up the details of your first four to six months and will forward information on this to you sometime in the coming few weeks.

All of us here at St. Marys are awaiting with anticipation your joining our administrative team. You are coming during exciting and challenging times and, based on our conversations over the last few months, I think you will be quite taken with some of the programmatic things that are getting off the ground at this time.

If, for some reason, you would like to visit once more before July 2, feel free to contact my office for arrangements. Otherwise, we look forward to seeing you in July.

Best wishes always.

Sincerely,

Sister Rebecca, S.S.M.
Chief Executive Officer

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707 South Mills Street
Madison, WI 53715-0450
608 251 6100

St. Marys
Hospital Medical Center
Madison, WI

November 28, 1984

John Aure Buesseler, M.D., M.S. (Business Administration)
Senior Consultant
Health Organization Management Systems International (HOMSI)
3313 23rd Street
Lubbock, Texas 79410

Dear Dr. Buesseler:

As Medical Director, now Emeritus, of this institution I recently had occasion to review our activities toward the development of an HMO of our own. As I am sure you will recall, your group, specifically you and Dr. Deshler, were involved as consultants from the very beginning of our deliberations on the subject in February and March of 1983. I am writing you at this time simply because I do not recall whether or not I have ever given you a follow-up account of the accuracy of your predictions and recommendations in light of what actually transpired since then.

First, let me say that there were some compelling reasons, of which we were unable to make you aware at the time, why we were unable to develop an independent HMO of our own. Despite that fact, however, and despite the fact that the plan you helped so much to develop never went beyond the conceptual stage, it was sufficiently complete and detailed that we were able to use significant elements of it to suit our purposes.

The course of action which we finally took, and which you could not possibly have predicted, was to support the development of a rural conglomerate which is now successfully established as the HMO of Wisconsin. As it has turned out, both it and the DeanCare HMO now provide us with most of our HMO patients. We do, in addition, draw a fair number of OB patients from Group Health. Just to complete this rundown, the other surviving HMO's in this area are the Jackson Clinic HMO and three HMO's run by CompCare (Milwaukee Blue Cross and Blue Shield). One of these is University's UCare, another is the Quisling Clinic CompCare program and the third is the Madison Physicians' HMO, a group of Madison General Hospital physicians. Of these, UCare takes its patients to the University Hospitals and the Jackson Clinic HMO hospitalizes its patients at both Methodist Hospital and Madison General Hospital. The remainder, including Group Health, utilize Madison General Hospital primarily.

I feel we are doing very well in this suddenly competitive milieu; DeanCare has blossomed into one of the largest in the area. It has maintained its very high quality and at a low price. As for HMO of Wisconsin, it is growing nicely and provides the widest geographic coverage.

I want to thank you most sincerely, Dr. Buesseler, for the splendid work which you did as a consultant on our behalf during that very early exploratory period on our part. Your work was most thorough and exceptionally farsighted. Now that HMO experience has been snowballing nationally over the past couple of years, articles now being published on the subject appear to be concurring more and more with your original recommendations as being the most efficient kind of HMO operation.

Again, many thanks for your very professional assistance.

Sincerely yours,

S.P. Vinograd, M.D.
Medical Director, Emeritus

kr

Dr. Sherman Vinograd

St. Mary's names medical director

Dr. Sherman P. Vinograd, director of biomedical research for the National Aeronautics and Space Administration, has been named medical director of St. Mary's Hospital Medical Center.

His appointment is effective July 1. He replaces Dr. George Hank, who retired in January.

A native of Milwaukee, Vinograd is a graduate of the University of Wisconsin Medical School and practiced internal medicine in Madison at an office at 1901 Monroe St. before joining the space program in 1961.

In addition to his work with the space program, Vinograd has been a visiting lecturer at the Harvard University Medical School and at the Massachusetts Institute of Technology.

WSJ
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MEMO

From
SISTER REBECCA, S.S.M.

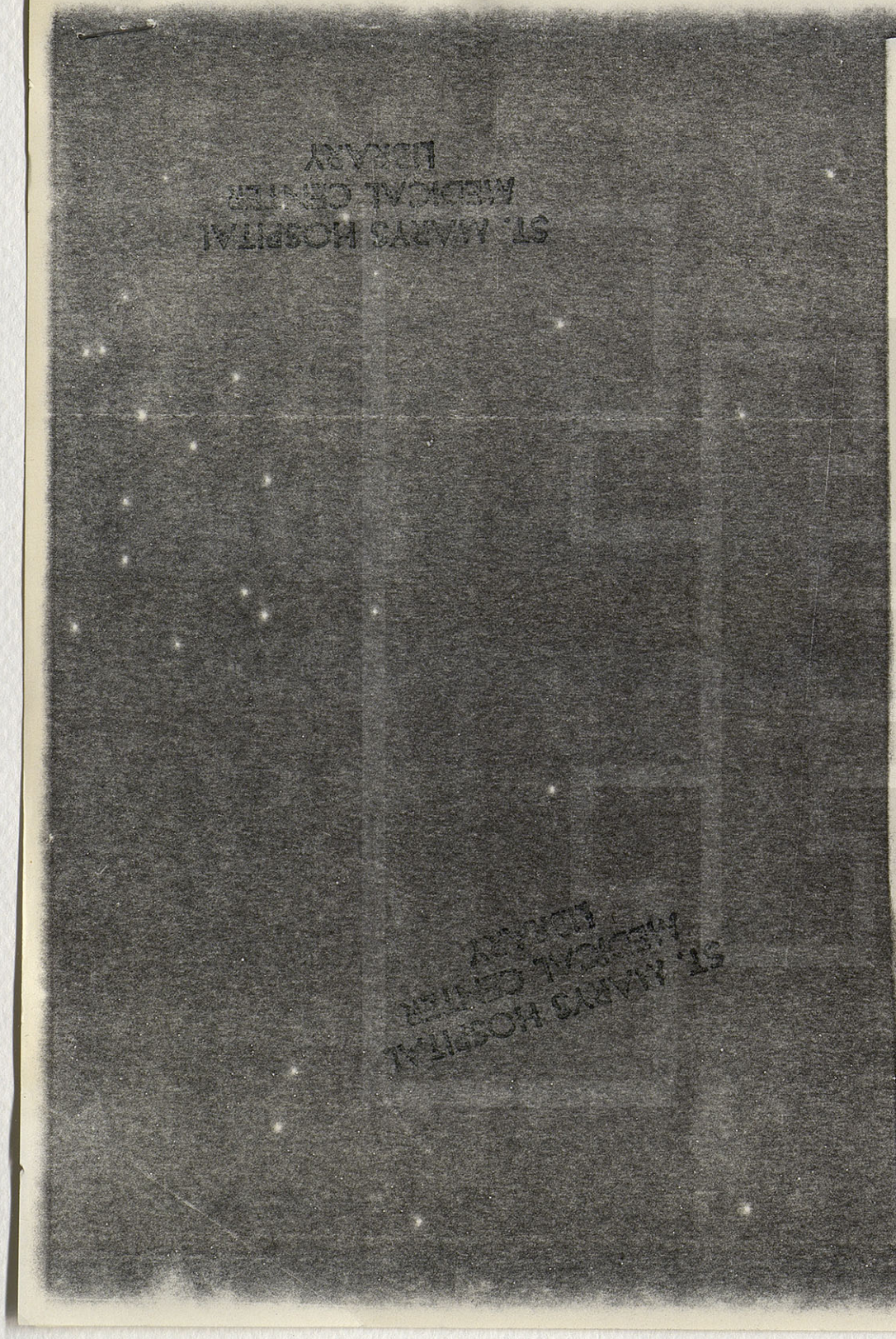
Date: 3-3-79

To: Sherman Vinograd, M.D.

These are a few articles; more to come —

SR

ST. MARYS HOSPITAL
MEDICAL CENTER
MADISON, WISCONSIN



Medical staff evolution: collegial friendship to collective accountability

Summary—The last 10 to 15 years represent a period of transition for medical staffs. The era of professional liability led to new demands for formal mechanisms of accountability, a much more defined organizational structure, and new medico-administrative careers. The medical staff's bylaws, rules, and regulations also increased in importance and complexity, as physicians had to incorporate provisions for due process and carefully select words.

THE COMPLEX PRESSURES exerted on hospitals eventually are felt by medical staffs. Medicare and Medicaid, Professional Standards Review, and the malpractice crisis are a few of the events that have sent ripples through the hospital organizational structure. New waves are either just beginning to be felt—Health Systems Agencies—or are gaining in momentum—cost containment. What many believe will be the tidal wave—National Health Insurance—hasn't started to roll yet. The upshot is that medical staffs and hospitals have been through some rough times and have more to come.

As the problems became too complex to separate into two neat piles, administrators and governing boards turned to medical staffs for help, and the importance of knowledgeable, involved physician leadership to an institution's well-being jumped. For several years the American Medical Association has sponsored medical staff leadership seminars to help physicians effectively participate in a rapidly changing hospital environment. The most recent seminar, held in New York City this summer, examined some of the basics of medical staff organization as well as some future trends.

In the last 10 to 15 years, "the whole medical staff scene has shifted dramatically," according to William Fifer, M.D. "In the old days, physicians did not have much collective responsibility. The medical staff was a collegial, pleasant body," and the election of the president of the medical staff was a friendly, respectful "game of musical chairs." Then came the *Darling* case, and physicians and hospitals entered the era of professional liability.

'In the old days, physicians did not have much collective responsibility. The medical staff was a collegial, pleasant body'

The hospital's heightened awareness of liability touched off a new interest in medical staff organization. Hospital governing boards felt helpless, Dr. Fifer said, and asked the medical staff to set standards for review and evaluation of care. The word "accountability" became very popular, and as a result, this "collegial" group found itself with a great deal of collective responsibility and a much more defined organizational structure, he said.

The emphasis on formal accountability for quality of care also led to a demand for more physician leadership, Dr. Fifer said. "We know that physicians cannot go on walking into the hospital and casually carrying out activities on an ad hoc basis. The medical staff must have enough continuity to be consistent in terms of policy and application of quality assurance methodology year after year." To achieve that continuity, Dr. Fifer said, many hospitals have decided that the medical staff's job has become too complex and time consuming to expect the president of the medical staff or its officers to do it on a voluntary basis, and new medico-administrative positions under various titles—medical director, director of medical education, chief of staff, vice-president for medical affairs—have evolved.

Medico-administrative jobs are "hot seats," said Dr. Fifer. However, these new careers are becoming more commonplace, and "some physicians must obtain the management, leadership, and administrative skills necessary to sit in that hot seat and accept these medical staff leadership positions."

Dr. Fifer had some advice for either the physician contemplating seeking such a job or the medical staff that has been asked to advise the governing board about creating and filling a medico-administrative position. He said the person and position will be more effective and better accepted if the successful candidate meets the following criteria:

Medico-administrative jobs are 'hotseats,' but some physicians must 'obtain the management, leadership, and administrative skills necessary to sit in that hot seat'

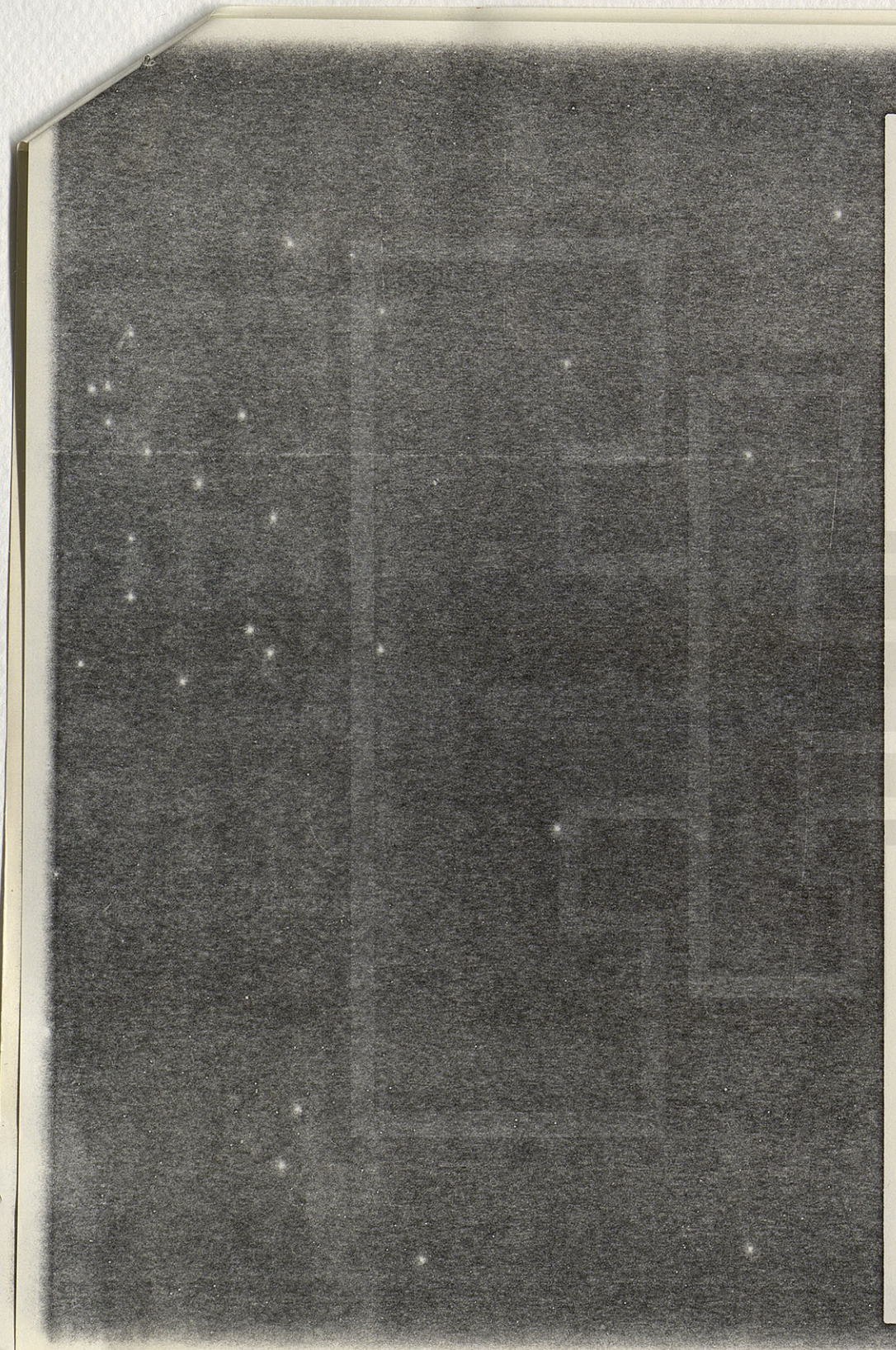
- He should be someone who would be eligible for medical staff membership.
- He should have peer acceptance and should be able to maintain it by continuing to see patients and take an active part in clinical matters.
- He should have demonstrated management skills.
- His job should be defined in both the medical staff and hospital bylaws, including provisions for due process.
- He should be selected by a search committee with representatives from the medical staff, administration, and governing board.

Medical staff organization is, of course, embodied in the medical staff's bylaws, and the bylaws, rules, and regulations have not been isolated from the changes taking place within hospitals. The task of writing and updating bylaws to accommodate accreditation requirements and to provide a just, self-governing framework for physicians has also been complicated by professional liability and accountability.

The dominant purpose of bylaws is to define the mechanism through which the medical staff fulfills its responsibilities of setting proper standards of medical care and ethical practice. To that end, William Isele, staff attorney for the AMA's Department of Health Law, views the provisions for denying and revoking staff privileges, particularly as they concern due process, as the most important part of writing bylaws. He suggests that medical staffs incorporate the following measures as basic due process procedures: 1. Bring specific charges prior to the physician's hearing. 2. Give written notice of when and where the physician can respond to the charges at a reasonable interval prior to the hearing. 3. Grant access to all relevant hospital and medical records. 4. Provide an opportunity to be heard by a decision-making body with authority that is spelled out in the bylaws. 5. Don't pull any surprises: the physician has a right to a decision based on the material that he has seen and had an opportunity to respond to. 6. Grant some form of right of appeal within the hospital structure, either the medical executive committee or the governing board.

The concept of a fair hearing is so important to due process, said Isele, that any provision in the bylaws that is tantamount to summary dismissal or suspension from the medical staff without a hearing negates whatever other carefully written procedures that exist. This applies in even the most extreme cases, he said: "If the guy is dangerous, get him out of the hospital but provide him with a fair hearing as soon as possible."

Bylaws also should specify



some channel of regular communication between the governing body and the medical staff. In addition to the existing mechanisms of physician membership on governing boards, joint conference committees, and joint meetings of the medical executive committee and the governing board, Isele suggested providing for trustee representation at medical staff meetings as a method of educating trustees about the problems and concerns of the medical staff.

Due process is not the only legal hurdle encountered by medical staffs while writing bylaws. Some physicians, in their zeal to comply with accreditation standards, may "paint the medical staff into a 'legal corner,'" according to James E. George, M.D., J.D. He warned against promulgating impossibly high standards of quality or assigning to individuals responsibility that cannot be discharged. A bylaw that makes the department chairman responsible for the quality of care rendered in his department is an example of such a lofty but impossible provision, he said. A much more effective and sensible approach, he suggested, is to diffuse the responsibility for quality of care throughout all elements of the medical staff committee structure so that "everyone feels that they must function as part of the team." Dr. George carefully specified that he was not suggesting that medical staffs dilute the effectiveness of their bylaws, but he was urging physicians to be sensitive to the words selected and the responsibilities assigned.

Some physicians, in their zeal to comply with accreditation standards, may 'paint the medical staff into a legal corner'

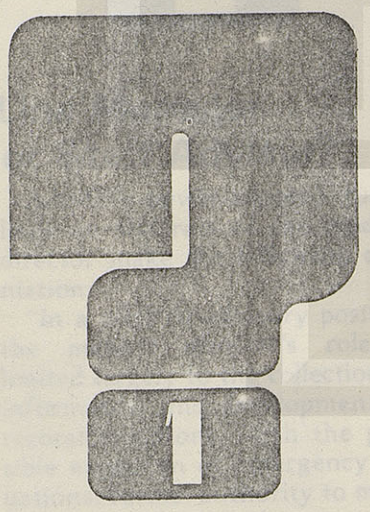
Although the Joint Commission on Accreditation of Hospitals is a major influence on the medical staff's functions and bylaws, many physicians know very little about the Joint Commission as a working organization, said George W. Graham, M.D., Vice-President for External Affairs, JCAH. Physicians may be misled because the word "hospitals" is part of the Joint Commission's name, he said in stressing that the JCAH is a medically oriented and dominated body. For example, 13 of the 20 JCAH commissioners—the body that adopts JCAH standards—are physicians, selected from physician organizations (the American Medical Association, the American College of Surgeons, and the American College of Physicians).

The JCAH is a strong proponent of a self-governing medical staff, Dr. Graham said, as evidenced by the Joint Commission's medical staff standards. His advice for medical staffs was direct: "You will never be able to cope with the hospital bureaucracy unless you strengthen your own organization and develop a good set of bylaws."

Sr. REBECCA
Sherman, this is quite basic;
Sr. Mary has passed this point long ago

The Four Toughest Questions New Medical Directors Ask

No wonder why so many "new" medical directors approach the position with fear and trepidation. Being part of a new profession with a quickly expanding role means sailing through uncharted waters. But the journey need no longer be alone, thanks to the emergence of the American Academy of Medical Directors.* In this article, medical directors and educators who have leading roles in the young Academy map some landmark answers to the four questions asked most often by newcomers.



Who Am I?

When Harry C. Stamey, M.D. became Medical Director of the Geisinger Medical Center, Danville, Pa., he soon noticed that "people began to look at me in a different fashion."

Wondering if he might be "a bit oversensitive," Dr. Stamey discussed the phenomenon with other medical directors and found it to be universal.

As he puts it: "It's as if people suddenly now think of you as one of 'them.' To your former colleagues on the medical staff, you are an administrator and therefore highly suspect. The administrative staff, who prior to this didn't think much about you one way or another, now begins to see you as one of the chief physicians who will probably be a major impediment to what they want to accomplish."[1]

Dr. Stamey has a sympathetic ear in Irwin Rubin, Ph. D. "The stresses and strains of becoming and staying a medical director are many, for one is truly a stranger in a strange land," writes the Harvard University business school professor. "By describing the sources and consequences of the most typical of these stresses/strains, we hope to mitigate somewhat the sense that 'I'm probably the only one who feels this way.' "

Adds Dr. Rubin: "Many of the stresses/strains felt by a medical director can be seen to stem from the consequences of this condition...'I used to be one of them.' "[2]

The main reason why the medical director feels so alone and so uncomfortable is that he/she is on the cutting edge of what AAMD Executive Director Roger S. Schenke calls "a new profession."

As Schenke told the Academy's second annual meeting last May, "The world has become so complex that we need people who are 'connectors'—people who are mediating, negotiating, adjudicating, compromising between parts or camps that view each other as being different, foreign, troublesome.

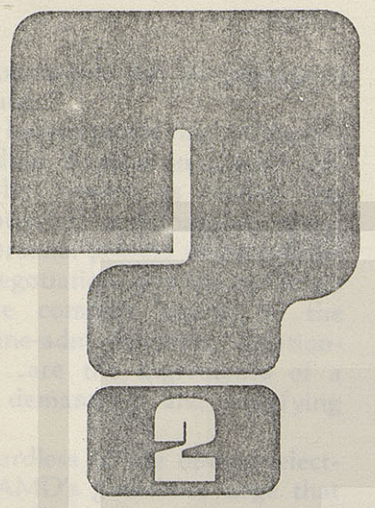
"One of the real dilemmas of being in this role," he added, "is that the two systems, or camps, are often operating under two different value systems and that these value systems are often in conflict. For example, management may be concerned about the integrity and financial condition of the organization. A legitimate value? Sure. Physicians may be concerned with patient welfare. A legitimate value? Of course. But what happens when patient welfare cuts across organizational welfare? Two legitimate values in conflict."

Being in the middle, said Schenke, is aggravated by the "identity crisis" of trying to learn management skills at a time when one's physician colleagues are saying, "We don't know what you are but you're really not like us anymore."

The reason why medical directors ask the question: "Who Am I?" continued Schenke, is that "The medical director—the connector—is a new profession." He termed it "A new but necessary profession, mandated by technology and specialization, and struggling to clarify its role, its territory, and its function."

Given the great demand for medical directors and increase in their job responsibilities, he said, "the uncertainties we face are eclipsed by the excitement of the challenges and rewards that lie ahead."

The Academy was founded in 1974 with financial and staff assistance of the American Group Practice Foundation. Open to medical directors of all health facilities, the Academy has grown to more than 330 members. It operates a professional placement service, publishes the bimonthly Medical Director, *and conducts a broad range of educational programs. Details about the Academy's activities may be obtained by writing AAMD, 20 S. Quaker Lane, Alexandria, Va. 22314.*



Line Manager or Staff Advisor?

AAMD's newly-adopted guidelines on the role of the medical director make the following deliniation:

"In a staff or advisory position the medical director's role is limited largely to the collection of information and development of recommendations. With the possible exception of emergency situations, formal authority to make decisions affecting the organization is limited.

"In a line or managerial role the medical director becomes an implementor of policies established by the governing body. He or she will have been given the responsibility and formal authority to carry out board policy and make decisions affecting the day-to-day operations of the organization within the limits established by the governing body. However, formal authority should not be confused with management style..."

Determining which form of medical directorship is superior may be impossible—and is at least impractical—at this early evolutionary juncture. The fact is that medical groups today employ both methods with success. The key decision is finding which form fits each group's particular structure and management lifestyle.

One succinct advocacy for the line manager method comes from Joseph L. Marcarelli, M.D., Chief Executive Officer of Health Maintenance Associates, Phoenix, Ariz. He writes that: "The fact that an organization obtains or is searching for a medical director implies that the medical staff is performing poorly or below expectations. It further implies that those in positions of authority (chief of staff, committee chairman, department heads, etc.) are either not exercising that authority or are not utilizing it to maximum advantage. A medical director appointed or elected in a staff (advisory) capacity leaves the authority where it was. This not only fails to correct the basic problem, but in fact can worsen it since, as usually happens, the responsibility is shifted to the medical director. A very difficult, if not impossible, situation is an end result with authority and responsibility divided."

Continues Dr. Marcarelli: "A medical director appointed or elected in a line or managerial capacity, theoretically at least, solves the problem since the medical director then has authority commensurate with his responsibilities. While theoretically the problem may be solved, from a practical viewpoint, serious pitfalls must be avoided. The pitfalls can be summarized in a word: acceptance. A medical director appointed or elected in a line capacity will win acceptance only if the staff is thoroughly and properly prepared for the implications of a line medical director and only if the individual is eminently qualified by credentials, experience and performance to earn the respect of his colleagues.

"Stated in another way: A line medical director must lead and not rule. A leader can succeed only if he has the respect of his colleagues. One earns and and does not command respect. A line medical director earns respect not only by his credentials and experience but by what he accomplishes and, as importantly, how he accomplishes it. Coordination, facilitation, arbitration, encouragement, reasoning, etc. are all techniques that a medical director (line or staff) can and does utilize, but these do not constitute authority and must not be confused as such."

Dr. Marcarelli adds one caveat: "My thesis has been presented in a simplistic, black or white, manner. The world of reality does allow for shades of gray. It may be necessary as an initial step to appoint or elect a medical director in a staff capacity and to evolve into a line posture as resistance lessens and acceptance increases. That is not to say, however, that an 'as is' situation (i.e., medical director in a staff capacity) shouldn't be changed to a 'should be' situation (i.e., medical director in a line capacity)."[3]

An articulate brief for the staff/advisor mode of management comes from C. Grant LaFarge, M.D., Director of Patient and Professional Services, The Children's Hospital Medical Center, Boston, Mass. From his perspective as part of a large medical center, he notes that when the various institutional departments are well-staffed and headed by "strong" physicians, the medical director "really doesn't direct." But Dr. LaFarge then asks:

"Does this undermine the power or authority of the medical director? I think not. The 'authority' of the role, to take decisions and to act within defined limits, is conferred by the governing boards —sometimes by the chief executive officer—to whom the medical director is accountable.

"The 'power' exerted by the medical director is 'a personal quality by which others can be caused to act.' This power is founded on the authority to monitor, to coordinate, and to participate in planning, and is expressed through articulate persuasion and negotiation.

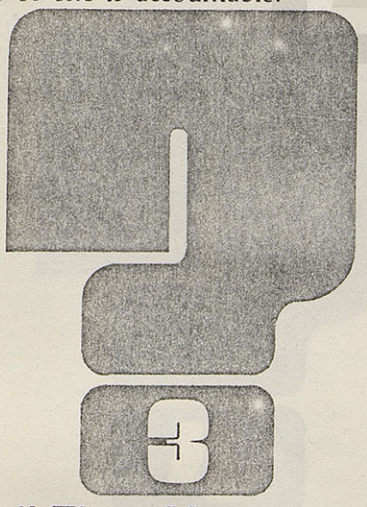
"Planning, monitoring and coordination are time-consuming occupations, and the medical director in this sort of staff role will spend very nearly full-time at it, with

(Continued on next page)

little or no time for the practice of medicine."

Dr. LaFarge adds that "Although a medical director in a staff role may be viewed as having less 'authority' in a managerial sense, the personal powers of persuasion and negotiation, and the challenge of the complex nature of the medicine-administration relationship....are the ingredients of a most demanding and satisfying role."[4]

Regardless of the option selected, AAMD's guidelines urge that the medical director's role be "documented clearly and agreed upon by other members of top management to avoid dysfunctional role conflicts or role ambiguity. The organizational relationship of the medical director and other key members of management," it adds, "should also be established clearly so that each understands to whom he or she is accountable."[5]



Full-Time Manager or Part-Time Clinician?

The most common arguments for straddling the clinical-administrative chasm are:

(a) "I don't expect to be medical director forever and can't afford to let my clinical skills get rusty;"

(b) "I must maintain my clinical reputation as the base of my administrative authority;"

(c) "Seeing patients keeps me in first-hand contact with the problems of my peers."

Theoretically and idealistically, none of the above are valid reasons for not taking the full plunge into medical management. As noted by Paul Torrens, M.D., M.P.H., Professor and Chairman of UCLA's Division of Health Services and Hospital Administration:

"First of all, a physician who is becoming a medical director for the first time must realize that he is entering a new and different profession, the profession of management. Not just a slightly different one—an entirely different one, with skills and traditions and training that are as a rigorous as his original discipline.

"Second, a physician who becomes a manager must realize that he must work to learn his new profession if he wants to be good at it. He cannot expect just to slide into it sideways and become a good manager simply by assuming a new title. That is not the way he gained his skill in his first profession. And if he wants similar skill in his second profession he has to work at it just as hard as he did before.

"Finally, if a physician assumes a manager's job and wants to succeed in it, he must have a firm commitment to management. He must have the will to manage and must be willing to make it a significant part of his life. He must see himself as a manager, not just as a physician—and probably most important of all, he must be willing to be keep learning his new profession."[6]

Having related the above, one must hasten to add that in reality, the great majority of medical directors in group practices *do* continue the part-time practice of medicine—and for very practical reasons. One of them is that the physicians over whom medical directors are given authority often don't behave the way most people do in organizational hierarchies. John Kralewski, Ph.D. notes that whereas organizational power is usually based on technical competency, groups or professionals "are highly dependent on the knowledge and creativity of individuals at the lower levels of the structure"—some whose activities "do not lend themselves to supervision."[7]

The above suggests that a reputation of clinical competency does indeed serve the medical director well at this point in time—justified or not.

There's nothing really wrong with the split role arrangement itself, says Harvard's Irwin Rubin. "The dilemma is one of being able to switch hats when needed and not confuse behaviors which are appropriate under two very different conditions."

Adds Dr. Rubin: "When you are seeing patients, you are not behaving as a manager. You are behaving like one of your subordinates. The daily work, in your role as medical director, is very different. In that role, your major responsibility is to manage the process by which and the environment *in* which your subordinates do their work, i.e. seeing patients and attending to patient problems."[8]

A similar view comes from Roger W. Perry, Jr., M.D., President of the Board of Directors and Medical Director of the Thomas-Davis Clinic, Tucson, Ariz. "Your firm commitment to management need not detract from the quality, and thus the professional satisfaction, of your medical practice but merely limit the *quantity* of your practice," he observes. "To assure this, you must provide adequate time for continuing education in both professions."

A look at the future indicates the training in management may be the better investment for anyone who expects to grow with his position. Dr. Kralewski, Director of the University of Colorado School of Medicine's Division of

(Continued on Page 16)

Health Administration, succinctly states why:

"Although it is undoubtedly desirable for the medical director to be a highly respected clinician," he writes, "these attributes unfortunately furnish a weak and unstable base for administrative authority. The renowned clinician may be respected by the professionals in his specialty area but will not enjoy this same respect from other specialties. He may in fact be suspected as being too biased to be effective."

Dr. Kralewski concludes that while clinical competency is important, "the physician-administrator must fill a power base and authority hierarchy based on administrative skills and knowledge. * * * A medical director skilled in administrative techniques will find that over time he will gain the respect of his colleagues."[9]

How Much Compensation? And in What Form?

The AAMD guidelines offer three general suggestions:

- "Compensation should reflect and be commensurate with that of other positions of top management.
- "Compensation should be within a specified percentile of all physician earnings.
- "In no event, or with rare exception, should a physician be financially penalized for assuming the position of medical director."[10]

Statistics on compensation of full-time medical directors are still sketchy. One of the very few known indicators is a survey taken by the AAMD at its first convention in May 1976. Of 33 full-time medical directors who returned a questionnaire, slightly more than half earned over $61,000 a year.

More specifically, two earned from $30,000 to $35,000, one from $36,000 to $40,000, two from $41,000 to $45,000, three from $46,000 to $50,000, eight to $51,000 to $60,000, and 14 from $61,000 to $75,000. Three reported over $75,000.[11]

Shattuck W. Hartwell, Jr., M.D. offers some additional thoughts on the delicate task of compensating the *part-time* medical director. "Physicians have 'billing power' that varies according to specialty," notes the Cleveland (Ohio) Clinic's Vice Chairman for Professional Affairs. "To recognize administrative skill and qualities of leadership required of the part-time medical director is to ask what billing power does he give up in being a part-time medical specialist. This must be considered in setting salaries for the job."

Continues Dr. Hartwell: "The job is not a piece of cake: a part-time commitment, the pressures and challenges, can mean a full-time preoccupation. The job bears a tremendously absorbing responsibility, and that, of course, should be part of the 'value' just as 'lost billings' are a part of the 'value.' "

Dr. Hartwell indicates that money is not the only form of needed compensation. He deems it important, for example, to accompany the man or woman with an "Office of the Medical Director."

"A medical director," he states, "will recognize the support his office can provide in the complex process of coordinating and assisting the surveillance of patient care, staff organization, professional standards, and institutional planning. The office should be visible, accessible, and adequately staffed to assist both the professional and administrative staffs."

But what about that first question: How much for part-timers? Sorry, says Dr. Hartwell. "Only you can answer" that one.[12]

The above comments and excerpts were compiled by GROUP PRACTICE Editor James D. Snyder, who also serves as Managing Editor of THE MEDICAL DIRECTOR.

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8) See Footnote 2.

9.) See Footnote 7.

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12) Hartwell, Shattuck W., Jr., M.D. "Issues to Consider In Compensating the Part-Time Medical Director." *The Medical Director,* March/April 1977, p. 6. ■

Who is in charge of your medical staff?

The Role of the Medical Director

K. J. WILLIAMS, MD

Continuing demands for improved surveillance of medical practice in the hospital setting, recognition of hospital boards' broadening corporate responsibilities for the actions of their medical staff members, increasing public demands for accountability from hospitals—these and other forces are causing trustees, administrators, and physicians to analyze the traditional patterns of hospital medical staff organization and management.

The time-honored practice of a staff-elected, one-year-term, voluntary chief of staff's supervising vitally important medical care appraisal functions, enforcement of bylaws, disciplinary measures, continuing medical education, and other essential activities is begging questions today. Can such a chief of staff give the time and effort needed for proper medical staff management, be free from conflict of interest, and at the same time maintain a private practice while being economically dependent upon staff members for referral of patients? Is it fair to expect a physician to give time voluntarily to such a position? Can the filling of this key managerial position by the traditional, annual musical chairs method (and usually without the elected physician's having had any formal preparation or having had an appraisal of qualifications) assure trustees that the most qualified person is in charge of the medical staff? Is it reasonable to expect a medical staff organization to maintain stability and have continuity of effort for its activities under the traditional system, particularly given the increasing demands made on hospital staffs today?

Some institutions have been attempting to answer those and other questions by establishing the position of medical director. Such a position can be a valuable asset to an institution's board of trustees, chief executive officer (CEO), and medical staff. On the other hand, when all the managerial dimensions of the position and their implications are not first fully understood and explored by these parties, its establishment can lead to serious misunderstandings and open conflict among them—and instances of such conflict are increasing.

Definition and Purpose of the Medical Director

The medical director, within the context of this article, can be defined as the official appointed by the hospital's board of trustees to be in charge of all medical staff affairs; to be held responsible for the effective discharge of the medical staff organizational

13 Years Later—
Another Look at the Medical Director's Status

In the January 1965 issue of *Hospital Progress,* K. J. Williams, MD, then a medical director himself, described the emerging position of medical director in a general hospital. Now, 13 years later, Dr. Williams reassesses the status of the medical director and expands on the position's implications for hospitals at a time when numerous internal and external pressures are converging to force them to reexamine old patterns of organization and to look for improved patterns.

Today, more than ever, basic principles of organization and management must be applied to the hospital's medical staff in order to integrate their activities into the rest of the hospital organization. This objective can be facilitated by establishing the position of medical director with full responsibility for medical staff organization; but this strategy can succeed only if the position is perceived in the proper organizational light by all concerned and is developed as part of a total organizational commitment to high-quality patient care. Dr. Williams emphasizes that establishing this position requires strategic planning, proper selection of the person to occupy the position, a clear definition of responsibilities and authority, and full appreciation of the impact it will have on the total organization.

To assist in this process, Dr. Williams provides both valuable insights into the dynamics of such a position and guidelines for developing a position description. He describes the all-important relationships that must be developed between the medical director and the board of trustees, the chief executive officer, the medical staff officers, and the general medical staff.

Dr. Williams concludes with a preventive approach to problems that may arise when the position is established and stresses the importance of consistently applying basic management principles to medical staff organization.

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functions, as set forth in the medical staff bylaws; and to implement policies promulgated by the board concerning the medical staff.

By establishing the position of medical director, the board makes clear throughout the entire organization that the medical director is responsible for medical staff activity and is accountable to the CEO and the board for managing and supervising all medical staff functions.

The medical director is a full-time, salaried physician who previously may or may not have been a member of the medical staff. This position includes the title of director of medical affairs, chief of professional services, or—in keeping with the current shift to corporate titles—vice-president for medical affairs. The medical director is, in effect, a full-time chief of staff. It should be noted, however, that when the position of medical director is introduced, the traditional voluntary, part-time chief-of-staff position disappears. (There cannot be two "bosses.") The medical director is not to be confused with the director of medical education, who is usually concerned only with the supervision of house staff training programs or educational programs for the medical staff and not with the more sensitive matters of evaluating clinical performance and enforcing hospital policies. The director of medical education should be accountable to the medical director; and in many hospitals the position of director of medical education is dissolved when the medical director position is established.

The medical director position is basically administrative. The medical director is a key member of the institution's administrative team, which is under the direction of the CEO. It is essential that the medical director have a reputation as a capable practitioner, but contrary to popular opinion, clinical skills need not be the strongest point. The medical director has much greater need for managerial and organizational skills; and if the skills are applied properly, the medical director will then have access to clinical counsel and guidance to a far greater extent than anyone could ever expect to possess independently.

Position Alters Traditional Relationships

Certain traditional relationships are definitely changed when this position is established. These changed relationships must be discussed, understood, and accepted by all concerned prior to the appointment of the new medical director. It is dangerous to assume that through the good will and fellowship of all concerned, the relationships will define themselves with the passage of time. To take that approach is tantamount to avoiding some important but sensitive issues.

In anticipating these changed relationships, it is essential to clarify terms. I have used the term "CEO" throughout this article to indicate the board's chief operating officer. That person may have one of several titles: administrator, president, executive director, or executive vice-president. The terms "chief of staff" and "president of the staff" are currently used interchangeably in hospitals, with many hospitals using the term "president of the staff" to indicate the physician who is supposed to be in charge of the medical staff. In this article when I am referring to the traditional organization, in which there is no medical director, I will use the term "chief of staff/president" for the physician in charge.

Chief of staff/president relationship. Because the medical director is a salaried, full-time chief of staff/president, the authority, responsibility, and power of the chief of staff/president transfers to the medical director; and the former position ceases to exist. One can conceptualize the changeover thusly—regardless of labels, there is a job to be done, namely, managing the medical staff organization; and there has simply been a transition from a voluntary, part-time manager, i.e., chief of staff/president, to a full-time, salaried manager, i.e., medical director.

With the demise of the chief of staff/president, members of the medical staff will surely ask who now represents or speaks for them? The answer is, A representative who, in most places, is titled "president of the staff." It is essential, however, to understand that this elected president does not hold a position synonymous with that of the former chief of staff/president. Where a medical director position exists, the president of the staff lacks formal authority but has considerable influence, similar to that of a shop steward. Only the medical director, however, is in charge of medical affairs and has the responsibility for seeing that medical staff quality-control functions are carried out.

Understandably, when such a medical director is employed, the altered relationships for a president frequently are quite disturbing to medical staff members, who do not always happily agree to surrender their traditional pattern of annually electing their own

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"boss," so to speak. They become particularly sensitive when they discover that the CEO—fearful of raising the ire and opposition of the staff—convinced them to approve the appointment of a medical director on the assumption that they would continue to have a president and that both persons would be in charge, only to find out later that such is really not the case. Such a tactic by management borders on deception and is to be condemned. This sensitive relationship with the president must first be discussed thoroughly with the key staff officials. Staff comprehension of the board's awesome corporate responsibility, staff participation in the selection of the medical director, the careful written definition of responsibilities and authority, the existence of checks and balances, the participation in a performance evaluation mechanism by key staff members and the CEO—these are some of the considerations that, when carefully conveyed to understanding staff leaders, can remove much of the distrust and suspicion about this changed relationship. If a CEO is unable or unwilling to establish such a dialogue, then the institution is not ready for a medical director.

Bearing in mind that the former chief of staff/president position is now filled by the full-time medical director, where does the elected president, the spokesman of the staff, fit in? As well as being an ex officio member of all committees, the elected president should serve as an active member of the executive and joint conference committees and should chair the quarterly/monthly staff meetings. This gives the elected president the opportunity to carry out the major function of that position, i.e., to serve as a representative of the electorate. As with any representative elected to a government body, the president must cooperate with those in authority and must recognize an obligation to report back on and gain support for policies recommended by the medical staff executive committee.

Executive committee relationships. Because the executive committee is one of the most important committees in the hospital organization and because the medical director is in charge of the institution's medical affairs, it follows that the medical director must chair this key advisory group. The extent to which relationships between the chairman and the executive committee might change will depend upon the role the executive committee has—and has had—in the institution. Because of organizational instability due to continued annual rotation of staff officials, it is not at all uncommon to find executive committees that over the years have assumed responsibilities that have, in effect, made the committee the "person in charge" of the staff. Understandably, this dimension of executive committee function must be considered when its relationships with the medical director are examined.

General staff relationships. Although the medical director has an obligation to see that the medical staff is kept abreast of medical staff problems and programs and to inform them on such matters at staff meetings, the medical director's relationships with the staff are not on a one-to-one basis. Rather, they are through the chairmen of clinical departments and committees who are accountable to the medical director. It is important to note that whereas the medical director's predecessor, the chief of staff/president, was answerable to the general staff who elected him each year, the medical director is not answerable to the general staff members. Nor can they remove the medical director. The medical director must serve at times as the conscience of the medical staff and may therefore have to stand alone. If the medical director were accountable to the medical staff members and subject to removal by them, his function could be greatly impaired. The medical director, like any good manager, should be *responsive* to the medical staff, yes—but *responsible* to the CEO.

Clinging to the erroneous assumption that a medical staff must be a model of democracy often results in the medical staff's exercising such authority as electing chairmen of clinical departments and the various committees. As relationships between the medical director and the general staff are defined, the previous role and influence of the staff in these and similar matters must be reappraised. The medical director—the person who is to be held responsible for the effective discharge of the functions of the medical staff organization—must have major influence in choosing the key operational officials in that organization.

CEO relationships. The medical director is a member of the corporation's administrative team and, as such, reports directly to the institution's CEO, who holds the medical director accountable. This is a sensitive matter and one that can trigger emotional reactions from the medical staff. It is sensitive because of a long-cherished belief that the medical staff is literally self-governing and reports to whom it wants. That is often interpreted to mean no one, or to mean directly to the full board of trustees, but never to a "lay administrator"! That the institution has failed to address the matter says something about the degree of sophistication of its governing authority and about how well the concept of corporate responsibility is understood and accepted. Regardless of whether a medical director or the annually elected chief of staff/president is in charge of the medical staff, the legal relationships of that medical staff to the total hospital corporation remain the same. The medical staff organization is not a separate entity, distinct from the rest of the corporation. It is legally "part and parcel" of the total organization and,

as such, must be accountable to the institution's overall management structure. Until this is understood and accepted, the likelihood of a board's exacting accountability in a meaningful manner from its medical staff is not great. Certainly, if an institution is to maximize the effectiveness of its medical director, this matter has to be addressed and resolved before someone is engaged for the position.

Board of trustee relationship. As a rule, the medical director relates to the board of trustees through the institution's CEO. This may entail the medical director's attending board meetings also to report on responsibilities and to serve as a resource person to the board on medical affairs. The medical director also relates to the board through serving on board-appointed committees.

Some contend that the medical director should be a full board member and that to deny board membership narrows the conduit for communications to the board and sets the stage for distortion of the reporting on medical matters. Such contentions ignore the existence of commonly used communications mechanisms between staff and board, such as the joint conference committee, a medical policy committee of the board, the president and members of the medical staff's being appointed to the board, trustees' attending executive committee meetings, and accepted channels of good organization.

> "To establish a medical director means having to come to grips with the obsolescence of tradition that is evident in many medical staffs—not always an easy task."

The Medical Director's Responsibilities

The medical director's position description should spell out duties and responsibilities in sufficient detail, but should not be expected to identify every single task. The description, however, should not be so brief that the responsibilities must be inferred. It is not uncommon that a position description omits certain major responsibilities because they are regarded as sensitive matters and displeasing to the medical staff but still implies—and the medical director is expected to assume—that the position entails those responsibilities and that eventually the medical director will convince the staff of this. Such an approach invariably leads to tension, conflict, and mistrust. The scope of a medical director's responsibility is covered in this list:

1. *To assure that appropriate systems—essential for the ongoing review, analysis, and evaluation of physicians' performance in all clinical departments and divisions—are established and maintained on a continuing basis.* This has specific reference to medical audit and to clinical surveillance. The medical director does not carry out such surveillance per se, but causes it to be done by directing and guiding clinical department chairmen and committees.

2. *To keep informed of the activities and findings of all medical staff surveillance programs and to promptly direct the necessary corrective educative measures.* This includes patterns involving a particular department or the whole staff and individual patterns of practice.

3. *To keep the administrator and the board informed of such findings and to report the necessary recommendations for action through the appropriate channels whenever the findings so require.* This reflects the medical director's very important role of expediter. Most medical staffs know where incompetency problems lie, and they don't usually have trouble identifying those problems for themselves. But as a rule they have great trouble getting them out of committee, i.e., recommending corrective action. Hence, problems concerning professional obsolescence are often allowed to become chronic before any corrective action is taken. The responsibility for reporting on these sensitive matters must be pinpointed on the medical director. This must be clearly understood by all concerned, and professional loyalties must not be allowed to interfere.

4. *To monitor and assure medical staff compliance with corporate bylaws, medical staff bylaws, rules and regulations, hospital policies, and local, state, and federal regulations.* It is necessary to spell out clearly that the medical director, not the president of the staff, has this responsibility.

5. *To keep the CEO, the president of the staff, and the executive committee of the medical staff informed of all infractions and violations of hospital policies, patient safeguards, medical staff bylaws, and rules and regulations for which corrective action is considered necessary now or in the future; and at the same time to submit to the executive committee a plan for correction.*

6. *To assure that the necessary criteria and professional standards regarding applications for appointments to the staff are established and strictly adhered to.* It is imperative that this responsibility be pinpointed on the medical director, thus helping to avoid the common failure to scrutinize references or to delineate privileges.

7. *To assure that a procedure for supervision of all new appointees for a stated period of time is established and kept viable and that routine reports are*

made at stated intervals to the executive committee and to appropriate committees of the board.

8. *To assure that a formal system for reappointment of members to the medical staff is established in accordance with predetermined criteria and that the recommendations for each reappointment consider the individual's past clinical performance and compliance with hospital policies.* Items 6, 7, and 8 frequently are not properly carried out in many hospitals simply because they are time-consuming and because the constant changing of officials and committees, with little or no continuity of effort, makes it difficult to establish a viable system.

9. *To make certain that all members of the medical staff are afforded all the necessary steps of due process whenever, for any reason, their clinical performance is open to question; whenever disciplinary procedures are contemplated; or whenever their clinical privileges may be reduced, rescinded, revoked, or temporarily suspended.* This is not to imply that the medical director has the authority to remove privileges. Such matters are pursued through channels defined in the medical staff bylaws. It is recognition of the fact, however, that medical staffs, when they take corrective action, often do not afford a confrere the procedural due process that the medical staff bylaws provide. Assuring that this process is always afforded is a safeguard for the individual member, and it can also protect the hospital from needlessly inviting litigation from an aggrieved physician alleging deprivation of constitutional rights.

10. *To establish and maintain formal programs of continuing medical education.*

11. *To direct and guide chairmen of clinical departments and committees in setting and attaining objectives for the continuing improvement of the quality of medical care.*

12. *To discharge whatever other responsibilities and duties may be assigned by the institution's CEO.*

The Medical Director's Authority

Medical staff bylaws usually do not acknowledge the authority of the chief of staff/president or of a medical director. Very often bylaws and position descriptions do not even mention the word "authority." Physicians often conceptualize authority only in negative terms, rather than appreciating how authority can be used positively to further the staff's objectives. The elected chief of staff/president is able to tolerate the frustration of undefined authority because the office is usually for only one year. It is imperative, however, that the medical director's authority be defined at the outset and be made known to the members of the staff. The position description should state the source of the medical director's authority and should contain these key points:

1. *The authority of the medical director derives from the board of trustees through the CEO.*

2. *The medical director shall have the authority to enforce medical staff bylaws, rules, and regulations; and such authority shall be exercised through existing medical staff channels called for by the bylaws of the medical staff.* This statement, albeit somewhat vague, is meant to imply that the medical director initiates disciplinary or corrective measures at the executive committee level and not arbitrarily. It is necessary to include statements for those members of the staff who are disbelievers and who contend that the staff gives authority to the medical director.

3. *The medical director shall have the authority to investigate, or cause to be investigated, the clinical performance or the personal conduct within the hospital of any member of the medical staff whose performance or conduct is not considered to be in the best interest of the patients or the institution; and to submit findings and recommendations to the CEO and to the executive committee of the medical staff.* Inherent in that statement is the medical director's obligation to initiate necessary inquiries or to instruct the respective clinical department chiefs to do so.

4. *The medical director shall have the authority to immediately and temporarily suspend any member of the medical staff when the professional or personal conduct of the member jeopardizes, or is likely to jeopardize, the safety of a patient or constitutes a willful disregard of medical staff bylaws, rules and regulations, or hospital policies.* When such action is initiated, the medical director must immediately assure the aggrieved physician of procedural due process that is available. Similar authority for immediate and temporary suspension should also be made available to clinical department chairmen, but with the proviso that it be invoked only after a conference with the medical director or the director's designate. Inasmuch as immediate and temporary suspension of a member invariably has its supporters and opponents and hence poses the threat of some degree of trauma to the institution, it is well to consider requiring the medical director to confer with the CEO before initiating such action.

5. *The medical director shall have the authority to appoint chairmen and members of all medical staff committees.* If the medical director is to be held responsible for the effective functioning (or for the dysfunctioning) of the medical staff, it follows that that person must have the authority to appoint those individuals who are to carry out the major work of the medical staff organization.

In this same vein is the question of whether the medical director should select or appoint clinical de-

partment chairmen because they are key lieutenants. In my opinion, the selection and appointment of such officials should not be the sole prerogative of the medical director. The medical director must, however, be allowed to participate fully in the selection process.

6. *The medical director shall have the authority to guide, direct, and counsel the chairmen of clinical departments, and such persons shall answer directly to the medical director.* For many hospitals this would be a major departure from traditional patterns where department chairmen are not accountable to the chief of staff/president but are answerable only to the executive committee of the medical staff. Such arrangements beg the question as to whether such department chairmen are, in effect, accountable to anyone. This must be resolved before the medical director is engaged so that all concerned understand the medical director's authority.

7. *The medical director shall have access to all general medical staff meetings and to all medical staff committees and shall chair the executive committee.*

The major points of the foregoing should—as well as being included in the medical staff bylaws and in the medical director's position description—be included in the institution's corporate bylaws. Whether the chief of staff/president or the medical director is being discussed, authority over the medical staff should be clearly defined in the corporate bylaws. It has not been usual practice for hospitals to do this; and in the absence of such a statement, the question of who is really in charge of the medical staff remains unanswered.

The Medical Director's Accountability

To whom, when, and on what subjects—these are the three key dimensions of the medical director's accountability that should be spelled out. Here, as in indicating responsibilities, detail is not needed; the intent should be to provide guidelines and to remove much of the past uncertainty with respect to the chief of staff/president's reporting on medical affairs to the administration and the board. This should also assure the medical staff that a mechanism exists for reviewing and evaluating the performance of the medical director, as it does for physicians, and as it should for everyone, including the CEO. In defining the accountability channels for the medical director, the following should be included:

1. *The medical director shall be accountable to the hospital's CEO and through the CEO to the board of trustees.*

2. *The medical director shall report all infractions of medical staff bylaws, rules and regulations, hospital policies, and established professional standards to the CEO and keep the CEO informed of all corrective steps being taken.* The degree of detail has to be worked out in this area between the medical director and the CEO; but it must be the latter who determines exactly what is to be reported and in what detail. One of the main points to get across here is that such incidents are not simply medical matters that fall only within the purview of physicians and the medical staff—rather they are legitimate concerns of the governing authority; and feeding them into the management system is part of the accountability process.

> "Where a medical director position exists, the president of the staff lacks formal authority but has considerable influence, similar to that of a shop steward."

3. *The medical director shall report monthly to the board of trustees on all matters pertinent to the discharging of the functions of the medical staff organization.* This statement is intentionally broad. The relationships of the CEO vis-à-vis the medical director dictate that the medical director establish with the CEO a format for written reports. Such reporting should include status reports of routine functions and of special programs underway and should indicate progress toward specific objectives within their specific time frames. The emphasis must be on informing the board as to the results and effectiveness of surveillance systems designed to assure that standards are being maintained at the generally accepted levels. Without this the board of trustees cannot be assured that the trustees themselves are properly discharging their corporate responsibility.

Depending on the organization and function of the board of trustees, the medical director's presence at board meetings may be more as a resource person than as a reporter of staff functions. If there is an effective, small subcommittee of trustees, i.e., a medical policy committee of the board, it will be examining, with the CEO and the medical director, all the details of staff functions, meeting of objectives, and disciplinary problems. Such a committee would report directly to the board. The detail with which it would report to the full board would depend on the amount of authority delegated to it. Thus, the organization and functions of the board will determine the extent to which it is necessary

for the medical director to actively report to the full board.

4. *The medical director shall report at the regular meetings of the medical staff's executive committee and at the meetings of the general medical staff on all matters pertaining to medical care appraisal programs —on the findings, on the educative programs designed to correct any deficiencies, and on the results of these programs.* It should not be inferred that because of the requirement to "report" to both the general staff and the executive committee of the medical staff the medical director is thus accountable to the staff. That is not so. As noted earlier, the medical director is accountable and responsible to the CEO; but like any good manager, he or she must also be responsive to those being lead and to that end must keep them informed.

5. *An annual evaluation of the medical director's performance shall be carried out by a committee appointed by the CEO.* Such a committee should consist of the CEO, two trustees, and two members of the medical staff. It is essential that prior to any attempt at evaluation, the CEO establish criteria by which the medical director's performance can be appraised in terms of responsibilities and attainment of objectives. The CEO should make known to the medical director the evaluation findings and recommendations and should report them to the board of trustees. The findings should be treated confidentially within the committee.

Avoiding Some Preventable Problems

When the various dimensions of the medical director position are not sufficiently probed and the implications of establishing it are not noted or understood by all concerned, considerable conflict between board and administration on the one hand and the medical staff on the other can result. With the intent of assisting both administrators and physicians to avoid such circumstances, I have listed a number of commonly encountered situations that lead to unnecessary misunderstanding and conflict.

Taking the easy way. Many CEOs, stimulated by the ever increasing demands for public accountability and the increasing regulatory measures being imposed with special reference to the medical profession, are realizing that they can no longer divorce themselves from the management and organizational aspects of quality-control programs for medical care in the hospital setting. CEOs quickly realize that their medical staffs, organized in the traditional manner with little or no provisions for exacting or rendering accountability, are not equipped to carry out meaningful quality-control programs and that responsibility for running the medical staff really has not been pinpointed. CEOs often conclude that a medical director is the solution to the question of who is in charge of the medical staff. Such CEOs delude themselves into thinking that all they have to do is to appoint a medical director, and things medical will be taken care of automatically.

To accomplish this, that CEO may have to indulge in deluding the medical staff into thinking the medical director will also be the answer to its problems. This situation does not necessarily have to result in conflict and revolt. If the CEO, as seems to happen often, sits back and has little to do with the medical director, and if the medical director is content to be left entirely on his own and doesn't rock the boat, then nothing usually happens—at least not until someone asks what the medical director does to justify his salary. On the other hand, the medical director who is not complacent may very well soon conclude that the CEO's lack of interest is equivalent to nonsupport. Failing to secure the CEO's support, the medical director may very well identify solely with the medical staff and lay the groundwork for a campaign of deprecation that will lead to a bitter struggle between the CEO and the medical director; and that will usually result in the CEO's dismissal—not an altogether uncommon result. This type of situation usually gets started in the first place because of a weak or less than competent CEO or because the CEO failed to clearly spell out relationships and responsibilities at the outset.

Misunderstanding the medical director's purpose. The CEO and the chief of staff/president, without any intent to delude one another, sometimes have completely different interpretations of the purpose of the medical director. The CEO and the board may regard the medical director as the person in charge of all medical affairs. The physicians, on the other hand, while acknowledging the medical director in that role in their discussions with the CEO, may regard the position only as that of an assistant to the chief of staff/president, the function of which is simply to relieve that chief of staff/president of paper work. And they may not view the position as having any responsibility or authority. It is absolutely fundamental to discuss, dissect, and commit to writing the medical director's purpose so that all principals concerned understand, accept, and commit themselves to the common purpose for which the position is being established.

Ignoring management functions. It is amazing how the basic administrative functions of planning, organizing, directing, and controlling, which are applied to other activities in the hospital, are put aside when it comes to medical staff management. Coupled with this neglect is a similar reluctance to specify such key

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dimensions of management as responsibility, authority, and accountability. One wonders if the CEO's tendency to sidestep such fundamentals of management is due to naiveté or simply to reluctance to raise questions that might possibly incur the displeasure of some medical staff members. Failure to specify and assign such responsibilities inevitably leads to misunderstanding, disagreement, and distrust, if not to open conflict.

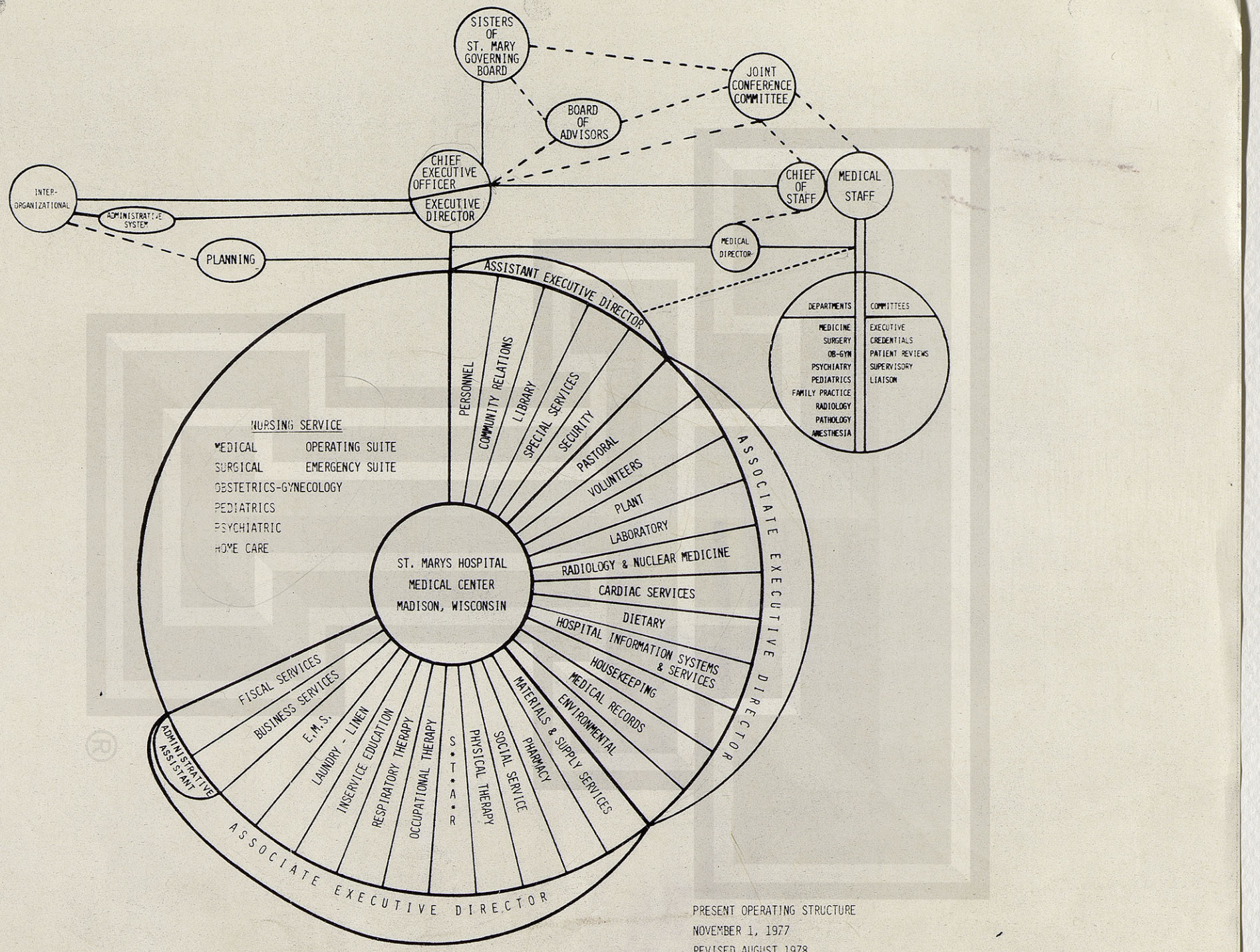
Purposely ignoring specific managerial parameters. The CEO—cognizant of the need for a position description and for having all the sensitive issues, such as responsibility and authority, defined—may decide that it would be better for the institution and all concerned if certain phrases like "in charge of medical affairs," "be held accountable for carrying out medical staff functions," and "be responsible for enforcing bylaws" were replaced with such vague phrases as "shall work closely with staff leaders," "shall assist staff officials to maintain good organization," "shall coordinate and act as liaison with staff officials." That same CEO may also decide it is not necessary, or even desirable, to point out that the medical director will replace the chief of staff/president. Rather, this CEO decides that that will be worked out with the cooperation of the chief of staff/president as the year progresses. Such tactics may be rationalized as smart administration—getting the doctors sold on it, getting the person aboard, and letting the situation work itself out. This borders on deception and invariably does not work. It almost always leads to acrimony, conflict, and downright crisis.

Ignoring bylaw revisions. The advent of a medical director dictates that certain changes in organization, in the medical staff bylaws, and in the corporate bylaws must be made to accommodate the position. The changes should be carefully worked through and incorporated into the bylaws prior to the medical director's assuming the position. Failing to do this and assuming instead that it will be done in the following year under the medical director's guidance is a common pitfall to avoid. It is not uncommon in that first year for a medical director to incur some opposition from colleagues after deciding to clean up the perennial problem of medical records or after surfacing some incompetency problems and making the staff face up to them. That opposition often evidences itself when the medical director attempts to effect changes in bylaws, and the CEO can forestall this by determining the proper organizational base at the outset.

Ignoring scope of changes. The position of medical director creates a number of organizational changes, and certain institutional trauma may well result. The degree of planning, preparation, mutual trust, and understanding among the board, medical staff, and CEO will determine the extent of any internal disruption that occurs. First and foremost, it must be realized that some or all of the following changes are inevitable:

- The time-honored system of annual election of the person in charge of medical affairs is now passé;
- The traditional person in charge of the medical staff is no longer elected annually by the medical staff;
- The new person in charge of the medical staff, i.e., the medical director, cannot be replaced at year's end just because the staff dislikes actions taken;
- The new person in charge of the medical staff is not beholden to it;
- There is now someone—a pretty permanent fixture—who is looking at (and causing to be looked at) patterns of practice on an ongoing basis, something that most staffs have not experienced before;
- The elected president under the new setup is not chairman of the executive committee;
- Inevitably, the new medical director who has effective systems will be surfacing problems and challenging the privileges of certain staff members. Such long-standing, entrenched problems are not usually handled without some strain on the organization.
- The medical director will soon challenge such outmoded procedures as the annual election of clinical department chairmen and members of the medical executive committee.

In short, establishing this position on a basis that will assure success and that will convince all concerned that it was a worthwhile move demands careful identification and examination of such changes well before any decision to make such a move. In effect, to establish a medical director means having to come to grips with the obsolescence of tradition that is evident in many medical staffs—not always an easy task. ★



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National Aeronautics and
Space Administration

Washington, D.C.
20546

Reply to Attn of: SBR-3

Mr. Steve Barney
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Madison, Wisconsin 53715

Dear Steve,

I did manage to get back to Washington that stormy weekend despite the airborn glaciers dumped on the midwest. It was quite a saga. I was unable to get any info on the status of my 2 o'clock flight from the hotel because the Northwest switch board was jammed with calls. I checked out and went to the airport, anyway, only to find that my flight had been cancelled. Having no other choices, I put myself on stand by for a 4 o'clock flight from Madison to New York. Much later I learned it had also been cancelled. Fortunately, while wating I ran into two gemutlich Madisonians who asked if I would be interested in sharing a rental car with them to drive to Milwaukee and catch a 6:30PM plane for Washington. It turned out that we could be ticketed for it in Madison before we left, the roads were clear and the Milwaukee airport was expected to be opened at 5:30PM. Fortune smiled. The automobile ride was pleasant, the company was good and after only a few more relatively modest delays, the three of us arrived in the comparative autumn of Washington a little after midnight that night (Sunday); and six eyeballs rolled silently toward heavan.

The next day and following two weeks were a paper nightmare snarled by frenetic crises - not too surprising, really, considering that I had been away since the Holidays as had most of the others in, affecting, or affected by the program. At any rate, now that roar has subsided to din I am at last able to write to you to thank you, and through you, Sister, Greg and your fine administrative staff for your considerate kindness and hospitality. That plus the pleasure of seeing George and so many of my old cohorts again precipitated the most fulminant case of perseverating de ja vu that I would ever flatly deny to Max Smith.

The growth of St. Marys was impressive to me, to say the least. Admittedly, my perspective is relatively unique, two data points separated by an interval of 18 years. After all, I missed the conceptualization, planning, and day to day long and probably often frustrating hours of hard work that a nucleus of inspired people must have put into it. Having missed the gestation period, in fact I think even the wedding, I am happily shocked at the result. But, more that that, the quality of the result, from standards of care to quality

of the medical staff, to administrative competence and methods, to functional relationships within and outside the community, all of this and a whole lot more seem to me to have achieved an eye opening level of excellence. I find this warmly reassuring on several counts, not the least of which are a general uneasiness about the humanity as well as quality of medical care around the country, and a sort of old grad feeling about St. Marys. Moreover, it is evident that the drive to improve even further continues, and with Viking determination at that.

As you no doubt know, Greg called me last week and as a result I will be there again on February 9, weather permitting. It was good to meet all of you and I look forward to seeing you then. My expenses for the last trip are attached. In closing, I would like to thank you, personally, for all that you did to make my visit so pleasant and informative.

With best personal regards,

S. P. Vinograd, M.D.
Director, Medical Sciences

EXPENSES

AIR FARE (round trip)	$176.00
1-11-79 Home to Wash Nat'l airport (family car)	-
1-11-79 Madison Airport to Edgewater (friends)	-
Edgewater Hotel 1-11 - 1-14-79	Paid (shared between SMH and self)
Additional expenses in Madison	None (More friends)
1-14-79 Cab to Madison Airport	$ 5.00
1-14-79 Rental car (shared) to Milwaukee	- (air fare refund will probably compensate)
1-14-79 Cab, Wash. Nat'l airport to home	$ 12.00
	$193.00

National Aeronautics and
Space Administration

Washington, D.C.
20546

Reply to Attn of: SBR-3

Mr. Steve Barney
St. Marys Hospital Medical Center
707 South Mills Street
Madison, Wisconsin 53715

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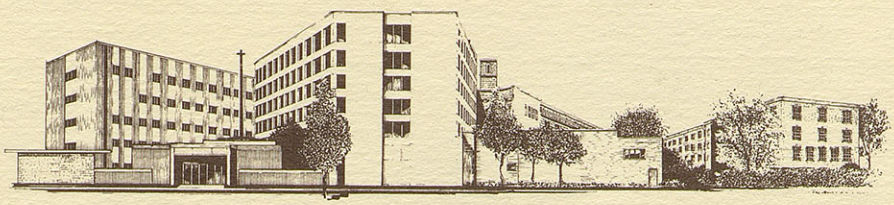
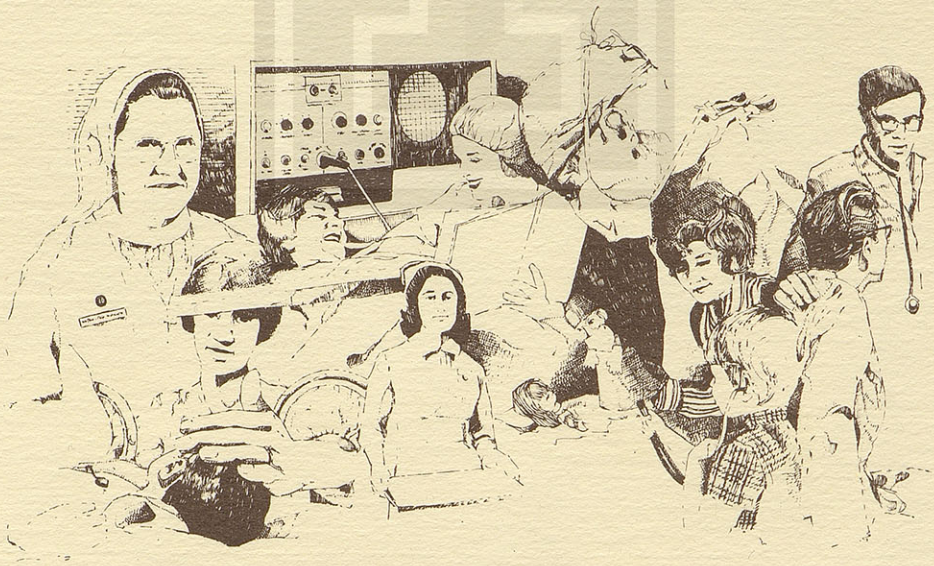


St. Marys Hospital Medical Center

Madison, Wisconsin

Patient Handbook



INTRODUCTION

When you enter St. Marys Hospital Medical Center as a patient, you can be assured that the duties of everyone here are directed toward you as an individual. St. Marys constantly strives to provide a complete range of modern health services designed to provide the best possible care available on a personalized basis for you. This has been our objective since the Sisters of St. Mary opened this hospital in 1912.

Since then the hospital has grown, and our services have become more sophisticated and specialized. Our personnel represent a broad range of skills and professional ability. The tradition of caring, however, remains. Patients are assured of quality comprehensive medical care; approvals are granted St. Marys Hospital Medical Center by numerous accrediting groups. The Joint Commission on Accreditation of Hospitals has certified our programs and facilities continually since the beginning of such accreditation.

Affiliations include many with the University of Wisconsin Center for Health Sciences, Madison Area Technical College, and St. Louis University. St. Marys is a member of the Catholic Hospital Association, American Hospital Association, and Wisconsin Hospital Association.

St. Marys Hospital Medical Center

707 South Mills Street
Madison, Wisconsin 53715
Telephone (608) 251-6100

A Hospital of the Sisters of Saint Mary

PATIENTS RIGHTS AND RESPONSIBILITIES RE-AFFIRMATION STATEMENT

PREAMBLE

Since the inception of St. Marys Hospital Medical Center, the staff has embraced the mission of providing quality health care in an environment where people care about people. We believe that:

---every human being is created by God for an eternal destiny;

---every human being, of any race, creed, color, sex, nationality or economic status, has been endowed by the Creator with certain natural rights;

---these natural rights impose corresponding obligations;

---every human being has the right to life;

---the dignity of each person warrants a response from the hospital in terms of excellence in the provision of care.

These beliefs have certain translations into everyday meaning for persons who use the health care system. St. Marys has compiled a list and brief description of rights which people have in relation to their health care. The rights itemized are innate to the person. St. Marys is not giving these listed rights to people, rather we are identifying, clarifying and reaffirming them.

These beliefs also have certain translations into patient responsibility. These responsibilities which are logical outgrowths of innate rights are also listed.

Healing involves the coordination and cooperation of many caring specialities. You, the patient, are an important and essential part of the team working to provide you with the best care. Therefore, it is important that you be aware of your rights and responsibilities which this statement partially describes in some detail. The statements herein pertain providing that the individual is not incompetent to make a rational judgement.

MEDICAL RECORDS

The Medical Record is a documentation of your hospitalization; it is the property of the hospital. Should you wish to know about the contents of your record or desire a copy of your record, it is preferred that you ask your physician, or a member of the nursing staff who will notify your physician, to assist you with the interpretation of the technical language contained therein.

CONTINUITY OF CARE

You are entitled to continuity of care from the physicians who are responsible for your medical needs. This includes the plan of care rendered within the hospital as well as planning for your care after discharge.

EMERGENCY CARE

Emergency care is available through St. Marys Hospital Medical Center and the Medical Staff and you have the right to expect quality care rendered in a manner appropriate to your condition.

POINTS TO BE EMPHASIZED IN PATIENT RESPONSIBILITIES:

Just as you have rights as a patient in your relationship to your attending physician, the hospital and other patients, you have responsibilities to your physician, the hospital and other patients.

1. You have the responsibilities of being direct and honest about information which relates to you as a patient. You have the obligation to supply accurate and complete medical history information to your physician and other health professionals.

2. You have the responsibility to follow recommendations of your physician. If, for any reason, you feel you cannot or should not follow these recommendations, you should discuss this with your physician or other member of the health care team.

3. You have the responsibility immediately to inform your physician or the nurse if you do not understand and/or cannot follow instructions or if you have other questions about your care.

4. You have the responsibility of being considerate of others by respecting your roommate's privacy in such things as his/her request for limiting visitors.

5. You have the responsibility to observe the safety regulations of the hospital of which you have been informed.

6. You have the responsibility to be considerate of and respect
   --your physician, nursing staff, other hospital personnel and other patients
   --the hospital's corporate obligations, policies, and moral and religious beliefs.

7. You have the responsibility to meet your financial obligations to the hospital. To assist in fulfilling this obligation the hospital business office personnel will work with you on payment arrangements.

THE PATIENT AS THE CENTER OF THE HEALTH CARE SYSTEM

The philosophy of St. Marys Hospital Medical Center encompasses the belief that the dignity of each person warrants a response from the hospital in terms of excellence in the provision of care.

If at any time during your hospitalization you have questions or concerns, please direct them to your physician or a member of the nursing staff. If your discussion with them does not appropriately address your concerns or questions, dial "0" for the hospital operator and ask for the general supervisor; or contact the Executive Director's office at 251-6100. Concerns relating to medical care will be referred to the Chief of Staff or designee; concerns relating to hospital care will be referred to the appropriate hospital administrator or designee.

REFUSING TREATMENT

You have the option, to the extent permitted by law, to refuse treatment and to be informed of the medical consequences of this action.

LEAVING THE HOSPITAL

You have the option, to the extent permitted by law, to leave the hospital against your physician's advice regardless of your condition. The hospital and your physician, however, are not responsible for any harm that may result.

You will be asked to sign a release form stating that you are leaving against the medical judgement of your physician.

CONSULTATION

Your physician may wish to consult another physician for his opinion about your care. You have the right to be informed of such consultations. You have the right to request your physician to seek the medical opinion of a consulting physician.

INFORMED CONSENT

Except where an emergency exists and to enable you to give an informed consent prior to the performance of any treatment or procedures, your physician has the responsibility to reasonably inform you of the significant risks of any proposed treatment or procedure, in view of your condition, the probabilities of success and any reasonably appropriate alternative treatment or procedures.

TEACHING

A hospital like ours, in addition to providing you with good medical care, nursing care, and related hospital services, helps with the education and training of a variety of health professionals.

House staff physicians enrolled in teaching programs work with your attending physician in your care. You have a right to have your attending physician introduce and explain to you the responsibilities of the house staff physicians cooperating with him in your care.

TEACHING (Con't)

St. Marys also cooperates with other institutions in educating and training nurses, technologists, technicians and clergy. These persons can be identified by their uniforms or their name tags.

Any questions regarding your relationship with learners at St. Marys should be directed to your physician or to a member of the nursing staff who will in turn contact the appropriate supervisor.

INNOVATIONS IN CARE

Innovations in care are carried out by qualified members of the medical staff and other qualified professionals. If your attending physician is considering an innovation as a part of your care he will inform you of its nature. You have the right to agree or disagree. The information shall include the purpose and methods of such procedures. If you agree your signed permission will be obtained ahead of time; if you disagree the innovation will be omitted.

DIGNITY, PRIVACY, CONFIDENTIALITY

You have a right to have your personal dignity respected at all times. You have the right to designate the manner in which you wish to be addressed.

You have the right to every consideration of privacy concerning your medical care. Case discussion, communications, records, consultation, examination, and treatment are confidential and you have the right to expect these to be handled accordingly. Learners may be invited to participate in your case. If you have some objections to any of these participants please, indicate this to your physician or to the nursing staff.

Visitation rules should be observed, however, arrangements can be made on the basis of special needs. If you do not desire visitors it is your right to request complete privacy.

CHARGES AND BILLS

You have the right to expect privacy and confidentiality in the discussion of financial arrangements.

Regardless of source of payment, a patient or the person responsible for paying the bill may examine and receive an itemized and detailed explanation of his/her total bill for services rendered in the hospital. Upon discharge the patient or responsible payor will receive a summary of the estimated bill. Once all charges have been recorded, the final bill will be sent and an itemized bill will be available upon request. Such request can be made by calling "Patients Accounts", 251-6100, extension 401 between 8:00 a.m. and 4:30 p.m. Monday through Friday.

PRE-ADMISSION (Things to Do)

Your admission to St. Marys has been arranged by your physician who is a member of our Medical Staff with "privileges" to practice here. Here are the steps to note as you prepare to arrive at St. Marys.

PRE-ADMISSION PHONE CALL

An admitting clerk will contact you a few days before your scheduled arrival. This call will obtain information and shorten the paper work on the day you arrive. If you do not receive a call, perhaps because time does not allow for this advance admission process, do not worry. The day you arrive, the admission process will be completed whether or not you receive the call.

CHECK LIST

Personal Articles. Items to bring with you should be limited: perhaps a few things like a bathrobe, night gown, and slippers. You will be provided with a hospitality kit that will meet most of your toilet article needs. However, you may wish to bring special toiletry items.

Electrical Appliances. If you bring along electrical appliances such as razors, hair dryers, or radios, the nursing staff will arrange for the Plant Department personnel to check the items for safety features before they are used.

Secure Your Valuables at Home. Please secure your valuables and large sums of money before coming to the hospital. The hospital cannot be responsible for lost or stolen property.

Medications. Prescription or non-prescription drugs should not be brought to the hospital. These might affect your treatment program. However, it would be helpful if you would list all medications that you have been taking and give the list to your nurse when you arrive at your nursing unit.

Bring Insurance Cards. Identification numbers, including Medicare and Medicaid documents, should be brought with you. These are important for the records that will be kept regarding your stay.

An important note: St. Marys accepts all patients without regard to race, color, creed, or ability to pay.