CLINICAL PRACTICE
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The clinical teaching of medical students was done by volunteer faculty from the inception of the College of Medicine until the 1950's. The fully accredited status of the College was tenuous for several reasons one of which was the absence of a full time clinical faculty. A few appointments were made prior to 1950. Then in 1954 four men were appointed to full time positions. Dr. Robert Grissom in Internal Medicine, Dr. Gordon Gibbs in Pediatrics, Dr. Roy Holy in Obstetrics, and Dr. Merle Musselman in Surgery. (2)

The situation remained essentially unchanged until the 1960's when Dean Cecil Wittson began actively recruiting full time clinical faculty. This resulted in the need for an increasingly diverse patient population, more non indigent or private patients and a system for reimbursing physicians for services rendered. (24) There was no policy regarding the professional fees generated by the treatment of private patients by the clinical faculty. (25) Some individuals were salaried full time and any professional fees generated by them went to their respective departments, others retained their fees and several modifications of these two themes existed. It became obvious that some definitive system had to be developed.

The history of the development of a reimbursement system for patient care by full time clinical faculty has been set down in detail in "University of Nebraska Hospital: The First 75 Years" (23) for those who are interested. The Nebraska Clinicians Group (NCG) was formed under a medical service plan which established a group practice of geographic full time physicians at the University of Nebraska Medical Center.

A Clinical Practice Board (CPB) was formed in 1986 when the hospital discontinued maintenance of the outpatient clinics. The Board took over the management and fiscal responsibility of all outpatient clinics on and off campus. The Nebraska Clinicians Group (NCG) retained fiscal responsibility through the Professional Fees Office (PFO) for the billing and collecting of all professional fees for outpatient services as well as inpatient.

In 1993, the University Medical Associates (UMA) was formed to take over the function of the Clinical Practice Board (CPB). In 1995, the Nebraska Clinicians Group was eliminated and the University Medical Associates became
the sole organization to manage all clinical activity, both inpatient and
outpatient, for the faculty. The PFO was retained as the fiscal agent of the
University Medical Associates to bill, collect and disperse professional fees. In
1995 the University Medical Associates became a not for profit 501(C)3
corporation. A number of departments and divisions had formed separate
corporations to handle their financial matters under the egis of the Nebraska
Clinicians Group. They were all dismantled and folded into the single entity of
the “University Medical Associates” which was essential to comply for
designation as a 501(C)3 organization.

New bylaws were drawn up and accepted by the Board of Regents.
Membership consisted of “.....all full-time, part-time, and volunteer physician
faculty members of the College of Medicine who provide clinical service at the
University of Nebraska Medical Center”. The affairs of the corporation are
managed by a Board of Directors. The Board consists of each clinical chair, four
at-large representatives (full-time faculty), the Associate Dean for Clinical
Affairs as Chair, the UMA Chief Administrative Officer, and the Dean of the
College of Medicine, ex-officio without vote. There is an Executive Committee
consisting of the four elected members at large plus four department chairs, and
the Associate Dean for Clinical Affairs. The UMA Chief Administrative Office
and the Dean of the College of Medicine are ex-officio members without vote.

A Physician Hospital Organization (PHO) was formed with representatives
from the hospital and the University Medical Associates for the purpose of
carrying out joint ventures relating to the provision of services to outside health
care organizations. It has continued to function subsequent to the merger of the
University and Clarkson Hospitals and now has representatives from NHS and
UMA and has fostered relationships and services to an increasing number of
outside health care organizations.

With the increase in full time faculty, the number and diversity of clinical
programs at the Medical Center expanded. Subsequent to 1980 in addition to
the growth of “standard” services a number of unique programs were started.
A kidney transplant program had begun prior to 1980. On July 19, 1985, the first
liver transplant was performed (28). Subsequently small bowel transplant,
pancreas transplant and multiple organ transplant programs were added. An
internationally recognized bone marrow transplant and leukemia treatment
program commenced in the 1980's. One of the first Robotic Surgical Equipment
systems in the region was installed at the University Hospital operating rooms
in 2000. (83) Extensive electronic communication systems were installed throughout the Medical Center. The number of sub-specialty services increased which is reflected in the list of fellowships offered in 2000-01 as compared to 1980-81 in the section on education. All of this attested to the rapid changes occurring at UNMC.

The expanding clinical services put an increasing burden on the limited physical facilities of the University Hospital. The proximity of Clarkson Hospital appeared to offer an obvious solution. However this was not as obvious as it seemed.

In 1953 the University acquired land north of Dewey Avenue and west of 42nd Street and leased it to Bishop Clarkson Memorial Foundation for the purpose of erecting a new hospital. The University agreed to extend, at its own expense, its steam and hot water to the hospital and to provide those services at cost. The University also agreed to do all the necessary laundry work for the hospital at cost. The lease contract stipulated “...in the event that the second party (Bishop Clarkson Memorial Hospital) should desire to cease operating the hospital the first party (University) shall have the option to buy said hospital and other facilities at the same price as may be obtained by the second party elsewhere.” (9) The Bishop Clarkson Memorial Hospital was subsequently built and began receiving patients December 16, 1955. (22)

The relationship between the two institutions was “at a distance” for most activities. However, from the onset a number of members of the Clarkson staff had appointments as volunteer faculty members at the College of Medicine. As the Medical Center began to acquire a full time staff (2), the majority of these individuals applied for and were granted appointments to the Clarkson staff.

Many of the Clarkson voluntary faculty offered electives for medical students which were usually full. Similarly residents in a number of services spent time at Clarkson under the egis of a Clarkson staff member. The Internal Medicine service had the largest number of residents through the years. The majority of these residents went through specialty services at Clarkson that were not available at the Medical Center. As the services were developed at the Medical Center, those at Clarkson were no longer used and the number of residents at Clarkson gradually diminished. Medical residents stopped going to Clarkson some time in the early nineties. A number of other departments of the College of Medicine had residents at Clarkson on the services of voluntary faculty members. This was quite variable through the years and there is no accurate record available.
Starting during the tenure of Chancellor Wittson, several attempts were made through the years to develop a closer physical and/or administrative integration. None were successful. One or the other party would pull back before any definitive agreement was reached.

In 1988, an outside consultant studied areas of possible integration between the University Hospital and Clarkson Hospital. The report concluded that the two hospitals should move to share use of their facilities and form common government and management strategies as appropriate. Each should maintain separate medical staffs and retain individual ownership of existing assets. It did not recommend a merger. (29) In 1989 a Joint Planning Board of the University Hospital and Clarkson Hospital was developed to study possible joint programs. (31).

In April 1993, a joint project was started which would provide new steam lines to three UNMC buildings and a larger steam line to Clarkson. In addition, chilled water levels were to be installed from Clarkson’s plant to UNMC to provide backup in the summer and chilled water to Clarkson in the winter. (41) About that same time BCMH and UNMC announced plans to pursue a lease agreement in which the University Hospital would lease bed space from Clarkson Hospital. To facilitate patient and staff traffic, a covered, all weather link connecting the two hospitals would be constructed across Dewey Avenue. (42)

In the Spring of 1994, negotiations were started between Bishop Clarkson Memorial Hospital and Columbia/HCA Health Care Corporation pertaining to Columbia purchasing Clarkson. (45) Subsequently the talks between the University Hospital and Clarkson Hospital regarding leasing of beds was discontinued. The Medical Center was concerned that a for profit institution would have an adverse effect on such joint programs as existed between UNMC and BCMH and seriously hinder further negotiations.

The attorneys for Clarkson Hospital inquired as to whether or not the University intended to exercise its option as per the 1953 agreement. Subsequently Clarkson was requested to provide information so that a prudent recommendation could be made to the Board of Regents regarding the University’s possible purchase of Bishop Clarkson Memorial Hospital. (48,49)

In June 1995 the Board of Regents voted to exercise its option to buy Clarkson Hospital. (50,51). Subsequently Bruce Lauritzen, Chairman of the
Clarkson Hospital Board, offered to meet with Medical Center officials to discuss Clarkson's future. He also said that any legal action would have to be filed by Columbia HCA whose offer to buy Clarkson had been accepted by the Hospital Board. (51) Columbia/HCA Health Service Corporation filed a lawsuit in Douglas County District Court on June 12, 1995 to determine the validity of the original agreement. Ultimately the court ruled in favor of the University and Columbia/HCA discontinued its negotiations with Bishop Clarkson Memorial Hospital.

Early in 1996, Alegent Health approached the University of Nebraska Medical Center regarding the feasibility of UNMC becoming a partner. On March 20, 1996, Alegent Health and the University of Nebraska Medical Center announced plans to partner (58) and a letter of intent was signed (59). Subsequently a major administrative problem occurred in the Medical Center which is discussed in the section on Administration. As a result, University President Smith requested that the target date for final agreement be pushed back 45 days (60). The Alegent Board did not grant this request and negotiations halted.

Dr. William Berndt was appointed Chancellor subsequent to the resignation of Dr. Carol Aschenbrenner. He asked Dr. Harold Maurer, Dean of the College of Medicine, to lead a UNMC effort to examine its approaches to selecting a potential partner. (64). Chancellor Berndt contacted Bishop Clarkson Memorial Hospital administration regarding the possibility of integrating both clinical operations and found they were interested. He subsequently appointed Dr. Maurer to head a UNMC group to meet with a group from BCMH to work out details for a possible merger. Ultimately it was recommended that UNMC and BCMH create a joint operating company to manage the hospital and clinic operations of both institutions. The 1953 agreement was to remain in effect for 5 years. (65)

In the fall of 1997 the Nebraska Health System (NHS) was initiated. The Board of Regents approved the merger at its meeting on September 29, 1997. The Clarkson Hospital Board of Directors had approved the merger at their meeting on September 15th. A signing ceremony consummated the merger on October 1, 1997. A 12 person Board with six representatives from each Institution became the governing Board. The 12 members were: For UNMC William O. Berndt, PhD, UNMC Chancellor, Dr. James Armitage, Chairman of the Department of Internal Medicine, Jan Thayer, Nursing Home Administrator in Grand Island, James Massey of Scottsbluff, past-president of JG Elliott
Company, Lt Governor Kim Robak, and Harlan Noddle, Chairman of Noddle Development Company and for BCMH Bruce Lauritzen, President of First National Bank, Kenneth Stinson, President and Chairman, Kiewit Construction Group, Dr. Timothy Kingston, a private practice physician and partner of Surgical Services of the Great Plains, Lewis E. Trowbridge, President of Mammel and Associates, Mogens Bay, President and Chief Operating Officer of Valmont Industries, and James T. Canedy, M.D., Chairman of Clarkson’s Private Practice Affairs. Dr. James Armitage was elected Chairman of the Board and Dr. Louis Burgher became Chief Executive Officer of the Nebraska Health System.

Medical staff bylaws were adopted which replaced the previous bylaws of each hospital. The Chief of Staff would come from the membership of the Medical Staff Executive Committee and be appointed by that Committee. Although it is not stipulated, the position would be alternated between the private practice physicians and the university physicians.

The Executive Committee of the Medical Staff was appointed by the Board of Directors of NHS and responsible to the Board. It consisted of 5 members from the private practice category and 5 from the academic faculty category plus 2 NHS nurses, one selected from each hospital.

The entire staff was divided into two categories. A private practice category consisting of those individuals who spent more than 50% of their professional activity at NHS and were not full-time academic physicians. Full-time academic physicians consisted of those medical staff members who spent more than 50% of their time as academic faculty.

Clinical services were divided into hospital-based services (i.e. anesthesiology, radiology, pathology) and non hospital-based services which essentially included everything else. Clinical service chiefs of the non hospital-based services “....shall be active staff members of the private practice category...” Individuals from the full-time academic faculty could not serve as clinical chief of a non hospital-based service. As to hospital-based services, the clinical chief could come from either category and would be selected by the CEO and the academic Department Chair. Term of service was two years and the position alternated between the two categories.

Without belaboring the point, the bylaws make it obvious that despite the merger, there are two Medical Staffs and much needs to be done to bring about a cohesive integrated clinical service. Clinical practice of both the “Clarkson
physicians” and the “University physicians” were and will continue to be modified by the merger.

In the Fall of 1998, the University Medical Associates (UMA) and the Nebraska Health System (NHS) arrived at a management agreement to jointly manage their respective primary care and specialty clinics. On or about September 15, 1998, all UMA clinics staff and clinic administrative employees became employees of NHS. All UMA physicians and midlevel providers remained employees of UNMC and UMA.

The agreement was approved by the UMA Board of Directors and the NHS Executive Council. The two UMA hospital based operations hematology/oncology and geriatrics were excepted from the rule. (88)

This management agreement was modified in 2000. At that time NHS signed a management agreement with UMA that UMA assume management of ten of the eighteen clinic settings which had been managed by NHS (73). As it turned out, those clinics were the ones primarily under UMA prior to the 1998 agreement. Remaining clinics were those that had been mainly “Clarkson clinics” prior to 1998 agreement. Therefore the situation was essentially as it had been before the merger and as far as outpatient clinics were concerned, a unified system of outpatient clinics did not exist.

In the Fall of 2000, the Board of Regents extended the original 5 year lease to 40 years. Chancellor Harold Maurer stated “.....by extending the lease agreement to 40 years, we are sending a loud and clear message that the partnership is working and that both members view this as a permanent arrangement.” The Board also approved several amendments to the Joint Operating Agreement the most significant being the termination of the 1953 Right of First Refusal Agreement and deletion of language that gave both parties the right to withdraw from the Joint Operating Agreement without cause. (77). In November 2000, Dr. Louis Burgher, CEO and President of NHS, submitted his resignation. He agreed to stay until a replacement was found. He noted that there were still a number of physicians and staff members who believed that the two hospitals were too different to maintain a lasting and equal partnership. The Nebraska Health System remains a campus divided, Clarkson to the North of Dewey Avenue and University Hospital and NU Medical Center to the South. The actual physical separation ceased with the construction of a corridor connecting the two hospitals which bisected Dewey Avenue. (89)
There was already some “bad blood” between the two institutions because of the court battle over the 1953 agreement. Not all departments joined together easily. The Radiology Department was an example. The Heads of each of the two Departments were unable to agree on anything. Ultimately resignations of both helped to begin to heal the wounds and at the present time there is a single Radiology Department and the director is Dr. Craig Walker, who is a full time faculty member. There was a jump in the number of doctors and administrators retiring or taking other jobs. There was a 10 percent loss the first year as compared to the normal staff turn over of 6 percent per year. Chancellor Maurer noted that some resignations were to be expected as a result of the merger. He stated that the physicians who replaced those that had resigned didn’t have the emotional attachment to the “old hospital” and would be more likely to “...embrace the opportunities of the new system.” Lastly Dr. James Armitage, Dean of the College of Medicine and former Chairman of the NHS Board said, “If you really don’t like it, this is the way its going to be. We haven’t done all the things we need to do, but there is no question that it will happen.” (15)

Further evidence that the merger has become a physical fact is manifested in the construction of a Center for Clinical Excellence. Groundbreaking for this structure occurred November 21, 2002. (86) It will connect the two hospitals across Dewey Avenue and will consist of four stories containing a common emergency room, a radiology and CT suite, a surgical suite, and a neonatal intensive care unit. Completion is expected May 2005.