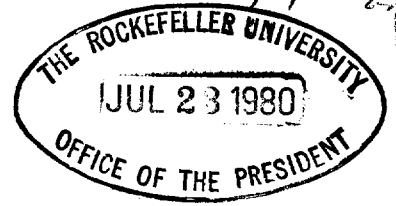


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The University of Oklahoma at Oklahoma City · Health Sciences Center

OFFICE OF THE PROVOST

July 9, 1980

Dr. Joshua Lederberg
President
The Rockefeller University
York Avenue & E. 66th
New York, New York 10021

Dear Josh:

I started to set down my thoughts about Stanford Medical School several weeks ago as you asked after our talk, but was distracted by moving and getting settled in Oklahoma, and finished only last weekend.

The school faces several fundamental problems which are interrelated and difficult to solve. All concerned are dug in because of strong perceptions that have not changed for years; in some cases, even though the reality has. The solution to these problems stems from current realities, which must replace these entrenched misperceptions.

I set forth what I think should be done below under four headings: general funds, the clinical practice, the hospital, and governance. These resolutions are interdependent, just as are the problems. I was working some of this out and beginning to move in some of these directions at the time I left Stanford.

Basic Objective: The most important contribution that Stanford can make is in fundamental research carried on in both basic science and clinical departments. However, general funds cannot even start to support this activity. Therefore, except for developing new programs and part of capital needs, research should be self-funded.

The second priority is MD education. I consider this the primary draw on general funds. Housestaff, Ph.D. and post-doctoral students also should be supported by general funds, but at much lower rates.

It is also important to develop the clinical programs, including the technically oriented departments such as surgery, radiology and anesthesia.* Most of these departments have been throttled at Stanford. They can contribute significantly to knowledge and technology as well as to patient care. As with research, these programs should be self-sustaining. At present, they are not.

General Funds: Now that excess MSP funds are no longer being transferred from the graduate/technical departments to the medical and basic sciences programs, the purely clinical activities are being subsidized by the basic science and medical departments. That is because part of the salary of all faculty is paid from general funds, irrespective of how much teaching actually is done. That creates a draw on general funds when faculty are recruited to meet clinical needs and not needed for additional teaching. That occurs almost exclusively in the graduate/technical departments. That draw on general funds used to be balanced by a transfer of MSP funds from these departments. In retrospect, I should have moved in the direction described below instead of taxing MSP funds to make up for salaries of faculty not needed for teaching.

It should be made explicit that general funds are provided to departments on the basis of medical student teaching actually accomplished (a dollar amount per medical student per hour of teaching in a specific course or clerkship.) An additional amount should be provided per Ph.D. student, graduate student and house officer (independent of the number of hours reported for teaching). The final component of general funds should be for departmental administration. This should be a set amount per department, plus two additional amounts, one proportional to the number of faculty and the other proportion to departmental grants bearing overhead. That would be the entire general funds budget for the department, including faculty salaries. That would change the general funds assignment to one that is proportional to measured outputs rather than estimates of input. It would result in substantially reduced general funds support of the clinical programs and would most effect that graduate/technical departments. It would result in increased general funds-support of basic science and medical departments because of their high level of medical student teaching and research. Depending upon the factors used to calculate the general funds assignments, there could be a reserve a few years after this change was made. That would be important so that new academic ventures could be stimulated and emergencies met.

* I divide the departments into three functional groups a) basic sciences; heavily involved in fundamental research and didactic teaching of medical students, b) medical (including medicine, pediatrics, neurology, etc.) heavily involved in research and clinical teaching of medical students, and c) graduate/technical (surgery, anesthesia, diagnostic radiology, etc) which tend to be more involved in technical clinical care and housestaff teaching than in research and medical student education.

There would be resistance to this from the graduate/technical departments because they don't think of their clinical programs as subsidized and wouldn't want to lose the support. However, the decentralization of clinical programs that is part of this approach (described below), and their regard for self-sufficiency would make it acceptable, once understood.

Clinical Practice: Currently, the clinical practice is more constrained than necessary or desirable.

Billing and collections were centralized because part of the funds received went to the school. Now that most of the fees remain with the departments, there is no advantage to centralization. In fact, the quality of service, satisfaction of faculty and promptness of billing all suffer. I would decentralize the financial operation of the clinics to the departments and divisions, except for management-auditing, financial auditing and ultimate university control.

The other constraints have been on size and cite of practice. The constraint on cite also was to make it possible to collect practice funds for use as general funds. Now that that is no longer possible (or, in my view desirable, once the changes in general funds policy indicated above were implemented), the requirement that all practice be located at University Hospital no longer would be necessary.

There are two reasons why the size of the graduate/technical departments have been constrained. One is a fear, both in other Medical School departments and throughout the University, that they would become too large, too influential and too commercial. Those are reasonable fears, but such problems are not the inevitable response to expansion. Several of these departments always have been too small to develop appropriate academic strength. (e.g. Neurosurgery; for long a one man show and, one year ago, too understaffed to allow development of research oriented faculty). I think the frustration they experience may be a significant cause of the negative attitude of the faculty in most of these departments.

The other constraint is the size of University Hospital. The compression of vigorous University and community practices into this hospital compromises both, perpetuates one of the most serious problems of the school, and threatens the position of the University in the community from which most of its funds are raised.

I think the school should get a small amount of gross receipts (4-5%) and that an equal amount should be put into a capital fund to be used to service debts for new construction. The rest should go to the generating departments for MSP business expenses, salaries, operational expenses and academic development. Management should be decentralized. The University should accept a larger number of full time clinical faculty appointments for clinical program needs, and some clinical speciality services (always including housestaff and medical students) should be allowed to develop programs in other hospitals.

These changes would result in an increase in the clinical programs of some of the graduate/technical departments, to the point where they can have reserve funds for a academic development. Growth beyond that point should not be allowed. I don't think that most of the departments concerned would want it, but realize that many at Stanford think that they would. The gains from having these departments well-developed should not be over looked.

The objections to such changes would be most intense in the University outside of the Medical School. Both Lyman and Miller basically saw the school as a threat and were determined to maintain rigid centralized control of size and policy. I think that there is a good chance that Don Kennedy will have a better understanding and be more flexible. The concerns of the faculty of the University could be reduced considerably by the leadership a president and provost who were less fearful, and by changes in governance described later, but would remain a difficult obstacle. The basic science and medical departments would accept such changes if they thought they would resolve some of the school's problems, and as the price of the increased and the more stable general funds support they would have from the revised policies described earlier.

Hospital: There is a strong tendency at Stanford to fix upon theoretically possible solutions, even though they are exceedingly unlikely, or even undesirable. These include the idea of a several hundred bed expansion of University Hospital (desirable but terribly unlikely), an exclusion of the community physicians (an improper reversal of commitments and obligations unless another hospital is built), a revision of the MSP to one that brings large sums into the general fund (unnecessary and politically impossible) the reduction of the graduate/technical departments to unsubstantial size (impractical) and selling the hospital (who on earth would buy it, and what problems would be solved?). These and other remote or foolish obsessions confound reasoning about practical steps to resolve the basic problems. In particular, the University needs a plan that does not count on greatly enlarging the hospital, a massive increase in hospital operating funds, or excluding the community physicians.

A solution to the current impasse can be worked out - I think. I would set aside a number of beds and part of the OR time for teaching medical students. This would reflect the real need for the core-clerkships in medicine, general surgery, pediatrics, obstetrics, etc. It would not reflect the practice-needs of the faculty beyond what is required for the basic medical student clerkships. These assignments would fit within the limitation of the quota because of policies that I describe below. I would also exclude community physicians definitively and permanently from the radiation therapy and pathology laboratories. The community would object but would accept these changes as reasonable for a university hospital.

I would then open all other current beds (new beds added in the future could be excepted) to University and community physicians alike, with admissions based upon patient-needs and uniformly applied hospital policies. The only quota that would apply to these beds would be the quota in the contract for the affinity staff and a very much reduced number of voluntary clinical faculty. The total number of admissions from these groups are too small to affect they system I am describing.

In order to reduce the number of community physicians who can admit under the quota, the departments would have to reduce the voluntary clinical faculty to the level actually necessary for teaching. (Note that voluntary faculty appointment no longer would be necessary for guaranteed hospital privileges). If legally practical, a new line of voluntary teaching appointments that would not grant a privileged quota under the contract should be started.

These changes would cause a small teaching service and several laboratories to be closed to the community. However, the hospital otherwise would be committed permanently to an open staff with no quotas in operation that had any practical consequences. Both the faculty and the community physicians would object but I think they would come around. There are advantages for each group, the policy is fair, and it offers a solution.

However, this would work only if restrictions on cite of practice are relaxed for some specialties. For example, there is far too much cardiovascular surgery (both university and private) at University Hospital now. It stifles development of other surgical specialties and runs the cost of general hospital care way above reimbursement-limits. A policy limiting this specialty, that would apply to community and university services alike, is needed. That is practical and reasonable only if other options exist for the university surgeons as well as for those in private practice. That is why I think that there should be exceptions to the restrictions upon cite of practice. An appropriate amount of cardiovascular surgery could remain in University Hospital, while the rest developed elsewhere. Such an option will become more important in the future as technical advances continue to emerge. If there is no way to decompress University Hospital, and if new beds cannot be built, current explosive pressures will mount.

Governance: Within the school there must be both a dean and a vice president. The scope of the job as well as some emerging conflicts between the needs of the faculty and dean, and the needs of the hospital, both are too great to make it practical to continue this single office. I note that, 1½ years after I left, no acting dean has been appointed. That over-centralizes power and prevents adequate development of the academic side, as contracted to clinical/hospital operations. I made a mistake by not splitting the office, and eventually was overwhelmed as a result.

I think that the executive committee should be revised to include the vice president, dean, three chairmen representing and selected by the chairman of the three departmental groups (basic science, medical and graduate/technical) but including the chairmen of medicine and surgery, the chairman of the senate and the most senior non-MD administrator; with no one else present. The current committee is excessively cumbersome and mixes policy and communication roles.

Nothing tried so far has resulted in good communications within the faculty. That is because most chairmen wont pass on information they receive in the Executive Committee to their faculty. I think there should be a news letter from the vice president and dean every two weeks to all faculty and budget heads.

The clinical program should be under a clinical policy committee different from the medical school executive committee, composed of the chief of staff, vice president, dean, clinical program directors (not necessarily chairmen) and the chief clinic administrator.

I never got departmental reviews underway. That is an important element of quality-control and should be done, with a formal external review every three years.

The final governance issue has to do with the University at large. The changes I recommend would result in some increase in the clinical full-time faculty. That would create legitimate concern about the composition of the University Senate. I think that the restriction on the number of clinical full-time faculty should be lifted or eased, and that only tenure-line faculty in the School of Medicine should be represented in the University Senate.

In summary, I think the academic program of Stanford Medical School will be funded better and more stably if general funds were channeled to support medical education (with research and clinical program both fully self-sustaining) and if the clinical programs are partially decentralized and allowed to become the source of funds for their own academic development. Some enlargement of some clinical departments is practical, warranted on grounds of the quality of academic programs that would result, and not a threat to other departments or the university. The community-conflicts could be reduced or solved by opening permanently all beds except for a moderate sized teaching service, taking steps that eliminate the impact of the quota, and providing for decompression by allowing some part of those services which unbalance the practice in the hospital to relocate elsewhere.

You should note that the solutions I have described must be approached together, rather than one at a time. Basic science and medical departments cannot develop their full academic potential unless there is a change in the way general funds are assigned. The graduate/technical departments cannot accept changes in the way general funds are assigned unless they are allowed to develop a level of practice that supports their operations and their own academic development. They can and would do this if allowed. That can't happen, and changes in the operation of the hospital that will resolve much of the conflict with the community cannot take place prior to major hospital expansion unless there are exceptions made to current restrictions on cite of practice. None of these current problems can be delt with unless the University can accept the proposition that the graduate/technical departments could become an asset if allowed the modest increase in size and moderate degree of decentralization that would reduce their current intense frustration.

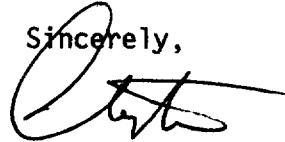
I have had a busy month in Oklahoma. The job so far has been quite interesting. There have been plenty of problems and number of crisis, but not as intractible (so far) as at Stanford. It is too early to be sure, but I think the opportunities for progress here may be quite good.

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I have bought a small house in a large oak grove fronting on a lake; really quite beautiful, and different from the usual ideas about Oklahoma City (not an oil well in sight, nor a house, for that matter). It has been a bit warm, but no tornadoes, so far.

I hope all goes well with you. Give Margurite my best regards.

Sincerely,

A handwritten signature in black ink, appearing to read 'Clayton Rich', with a large, sweeping flourish at the end.

Clayton Rich, M.D.
Provost

CR/pv