Per Se

A paper presented to SPHEX
by George Dawson
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"Per se". (1) As an adverb**:** by, of, or in itself or oneself or themselves: as such: intrinsically. (2) As an adjective: being such inherently, clearly, or as a matter of law: a per se conflict of interest. https://www.merriam-webster.com/dictionary/perse

In 1890 Congress passed the first federal antitrust law, the Sherman Act, named for its principal author, Senator John Sherman of Ohio. The FTC website presents it as the "comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade." The Sherman Act, together with the 1914 Federal Trade Commission Act, which created the FTC, and the Clayton Act, are the three core federal antitrust laws still in effect today. For the past 120 years these laws have been applied with variable success – but with the belief that fair and free trade and competitive markets will best serve the public interest in the long run. https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/antitrust-laws).

Long ago, the Supreme Court decided that the Sherman Act does not prohibit *every* restraint of trade, only those that are *unreasonable*. On the other hand, certain acts are considered so harmful to competition that they are almost always illegal. These include arrangements among competing individuals or businesses to fix prices, divide markets, or rig bids. These acts are "*per se*" violations of the Sherman Act; in other words, no defense or justification is allowed. *(Ibid.)*

But when it comes to healthcare, the effectiveness of Adam Smith's free market "invisible hand" has been less universally accepted. "From the late 1950s to the early 1980s, health planning formed a major theme of American health policy. Seen by its advocates as a "movement," planning aimed to make widely available coordinated health facilities and services, especially hospitals, and to foster their orderly and efficient development, that is, to meet need without duplication."
(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690168/.

The Hill-Burton Act funded hospitals development in underserved areas from 1946 and through the 1950's. President Johnson's Comprehensive Health Planning and Public Health Services Amendments of 1966 promoted funded state and federal health planning with the lofty promise of attaining "highest level of health attainable for every person." As health care costs increased and access inequalities prevailed, the adoption of state level "certificate of public need" (COPN) legislation began to proliferate during the 1970's. In 1975, PL 93-641 created a national framework for local Health System Agencies to control and plan for health services. Meanwhile technology developments like CT scanners, the growth of investor-owned hospitals, and the rise of public and private health insurance plans all fueled expansion of health care for those with access and insurance. But not for all. Lack of access, poor quality, segregated facilities, and structural inequality – these remained as realities for many people of color, the poor, the rural communities.

Through the '50s and into the 1970's, physicians experienced a changing world. The nonprofit community hospital that had existed as a "workshop" for doctors was undergoing change. Hospital boards and administrators gained authority and responsibility. The 1965 landmark case, *Darling vs. Community Hospital,* established institutional responsibility for the care delivered within by hospital employees but also by members of the medical staff. And the Joint Commission on Accreditation of Hospitals prescribed responsibilities for medical staff organization and privileging. The ability of hospitals to impose liability insurance requirements for hospital staff membership was upheld by courts. And increasingly hospital-based physician staffing arrangements were negotiated – including exclusive arrangements in many cases. To be sure, doctors still enjoyed an elite status within institutions - but physician authority, control, and autonomy were in decline.

Proliferation of private health insurance was a major factor. By 1951 community based Blue Cross plans, which helped to finance the costs of hospital care, covered more than 37 million Americans. More than one-half of the hospital patients in America entered with some form of health insurance (the percentage had been 9% in 1940). In that same year, more than 40 million people had some form of private insurance to pay for doctors' bills. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194925/. State and regional Blue Cross/Blue Shield plans transitioned from hospital and doctor sponsored entities to consolidated and aggressive financial adversaries. Reduced hospital stays, prior approval for tests, increased documentation, and hard-nosed contract negotiations became the norm.

On July 30, 1965, President Lyndon Johnson signed the Medicare and Medicaid Act (https://www.archives.gov/milestone-documents/medicare-and-medicaid-act) By threatening to withhold federal funding from any hospital that practiced racial discrimination, as required by Title VI of the 1964 Civil Rights Act, Medicare forced the desegregation of every hospital in America virtually overnight. In his 1916 book, *The Power to Heal: Civil Rights, Medicare, and the Struggle to Transform America's Health Care System*, David Barton Smith describes the remarkable effort by Wilbur Cohen and the people in the Social Security Administration to transform "the nation's hospitals from our most racially and economically segregated institutions to our most integrated," (https://khn.org/news/1965-the-year-that-brought-civil-rights-to-the-nations-hospitals/). Prior to the Act, he describes the status quo like this, "The doctors were segregated, and their patients were segregated. The degree of segregation between indigent patients and private patients was much more extreme than it is today. There were separate wings, separate china. Most medical offices in the South, particularly for primary care doctors, had separate waiting rooms, and black patients would be seen only after the white patients were seen." (Ibid). Hospitals in the South complied with Jim Crow laws, excluding blacks from hospitals reserved for whites or providing basement accommodations for them. "There were a lot of black communities in the South that had basically no access to hospitals," says Smith. (Ibid).

In the north, segregation was more subtle. Black physicians couldn't get privileges to practice at hospitals dominated by whites, and white physicians were pressured to send black patients elsewhere, either to county hospitals—where they often sat for hours on wooden benches waiting to be called—or historically black institutions. The black

institutions were a far cry from whites-only hospitals, Smith says. "They were put together with "scotch tape and bailing wire." (Ibid).

Black patients could sometimes get care at medical schools and teaching hospitals by serving as "teaching material"—a dehumanizing term used to describe black patients who allowed medical students to hone their skills by treating their illnesses, says Smith. (Ibid).

The Story.

On a wintery day in in early 1988 things were coming to a head in a meeting room at the Federal Trade Commission in Washington, D.C. The FTC attorney looked across the table at Ken White and Joe Sims and said, *"Let me make sure I get this straight. You guys are saying we should ignore this hospital monopoly your clients created in Lynchburg because it's lot better than the per se violation of the Sherman Antitrust Act that they were engaged in before they merged? Have I got that right?"*

This is a paper about the forces, events, and people that caused Centra Health to be created by the merger of Lynchburg General Hospital and Virginia Baptist Hospital on January 1, 1987. It's a biased version of a cautionary tale – researched from the Board minutes of LGH, VBH, and Centra– but told from the perspective of one of the participants. I think it's a story worth telling. How were decisions made about important community assets? Who had a seat at the table? And what were the forces in play? Most importantly, what can we learn from the past to help us negotiate the future?

There is no obvious place to start the story. Maybe it should be in 1912 when LGH was founded by the City of Lynchburg as a hospital for black and poor white patients. Or maybe in 1886 when the Masons established The Marshall Lodge Retreat and Home in the wealthy Grace Street neighborhood. Or in 1922, when the Baptist General Association of Virginia picked Lynchburg as the site for the Virginia Baptist Hospital. Perhaps on Feb 14, 1893, when 17 Lynchburg physicians met to form a medical society that would become the Lynchburg Academy of Medicine that we know today. (Rick Piester, *Our Health: Healthy Living in Lynchburg and Southside, Chapter 1,* https://issuu.com/ourhealthvirginia/docs/lbss_historyiii2013.

But my time this evening is limited – so let's start on January 1, 1970. Lynchburg General had grown and prospered since it's humble 1912 beginning as a city-owned facility. After several additions to the original site at Hollins Mill and Federal Streets, LGH began to attract private paying patients as well as the poor. In 1946 the independent Lynchburg Hospital Authority was established by an act of the Virginia General Assembly. A nine-member authority Board assumed responsibility for the hospital without direct subsidy from the City. Hugh Dillard, President of Old Dominion Box Corporation, served as Board Chair from 1946 to 1960 and Robert Hudgens was recruited from his role as the administrator of the Medical College of Virginia Hospital to plan, build and lead the "new" Lynchburg General. It opened in 1956 on the site of the former Tate Springs Farm, where it remains today. The new facility cost about $4 million with funds coming from donations and the federal Hill Burton program. Ownership was transferred from the Hospital Authority to a newly organized private, non-profit corporation created to operate LGH. The two hospitals on Grace Street – Guggenheimer and Marshall Lodge had come under joint management during the 1960's – and by 1969 they affiliated with LGH. It

would not be long before all acute care inpatient care functions were transferred to the LGH Tate Springs campus. With a new modern facility and control of three of the four hospitals in Lynchburg, LGH entered the 1970's in a strong position under the leadership of Ray Hogan. Hogan had been hired in 1957, to replace Hudgens who had returned to head the Hospital Administration Master's degree program at the Medical College of Virginia.

Virginia Baptist Hospital also entered the 1970's in a good place. VBH was opened In 1924 under the auspices of the Baptist General Association of Virginia. Businessman and Southern Baptist, O.B. Barker, headed a local Board which oversaw the construction and operation of the facility. Initial construction was with financial support from local citizens and from Southern Baptists across the state. Located on 26 acres in the fast growing and attractive Rivermont area and with impressive architecture and facilities, the facility was used and supported by the city's more prominent citizens. Subsequent additions included a School of nursing and new wings were added during the 1950's and 1960's,

A Pivotal Decade – 1970-1979

What would determine the future of hospital care in Lynchburg? Would it be unfettered free market competition as prescribed by the Sherman Act or the spirit of enlightened health planning that had dominated health policy and legislation during the 1960's and 70's? It would be a pivotal decade for Lynchburg healthcare.

- The general sense of cooperation that had informally been part of the culture between Lynchburg's hospitals became more explicit and formal as the decade began. In 1970 the Boards of both VBH and LGH agreed to appoint a Liaison Committee between the two Boards and to include active medical staff participation. An agreement to divide certain clinical services soon followed. Obstetrical and pediatric care would be at VBH and emergency services at LGH. Cobalt therapy at LGH and neonatal intensive care at VBH. Plans for expansion and the addition of new clinical services were mutually discussed and fund-raising plans were coordinated so as not to conflict.

- Physician leadership and influence regarding the "cooperative agreement" was an important dynamic. Most doctors strongly supported the effort to avoid unnecessary duplication of services. In the mid-70's, the creation of the "Joint Medical Staff" – one organized staff serving both hospitals- unified this influence. Physicians recognized that the need for "critical mass" to support advanced treatment modalities and facilities was in the patient's and community's interest. Without specialized equipment and surgical capabilities and intensive care units, it was hard to recruit new doctors – especially well-trained specialists. But doctors also clearly had a self-interest in the "cooperative agreement". Most doctors did not want to cover duplicative call rosters for emergency cases or consultations. The prospect of two emergency rooms was presented a dilemma: cover both or risk recruitment of competing specialists? Rounding at two hospitals hurt productivity. Upsetting the status quo would also threaten some hospital-based specialists who benefited from their exclusive contracts.

- As the decade progressed, strategic positioning by each hospital and the effect on hospital finances became a factor. The Emergency Department, with full time physician staffing, was becoming a key driver at LGH and a differentiator for related services like orthopedics and intensive care. Many surgeons preferred scheduling elective surgery at LGH where they already were concentrating emergency cases. It was efficient, convenient, and good patient care.

- In 1976 a proposal for a joint long-range strategic study by both hospitals was rejected by LGH which was about to initiate it own expansion project and fund-raising drive both of which began shortly thereafter. (LGH Board minutes, September 27, 1976). A VBH plan to provide in-house physician coverage for the outpatient department was seen as a ploy to create a de facto emergency department and met with significant physician resistance.

- In the mid-'70's VBH made several strategic mistakes. A poorly conceived addition (the English Building) was added to be a "self-care" facility. Most commercial insurance plans would not cover fees for such a facility and the clear trend was toward outpatient care. An agreement to lease space to a private developer for the construction of a Medical Office Building also proved to be problematic and time consuming. Meanwhile, addressing other important facility needs was delayed – including pressing fire and life safety licensure requirements and seriously outdated surgical facilities. Cash flow and debt capacity became issues at VBH, and billing and collection problems added to the problem. The VBH administrative team included no CPA or senior financial officer.

- Things began to happen as key members of the VBH Board of Directors stepped up their involvement taking on new leadership roles. Among these were: banker, Sam Cardwell, who would become Board President; attorney Buster Baldwin who would become first-Vice President; C.B. Fleet President, Bill Chambers, who would personally supervise finance and budgeting; educator and community leader, Rosel Schewel; and banker, Lewis Goode who would be instrumental in raising donations.

    - VBH also benefited from a contentious split in the anesthesia group which covered LGH resulting in two young anesthesiologists moving their practice to VBH. Drs. Fred Ochsner and Jim Sublett were skilled and progressive in anesthesia for outpatient services and were preferred by many of the surgeons with large elective caseloads. Surgical volume at VBH picked up.

    - With financial performance improving, in March of 1979 the VBH Board approved an ambitious plan for expansion – authorizing architectural plans and a COPN application for a $15 million construction project, a bond issue feasibility study, and a fund-raising campaign. (VBH Board minutes, march 26, 1879.)

    - As the decade closed, Charlie Elliott, the 27-year veteran CEO announced his early retirement, and the VBH Board considered its options. Signing a management contract with an investor-owned hospital company was seriously considered but tabled pending further recruitment efforts.

The decade had begun with the LGH Board expressing "its belief in a philosophy of cooperation" and "perfectly willing to commit itself to working actively to achieve such cooperation" (LGH Board minutes, February 16,1970). It ended with increasing tension as the gap widened between the two hospital and VBH's future was in anything but clear.

New Kid on the Block

Rosemary and I moved to Lynchburg in April of 1980, along with our 16-month-old son. I was 34. Rosemary and I grew up in Virginia but were new to this area. The selection process had been rigorous- managed by a professional recruiting firm and a Board Search Committee chaired by Sam Cardwell, and including Rosel Schewel, Buster Baldwin, Bill Chambers and Dr. Charles Sackett. My first visit had included individual interviews by each of them – and then a couple of more hours with Sam. Two additional trips and multiple reference checks followed. And, I had done my due diligence – or at least so I thought.

There were multiple priorities - most of them intertwined. Virginia Baptist had a good public image with a reputation for care and concern. It was the hospital of choice for Lynchburg's more affluent. But beneath the water there were problems.

- Finances had improved over the past. 18 months – but were far from stable. Cash flow was very tight and at least one supplier required us to pay for orders with a cashier's check on the loading dock. VBH relied on an unsecured line of credit from our Board Chair's bank – United Virginia Bank. (Different banking regulations in those days!).
- The Hospital was operating under a provisional license because of fire code violations cited by the State fire Marshall. These were largely related to the construction and age of our Main Building and adjoining structures.
- The Baptist surgical operating rooms and labor and delivery facilities were seriously inadequate. I'll never forget my first walk thru of the OR's – located in the Krise Building. There were fly strips hanging from the OR lights to catch the flies that flew through the main Rivermont entrance and across the lobby and into the OR. When it came to obstetrical care – the only maternity hospital in town had a 1950's vintage labor and delivery suite with a very different set of expectations from the young mothers expecting a Lamaze experience.
- In the spring of 1980, LGH administrators presented plans for further construction to the Liaison Committee of the two Boards. The project would remodel and expand the Emergency Department, Intensive Care Unit, and the Radiation Oncology Department and relocate OR support areas. VBH's plan to develop proposals for improvement in the (VBH) Outpatient Department were discussed in relationship to LGH's project and "it was the consensus of the Liaison Committee that the two matters would not affect each other." (VBH Board Minutes, June 23, 1980). Based on this understanding the VBH Board reluctantly issued a letter supporting LGH's COPN for the project. VBH had been out maneuvered again. While the Baptist project was stalled, LGH was solidifying its position as the dominant acute care and critical care facility. The vague reference to the VBH "plan to develop proposals" for the Outpatient Department improvements was

largely a smoke screen. The Medical Staff was adamantly opposed to any plan that would provide physician staffing in the OPD. Without staffing, patient access was limited to those relatively few who had a private physician to meet them there. This would continue as a thorny issue for the next 6 years.

- On September 1, 1980, a $22 million bond issue was successfully completed. It retired some $4 million in existing debt and provided financing for the project to renovation the existing facilities and construct a new surgical and obstetrical building. Work began immediately. Virginia Baptist Hospital was closing the gap. (VBH Board Resolution, Aug 22,1980).

From the time we started at VBH, my team and I regarded our counterparts at LGH as competitors. In reality, the "cooperative relationship" was about non-duplication of certain advanced and expensive key services. There was little interest in coordinated provision of care or in sharing joint ventures in administrative or support services that might yield significant cost services. Nor was there any real trust between the administrative staffs. Ray Hogan was a competitive, dominating, successful person. We were the "new kids on the block." Perhaps this personality helped Mr. Hogan accomplish all that he did over the course of his career. It always seemed to be present to me. There is the story of the notorious softball game between LGH and VBH that occurred a few years before I arrived. It was supposed to be fun event promoting sharing by both staffs. Chaplains from each hospital were deputized to umpire. The game ended in an uproar with both teams walking off the field after a disputed call by one of the chaplains. Or the legendary incidents of inaccurate line calls by Mr. Hogan during the interhospital tennis league. Simply stated, cooperation was not part of his nature – and he set the tone for the LGH team.

To be fair, the "cooperative relationship" was not the top priority for me and the VBH executive team. We were working the ambitious agenda set by the Board. That agenda included stabilizing finances and operations, financing and completing the construction project, and setting the strategic direction for the hospital. The Board recognized that a closer relationship with Lynchburg General might be an option but wanted to deal from a position of strength if those discussions were undertaken. Many thought the "cooperative relationship" had favored LGH more than VBH and complicated the Baptist mission.

The combination of the Joint Medical Staff structure and the "cooperative relationship" also presented a major complication in our ability to work with doctors. I was accustomed, as was Tom Jividen my senior assistant, to an open, transparent, and collaborative approach with the organized medical staff and with individual physician groups. This approach had served us both well in previous positions. We had used meetings of medical staff departments, committees, and the monthly meeting of the Medical Staff Executive Committee as collaborative forums to explore new ideas and discuss issues between administrators and doctors. But with the Joint Medical Staff, administrative representatives from both hospitals were in attendance. Our competitor was at the table. Secrecy, ambushes, and one upmanship were common tactics by both administrative staffs. Physicians were also conflicted. On the one hand trying to maintain the balance of power between two hospitals; on the other, representing patient, community,

and self-interests interests as they saw them; and still preserving a level of physician autonomy and control.

The Baptist General Association of Virginia

In the Fall of 1980 Carol DeFord, a nurse in the Virginia Baptist Hospital ICU, blew the whistle on the abortions at Virginia Baptist Hospital. In a letter to the editor of the *Religious Herald,* the newspaper publication of the Baptist General Association of Virginia (BGAV), she reported on the continuing performance of abortions at the Hospital basing her report on daily tabulations from the surgical schedule.

This brought to a head a controversy that had been brewing over the Hospital's abortion policy and the whole relationship with the BGAV. In the Association's 1978 Annual Meeting , the Hospital was singled out in a floor vote which recommended that the VBH Board adopt a policy restricting abortions at the Hospital. The VBH Board did subsequently pass such a policy which was to go into effect upon approval by the OB-GYN staff. When the doctors objected, the matter was simply dropped, apparently in the hope it would go away. DeFord's letter made sure that didn't happen.

The Hospital abortion policy was a hotly debated topic, locally and among Southern Baptists state-wide, for the next four years. The Hospital Board and obstetricians agreed on and implemented policies that significantly reduced abortions. This met with approval of most members of the denomination. But the matter had planted a seed that eventually led to the separation of the relationship between the Hospital and the BGAV. The VBH Charter and Articles of Incorporation required that 80% of the Hospital Board be Southern Baptist and that the election of all Board members be approved by the BGAV. Moreover, any transfer or sale of assets was subject to BGAV approval. In effect, any merger or other restructuring of VBH was subject to control by the BGAV thru a provision in the Articles of Incorporation. This was a time of division within the Southern Baptist denomination in Virginia and nationally. Conservatives were gaining power within the denomination seeking to control the boards of institutions and colleges with denominational ties. This was a serious matter and a significant distraction for the VBH Board and administration.

Discussions, studies, hearings, and BGAV politics stretched over the next four years. A strange de facto coalition emerged. The most conservative elements wanted to end the relationship and remove Baptist from the hospital name. A majority of the denomination was comfortable with the revised abortion policy but many felt the Hospital was essentially a local rather than state-wide institution and BGAV financial support should be limited. Our strongest supporters wanted to protect the Hospital from take-over by denominational factions they saw as extreme. In the end these different groups voted to limit BGAV support and restrict it to the Hospital Chaplain service. Relaxing control of Board appointments followed. The final piece occurred in 1985 when the BGAV quietly gave up control over the Articles of Incorporation and the right of approval over corporate reorganization, merger, and sale of assets – thus leaving the VBH Board in full control of the Hospital's future. (VBH Board minutes, September 23,1985)

1981-1985: A Stress Test

The next four years proved to be a "stress test" for the Liaison Committee and the "cooperative approach" between LGH and VBH. It was a period of growth and diversification for both. With construction underway, both focused on strategic developments including some non-traditional services. Minute books reflect discussion and reports on topics including: the Altavista Medical Center (LGH) and MedChoice in Timberlake (VBH), Courtside Athletic Club (VBH) and Pathways Treatment Center (VBH), a commercial laundry (LGH) and a retirement community at Villa Maria (LGH). VBH formed a strategic planning committee of its Board and engaged a consulting firm to conduct a study of its market. In 1984 the LGH administration began to review a corporate reorganization which would eventually lead to a proposal for LGH to adopt a holding company structure with a 13-member Board and hospital and various other activities placed into separate sub corporations. (LGH Board minutes, Aug 13, 1985)

Development of two new services at Virginia Baptist during the 1984 and 1985 had long-term implications. The first was in psychiatric care. VBH had operated an inpatient adult unit for some time. In September of 1984, the VBH Board approved a plan for VBH to seek a COPN for a child and adolescent inpatient unit and a residential center. VBH would be competing for COPN approval against an effort by Hospital Corporation of America to open a child and adolescent hospital and residential facility. The VBH admin team, led by Tom Jividen, was moving quickly to present a strong alternative fearing that HCA was seeking an entry point into the Central Virginia market. At the end of the day the VBH application prevailed and formed the basis for a core business that grew to include inpatient units for adults and kids, Pathways substance abuse treatment center for adults, the Bridges Residential Center for Children, Rivermont School with campuses in 12 communities across the Commonwealth, and the Piedmont Psychiatric Group.

The second new service development was for cardiac cauterizations services at VBH. In conjunction with an 8-member task force from the Medical Staff and with the key involvement of Dr. Charles Sackett and George Dawson, a plan had been developed to seek approval for the opening of a cath lab at VBH in some unfinished space in the newly constructed Carter Building. A skilled young cardiologist on the UVa Cath Lab staff, Thomas Nygaard, MD, provided planning assistance and committed to relocate to Lynchburg if the new service was approved. In January of 1985 the VBH approved a resolution to seek COPN approval with support from the business community and from the Liaison Committee. Ultimately COPN approval was granted, Dr. Nygaard was named Director of the Cath Lab at VBH leading to the future addition of cardiac surgery services initiated by Dr. David Frantz and to the eventual formation of the Stroobants Heart Center.

During all this growth and activity, the involvement of the Liaison Committee was infrequent, and many felt, uneven. The Medical Staff was particularly concerned that competition rather than cooperation seemed to rule the day. In 1984 a Special Study Committee was formed to investigate ways to enhance cooperation between the hospitals.

In a report to the VBH Board, Dr. George Hurt reported on the initial work of the ten-member task force consisting of four Board members and the administrator from each hospital. (note: one of the Board members from each was also a physician – Drs. Hurt and Barney). The concept

of giving the Liaison Committee the authority to make decisions that would be binding on each hospital Board was discussed but rejected based on legal advice regarding Federal anti-trust laws and state corporate practice of medicine concerns. This left, in the opinion of the Task Force, three alternatives: (1) full merger, (2) full competition, or (3) a reactivated and restructured Liaison Committee. (VBH Board minutes, October 22, 1984).

Two months later, Dr. Joe Calicott, President of the Joint Medical Staff, updated the LGH Board on the recommendations of a Medical Staff committee convened to consider the situation. He reported the Staff "does not support merger between the two hospitals" but felt " that the Liaison Committee had become ineffective" and requested a moratorium on any new proposed expansions of other services. Chairman Franklin Moomaw reported to the LGH Board on the matter. He noted a further meeting of the Merger Committee would occur on Dec 28,1984. He cited George Dawson as slow to respond to a Hogan proposal and that the LGH Board had previously set a deadline of Dec. 31, 1984, for a final report on merger. The minutes end by stating that Mr. Moomaw, "noted that merger is no longer considered a viable alternative." (LGH Board minutes, Dec 17, 1984).

A month later, the VBH Board approved the revised Liaison Committee guidelines. In reporting on the matter, Mr. Baldwin noted that the task force had approved the guidelines as had a committee acting on behalf of the Medical Staff and Mr. Ken White, VBH attorney. The new guidelines called for regularly scheduled meetings, and "a three-party format including both hospital and representatives of the medical staff." The chair would be from the medical staff. (VBH Board minutes, January 28, 1985).

A review of the Board minutes suggests that any real hope that these new guidelines had rebooted the "cooperative spirit" were short-lived. The LGH Board minutes of April 15, 1985, mostly reflect a "business as usual" report noting that the new guidelines will require "appropriate matters to be presented to the Liaison Committee before final approval is granted" by the hospital board. It was implied that two LGH projects, the Villa and the Linear Accelerator, had not met this requirement. Dr. William Barney also noted that "some feel we will end up at one extreme or the other, such as pure separation, including separate medical staffs, or a merger". (LGH Board minutes, April 15, 1985)

When the VBH Board met a week later, the discussion was highly critical of LGH Board and administration's attitude toward the "cooperative relationship" and the Liaison Committee. Chairman Jim Candler referred to the history of cooperation between the hospitals while "looking at issues from a community perspective" and expressed his disappointment noting and that the last meeting of the Liaison Committee had been "a real set back." Dr. George Hurt questioned the future of the Liaison Committee saying it was "not dead, but definitely in the ICU." Dr. Hurt went on to note that it may be the time to possibly consider merger. Dawson noted that since the last meeting of the Liaison Committee members of the LGH had violated the cooperative spirit in several ways including asking the Virginia Commissioner of Health to revoke or reconsider COPN approvals previously granted to VBH. (VBH Board minutes, April 22, 1985)

There seemed to be alternate views by the two Boards. LGH was paying lip service to the cooperative approach while heading full speed down the path to corporate restructuring and

independent decision making. VBH was living within the Liaison Committee framework – but preparing for the likelihood of a competitive future**.** ***In June of 1985, the Joint Medical Staff stepped into this gap*****.** A year earlier it had rejected the idea of merger. Now, by a vote of 96 to 3, it voted to "re-examine the future relationship between the hospitals" provided that the medical staff was afforded appropriate representation in the process. (VBH Board minutes, June 24, 1985.)

Finally…

The turning point had occurred somewhere during the summer of 1985. Exactly when and where remains a mystery to me. Clearly, physician opinion had been a major driver. The over whelming majority vote by the Joint Medical Staff to reconsider options was a major factor. There were undocumented reports of a private pivotal discussion between the two Board Chairs, Franklin Moomaw and Jim Candler. The rumor was that an informal but significant discussion took place after the funeral of a mutual friend. Mr. Moomaw and the LGH Board finally seemed willing to exert control over an administrator who was accustomed to calling the shots. Opinion within the business community also probably played a part. Corporate influence was significant, and the prevailing view was that a uncontrolled "hospital arms race" would only further drive up costs. Among the privileged public at large, there was a level of civic pride in a healthcare system that exceeded rightful expectations. Lynchburg healthcare was noteworthy for it's quality, sophistication, caring attention, and low cost. The 'cooperative relationship" was given credit and a merger offered future benefits.

Things moved quickly after the ice was broken. A joint committee to consider the relationship between the hospitals was appointed and consultants and attorneys were engaged. Ken White was selected to facilitate and coordinate the effort and to ride herd on both administrators. Ernest and Whinney led the economic analysis and the community impact study. Cost comparisons documented favorable hospital costs and rates as compared to other similar markets. More than 100 stakeholders were interviewed during the initial phase. Mr. Joe Sims of the Washington law firm of Jones, Day, Reavis and Pogue was hired to lead the anti-trust analysis and defense. Cost savings and reductions of $11.5 million were identified and capital finance capacity gains of $15 million were projected. Letters of support from the Business Coalition and Blue Cross of Virginia wee obtained. Options for corporate organization were studied and a consolidated corporation with a single Board of Directors emerged as the preferred choice. Dawson and Hogan met over several months and ultimately agreed on a plan for Executive leadership of the new system.

On January 1, 1987, Centra Health was established.

On that wintery day in in early 1988 in Washington, D.C. at the Federal Trade, Ken White responded to the FTC attorneys across the table, "I *guess that's one way to look at it. The way we see it is that the cooperative approach by our clients has provided high quality healthcare at a below market cost. There are no opposing parties. The merger is supported by the business community, Blue Cross, and community doctors. If you really view this as the best place to establish FTC jurisdiction over hospital mergers, the starting point is federal district court in Lynchburg, Va. "* Or words to that effect.

On March 28,1988, Ken White informed the Centra Board that the FTC has closed the file on the merger, noting that it "may reopen in the future but Joe Sims does not anticipate this happening." (Centra Health Board minutes, March, 28, 1988)

On May 27, 1988, the Department of Justice took a new step in the 98-year history of federal antitrust enforcement. The Department challenged consolidations of non-profit charitable hospitals bringing injunctive actions designed to stop proposed transactions in Roanoke, Virginia and shortly thereafter in Rockford, Illinois. The hospitals in Roanoke prevailed with the formation of the Carilion Clinic as the result. The Justice successfully blocked the Rockford merger.
https://www.washingtonpost.com/archive/business/1988/06/13/va-hospital-merger-battle-could-set-national-precedent/c0887fa4-31cd-4be3-84d8-a338f55baf2c/.

Where does public policy stand today? On July,18, 2022, the Kaiser Health News service reported on the FTC's successful challenge to four hospital mergers stating that President Biden's FTC is, "primed to combat consolidation more aggressively in the health care industry than it has in past years." It went on to quote President Biden comments that, "hospital mergers and acquisitions had left the 10 largest health care systems in control of a quarter of the market and led to the closure of hospitals in rural and other underserved areas." Mark Seidman, an assistant director in the FTC Bureau of Competition was quoted, "We are feeling invigorated and looking to fulfill the executive order's call to be aggressive on antitrust enforcement. The trade commissioners say this is a key way to slow health care price increases; protect patient access to and the quality of care; and prevent employee layoffs, pay cuts, and unfair labor practice." https://khn.org/news/article/biden-ftc-block-hospital-mergers-antitrust/

In Conclusion…

Researching a writing this paper has been a trip down memory lane. Along the way it has raised some things for me to ponder.

- One striking aspect of the Lynchburg's "hospital history" is the remarkable contributions of citizen leaders willing to devote tremendous time, expertise, energy, and personal fortune to build and manage these institutions. The institutions and organizations that serve us today still depend on that civic spirit. I am especially struck by the significant responsibility that goes with being a Board member at Centra.

- I have also been thinking about whose opinion counted. Two groups seem to have been discounted or not seriously consulted. One of those were the staff employees of the hospitals. I don't recall an effort to solicit employee questions or support. I expect that would be different today in an environment with serious staff shortages and labor organizations. The impact of consolidation on the black and low-income minorities was not, to my recollection, a major discussion. I think Centra has done a lot over the years to improve healthcare access for those groups, but I think that came after the fact rather than a key consideration in the debate. That whole area would make a great topic for someone's future SPHEX paper.

- Most on my mind, has been a question I used to get asked a lot: “Who owns Centra?” Of course, there is the legal answer describing the structure of a private, nonprofit 501 (c) (3) organization. And there’s the “speaking to the Rotary Club” answer: “the community – everyone’s a stockholder…”

  But I want to go deeper. Centra is composed of assets accumulated over time from at least four hospitals and from countless public and private sources. Among them are the original investment by the Masons in Marshall Lodge, public funds from the City of Lynchburg, Hill-Burton Funds and various other grants, funds from the Baptist General Association of Virginia, and countless private donors from Max Guggenheimer and Hugh Dillard to Jimmy and Jewel Carter and from Al Stroobants to Alan Pearson. Not mention the time donated by countless volunteers, Board members and doctors over the years.

  In this time of consolidation and change in the healthcare, how does a non-profit Board deal with the question of asset value, ownership, and control. How is mission defined? How are “community interests” defined and represented by decision makers. What happens when those interests’ conflict or compete – internally and externally? How is the actual geography of the community defined. How are assets leveraged, deployed, and protected? These are hard questions. I am especially struck by the significant responsibility that goes with being a Board member at Centra.