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Pleasant Valley Community Hospital

Milton C. Devolites¹

Pleasant Valley Community Hospital was established in 1965 by a group of middle-class merchants, business executives, and physicians. It was built in a rapidly expanding upper middle-class suburban area about 5 miles from a large city and separated from it by a large river. In 1965, the hospital service area included 92,000 persons from the city and 25,000 from its own suburb. By 1990, the population of the suburban sector increased to 106,000 and the urban sector to 102,000.

Demographic data on the urban population showed that considerable change had occurred in 25 years. Ninety-six percent of the people were nonwhite, 53% were foreign born. Only 29% of those over age 25 had completed high school. In contrast, the suburban population was 88% white and 12% nonwhite, with only 2% foreign born. The birth rate in the urban sector was 24/1,000 persons compared to 14/1,000 in the suburban sector. In 1965 there were fewer than 1,000 persons receiving public assistance, exclusive of aid to the aged. In 1990, approximately 75,000 persons in the urban sector were receiving public assistance, whereas in the suburban area the welfare rates increased from 0.1% in 1965 to 3% in 1990. In 1969, the state implemented the Medicaid program to serve the medically indigent and poor population.

The health department of the city operated the following facilities in the urban area served by the hospital: a general medical clinic, a children's dental clinic, and a small mental health clinic. None of the physicians employed by the city health department had hospital privileges at Pleasant Valley.

Crime, AIDS, and drug abuse are prevalent in the urban sector. The deterioration of the area is underscored by the lack of public transportation. The municipal transit

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system operates only during daylight hours. Taxi drivers are reluctant to enter the area after dark. The metropolitan police force is understaffed.

In 1990, the hospital had 418 operating beds, distributed as shown in Table 1. Bed occupancy frequently exceeded 100%, giving the board of trustees concern about hospital expansion. The medical staff included 256 physicians, distributed as shown in Table 2.

HOSPITAL OFFICIALS

The president of the medical staff was Dr. Mark Lerner, chief of surgery and a strong influence in the community for many years. His wife was president of the ladies' auxiliary and a member of the board of trustees. Lerner was admittedly seeking power. He had a personal vendetta against the chairman of the board and the hospital administrator and wanted to remove them from office. During 4 years as president of the medical staff, Lerner was able to pack the executive committee of the medical staff with 7 of 10 members who were clinical department chiefs in surgery. Thus, in effect, he had come to dominate the decisions of the executive committee.

The hospital administrator is Mr. Bender. He is 55 years old, a Fellow in the American College of Healthcare Executives, chairman of the Metropolitan Hospital Council, and a delegate to the congress of the American Hospital Association. Bender is of the "old school." He does not believe in organization charts and has only a draft of one in his desk. He claims he has four assistants to help him operate the hospital but has never assigned their duties in writing. Bender has been the administrator of the hospital since 1980.

The hospital corporation was organized to establish a treatment facility to meet existing and future needs of the community. Membership is met by payment of a nominal \$10 initiation fee and \$10 annual dues. The membership elects a board of trustees, serving 3-year staggered terms. The board includes 21 members and elects its own officers each year after an annual meeting. The officers serve a 1-year term. The bylaws contain no succession limitations. Trustees and officers may continue to serve as often as reelected.

The board of trustees is organized into various committees that meet monthly and submit their recommendations to the executive committee, which is the only one

Table 1. Types and number of beds

Type	Number
Medical/surgical	252
Pediatric	38
Gynecological	30
Obstetric	30
Intermediate care	28
Intensive care	10
Coronary care	8
Psychiatric	22

Table 2. Medical staff

Specialty	Number
Internal medicine	89
Surgery	87
General practice	14
Psychiatric	13
Pediatrics	11
Obstetrics/gynecology	9
Other	33

empowered to make decisions. The executive committee has eight members, and each one is a chairman of the other committees of the board or an officer of the corporation. With one exception, the committee is made up of persons who were part of the original community group that founded the corporation.

In addition to the reports from standing committees, the executive committee of the board receives monthly reports from the administrator, medical director, and president of the medical staff. The committee also approves all contracts for the hospital, including those for radiology and pathology.

Mr. Wright, age 60, has been board chairman for 10 years. He is a powerful and wealthy industrialist, socially adept and popular. Wright has wide influence in the greater metropolitan area.

The hospital has 1,400 full-time equivalent (FTE) employees: 676 in nursing, 120 in administrative services, 385 in support departments, and 219 in the professional ancillary services. Wages and benefits are considered good and above average in the metropolitan area. The employees are racially mixed at about 65% black, 5% Hispanic, and 30% white. Except for one assistant director of nursing and the director of security, there are no minority department supervisors and none in top management.

Recently, Local 1199 of the Health Services Workers Union began a campaign to organize the support service personnel. Many criticisms and complaints were directed against the administrator and his staff as well as against the board. The grievances related to poor environmental conditions in the laundry, supply, and plant operations; favoritism in promotions and day scheduling in nursing; crowded and poorly ventilated restrooms; crowded cafeteria; no fans in the dishwashing area; lack of security in the parking lots; and harsh treatment by some supervisors.

Bender asked the human resources director to prepare materials for employees to counter union criticism and keep the union out. The human resources director and his staff worked diligently for 3 weeks to prepare a series of meetings with all employees and top management. They organized employee "gripe" sessions at which employees of each shift could voice complaints. They produced fliers and mailings explaining the benefits available and comparing them to union promises. Bender was amazed. "Do you really expect me and very senior people to come to gripe sessions at 1 A.M. for the night shift?" he asked the human resources director. "You must be crazy. It will never work."

When the human resources director returned to his office, he found Mr. Burgess, the labor relations consultant hired by Bender to help fight the union. "Pleased to meet you," he said to the human resources director. "I've been reading your program materials and I admit that I couldn't have done them any better. I wonder why Bender retained me to assist you. You seem to be doing OK."

Early in 1990, minority group residents of the urban service area filed suit claiming representation on the hospital board in accordance with provisions of certain federal laws. The board negotiated a settlement and gave them one third of the board seats. This action so unnerved the medical staff that it filed a countersuit demanding an equal voice in policy decisions. In addition, it demanded the removal of the entire administrative staff, which it deemed grossly incompetent. The trustees again settled out of court by granting the physicians one fourth of the seats on the board. Moreover, they permitted the medical staff bylaws to be amended to provide that any act of the board that related to patient care would have to be first approved by the executive committee of the medical staff, or the entire medical staff if the issues were substantial. In return, the medical staff abandoned its countersuit and dropped its demands for removal of the administrative staff.

THE COMING OF A MEDICAL DIRECTOR

By late spring of 1990, the relationship between administrator and medical staff had deteriorated so completely that the president of the medical staff, Dr. Lerner, demanded that the board recruit and hire a qualified medical director to oversee the quality of care because "Mr. Bender is so grossly incompetent."

The board chairman, Mr. Wright, established a committee to study the feasibility of having a medical director and the organizational placement of the position. In April, just before the annual meeting and election of trustees, Lerner submitted a petition nominating himself as a trustee. He sent a letter to all voting members of the hospital corporation telling them of his qualifications to serve as a trustee and castigating the present board chairman and administrator as being in collusion to operate the hospital for their own benefit without regard for patient care or the needs of the physicians in delivering the "best care in America."

Lerner lost the election by nearly 300 out of 700 possible votes. This so infuriated Mrs. Lerner, a trustee of long standing, that she behaved belligerently at every executive committee meeting thereafter.

In the meantime, the search and organization committee of the board recommended that, if a medical director were hired, he or she should be made responsible to the administrator. The committee reported interviewing five physicians who, after learning about the medical staff situation, would have nothing to do with the job. In the dilemma, Lerner said he had found a Dr. Calvin Buford, who was just right for the job and who had experience and maturity to resolve all administrative problems of the institution. However, he would only accept the job if it paid \$175,000 and allowed him to report directly to the executive committee of the board—Lerner added, "with no

interference from a layman who knows nothing of medical practice or very much about administration."

The board of trustees defeated a motion introduced by Mrs. Lerner to meet these conditions and hire the physician her husband wanted. Ensuing discussion was led back to this point, however, by Dr. Lerner, who declared in pontifical terms that "if Dr. Calvin Buford were aboard as our medical director, you, ladies and gentlemen, would not be dealing with such petty problems. Dr. Buford is fully capable through experience, credentials, and professional status of making these problems disappear." Mr. Roberts, a trustee, moved to reconsider Dr. Buford's appointment. It was duly passed and approved.

FURTHER CONFLICT

Buford was very aggressive and in no time he was in conflict with Bender. Because both reported to the board, they each felt that they did not have to consult the other, even though their responsibilities overlapped.

Within the first month of the medical director's tenure, a problem arose between the chief of radiology and the chief of emergency services. The latter claimed that physicians in the emergency department were not qualified in radiology and therefore consultant services were needed at least 16 hours each day. The chief of radiology argued that such coverage was not necessary because his staff would read evening and night X-ray films on the following morning. The problem was referred to the medical director, who claimed he had no authority to act. The radiologist stated he would not abide by the decision in any event, so the matter was referred to the executive committee of the board. At the board meeting, Bender, who had signed the radiology and emergency department physician contracts, stated he had not been consulted by any of the parties involved and because of this he could not render a judgment about what should be done.

About the same time the board of trustees was presented with a request by a physician trustee to expand the intensive and coronary care units. He was asked why this matter had not come up through the administrator or the medical director. His response was: "We don't have time to wait for the bureaucrats of your institution to plan such eminently necessary changes in the configuration of the hospital." The board chairman then appointed an ad hoc committee of trustees to meet with the physicians and recommend a course of action the following month.

In June, the medical director demanded that the board reinforce his authority within the institution by putting the departments of nursing, admitting, and medical records under his control. In addition, he demanded control over scheduling of surgical cases and accused the chief anesthesiologist of "controlling the operating rooms to further his own interest, totally disregarding the needs of the patients and attending staff."

To support his claim, Buford introduced to the executive committee of the board three operating room (OR) nurses, including Ms. Angela Correlli, assistant supervisor. Correlli read a list of grievances to the committee, chief among them being a complaint

that the surgical reservation function created too much of a clinical problem in managing an efficient operating suite. The nurses also stated that control of scheduling by the anesthesiologist resulted in poor patient care and created undue hardship for the OR nursing staff. They demanded the assignment of this function to the medical director, and they further demanded the immediate termination of the present OR supervisor and appointment of Correlli as her replacement. The three nurses informed the board that they had no intention of starting the next day's or any subsequent day's elective schedules until their demands were met. Said Correlli: "I will order the rest of the OR nursing staff to walk out until the problem is solved." They later added they would provide support for emergency surgery.

One of the trustees asked the chairman of the board if it was proper for the executive committee to be considering this matter. He believed this was the responsibility of the administrator to resolve. Bender interjected that the first time he knew of any discontent in the OR staff was when Buford had brought it up at the meeting. He added: "It would seem that this is an appropriate matter for the personnel committee to resolve." Wright then referred the matter to the personnel committee of the board for consideration and recommendations.

The next week Wright began a series of weekly meetings with Bender and Buford in an effort to resolve the apparent conflicts that existed between them. However, he made little progress because of the divergent backgrounds and philosophies of the two men. Buford had been a lieutenant colonel in the U.S. Army Medical Corps and felt strongly that physicians should run hospitals.

About this time, in July, a prominent minority group leader presented the hospital with a list of demands to meet the health needs of the minority community. These demands were:

1. The hospital take immediate action to establish and staff a community health clinic to provide primary care on an appointment basis for all community members, regardless of ability to pay.
2. The hospital establish a sliding scale payment schedule that would provide care at no charge to families whose gross income was less than \$10,000. Families with income under \$15,000 would pay one half, those with incomes under \$20,000 would pay three fourths, and those whose income was over \$20,000 would pay full charges.
3. The hospital make it a mandatory condition of appointment that an attending staff physician must treat welfare and Medicaid beneficiaries.
4. The hospital establish a health education program for the community.
5. The hospital guarantee admission of urban patients ahead of suburban; that it never transfer urban patients to the central city hospital; and that it ensure that, at a minimum, 60% of the patients cared for be from the urban sector and no more than 40% from the suburbs.
6. The hospital recruit medical residents and attending medical staff who would represent the minority groups up to a level of 50% of the total physicians.

The spokesman further stated that, if the hospital did not comply within a reasonable time, the citizens would sue to have these demands met.

PROBLEMS OF EXPANSION

About this time, the architects and engineers who had been hired by the board at the insistence of the medical staff to develop construction plans submitted recommendations on space allocations and costs. The estimated space requirements were 1,000 square feet per bed for an additional 210 beds and 38,000 square feet for outpatient treatment facilities. On completion of the expansion, the hospital would have a total of 628 beds. In addition, the plans called for the construction of an expandable physician's building of 50,000 square feet and a 400-car parking garage.

The state health planning agency had indicated favorable consideration of the ambulatory care center but not additional beds. The argument advanced was that the metropolitan area had plenty of empty beds on one side and on the other a group of doctors was asking to build a new 200-bed hospital some 15 miles from the hospital but in the same county. The Pleasant Valley Community Hospital was planning to finance the new construction with a Farmers Home Administration (FHA) loan.

Mr. Martin, the controller, had recommended to the board that it engage a consultant to assist the hospital in developing long-range and master-site plans, as well as instruct the staff in using a proper planning process. In addition, he urged that both a program summary and an economic feasibility study be prepared before design of facilities was undertaken. He believed that two things had to be demonstrated to the health planning agency, the FHA, or other lenders: an urgent community need and an ability to repay a multi-million dollar loan. In his opinion, the hospital could demonstrate either very well, except for ambulatory services. The board was convinced of the soundness of Martin's recommendations and hired a consulting firm with a national reputation to conduct the studies.

The consulting firm completed its survey in early October. During the study, the consultants became concerned about the apparent lack of managerial direction and controls, particularly over the professional service departments. Their report concluded that, in order to make a multi-million dollar construction program even marginally feasible, operating costs would have to be controlled so that annual increases would not be more than 10%. The study further recommended that the hospital adopt a corporate organization structure with a strong chief executive officer who would be a voting member of the board, and with two senior vice presidents for operations and finance who would also be voting members of the board. The consultants recommended that all financial matters be vested in the chief financial officer and that this person report to no one other than the chief executive. They recommended also that a system of accountability be established in both the clinical and administrative departments.

On receipt of the consultant's report, Lerner called Wright and told him that, if anything was changed in the hospital, the executive committee of the medical staff would resign en masse and file immediate suit on restraint of practice and professional

judgment against the hospital. Furthermore, he said he would sue the chairman personally for nonfeasance in office and that the hospital must immediately commit itself to the full construction and expansion program the medical staff desires.

At this time the controller informed Bender that he had been offered a job by a large health care corporation to oversee the construction of a 300-bed hospital and 100-bed nursing home in another city and become the administrator. The challenges and opportunities appeared very good to him and he thought he should take the offer. Bender said, "You owe it to yourself. Of course, we do not wish to lose you, but if you must go, you must."

When Wright learned of Martin's new job offer, he telephoned him and said, "Andy, we do not want you to leave; tell us what you require to stay and let's see if we can meet it. You have done an outstanding job for us."

"Mr. Wright," replied Martin, "It's not money. You pay me well. It is the terrible frustration of committee management and the inability to do what you pay me for. Until that is removed there is nothing more I can do for you, nor you for me." Wright assured Martin that he would spend more time in management and that if Martin would stay, he would be allowed to perform his job.

Two days later Bender informed Wright that Martin had given formal notice of his intention to leave. The next day Wright had a secret meeting downtown with the director of the consulting team. The outcome a few days later was notice to Bender that his services were no longer required and that a search committee of the board would look for a replacement as soon as possible.