section two

THE BOARD OF GOVERNORS ERA

6. THE LEFEVRE YEARS
1955-1968

BY SHATTUCK HARTWELL

The physician must have at his command a certain ready wit,
as dourness is repulsive both to the healthy and the sick.
—Hippocrates, about 400 B.C.

INTO A NEW ERA

LITTLE DID THE GROUP OF PHYSICIANS WHO FIRST MET AS GOVERNORS IN December 1955 realize the magnitude of the responsibilities they would come to assume and the importance of the decisions they and future Boards of Governors would make. Nor, obviously, did LeFevre know that he would serve as chairman for the next 13 exciting and formative years. Following months of discussion and deliberation, the Planning Committee recommended, and the Board of Trustees approved, the policy that delegates responsibility for all professional matters to the Board of Governors.

Fay A. LeFevre, M.D., became the first chairman of the Board of Governors on December 7, 1955, just four months before his 51st birthday. A lifelong Clevelander and son of a physician, LeFevre was a graduate of Cleveland Heights High School, the University of Michigan, and the Western Reserve University School of Medicine. His postgraduate training included an internship at St. Luke's Hospital and further training in cardiovascular disease at The Cleveland Clinic. After a few years of private practice, he joined the Clinic's staff in 1942, and in 1947 he founded the Department of Peripheral Vascular

Fay A. LeFevre, M.D., Chairman, Board of Governors, 1955-1968

Disease, now the Section of Vascular Medicine. In addition to chairing that department for eight years, he served a four-year stint as the Clinic's Director of Education beginning in 1952. LeFevre's gentlemanly demeanor, impeccable integrity, and reputation as an outstanding physician made him the ideal choice for the chairmanship of the new board.

Besides LeFevre, the first Board of Governors consisted of W. James Gardner, M.D. (neurosurgeon), William J. Engel, M.D. (urologist), George Crile, Jr., M.D. (general surgeon), E. Perry McCullagh, M.D. (endocrinologist), A. Carlton Ernstene, M.D. (cardiologist), and Irvine H. Page, M.D. (research). It was their responsibility to plan and coordinate all professional activities. Among their most important duties were the appointment, promotion, and termination of members of the professional staff. With the growth of the institution, this became increasingly crucial and difficult. Members of the Board also reviewed criticisms and complaints concerning relationships with patients and initiated corrective measures. In addition, it was their responsibility to review and establish fees for professional services and to review at regular intervals the financial results of professional activities. As the Clinic expanded, planning and policy-making were tasks that took increasing amounts of time. The success of these efforts required the cooperation and collaboration of trustees and governors.

LeFevre had for many years served as a director of the Chesapeake and Ohio Railroad and was knowledgeable in business and finance. Although he was chairman of the Board of Governors, he wished to continue the part-time practice of medicine. He believed that by keeping in touch with his medical practice roots he would be in a better position to understand issues and problems associated with them. For some time LeFevre was able to do this, and he found it both satisfy-

ing and stimulating. “It was also a great protective mechanism for me,” he said. “When things got ‘too hot’ in the first floor administrative offices, Janet Getz would call me and say that my patients were ready on the third floor. This gave me an ideal opportunity to excuse myself. Likewise, when some patients became too long-winded, I could politely say that an urgent problem had occurred in the administrative office that would require my immediate attention. This best of two worlds did not last long, however, for it was necessary to spend more and more time in the administrative office.”

TRUSTEES AND GOVERNORS

In the early years, some of the trustees thought that the administration of medical affairs by the Board of Governors would not succeed. The responsibility for professional affairs had been delegated to a professional group, and business affairs were under the direction of a business manager. The weakness in this arrangement was that no one person or group had the final authority to make a major decision when professional and business issues were both involved.

Throughout this era, the trustees kept a tight rein on the management of the Clinic by placing their representatives in key authoritative roles—those of business manager and hospital administrator.

Board of Governors, 1956 (Left to right): Drs. W. James Gardner, E. Perry McCullagh, Walter J. Zeiter (Executive Secretary), Irvine H. Page, Fay A. LeFevre (Chairman), George Crile, Jr., A. Carlton Ernstene, William J. Engel

Nonetheless, the Board of Governors had plenty to do. There were pressures to provide new facilities, to expand existing services, and to subspecialize clinical practice to meet both the demands of patients and the opportunities of practice. These pressures led to the growth of the professional staff and ultimately to the need to acquire property and build new facilities. The impetus for these changes (growth and increasing numbers of patients) lay with the professional staff, but it was for the Board of Governors to interpret and present the needs of patients and staff so that the trustees could understand and respond.

Between 1956 and 1968, the trustees were ably led first by John Sherwin and then by George Karch. James A. Hughes became chairman in 1969 and, except for the period when Arthur S. Holden, Jr., served in that post (1973-1974), continued his leadership through 1984. The first members of the professional staff to serve on the Board of Trustees were Drs. W. James Gardner, Fay A. LeFevre, and Irvine H. Page, and since 1956, members of the staff have always been included in that body. This representation quickened the tempo of decision-making and the rudimentary planning process of that time, but decision making was still not easy. Investment in new property, buildings, and equipment led to increased amounts of work and therefore to increases in revenues, staff, and the total number of employees. The Board of Governors looked to the trustees for authorization of its plans and allocation of the money necessary to fund them. The money for all these expansion projects was in hand. There was no debt financing, and funds set aside from operational revenues were adequate for payment in full. Long-term financial obligations would not be incurred until a later era.

COMMITMENT AND GROWTH

Several construction projects undertaken during LeFevre's administration laid to rest a nagging issue for the Clinic, i.e., whether or not to abandon the inner-city location of the Clinic and move the entire operation into or even beyond the eastern suburbs of Cleveland. A bequest from Martha Holden Jennings financed the Education Building, and that was followed by additions to the Clinic and Hospital buildings and by the construction of a hotel (now called the P Building) to lodge out-of-town patients and their families.

Parking garages were built, and the trustees authorized the acquisition of real estate adjoining the Clinic to allow for future expansion. The die was cast: the Clinic would remain in the city.

The Board of Governors made a decision in December 1965 that was to have an impact far beyond what they imagined. This was the decision to close the obstetrical service, which then occupied the south wing of the hospital's sixth floor. Behind this move was a steadily mounting pressure for space and facilities for cardiac surgery. Something had to give, and a declining national birth rate and low obstetrics-unit occupancy eased the decision. The winner of the institutional support sweepstakes was the heart disease program.

Obstetrical services in American hospitals, as decreed by the Joint Commission on Accreditation of Hospitals, must be isolated from the rest of the hospital. Therefore, delivery rooms, newborn nurseries, and the rooms for mothers were separated from rooms for medical and surgical patients and the general operating rooms of The Cleveland Clinic. The Department of Thoracic and Cardiovascular Surgery moved their inpatient functions into this area, thereby consolidating the operating rooms, recovery room, intensive care unit, and convalescent wards into what would become the most productive and renowned department in the Division of Surgery.

During the LeFevre era, two sets of issues generated conflict in matters of governance and authority. Conflict was inevitable because Mr. Richard A. Gottron, the business manager of the Clinic, and Mr. James G. Harding, the administrator of the Hospital, reported to the Board of Trustees and not to the Board of Governors or its chairman. Sitting *ex officio* with the Board of Governors was helpful to Gottron and Harding in the exercise of their duties and provided them the opportunity to be sympathetic with the wishes and the ideas of the governors, but their sympathy could not have been expected to endure, and it didn't.

The main issue was institutional growth and its capital cost. The trustees were anxious that the ambitions of the staff might launch the institution on a breakneck pace of development in which the prudence of businesslike standards could easily be cast aside. Gottron nourished that fear, and his pessimism respecting the growth of the Foundation irreconcilably alienated him from the governors by the summer of 1968. Gottron was ill at this time, suffering from an unrecognized serious depression.

Aerial view of The Cleveland Clinic, 1968

The second and subtler issue had to do with management, authority, and control in what by then had become a large enterprise. By 1968, it had been nearly 13 years since the first meeting of the Board of Governors, and that body had successfully faced matters of policy, planning, and professional practice. Under LeFevre's leadership, the governors had worked together and had discovered that they represented the strength of the professional staff. Governance of the organization was beginning to take on a new meaning. The governors could not take the next step, however, without the willingness of the trustees to recognize them as a responsible body and to delegate the operations of the Clinic and the Hospital to them. Dialogue between trustees and governors in the summer of 1968 led to that next step. Mr. James H. Nichols replaced Gottron as business manager, and both he and Harding were directed to report to the chairman of the Board of Governors. When Nichols replaced him, Gottron received the job of president of the Bolton Square Hotel Company, a subsidiary operation of the Clinic. Not long thereafter he took his own life. LeFevre, who was ready to retire, would be succeeded by a chairman who was destined to function like a chief executive officer of a large corporation.

7. THE WASMUTH YEARS

1969-1976

BY SHATTUCK HARTWELL

More history's made by secret handshakes
than by battles, bills, and proclamations.
—John Barth, 1960

THE WINDS OF CHANGE

CARL E. WASMUTH, JR., M.D., LL.B., BECAME THE SECOND CHAIRMAN OF THE Board of Governors on January 2, 1969, about six weeks before his 50th birthday. A native of Pennsylvania, he had received his undergraduate and medical degrees from the University of Pittsburgh and interned at Western Pennsylvania Hospital (Pittsburgh) followed by nine years of private practice. He then completed a fellowship in anesthesiology at The Cleveland Clinic and joined the staff in 1951. Wasmuth obtained his LL.B. degree, on his own initiative and at his own expense, from the Cleveland-Marshall Law School in 1959 and taught there until 1974. He became chairman of the Department of Anesthesiology in 1967, a post he held until he was appointed chairman of the Board of Governors. He was elected president of the American Society of Anesthesiologists in 1968.

Wasmuth's chairmanship was the outgrowth of a struggle between the non-physician administration (led by Gottron), who wanted to constrain the organization's growth, and the medical staff, who wanted the Clinic to grow. Although he was never elected to the Board of Governors, Wasmuth was chosen to lead the staff because he

Carl E. Wasmuth, M.D., LL.B., Chairman, Board of Governors, 1969-1976

was viewed as the toughest proponent of the staff's viewpoint. His law degree lent credibility to this perception. In a secret meeting at Cleveland's Union Club, from which LeFevre was excluded, a small group of Clinic leaders made the decision to put the administrative functions of the organization, which had previously reported to the trustees, under the Board of Governors.

According to the recollections of Dr. Ralph Straffon and Dr. Thomas Meaney, those present at the meeting were Mr. James Hughes, Mr. John Sherwin, Mr. George E. Enos, Meaney, and Straffon. Gottron was removed as business manager and placed in charge of subsidiaries, as noted in the previous chapter. Nichols remained as secretary, taking over Gottron's managerial functions. Harding, Gottron, and Nichols were to report to the Board of Governors. Subsequently, the Board of Governors selected Wasmuth to replace LeFevre and put the Clinic on a new, centrally directed course with true physician leadership.

The Cleveland Clinic's modern era began with Wasmuth's chairmanship of the Board of Governors. He was the Clinic's first genuine physician manager, and the tasks he addressed in this role were similar to those faced by executives in industry, government, or education. In his first year as chairman, he was confronted by a formidable workload, compounded by the fact that there was no one else in the organization to whom he felt comfortable delegating authority. There was no other physician administrator. Wasmuth recalled that he relied heavily on Messrs. James E. Lees, Robert J. Fischer, and Paul E. Widman when he became chairman. However, Wasmuth reserved ultimate administrative control for himself. Lees functioned as an executive assistant, Widman as director of operations, and Fischer as treasurer.

Early in Wasmuth's administration, both Nichols and Harding, the

most seasoned professional managers in the administration, resigned. The governors were clinicians with little managerial experience. Wasmuth, therefore, assumed a degree of personal authority unknown since the early days, when the founders themselves had provided day-to-day direction. He considered it essential that he devote full time to his office; therefore, he gave up clinical practice as well as his post as head of the Department of Anesthesiology.

As early as 1968, it was clear that the scope of the chairman's responsibility had become too broad. The Board of Governors was in charge not only of all professional matters but also of operations and could not be conversant with all the necessary details. The key administrative team that kept the Clinic running smoothly and tended to the details in those early years of the Wasmuth era consisted of John A. Auble, general counsel, and Gerald E. Wolf, controller, as well as Fischer, Lees, and Widman. Neither Wasmuth nor any other chairman could have functioned without them. The Board of Trustees required increasing amounts of time and attention, as did a vast array of public interests.

Wasmuth assumed this burden with energy and enthusiasm, but he, the trustees, and the governors realized the need for an "understudy." A search committee identified Dr. William S. Kiser, a urologist who was serving on the Board of Governors, to fill the role of Wasmuth's assistant. Like Wasmuth, Kiser gave up his clinical practice, a decision that was difficult for many staff members to understand. However, the professional staff was determined to have a strong voice in the direction of the institution, and this sacrifice was seen as necessary. Kiser enrolled in the Advanced Management Program at Harvard University, where he became the second physician to complete that course. In due time, he was named vice chairman of the Board of Governors and placed in charge of operations.

During the LeFevre years, the west wing of the hospital had been added. Soon after it opened, however, it became clear that escalating patient demand would require more beds before long. Plans for the south hospital addition and a new research building were developed. It was also necessary to build a hotel and two parking garages. Financing the new development was one of Wasmuth's most important priorities.

The Clinic's traditional "cash on the barrelhead" method of financing capital projects was no longer tenable. The costs were too high, and the Clinic's ongoing operations and routine capital needs required

most of the available cash. Therefore, Wasmuth proposed the use of long-term borrowing from local banks to pay the construction costs that could not be supported by current operations. This was the first use of debt financing by The Cleveland Clinic.

Nonetheless, significant commitments of operating funds for these projects in the early 1970s severely restricted cash flow, and money for routine needs was limited. To make matters worse, the federal government imposed price and wage controls at that time. The staff began to grumble. General paranoia was exacerbated by the fact that cost-containment methods were carried to ridiculous lengths, for example, eliminating pens and removing sanitary napkin dispensers from the women's rest rooms. The bitter aftertaste of these ineffective, petty measures dissipated slowly. Yet, throughout the 1970s the Clinic thrived, largely because of the expansion that had increased the capacity to provide patient care. Although the cash squeeze produced by those projects was stressful, the organization's leadership learned important lessons that they would eventually apply to the more grandiose building programs of the 1980s. Few would now deny that Wasmuth deserves plaudits for launching the expansion of the 1970s and for persuading the governors and trustees that all available real estate adjacent to the Clinic should be acquired. He clearly foresaw the Clinic's position as the national and international health resource that it eventually became.

CONFINED EXPANSION AND COMMUNITY REACTION

As the Clinic purchased land and razed the deteriorated buildings on its new property, its presence became increasingly conspicuous. These activities began to be viewed by some detractors not as neighborhood improvements but rather as evidence of the Clinic's voracious appetite for growth. To put it bluntly, the Clinic was developing a predatory image. As the Clinic became more dependent on public good will to permit new projects and methods of financing growth, the days when it could remain aloof and ignore the public's perceptions and feelings about its actions were over. During the Wasmuth years, there was more adverse public feeling against the Clinic than at any previous time.

During Wasmuth's administration, the Clinic became involved in two public arenas: increased social responsibility and city politics.

The organization gave one million dollars in aid and assistance to the Forest City Hospital, a hospital struggling to survive as a provider of care to many of the urban poor. This hospital later closed its doors. The Collinwood Eldercare Center was partly supported and staffed by the Clinic, and in cooperation with the Cuyahoga County Hospital System the Clinic helped to establish and maintain the Kenneth Clement Family Care Center. A neighborhood revitalization effort, the Fairfax Foundation (now the Fairfax Renaissance Development Corporation), received both financial aid and operational assistance from the Clinic.

The Cleveland Clinic had little or no experience shaping opinions held by such diverse groups as the neighborhood, underserved minorities, the professional community, health care planning agencies, payers, and local politicians. And yet the resolution of issues such as zoning changes and neighborhood use variances, the building of viaducts over city streets, street closures, and the addition of costly technology and hospital beds were all increasingly dependent upon the attitudes and opinions held by these constituencies. For example, a conflict with the local health-planning agency, then called the Metropolitan Health Planning Corporation, took place over the issue of the Clinic's need to add 173 hospital beds in the new South Hospital. Although the Clinic prevailed, it was an unpleasant experience and attracted unfavorable public notice.

In 1976, a committee of governors and trustees chaired by Hughes conducted a confidential inquiry into these matters. The courts eventually had to address some particularly blatant improprieties. The most visible outcome of this inquiry was a change in the Clinic's leadership. The trustees, general counsel's office, and governors worked well together in this effort to preserve the integrity of the Clinic.

While all this was going on, the staff was becoming restless. They felt the Board of Governors had become increasingly estranged from their concerns. This apparent alienation was symbolized by the removal of Wasmuth's office and the boardroom from the first floor of the Main Clinic Building to the new south wing of the hospital in 1974 to an area known informally as "mahogany row." Nearly all the staff had walked by his office door many times a day for several years, and the remoteness of the new, well-furnished location seemed to represent an aloofness. Perhaps a more appropriate symbolism for this move was the shift in emphasis from the outpatient clinic to the hospital, which was, by this time, assuming the financially dominant role

Shattuck W. Hartwell, Jr., M.D., Vice Chairman for Professional Affairs, Founder of the Page Center, Editor of the second edition of To Act As A Unit

in the Clinic's operations.

The staff was far larger than it had been in the 1950s and early 1960s, and the institutional issues that faced the governing boards took precedence over some of the professional and personal matters that the staff felt should be addressed by the governors. The governors met only once a week, and Wasmuth did not have time for these concerns. Therefore, the Board of Governors appointed Dr. Leonard L. Lovshin, chairman of the Department of Internal Medicine and a former governor, to function as mediator and liaison to the professional staff. He was given the title of Director of Professional Affairs. Lovshin's amiability, popularity, and seniority were assets, but the job was not designed to allow the director to influence policy-making and decisions at the highest level. Recognizing this, the governors eventually took another step to augment the administrative staff that Wasmuth sorely needed by appointing one of their own members to be Vice Chairman for Professional Affairs.

The person they selected to fill this role was Dr. Shattuck W. Hartwell, Jr., a plastic surgeon and member of the Board of Governors and Board of Trustees. Hartwell and Lovshin worked together through the Wasmuth years and into the Kiser era, when Lovshin retired. By that time the Office of Professional Affairs had evolved into a full-time extension of the Board of Governors, assisting the professional divisions in matters of staffing, recruitment, benefits, policy, and dispute resolution. In time, the title of vice chairman of the Board of Governors would be reserved for the chief operating officer, and the title of vice chairman for Professional Affairs would become director, Professional Staff Affairs. Thus, the physician manager continued to evolve toward specialization and assumption of a more important role in the governance of the Clinic during the Wasmuth years. In the Kiser era the position of physician manager was to become even more essential.

8. THE KISER YEARS
1977-1989

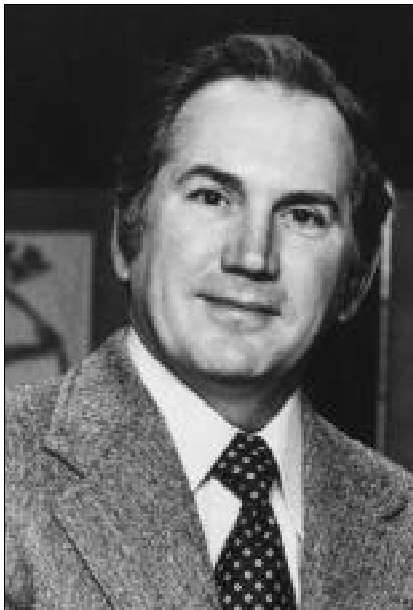
BY SHATTUCK HARTWELL AND JOHN CLOUGH

A decision is an action an executive must
take when he has information so incomplete
that the answer does not suggest itself.
—Arthur William Radford, 1957

A GENTLER STYLE

WILLIAM S. KISER, M.D., OFFICIALLY BECAME THE THIRD CHAIRMAN OF THE Cleveland Clinic's Board of Governors in January 1977, just before his 49th birthday. A native of West Virginia, Kiser had received his undergraduate and medical degrees and postgraduate training as a urologist from the University of Maryland. He had served in the United States Air Force from 1954 to 1957 with tours of duty in Texas, Morocco, and Germany, receiving Commendation Medals in 1956 and 1957. After completing his residency in 1961, he had joined the Surgery Branch of the National Cancer Institute in Bethesda, Maryland, where he had held the positions of senior investigator and staff urologist. He had remained at the National Institutes of Health until he was recruited to join The Cleveland Clinic's Department of Urology in 1964 by chairman Ralph Straffon, who wished to add a research dimension to the department.

Kiser's unique background, his bright, enthusiastic personality and personal warmth, and his clinical skill made him a popular addition to the staff. His election to the Board of Governors in 1972 set him



William S. Kiser, M.D., Chairman, Board of Governors, 1977-1989

on a course that led to his selection by Wasmuth for ultimate succession to the chairmanship, through a search process concluded in 1974 (see chapter 7). Although he was thrust into this role somewhat prematurely and unexpectedly, he rose to the occasion and eventually left his own indelible mark on the Clinic's developmental history.

The Cleveland Clinic's modern period of physician governance had begun with Wasmuth. When Kiser succeeded Wasmuth as chairman, the Board of Governors had been in existence for 20 years. Governance of the Clinic had been evolving over that period of time, and the purview of the board now included a number of new responsibilities, such as policy development, fiscal responsibility, long-range planning, and day-to-day operations. Under Kiser's leadership, these management functions would be increasingly systematized in line with his belief that a corporate model of management should replace the traditional scientific model with which physicians were comfortable.

By 1982, the day-to-day operation of the institution required the cooperative input of the division chairmen whose managerial role was now better defined. This cooperation was formalized by the creation of a committee of the division chairmen called the Management Group. The Management Group reported to the Board of Governors through its chairman, Dr. John J. Eversman. Eversman, an endocrinologist, became the first chief operating officer of the Clinic and a vice chairman of the Board of Governors. He was well suited to these tasks by virtue of his intelligence and additional education, having been the first member of the staff sent by the Clinic to complete an executive M.B.A. program. Kiser, Eversman, and Hartwell were members of the Board of Trustees and its Executive Committee by virtue of their positions.

Differences between Wasmuth and Kiser may be partly due to the way each perceived himself as a chief executive: where Wasmuth had concentrated authority centrally, Kiser encouraged decentralization of operating responsibility among a group of physician managers (the division chairmen) and lay administrators. These managers were accountable, through the chief operating officer, to the Board of Governors (the policy makers). The Board of Trustees held the chairman of the Board of Governors responsible for the operational management of the Clinic.

The distinction between policy making and the implementation of policy has been an important development. It has happened because there has been a conscious effort by institutional leaders to define carefully what the responsibilities are for all groups and individuals and to place accountability appropriately. This has not been easy to do. Doctors are trained in their formative years not only to decide for themselves what is the right thing to do (policy) but also to implement it (operations). Training programs are available for Clinic doctors to enhance their managerial skills. These programs have been very popular.

With the delegation of operational responsibility to the divisions and the departments, decentralization meant that preparation of the annual budget would require input from the department and division chairmen. Inexperience made this problematic at first, but by 1979 budgeting had become a more manageable process for the chairmen, many of whom by then had dedicated administrators. The divisions and departments became responsible for other managerial functions, although there was still a strong egalitarian culture within the staff that made it difficult for the chairmen to be true managers. It seems almost quaint today to review the language of the second edition of this book, which stated, "Large organizations tend naturally to be hierarchical. The titles of department chairman and division chairman indicate responsibilities and influence, but they are not autocratic; this would not be tolerated by the staff."

NEW MANAGERIAL APPROACHES

Beginning in 1975, the relationship of the staff to the Board of Governors was formalized in a process known as the Annual

Professional Review. This relationship was linked to an annual appraisal of the professional departments and of each member within the departments. The reviews, organized by the Office of Professional Staff Affairs, are conducted throughout the year and provide the doctors an opportunity to discuss their accomplishments, plans, career goals, and departmental issues with representatives of the Board of Governors and divisional leaders. More than anything else, the Annual Professional Review keeps the division chairmen and the Board of Governors in touch with the staff and is a potent check on the performance of departmental leadership. The Compensation Committee of the Board of Trustees is apprised of the annual reviews. The reviews, begun in a rudimentary form during Wasmuth's tenure, matured under Kiser and Hartwell and have become a well-established and accepted part of professional life at the Clinic.

The Compensation Committee of the Board of Trustees is regularly informed about the Annual Professional Review of the staff. Since 1975 trustees have been advised by consulting firms that specialize in executive compensation programs. The reviews and the consultants' reports have been key elements in the salary program for the staff and key administrative personnel. Better organized and administered than in the past, the review of salaries and benefits is one of the most important activities of the trustees.

Hartwell, always curious and innovative, left the Office of Professional Staff Affairs in 1986 to form the Page Center for Creative Thinking in Medicine. After an exhaustive search process, he was succeeded as chief in 1987 by Dr. Ralph Straffon, who also received the new title of Chief of Staff. Straffon had been chairman of the Department of Urology and later of the Division of Surgery. He was one of the most highly respected and well-known members of the professional staff. He further strengthened the Annual Professional Review process and computerized the Office of Professional Staff Affairs. In addition, he modernized the staff recruiting process and developed new policies governing the professional staff. Notable among these were redefinition of the category of assistant staff and adoption of the requirement that all members of the full staff be board certified in their (sub)specialties.

One of the important new features of the Clinic's management under Kiser was an attempt to begin an organized long-range plan-

ning process in 1979. This was to be a cooperative effort of the Board of Trustees and the Board of Governors. It was necessitated by increasing demand for services, proliferating technology, and staff growth, all leading to crowding of the facilities. The Minneapolis consulting firm Hamilton and Associates worked with the staff and governing groups for two years to develop the Clinic's Master Plan. Although this plan was flawed, and many details were never implemented, it spawned the most ambitious facilities expansion program the Clinic had ever seen—the Century Project—described below.

Concurrent with the planning effort, studies were carried out to determine the best way to finance the growth of the Clinic. Robert Fischer, treasurer of the Foundation, and Gerald E. Wolf, controller, were responsible for financial forecasting, a risky business at best. They correctly predicted that an enormous amount of money would be needed over the next ten years to expand the Clinic. The unfortunate experiences of the mid-1970s, when major capital expansion had been funded from operating revenues, suggested that alternative financing methods should be sought. It was eventually concluded that long-term bonds issued by the county would be the method of choice. The Board of Trustees authorized a bond sale to raise $228,000,000, and in June 1982, all the bonds were quickly sold. This was the largest private financing project in the history of American health care at the time.

Kiser also established offices of public affairs, development, archives, staff benefits, and long-range planning. Wasmuth had been farsighted enough to see the value of a full-time architect, planner, and an internal auditor, and he had filled these positions. Kiser advanced the idea that a support staff of administrative specialists was essential to the continuing development of the Clinic.

CHANGING TIMES

Kiser recognized early on that times were changing for health care and hence for medical practice. Although he initially clung to his modified idea of the Clinic's mission, i.e., "better care of the sick *through specialty care*, research, and education," he knew that an ongoing planning process would be critical and that the institution would have to be prepared to change to meet the new environment.

Frank J. Weaver,
Director of Public Affairs, 1980-1989

In 1980, Frank J. Weaver became the Clinic's first director of Public Affairs and Corporate Development, later known as the Divisions of Marketing and Managed Care and of Health Affairs. After Weaver's arrival, the rhetoric changed as well.

Weaver was a professional health care marketer from Texas. Everything about him was big, including his physical size, intellect, capacity for work, and appetites. He cut a natty figure with his boisterous (usually jovial) demeanor, flamboyant clothes, and boutonniere. Weaver had a clearer vision of what lay in store for health care than anyone else at the Clinic, and during his nine-year tenure with the organization, he imprinted many innovative concepts and ideas, which have only recently begun to be appreciated and, in some cases, implemented. He had Kiser's confidence, and for his first years at the Clinic, much of what Kiser said reflected Weaver's thinking.[1]

During the early 1980s, Kiser made some prophetic pronouncements about health care in his "State of the Clinic" addresses, which were traditionally delivered at the second or third staff meeting of each year. In his 1982 speech, for example, he said:

> "[N]o single institution can remain an 'island unto itself' in these times. We must seriously consider a departure from the past by developing a strategy for alliance with other groups of physicians and with other health care institutions. We can no longer stand in splendid isolation hoping that patients will come for our attention.
>
> "In the last month Dr. James Krieger [chairman, Division of Surgery], Mr. Dick Taylor [public relations], and Mr. Bill Frazier [head of planning] visited the 15 major group practices in Ohio

and Indiana. The observations which they made on location at the various clinics in our region were sobering:

- Referrals of patients more frequently go to other local hospitals because of comparable care and easier access.
- Cleveland Clinic postgraduate courses are no longer a strong attraction to referring physicians due to excessive numbers of CME courses throughout the country—more than 15,000 in 1980!
- Local and university hospitals are actively 'courting' each group for referrals, using incentives the Clinic has used for many years (CME, circuit-riding consultants, timely reporting, etc.)
- Larger groups are developing their own specialty staffs.
- Increasing difficulty communicating with individual Clinic staff members and. . .problems with patient access to our system.

"The conclusions from this survey are that The Cleveland Clinic can no longer count on the reputation of the institution or of its staff to ensure flow of patients in the future. We must formalize relationships with referring doctors or with multi-institutional systems to insure access to patient populations of sufficient size to maintain the economic viability of the Foundation in the future."

BUILDING FOR THE FUTURE

During Kiser's tenure as chairman of the Board of Governors and executive vice president of the Foundation, three major projects that were to change the shape of the organization radically were undertaken. These were (a) the Century Project, (b) the establishment of Cleveland Clinic Florida, and (c) the Economic Improvement Program. Each of these projects warrants some additional discussion.

The Century Project was a building program that grew out of the long-range planning activities referred to previously. Although the Century Project was designed to accommodate the projected growth of the organization through the turn of the century, it was so named because an important feature of it was the construction of a spectacu-

The Crile Building viewed from the mall; in the foreground, Dennis Jones's sculpture "Three for One," a gift from the family of Thomas Vail, Trustee

Hospital addition, the "G Wing," 1985

lar new outpatient facility on East 100th Street. The major components of the Century Project as outlined in the Master Plan of 1980 were (a) the East 100th Street outpatient facility (initially called the A Building, but later dedicated as the Crile Building), (b) the enclosed pedestrian walkway from the hospital to the A Building, now known as the Skyway, (c) the southeast wings of the hospital (F and G wings), and (d) the East 100th Street parking garage.

The A Building, designed by award-winning architect Cesar Pelli, opened in September 1985 with an outdoor extravaganza choreographed by Weaver, including speeches by Clinic officials, Speaker of the Ohio State House of Representatives Vernal Riffe, and a congeries of local dignitaries. A high point of the program was the introduction of the newly appointed chairwoman of the Division of Research, Bernadine P. Healy, M.D. Dr. Healy was the first woman appointed to a Cleveland Clinic division chair. Members of the Cleveland Orchestra provided ruffles and flourishes, and they had, fortunately, left by the time a gust of wind blew down their platform. The new building had more than 520,000 square feet of space designed for efficiency by the projected occupants.

The formidable task of moving the outpatient practices of 70% of the staff to the A Building was carried out in just 4 weekends with no interruption of service. The move included the Departments of Allergy, Otolaryngology, Dermatology, Plastic Surgery, Endocrinology, Hypertension and Nephrology, Urology, Internal Medicine, Pediatrics, Pulmonary Disease, Rheumatic Disease, Orthopaedics, Colorectal Surgery, General Surgery, Gynecology, and Ophthalmology. The "stay-behind" departments included Neurology, Neurosurgery, Cardiology, Cardiothoracic Surgery, Vascular Medicine, Vascular Surgery, Primary Care, Gastroenterology, and Infectious Disease. An attempt was made to keep sister services together. Although some shifting of locations has occurred, most departments have remained in their 1985 locations, and the whole design has functioned quite efficiently.

An interesting outgrowth of the work with Pelli on the A building was the creation of a new logo for the organization. Hartwell led this effort, along with architects Pelli, his wife Diana Balmori, and Peter van Dijk, designers Carole Fraenkel and William Ward, and the Burson-Mosteller organization. After 14 months of deliberation, the group proposed the graphic design for the current logo, which was accepted by the Board of Governors and the Board of Trustees.

Hartwell noted that it consists of "four green squares, each showing three rounded corners and overlaid by a perfect golden square," green for medicine and gold for quality. This logo has generated controversy from time to time, on one occasion in a staff meeting having been referred to as a "squashed bug." Nevertheless, it has had remarkable staying power, having survived several efforts at replacement, and according to Mac Ball of the Pelli organization, "it manages to symbolize growth and stability simultaneously . . . [conveying] . . . an optimistic and reassuring feeling."

The Skyway opened at the same time as the A Building. Originally envisioned merely as an environmentally protected, quarter-mile connecting link between the hospital, the new outpatient facilities, and the new garage, it has turned into a meeting ground for all who work at the Clinic. Nearly everyone at the Clinic traverses the Skyway at least once a day, and it is nearly impossible to get from one end to the other without encountering someone with whom some item of business needs to be transacted. Many "curbstone consultations" are conducted on the Skyway, and patient care is the beneficiary. The Skyway has also become the preferred site for numerous events, including the poster sessions for Research Day and many of the events of the annual Martin Luther King, Jr., Celebration of Diversity. It is truly one of the major focal points for life at the Clinic. The comparability of this meeting-place function of the Skyway with that of the "pike" in Boston's old Peter Brent Brigham Hospital was described by Clinic staff member James K. Stoller, M.D., in an article entitled "A Physician's View of Hospital Design" in the December 1988 issue of *Architecture*.

About 3 months after the opening of the A Building, with its associated 1,500-car Carnegie Avenue garage and Skyway, a modern 400-bed addition to the hospital was dedicated. This up-to-date facility included new medical, surgical, and neurological intensive care units, several telemetry units for cardiology patients, a number of regular nursing units and classrooms, and a VIP ward. This allowed closure of some of the oldest areas of the hospital and, thus, represented a net addition of only about 200 beds, bringing the maximum potential bed count to almost 1,200. Given the changes in the health care environment, which were beginning about that time, including a trend to delivering more care in the ambulatory setting, the maximum number of staffed beds peaked at 1,018 during the Kiser era.

A MOVE TO THE SOUTH

While the Century Project was under way, work was beginning on an even more significant undertaking, the establishment of a remote satellite. In 1984, Kiser was approached by physician groups in Florida regarding a possible joint venture with the Clinic. A two-man task force consisting of Robert Fischer, the chief financial officer, and Frank Weaver, the head of public affairs and corporate development, was dispatched to Florida to investigate the possibilities there. At the same time, another task force, pursuant to a 1983 invitation from the Singapore Ministry of Health, was looking into the feasibility of establishing a Cleveland Clinic-like institution in that country. Teams were also created to look at opportunities in Turkey, Sweden, the United Kingdom, Ireland, and Morocco. But eventually attention focused on Florida. Several sites in Florida were evaluated, and, with the help of a 1986 study by the Peat Marwick Mitchell Company, Broward County eventually was selected as the most favorable.

The preliminary work needed to establish a Cleveland Clinic-style group practice in Florida was formidable indeed. In addition to finding the appropriate site, identifying the appropriate physicians, and setting up the necessary hospital affiliations, state legislation allowing The Cleveland Clinic to practice "corporate" medicine had to be passed. All of this was done with some difficulty, but due to the astute work of John Auble, the Clinic's general counsel, James Cuthbertson, Cleveland Clinic Florida's first chief operating officer, and William Hawk, M.D., Cleveland Clinic Florida's first chief executive officer, it was achieved. On February 29, 1988, Cleveland Clinic Florida opened its doors on Cypress Creek Road in Fort Lauderdale with 28 staff physicians and a total of about 100 employees. A month later, Hawk retired, and Carl Gill, M.D., a pediatric cardiac surgeon and medical director of Cleveland Clinic Florida, became chief executive officer.

The Florida physicians had privileges at North Beach Hospital (a for-profit hospital owned and operated by Health Trust, Inc.) located about 10 miles away on the beach. The Cleveland Clinic had leased 50 beds at North Beach and was responsible for filling them or paying for them. Since that 153-bed hospital did not have a certificate of need allowing the performance of cardiac surgery, and because the Clinic was not able to secure one, an arrangement was eventually

worked out with Broward General Hospital for the cardiac surgeons to work there. The medical staff of the hospital balked, however, at allowing Cleveland Clinic physicians to have hospital privileges there or even at providing support for the Clinic's cardiac surgeons. This led to a bitter battle and finally to an investigation by the Federal Trade Commission, which found against the Broward General Hospital staff, all of whom were forced to sign a consent decree to avoid prosecution.

During the months before Cleveland Clinic Florida opened, a 320-acre property in Weston, Florida, was acquired. This was to be the ultimate site for the envisioned hospital-clinic-research complex that was to be the fully developed Cleveland Clinic Florida, with initial occupancy of a 200,000-square-foot clinic and a 150-bed hospital at the Weston location by 1992. Although the projected size of the facilities was out of proportion with Peat Marwick Mitchell's estimate that 63 physicians would be needed by 1994, Kiser felt strongly that this institution could grow as large or larger than the Cleveland campus because of (a) the rapid growth of the population in south Florida as compared with the shrinking population in northeast Ohio and (b) the greater accessibility to travelers from Europe, the Middle East, and Latin America, all growing markets for The Cleveland Clinic. This dream sustained the new group through the tough early going. The going remained tough longer than expected, however.

Just as the fledgling clinic was enduring its perinatal angst, the health care environment was changing dramatically. Costs were rising rapidly. Hospital and specialty care, both traditional mainstays of The Cleveland Clinic, were giving way to ambulatory and primary care. Managed care was on the rise. Competition among providers was getting more vicious. All these factors, together with some misreading of the unfamiliar south Florida market by the Clinic's leaders and consultants, led to poor initial financial performance. This was to be one of the major factors necessitating the third big project, the Economic Improvement Program.

Because of reimbursement and practice changes, hospital management was getting more difficult. It was no longer possible to pass cost increases on to the third-party payers; the golden era of cost-based reimbursement had become a thing of the past. In the case of The Cleveland Clinic, in both Cleveland and Florida, this problem was compounded by the relative complexity of the organization,

inexperience and lack of training of physician managers to whom authority had been decentralized, and a false sense of permanence created by a period of prosperity that had spanned the entire careers of the majority of the relatively young professional staff.

But the storm clouds were gathering. Although the size of the organization continued to grow unabatedly, growth in new patient activity was slowing, and there were some unexpected cash hemorrhages that began to make the trustees nervous. The Florida project was losing over $1 million per month. A major computer project on the Cleveland campus, which was to have resulted in an electronic medical record and billing system, was floundering, finally failed, and eventually was estimated to have cost the organization millions of dollars. For good measure, it was disclosed that the Florida land had somehow escaped appraisal and was worth less than half of the $55,000 per acre that had been paid for it. Much of this loss was recovered over the next few years by obtaining a land-use change and selling the bulk of the property for residential development. A great deal of the credit for this goes to Mr. Samuel H. Miller, chairman of the board of Forest City Enterprises, Inc., who became one of the Clinic's most active trustees.

The trustees requested Kiser and the Board of Governors to retain McKinsey & Company, a consulting firm with offices in Cleveland noted for masterminding turnarounds for failing companies. Although McKinsey had little health care experience at the time, they took on the project with gusto, and the resulting plan became known within the organization as the Economic Improvement Program. Their initial assessment of the institution's financial status was that if nothing were done, within 18 months the Clinic would have a negative cash flow of $75 million and would begin an economic death spiral from which it could not recover.

On a hot July afternoon in 1989, the Board of Governors held an executive session to consider the situation. During that meeting, Kiser announced his intention to step down as the Clinic's chief executive officer. He agreed to stay on until plans for a smooth transition could be made. The Board of Governors and the Board of Trustees decided to run the institution with a transition team consisting of three of the senior governors, Fawzy G. Estafanous, M.D. (chairman of the Division of Anesthesia), D. Roy Ferguson, M.D. (a member of the Department of Gastroenterology), and Carlos Ferrario,

Ph.D. (chairman of the Department of Brain and Vascular Biology in the Research Institute) along with trustees William MacDonald (chairman of the Board of Trustees), E. Bradley Jones (who became chairman of the Board of Trustees in 1991), and Arthur B. Modell (who became president of The Cleveland Clinic Foundation in 1991). This dedicated team took over the functions of the chief executive officer on July 20, 1989.

The Board of Trustees accepted Kiser's resignation with regret. They approved the hiring of McKinsey in August 1989, and they approved the Economic Improvement Plan the following month.

The Economic Improvement Plan called for implementation of ten projects in two waves. The first five projects included (a) development and implementation of a plan to bring Cleveland Clinic Florida to a cash-flow break-even status by the end of 1991; (b) restriction of capital expenditures to $50 million, freeing $25 million in cash; (c) reduction of costs in Cleveland by $35 million through a combination of difficult measures, including careful control of the employee "head count"; (d) improvement of the budgeting process; and (e) contingency planning. These projects were to start immediately. The second wave of projects, slated to begin during the first quarter of 1990, included (a) the AVA (Activity Value Analysis) project[2]; (b) a "level scheduling" project to improve access; (c) an incentive pay project, euphemistically referred to as "professional staff motivation and rewards"; (d) development of a marketing program that would lead to a 10% increase in patient activity by 1993; and (e) a demonstration project to examine the feasibility of reorganizing into patient-focused activity units rather than traditional specialty departments.

On October 9, 1989, the transition team decreed that the actual first-wave projects would be (a) the Cleveland Clinic Florida project; (b) revenue recapture; (c) AVA; (d) resource utilization; and (e) market strategy. The second-wave activities were to be (a) planning and budgeting; and (b) head count and remuneration. The transition team took on for themselves the tasks of communication and evaluation of information services.

As these projects were getting under way, a search committee composed of the elected members of the Board of Governors and several members of the Trustees' Executive Committee was going about the work of identifying Kiser's successor. Unlike Wasmuth, Kiser had

done no succession planning, and there was no one in line to step into the position. Kiser did, however, identify certain promising staff members who were encouraged to obtain further education in management, organizational behavior, or law, who would be candidates for managerial roles in the future. Some have moved into such roles. The search committee reaffirmed the concept that the chief executive should be a physician and interviewed several inside and outside candidates. After deliberating for nearly four months, they chose Floyd D. Loop, M.D., then chairman of the Department of Thoracic and Cardiovascular Surgery and a member of the Board of Governors.

[1] Weaver left the Clinic in 1989 to join Dallas Medical Resource, where he assembled a nine-hospital network to work with self-insured companies in north Texas to provide medical care for their employees. Tragically, he died unexpectedly at the age of 49 on June 16, 1995, in Boston, where he was to have addressed a medical conference.

[2] Activity Value Analysis is a management engineering term that refers to the setting of stretch goals for cost savings followed by the development of ideas for achieving the savings. The ideas are then written up and presented to a leadership team for decisions on which ideas are to be implemented. Many of the ideas involve reductions in personnel.

9. THE LOOP YEARS (PART I), 1989-1995

BY JOHN CLOUGH

It is the bright, the bold, the transparent
who are cleverest among those who are silent:
their ground is down so deep that even
the brightest water does not betray it.
—Nietzsche, 1892

TURNAROUND TIME

FLOYD D. LOOP, M.D., BECAME THE CLEVELAND CLINIC'S FOURTH PHYSICIAN chief executive on November 8, 1989, a month before his 53rd birthday. A native of Indiana and son of a country doctor, he was educated in science at Purdue University. He received his medical training at the George Washington University. After he graduated in 1962, he completed a residency in general surgery at George Washington, interrupted by two years in the Air Force. During this residency, his mentor was Brian Blades, M.D., who influenced him to become a thoracic surgeon. Blades was at that time the chief of surgery at George Washington; he was a noted thoracic surgeon, a pioneer in the field of lung cancer surgery, and a friend of the Criles.

Blades arranged for Loop to receive cardiac surgery training at The Cleveland Clinic with the understanding that he would subsequently return to the university to practice cardiovascular surgery. His cardiothoracic surgery training was supervised by Donald B. Effler, M.D., who had been Blades's first chief resident after World

Floyd D. Loop, M.D.,
Chairman of the Board of Governors
and Chief Executive Officer, 1989-2004

War II. Loop's training in Cleveland coincided with the beginning of coronary artery surgery. Effler and his colleagues René Favaloro, M.D., and F. Mason Sones, Jr., M.D., taught him well. When George Washington University was unable to comply with Loop's plans for cardiac surgery there, he joined the Clinic staff in 1970 and, upon Effler's retirement, was appointed department chairman in 1975. Under his leadership the department doubled the volume of cases and became one of the world's great heart centers.

In 1988, Loop was elected to fill the unexpired term of Dr. Carl Gill on the Board of Governors when Gill became a permanent member of the Board by virtue of his executive position with Cleveland Clinic Florida. Loop's unrelenting pursuit of quality led to his appointment with Richard G. Farmer, M.D., then chairman of the Division of Medicine, to co-chair the Quality Assurance Task Force.

At the time Loop succeeded Kiser, shortly after the initiation of the previously mentioned McKinsey "turnaround" projects, the Clinic's future was uncertain. Cash flow had begun a downward spiral in early 1989. Cleveland Clinic Florida had become a symbol of the cash hemorrhage, and there was talk of shutting it down. Loop gave his first *Health of the Clinic* address on February 12, 1990, which he began by citing DaCosta's comment that "[i]t won't help a man much to be a hundred years ahead of his time if he is a month behind in his rent." Though not formally trained in business, Loop became the most visionary and, at the same time, the most fiscally prudent and conservative of the Board of Governors' chairmen. He recognized the opportunity represented by the Florida project, and he knew that the Clinic's future, both in Ohio and Florida, would depend on controlling costs and building market share. The latter

could only be accomplished by acknowledging that "[f]or the first time we need to think strategically. We must adapt or we will go the way of the dinosaurs ourselves. We can't rest on our laurels. For a competitive advantage, the choices are clear—we must provide exemplary service of highest quality, increase our patient activity, manage internal systems better, and individually manage our practices better. In other words, if we want to stay the same, things will have to change."

Ralph A. Straffon, M.D., Chief of Staff, 1987-1999

With Loop, the pendulum of leadership had swung back to a more centralized, hierarchical approach, although decentralization of marketing clinical "product lines" was an important feature as well. He reorganized his management team to decrease the number of individuals reporting directly to him. The "professional" divisions (including Medicine, Surgery, Anesthesiology, Pathology and Laboratory Medicine, Radiology, Education, Research, and the "Centers of Excellence") all reported to the Chief of Staff, Ralph Straffon, but the chairpersons of these divisions and centers had direct access to Loop in the Medical Executive Committee, which he also chaired.

THE NEW TEAM

Perhaps more than any other individual Clinic staff member, Ralph Straffon, whose name appears many times in this book, personified all that is excellent about The Cleveland Clinic's system of medical group practice. A native of Michigan and a graduate of the University of Michigan, he came to the Clinic's Department of Urology in 1959. Just four years later he assumed the department chairmanship and, in 1978, became chairman of the Division of

Robert Ivancic, Executive Director, Human resources

Frank L. Lordeman, Chief Operating Officer

Surgery. He was appointed Chief of Staff in 1987, and he held that position until his retirement in 1999. He served on the Board of Governors, both as an elected member (1967-1971, 1973-1976) and as a permanent member by virtue of his office (beginning in 1987). He also served on the Medical Executive Committee and the Administrative Council. His professional achievements are too numerous to list completely here, and through all of this he consistently set an enviable example of the group practice ideal of leadership combined with collegiality. A few examples of his national leadership positions include trustee (1973-1979) and president (1979) of the American Board of Urology, member (1974-1980) and chairman (1978) of the Residency Review Committee for Urology, president of the Council of Medical Specialties (1983-1984), and president of the American Association of Genitourinary Surgeons (1986-1987). His crowning achievement was his election as regent (1980-1989) and later to the presidency (1991-1992) of the American College of Surgeons. He has also received the Distinguished Alumnus Award of the University of Michigan (1980), the American Urological Association's Hugh Hampton Young Award (1983), and

the National Health Professional Award of the VNA (1989).

Gene Altus, Executive Administrator, Board of Governors

On the administrative side, Robert Ivancic was recruited from the Meridia Hospital System to head the Division of Human Resources. John Clough, M.D., relinquished his chairmanship of the Department of Rheumatic and Immunologic Disease to head a new Division of Health Affairs, which encompassed many of the Clinic's external relationships. Daniel J. Harrington, who had been Director of Finance and an officer of the Foundation since 1986, became the Chief Financial Officer. Frank L. Lordeman, formerly the president and chief executive officer of Meridia Hillcrest Hospital, was recruited to the position of Chief Operating Officer to head the Clinic's vast Division of Operations. Along with the rest of the new administrative team, he worked with Loop to engineer the changes that needed to be made in the organization. This team, together with Loop's administrator, Gene Altus, who was also the administrator of the Department of Plastic and Reconstructive Surgery and who had played a vital role in the restructuring of Cleveland Clinic Florida, became the Administrative Council chaired by Loop. After the retirement of John Auble, who had founded the Clinic's legal office two and a half decades before, the office of general counsel was eventually outsourced to Squire, Sanders and Dempsey, a Cleveland firm that appointed David W. Rowan to oversee the Clinic's legal activities. Rowan worked closely with Loop and the Administrative Council on issues requiring his legal input.

In order to strengthen the marketing program in managed care, Peter S. Brumleve was recruited from Group Health Association of Puget Sound in 1994 to become Chief Marketing Officer. Marketing and Managed Care became a separate division under his leadership,

Alan London, M.D., Executive Director of Managed Care, 1995-

and he joined the Administrative Council. Two more members were added to the Administrative Council in 1995. Robert Kay, M.D., a pediatric urologist who also held the position of Chief of Medical Operations, and Alan E. London, M.D., Executive Director of Managed Care, formerly medical director of National Medical Enterprises, a California-based corporation that owned a chain of hospitals and managed care organizations, rounded out the Council.

Two more members were added in 1996. C. Martin Harris, M.D., for many years the chief information officer at the Hospital of the University of Pennsylvania, was recruited during the summer of 1996 as the Clinic's first Chief Information Officer and charged with the responsibility of building the ultimate information system to support the Clinic and its network partners. Finally, Melinda Estes, M.D., a neuropathologist and the first woman member of the Board of Governors, was appointed head of a newly created Office of Clinical Effectiveness.

The heart of the Board of Governors continued to be nine elected staff members serving staggered five-year terms. In addition, the Chief of Staff, Chief Financial Officer, Chief Operating Officer, and Chief Executive Officer of Cleveland Clinic Florida, as well as the Chairman, were permanent appointed members. Thus, Loop, Lordeman, and Straffon were members of all three of the major governing bodies.

These administrative changes coincided with the appointment of approximately 30 physician-managers to assume new roles in heading most of the clinical functions. Included among these were Norman S. Abramson, M.D. (emergency medicine), Muzaffar Ahmad, M.D. (Division of Medicine), Jerome L. Belinson, M.D. (gynecology),

David L. Bronson, M.D., Chairman, Division of Regional Medical Practice, 1995-

David Bronson, M.D. (general internal medicine, later Division of Regional Medical Practice), Delos M.Cosgrove III, M.D. (cardiothoracic surgery), Vincent Dennis, M.D. (nephrology/hypertension), Cynthia Deyling, M.D. (Cleveland Clinic Independence), Charles Faiman, M.D. (endocrinology), William R. Hart, M.D. (pathology and laboratory medicine), J. Michael Henderson, M.B., Ch.B. (general surgery, Transplant Center), Gary Hoffman, M.D. (rheumatic and immunologic disease), Hilel Lewis, M.D. (ophthalmology, Eye Institute), David Longworth, M.D. (infectious disease), Hans Lüders, M.D., Ph.D. (neurology), Roger Macklis, M.D. (radiation oncology), Maurie Markman, M.D. (hematology/oncology, Cancer Center), Kenneth E. Marks, M.D. (orthopedics), Daniel J. Mazanec, M.D. (Center for the Spine), Harry K. Moon, M.D. (chief of staff, Cleveland Clinic Florida), Thomas J. Morledge, M.D. (Cleveland Clinic Willoughby Hills), Robert Palmer, M.D. (geriatrics), Robert Petras, M.D. (anatomic pathology), Elliot Philipson, M.D. (obstetrics), Joel Richter, M.D. (gastroenterology), Vinod Sahgal, M.D. (physical medicine and rehabilitation, Rehabilitation Institute), Marshall Strome, M.D. (otolaryngology), George Tesar, M.D. (psychiatry), Eric J. Topol, M.D. (cardiology), A. Mary Walborn, M.D. (Cleveland Clinic Westlake), John A. Washington, M.D. (clinical pathology), Herbert P. Wiedemann, M.D. (pulmonary disease), and James Zins, M.D. (plastic and reconstructive surgery).

In the midst of all these changes, George "Barney" Crile, Jr., M.D., the last direct link with the Founders of The Cleveland Clinic, became terminally ill. In a moving ceremony on May 30, 1992, shortly before his death at age 84, the A Building was rechristened the Crile Building in honor of Barney and his father, both of whom

had given so much to The Cleveland Clinic throughout its history. More than 40 members of the Crile family attended this Founders Celebration. The building is a living monument to the Criles as well as to the Clinic itself. But within ten years after its grand opening and five years before the turn of the century, it was filled to capacity, and space continued to be an issue for the organization.

FULL STEAM AHEAD

With his team in place, Loop set out to move the Clinic forward into the era of managed care, rapidly accelerating technological development, and growing consumerism. Implementation of the Economic Improvement Plan was the highest priority during the early part of his administration. This included reducing costs through Activity Value Analysis (AVA), revenue recapture, stepping up the marketing effort, making Cleveland Clinic Florida cost effective, and reorganizing the Clinic's management structure. About 135 jobs were eventually eliminated through the AVA process, generating some savings. Among other things, the revenue recapture project led to the first of several revisions of the inpatient and outpatient billing processes, which, according to some, still have plenty of room for improvement. Marketing was initially placed in the Division of Health Affairs, and there emerged a new marketing strategy that emphasized building the Clinic's traditional business while developing managed care capability. In Fort Lauderdale, the Clinic purchased North Beach Hospital from Health Trust, Inc., and started down the difficult path toward converting red ink to black. By early 1990, these measures had produced a $60 million turnaround in cash flow (from –$30 million to +$30 million), and the future seemed brighter.

The Clinic was now poised to tackle several major projects, which would keep the news media, the Ohio Department of Health, and the competition in an unprecedented state of agitation for the next few years. Among these projects were (a) affiliation with Ohio State University; (b) affiliation with Kaiser Permanente; (c) establishment of an inpatient rehabilitation unit; (d) management of the William O. Walker Center for Vocational Rehabilitation; (e) construction of a new state-of-the-art Access Center and emergency

facility; (f) formation of the Cleveland Health Network; (g) creation of the Division of Regional Medical Practice; (h) development of the Cleveland Clinic Eye Institute and an eye care network; (i) building of a cancer center; (j) creation of a Division of Pediatrics and a Cleveland Clinic Children's Hospital; (k) reestablishment of obstetrics; and (l) initiation of a major fund-raising campaign to build the Cleveland Clinic Research and Education Institute, the Eye Institute, and the Cancer Center.

Bernadine Healy, M.D., chairperson of the Research Institute from 1985 to 1990, had long recognized the need for the Clinic to develop a strong academic affiliation with a medical school. She and her associates tried hard to work out a satisfactory arrangement with Case Western Reserve University, but for a variety of reasons (mostly related to competition with University Hospitals of Cleveland), this was not possible. So she turned to Ohio State University, where The Cleveland Clinic received a cordial welcome. An affiliation with Ohio State University was consummated and announced in 1991.

This led to an incredible series of events locally, culminating in the appointment of a blue-ribbon panel by the Cleveland Foundation to explore the area's opportunities in medical research and to make recommendations about the advisability of having two separate academic medical centers in the city. After protracted deliberations, the panel finally recognized The Cleveland Clinic as a separate "emerging" academic medical center. Shortly thereafter, officials at Case Western Reserve University arranged an affiliation with the Henry Ford Hospital in Detroit. The Clinic's Ohio State affiliation, though beneficial, did not progress to the establishment of a medical school on the Cleveland Clinic's campus. As it became clear that this would be necessary, the Clinic and the University parted amicably over a three-year period beginning in 2001.

The Clinic's exposure to managed care was greatly enhanced by the completion of a contract with Kaiser Permanente in 1992 under which Cleveland Clinic Hospital became the major inpatient care site for Kaiser members in northern Ohio. The earliest discussions about possible affiliation had taken place in the late 1980s between the Clinic's Dr. Shattuck W. Hartwell, Jr., and the Ohio Permanente Medical Group's Dr. Ronald Potts. Loop resurrected the concept after he assumed the role of chairman of the Board of Governors. Dr.

Robert Kay played a key role in bringing about the affiliation. This dramatic and, in the eyes of some, unlikely linkage was made possible through the strong leadership and vision of Loop along with Ronald Potts, M.D., Medical Director of the Ohio Permanente Medical Group, and Kathryn Paul, Regional Manager of the Kaiser Health Plan. Hospitals that had previously provided inpatient facilities for Kaiser Permanente (St. Luke's on the east side and MetroHealth[1] on the west side, which had recently merged) waged media campaigns and filed lawsuits in an attempt to derail the affiliation, but to no avail. As a result of this agreement, many physicians in the Ohio Permanente Medical Group were granted staff privileges to admit and care for their patients in Cleveland Clinic Hospital, and Kaiser, which had at one time operated three hospitals in the Cleveland area, closed its last remaining hospital. This was the first time that physicians other than those employed by The Cleveland Clinic had been admitted to the Clinic's medical staff, an arrangement that was problematic for some Clinic physicians in their quest to continue to act as a unit. However, the affiliation has greatly benefited both organizations since full consolidation occurred in January 1994, and the Clinic doctors have had an enlightening look at HMO-style primary care as delivered by the experts.

Clinic leaders saw the necessity to develop satellites to deliver geographically distributed primary care services. This became the responsibility of the new Division of Regional Medical Practice under the direction of David L. Bronson, M.D. Five satellite Family Health Centers were planned, each to be 30-45 minutes' driving time from the main campus. This was the "ring concept," first proposed by Frank Weaver, director of marketing in the early 1980s. In Weaver's proposed strategy, there was to have been an "inner ring" of primary care facilities within 45 minutes of the main campus and a more distant "outer ring" of such facilities, to provide easier access to the Cleveland Clinic for patients from surrounding areas. The first of these facilities to open was in Independence, located in the Crown Centre Building at Interstate 77 and Rockside Road. The second was in Willoughby Hills on Ohio Route 91 (S.O.M. Center Road) and Interstate 90. The third was in Westlake at Interstate 90 and Crocker-Bassett Road. The further development of the satellites, called Family Health Centers, is described more fully in the next chapter.

Vinod Sahgal, M.D., an internationally known physiatrist from

the Chicago Institute of Rehabilitation, joined the staff in 1992 to build a Rehabilitation Institute. As a necessary first step in this process, the Clinic applied for a certificate of need to operate a 34-bed rehabilitation unit. The Cleveland Clinic had never had a problem obtaining state approval for new programs or technology, but times had changed. Nonetheless, despite opposition from the competition, Loop negotiated a settlement with the Director of the Ohio Department of Health, which allowed the Clinic to open a 20-bed unit. Legal appeals went on for another two years before finally being laid to rest.

Because of an increasing need for an improved emergency medicine facility, both on the part of the Clinic's established patients as well as residents of the inner city, Clinic leaders decided to build a new Emergency Medicine and Access Center. It was located on the south side of Carnegie Avenue between East 93rd and East 90th Streets and was designed to house four separate units on its first floor: (a) The Cleveland Clinic's Emergency Medicine Department, which was about six times the size of the old facility, (b) Kaiser Permanente's Emergency Department, which enabled them to close their old east-side emergency room, (c) a shared Clinical Decision Unit with 20 observation beds, and (d) The Cleveland Clinic's Access Department, intended to provide same-day service for outpatients. These departments opened in the spring of 1994 and were formally dedicated in October of that year. The second floor of the Access Center Building, which opened in 1996, housed 24 new operating rooms, replacing the same number of outmoded operating rooms that had served the Clinic's needs for some four decades. The third floor contained the offices of the Divisions of Surgery and Anesthesia as well as a high-tech training facility for minimally invasive surgery.

After many months of intricate negotiations led by Frank Lordeman, Loop hosted a press conference on May 13, 1994, to announce the formation of the Cleveland Health Network. Flanked by Robert Shakno, chief executive officer of Mt. Sinai Hospital, and Thomas LaMotte, chief executive officer of Fairview General Hospital, representing the charter members of the network, Loop announced the association of ten hospital systems (Cleveland Clinic, Mt. Sinai/Laurelwood, Fairview Health System [Fairview/Lutheran], Parma, MetroHealth, Elyria Memorial, Summa [St. Thomas/Akron

City], Akron Children's, and Aultman [Canton]; Marymount joined later) and their affiliated physician hospital organizations (PHOs) for the purpose of contracting to provide managed care.

The Cleveland Health Network was unlike the other local hospital systems (Meridia and University Hospitals Health System) in that it did not involve single ownership of all the participating hospitals. It was also considerably bigger and geographically more far flung, with participating hospitals in five counties. It encompassed three preexisting two-hospital networks: Summa (Akron City and St. Thomas Hospitals), Fairview Health System (formerly Health Cleveland, including Fairview and Lutheran Hospitals), and the Mt. Sinai Health System (Mt. Sinai and Laurelwood Hospitals). Marymount Hospital merged with The Cleveland Clinic and joined the network in 1995, and ties with MetroHealth became stronger. Development of a Cleveland Health Network managed care organization, composed of the above-named hospitals and hundreds of their affiliated physicians, was the major focus of the network, and the development of this was considered crucial to the overall success of the network. Dr. Alan London had the responsibility of organizing this important component of the Cleveland Health Network.

To outsiders, the most surprising member of the network was MetroHealth, the Cuyahoga County hospital, which had recently been at odds with the Clinic over the Clinic's reestablishment of rehabilitation services and had a long history of close affiliation with Case Western Reserve University, the parent organization of University Hospitals. MetroHealth and The Cleveland Clinic had complementary strengths, however, and the association was beneficial for both.

The acquisition of Marymount Hospital was more significant than most people realized at the time. It turned out to be the first step in formation of the Cleveland Clinic Health System (see the next chapter), initiating another quantum leap in the size and complexity of the organization and signaling the beginning of the institution's third era, that of system and consolidation.

Meanwhile, on the main campus, in preparation for the formation of The Cleveland Clinic Eye Institute, Hilel Lewis, M.D., was recruited from the Jules Stein Eye Institute of Los Angeles to head it. The Department of Ophthalmology was removed from the Division of Surgery and accorded divisional status. Plans were

developed for a new building to house both clinical and research activities related to the eye. Lewis expanded the already excellent ophthalmologic services available at the Clinic by adding new talent to the group, and he set about forming a network of community ophthalmologists and optometrists to offer eye services on a contractual basis.

Pediatrics, which had existed as a department since the early 1950s, was also granted divisional status and removed from the Division of Medicine. Under the chairmanship of Douglas Moodie, M.D., the new Division of Pediatrics, together with The Children's Hospital at The Cleveland Clinic, newly remodeled and containing a state-of-the-art pediatric intensive care unit as well as new pediatric cardiac surgery suites, assumed a leadership role in the care of diseases of children. The Cleveland Clinic Children's Hospital had been accepted as an associate member of the National Association of Children's Hospitals and Related Institutions (NACHRI) in 1987. In 1989, the Ohio Children's Hospitals Association successfully lobbied the state to add a definition of the term "children's hospital" to the certificate-of-need law that specifically excluded The Cleveland Clinic Children's Hospital on the grounds that it did not have 150 beds! No other state has such a law, and NACHRI does not have this requirement. Fortunately, it was (and is) not necessary to have a certificate of need for designation as a children's hospital.

In Chapter 6, we noted that the Clinic's obstetrical program had closed down in 1966 to make room for the growing cardiac surgery program. On June 1, 1995, the program was reopened under the direction of Elliot Philipson, M.D. Its location on the sixth floor of the hospital is just around the corner from its original site, and the delivery suites, which had in the interim sequentially served cardiac surgery, orthopedic surgery, and ambulatory surgery, were returned to their original function. Outpatient obstetrical services became available both on the main campus and in the satellites.

After several fits and starts at fund raising, and one successful, but relatively small, campaign that raised $30 million for phase 1 of the Research and Education Institute (the Sherwin Building), the Board of Trustees approved a full-scale five-year campaign, designated "Securing the 21st Century." This campaign had a $225-million goal to build the remainder of the Research and Education Institute, the Cancer Center, and the Eye Institute. William Grimberg

was recruited from Cleveland Tomorrow to head the Department of Institutional Advancement, which had the responsibility for organizing the campaign. Grimberg had cut his teeth on the campaign that revitalized Cleveland's Playhouse Square a few years earlier, and he had become interested in health research and technology through his association with the Technology Leadership Council of Cleveland Tomorrow. He was no stranger to The Cleveland Clinic, having labored mightily to develop collaborative arrangements between the Clinic and Case Western Reserve University to attract state money to support research at both institutions. This campaign was completed two years early, having raised some $236 million, up to that time the most successful campaign ever conducted at The Cleveland Clinic.

By the end of 1994, The Cleveland Clinic's prospects had never been brighter. National and international recognition of the Clinic as a provider of extremely high-quality medical care was at an all-time high. In the *U.S. News and World Report's* annual evaluation of hospitals, The Cleveland Clinic had been recognized among the top 10 hospitals in the country every year the survey had been done. Singled out for special recognition were cardiology (tops in the nation each year from 1995 through 2003), urology, gastroenterology, neurology, otolaryngology, rheumatology, gynecology, and orthopedics. No other hospital in the state or the region had been so recognized. Moreover, many of the staff had received similar recognition in lists of "best doctors" assembled by various organizations. Although the health care scene was undergoing fundamental change, characterized by a shift to managed care and increasing emphasis on primary care and prevention, the Clinic's new initiatives were designed to allow the organization to continue as a major player in the health care of the future while maintaining the institution's underlying values. But now the organization was entering a new era, and the formation of the Cleveland Clinic Health System had quietly begun.

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[1] MetroHealth is the reincarnation of the old Cleveland Metropolitan General Hospital. It was set up to provide an umbrella organization for the merger of that hospital and St. Luke's into a "system." Shortly after the completion of the agreement between The Cleveland Clinic and Kaiser Permanente, the merger was dissolved, and the name "MetroHealth" subsequently referred only to the county hospital.