



**WILLIAM D. PETASNICK**  
**In First Person: An Oral History**

American Hospital Association  
Center for Hospital and Healthcare Administration History  
and  
Health Research & Educational Trust

**2017**

**HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION**

**WILLIAM D. PETASNICK**

**In First Person: An Oral History**

**Interviewed by Kim M. Garber  
On March 20, 2017**

**Edited by Kim M. Garber**

**Sponsored by  
American Hospital Association  
Center for Hospital and Healthcare Administration History  
and  
Health Research & Educational Trust  
Chicago, Illinois**

**2017**

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Coordinated by  
Center for Hospital and Healthcare Administration History  
AHA Resource Center  
American Hospital Association  
155 North Wacker Drive  
Chicago, Illinois 60606

Transcription by Chris D'Amico  
Photographs courtesy of the Petasnick family, Froedtert Health and the University of Minnesota

**EDITED TRANSCRIPT**  
**Interviewed in Chicago, Illinois**

**KIM GARBER:** Today is Monday, March 20, 2017. My name is Kim Garber, and I will be interviewing William Petasnick, who retired in 2012 as President/CEO of Froedtert Health. Prior to the 19 years that he spent in leadership at this academic medical center in Milwaukee, Mr. Petasnick was Administrator/Chief Operating Officer at the University of Iowa Hospitals & Clinics. He has served as Board Chairman for the American Hospital Association, the Wisconsin Hospital Association and the Council of Teaching Hospitals, among other professional volunteer work. Bill, it's great to have the opportunity to speak with you this morning.

We always like to start by remembering people who were important during your childhood. Both of your parents were born in the U.S. and grew up in Sheboygan, Wisconsin, but all of your grandparents were immigrants from Russia, I believe.

**BILL PETASNICK:** Right.

**GARBER:** Did you have the chance to know your grandparents? What values did you learn from them?

**PETASNICK:** Unfortunately, I did not, except for my maternal grandmother. She gave me a link to what she always referred to as the "Old Country." I used to kid that Sheboygan was like a little Anatevka – from *Fiddler on the Roof*. It was a community of 42,000. We were a close-knit family with my aunts and uncles living nearby. They all influenced my life. They were successful small business owners; one of my uncles in particular was actively involved in various civic activities and was well known in the community. All played a role in the development of my core values.

Sheboygan was your typical midwestern small town. Everyone knew each other and as a result it was a protective environment. Nobody locked their doors. As mentioned, everybody knew each other, which later in high school could be a problem because my dad would say, "Where were you last night?" I had to be careful what I said because a customer might say, "Oh, I saw your son at ..." – where maybe I shouldn't have been.

**GARBER:** What was your grandmother's name?

**PETASNICK:** Rose. My parents had contemporary names. My mother's name was Caroline. My dad's name was Morris. They were born in this country around 1910. My dad was 93 when he passed away, and he certainly had a great influence on me and my older brother and sister.

**GARBER:** You spoke of your family's small business. There was the Petasnick Food Market.

**PETASNICK:** Yes, it was a mom-



and-pop business. My dad was greatly impacted by the Great Depression. He was a sophomore at the University of Wisconsin-Madison when he had to return home to help support his family. I often wondered what he could have achieved if he had been able to obtain his degree in engineering. Dad never spoke about this, but he always reminded us of the importance of getting a college education

**GARBER:** Did your mother go to college?

**PETASNICK:** No. She wanted to go to college and become a nurse. Like my father, she was unable to fulfill this dream because of other family obligations. It's too bad because she would have made an excellent nurse – very caring. My parents were greatly impacted by the Great Depression. They struggled together and the store enabled them to keep their heads above water. My mother had a zest for life – an unyielding optimist. She gave all of us a sense of purpose, stability, bedrock values and a compassion for helping others. As a family we were not rich in material things, but the importance of helping others was engrained in our value system.

**GARBER:** Did you work at the store?

**PETASNICK:** We all did. Our lives were intertwined with my dad's store. Each of us had specific "chores" that would change as we got older. I've come a long way since my first job – wiping off the beer and soda bottles! Running a mom-and-pop business was all consuming and at times it felt like an albatross around our necks.



**Bill's parents,  
Caroline and Morris Petasnick**

Meeting the needs of the customer was a guiding principle at my dad's store. Our small store was dependent upon the customer service relationship. Years later, when talking to our staff, I always stressed the importance of focusing on the needs of our patients. I felt like my father in stressing the importance of customer service

**GARBER:** How did World War II and the Holocaust affect your extended family in Europe?

**PETASNICK:** Most of our family had migrated already, but we did know other families that were directly impacted by the Holocaust. Growing up, I was protected from the full meaning of the Holocaust. I didn't fully understand what the Holocaust represented until I was much older. I remember coming across the name in an encyclopedia and was shocked by the pictures and suffering depicted. The Holocaust did have a major influence on my parents. They were great patriots and assured me that nothing like this could happen in America.

**GARBER:** You were the youngest of three children and you all graduated from Sheboygan North High School.

**PETASNICK:** That's correct.

**GARBER:** Your brother, Jerry, who is eleven years older than you are, became an eminent physician and professor. He’s a radiologist?<sup>1</sup>

**PETASNICK:** Yes, and for many years he was the chair of radiology at Rush University.

**GARBER:** Did you feel pressure when you were in school because your brother, I’m sure, had had an eminent academic career at Sheboygan North?

**PETASNICK:** Because of the difference in our ages, I didn’t have a close relationship with my brother until later. He did set a high standard, and I always admired what he had accomplished. He was always the big brother and I was the little pest. I recall one time when we were downtown, and he was with a girl. I came up and said, “This is your girlfriend?” in an obnoxious way. He tore my shirt trying to catch me. On the other hand, my sister and I always had a close relationship. There was a seven-year difference in age; I could always turn to her for advice and guidance.

**GARBER:** According to your high school yearbook, you tried different things when you were in high school. You participated in sports. You were a reporter. You sang. The quote that you picked to accompany your senior portrait in the yearbook was, “I try all things. I achieve what I can.” I’m not familiar with that quote.

**PETASNICK:** I was an assistant editor of the yearbook. The editor-in-chief coined that saying. I did go out for a lot of things – some stuck and some didn’t. I was a terrible athlete. I had no business trying out for football, and I stayed long enough to get my picture taken. The unique thing about high school was the ability to try different things. I liked writing and I think being a reporter was a way of exploring different things. That passion for exploration continues.

**GARBER:** What made you decide to go to the University of Wisconsin-Madison?

**PETASNICK:** From childhood I had been told, you’re going to go to college, you’re going to go to college. We were strong supporters of the University of Wisconsin at Madison – we were all Badger fans. My brother had gone there, and the decision was that both my sister and I would follow him. It was an incredible time to be there, in the ‘60s.

**GARBER:** How involved were you in political activism?

**PETASNICK:** It would have been impossible not to be. Wisconsin was a hotbed of social action. I was a political science major and I became an activist. My father was a patriot and thought that I was being influenced inappropriately. We



**Bobbe and Bill**

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<sup>1</sup> Jerry P. Petasnick, MD, was professor and department chair of radiology and nuclear medicine at Rush-Presbyterian-St. Luke’s Medical Center in Chicago. He also served as president of the Radiological Society of North America (RSNA). [Huckman, M.S. (2001). Jerry P. Petasnick, MD, president Radiological Society of North America, 2001. *Radiology*, 218(1), 5. <http://pubs.rsna.org/doi/pdf/10.1148/radiology.218.1.r01ja745>]

used to argue about that. College was an incredible experience and it changed me. I became open-minded. As a liberal arts major, I was exposed to things I never had experienced, growing up in a small town. Madison was also a place where I met my future wife, Bobbe.

**GARBER:** Are there any professors you would wish to mention?

**PETASNICK:** I had a speech professor as my advisor; he was extremely helpful and made himself available. My advisor spoke about the importance of having good communication skills and being able to quickly organize your thoughts.

**GARBER:** How important is it for a CEO to be able to speak in public?

**PETASNICK:** It's incredibly important. I've benefited from several mentors who were excellent speakers, who had a way of putting together words in a succinct, focused way, who were able to get their message across and inspire others in the organization. My interest in public speaking started in high school when I went out for forensics – and was successful competing at the state level. This is a critical skill and one that you have to continue to refine. Sadly, one of the effects of Twitter and other social media today is that people are losing the skill to communicate effectively. That's something that we're going to regret.

**GARBER:** Is it equally important to be a good writer or, as an executive, do you have staff prepare drafts for your review?

**PETASNICK:** Writing is important in terms of getting your thoughts together. I did my own PowerPoints because this was my way of organizing my thoughts. I would draft the presentation and then have staff refine it, as opposed to the other way around. Part of our role as chief executive officers is to provide a clear sense of vision, to create excitement around achieving that vision and then to be consistent in terms of messaging.

**GARBER:** Let's go back to the University of Wisconsin. You met Ed Connors,<sup>2</sup> who has been interviewed as part of this oral history series.

**PETASNICK:** I was a political science major working on a paper. Medicare had just been enacted and it was highly contentious. The American Medical Association was against it. There was a strong political element against it. It was a profound social document.

I had done a lot of reading, but then I went over to the university hospital, which was called Wisconsin General at the time. I went into the administrative office and asked if I could talk with one of the assistant superintendents and get their perspective on the new legislation. The offices were laid out with the superintendent on the right and the lieutenants on the left. The superintendent's secretary heard my request and said, "Mr. Connors is here and he may be willing to share his thoughts with you." This encounter was the beginning of a lifelong mentorship with Ed Connors, truly one of the most inspiring leaders I've ever met. He had a great impact on my professional life. I was thrilled to

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<sup>2</sup> Edward J. Connors served as superintendent of the University of Wisconsin Hospital & Clinics from 1960 to 1968, later becoming president of Mercy Health Services. His oral history, Weeks, L.E. (Ed.). (1983). *Edward J. Connors in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

have him as one of the speakers at my investiture.

I began searching the literature on the field of “hospital administration.” I remember writing to the American College of Hospital Administrators, and getting a list of universities that were offering a masters programs in hospital administration. At that time there were only a few programs – it was an evolving discipline – which I found to be very exciting. I had found my vocation and never thought twice about pursuing a career in hospital administration.

**GARBER:** It was remarkable that you were able to just walk in off the street and have an interview with Ed Connors, the superintendent. I wonder if that would happen today.

**PETASNICK:** Probably not. To be admitted to the Minnesota program, you had to go through an interview with alum. I interviewed with Gordon Johnsen who was the administrator of Madison General Hospital,<sup>3</sup> and it was a challenging interview. I remember sweating profusely through it and I was sure I never would get into the program. What I liked about the University of Minnesota’s program was its strong emphasis on mentorships. It was through this emphasis that you could be exposed to some of the great leaders in the field.

The experience I had with Ed Connors was unique in that I was able to do an administrative fellowship with him. He had left the University of Wisconsin and had spent a year in Washington and went on to become the director of the University of Michigan Hospitals and Clinics. I had an opportunity to follow him to Michigan as an administrative resident. I basically lived outside his door. I found him to be an incredible teacher. He had a way of putting things into context, and he had great people skills as a part of that.

As a leader, Ed was analytical and valued people who were analytical in their thinking, too. He wouldn’t let you get away with generalities. He was a great organizer in terms of putting complicated matters in a context that people could understand and work with. He valued good writers. My year as an administrative resident was an incredible one. It not only reinforced why I wanted to stay in an academic medical center environment, but also opened the doors to so many different people that I met through Ed Connors.

**GARBER:** What you mentioned as a fellowship, was this your residency year?

**PETASNICK:** Yes.

**GARBER:** That was a typical model for a graduate program in hospital administration at the time – one year of academic work and then a one-year residency.

**PETASNICK:** That’s correct.

**GARBER:** Other people have told me how much they valued their administrative residencies. That’s a gone by the wayside a little bit.

**PETASNICK:** Yes, it has. Later on, I always accepted an administrative resident myself

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<sup>3</sup> Gordon N. Johnsen (1926-2013) served nearly his entire career in leadership at Madison General Hospital (Madison, Wisconsin). [*Gordon N. Johnsen: Obituary.* (2013). <http://www.cressfuneralservice.com/obituary/121445/Gordon-Johnsen/>]



because I thought it was an important part of the program.

When I was at Ann Arbor, I took courses in the Michigan program. That's where I met John Griffith<sup>4</sup> as a professor. I benefited from these two very different programs. Michigan had just gone to a two-year program. Minnesota later followed that.

**GARBER:** Minnesota had been a one-year program?

**PETASNICK:** It was one year, and then you had to write a major thesis the second year.

**GARBER:** You were at Minnesota right after James Hamilton<sup>5</sup> had left the directorship of the program.

**PETASNICK:** Right.

**GARBER:** He was a legend there. Did you have the opportunity to meet him?

**PETASNICK:** I did, because he came back and taught a series of courses, and we were able to get exposed to him. Hamilton was a challenging individual. He was an "in your face" kind of guy that you either liked or didn't. We had several returning veterans from the Vietnam War and they found it very hard to accept his teaching methods. He was very different than Bright Dornblazer,<sup>6</sup> who replaced him. In fact, you couldn't have asked for two more different personalities.

Dornblazer was very theoretical and kept referring to our role as "social change agents." Hamilton's approach was to turn out good problem solvers. He wanted his students to be able to act under pressure and be good thinkers. Personally, I prefer the role of being a social change agent and being a progressive leader.

**GARBER:** Can you give an example of how you felt you were an effective change agent?

**PETASNICK:** I came of age in the 1960s. Like many others in my generation, I wanted to impact the world in a positive way. The '60s were a time of hope, optimism and a feeling that if we worked together we could truly make a difference. I always wanted to use my administrative talents to improve things and be that change agent that many of my professors talked about. I've had the opportunity to work in a variety of settings ranging from the U.S. Public Health Service to an urban health system that includes a major academic medical center and regional community hospitals. Each experience has helped me to build a better understanding of what health care means to different people and different communities. Early on in my career I felt that health care was a right and it was our role

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<sup>4</sup> John R. Griffith is the Andrew Pattullo Collegiate Professor Emeritus at the University of Michigan, where he spent his entire career. His oral history, Garber, K.M. (Ed.). (2010). *John R. Griffith in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <http://www.aha.org/research/rc/chhah/Griffith.pdf>.

<sup>5</sup> James A. Hamilton (1899-1985), was director of the Program in Hospital Administration at the University of Minnesota from 1946 to 1966. His oral history: Weeks, L.E., (Ed.). (1983). *James A. Hamilton in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

<sup>6</sup> Bright M. Dornblazer served as director of the University of Minnesota's Program in Hospital and Health Care Administration from 1967 to the early 1980s. [University of Minnesota. *Dornblaser, Bright*. <http://editions.lib.umn.edu/ahc-ohp/2012/03/29/dornblaser-bright/>]

to develop a health system that would provide coverage for all.

**GARBER:** At the time, were you of the mindset that change for change's sake has merit?

**PETASNICK:** That was my position and, as a young administrator, I was rather naive. I remember one Saturday morning meeting of the administrative team at the University of Michigan Hospital and Clinics. I had just heard Walter Reuther speak. He was a proponent of health care for everyone – the same terms we're using today. I made the comment at this meeting that this was important because we need change for change's sake. Ed said, "No, no, no, you've got it wrong. Change for change's sake is not a strategy, and without a strategy you have chaos". It was a good learning session and I have never forgotten the lesson.

**GARBER:** Is there anything else you'd like to say about Minnesota before we move on?

**PETASNICK:** At Minnesota, the program had a tremendous network of alumni who would often return to share their administrative philosophy, and the strategies they were following to bring about meaningful change in their organizations and the communities they were serving. Every Friday there was a presentation based on practical experience. One speaker in particular was very special.



**University of Minnesota Master of Healthcare Administration class of 1970 –  
Bill Petasnick is in the second row center in the brown suit**

Hubert Humphrey had just lost the race for the presidency and was giving a series of lectures at the University. He talked about the history behind Medicare and brought in several of his colleagues to talk about the bipartisanship that was necessary and the duration of the interaction to bring Medicare into existence. Humphrey had a profound impact on my thinking in terms of the importance of health

care and the political process as a part of it.

**GARBER:** Do you have any thoughts about those early days of the implementation of Medicare and how hospitals adapted to the program?

**PETASNICK:** I've written articles about this – Medicare was more than just a piece of legislation; it was a social change document. It caused profound change. As a condition of getting payment for Medicare patients, hospitals had to discontinue segregated black wards and white wards. Medicare was a change agent through this legislation. It established the framework for organizations to start thinking in terms of being a community resource more than just a hospital.

The enactment of Medicare was understood to be a beginning, not the end. It was designed in a way that it would have to be changed constantly because the government was moving into territory where no one really understood what would happen. There was a sense when Medicaid was enacted that maybe public hospitals wouldn't be necessary anymore. We could close all the public hospitals. In fact, it put a greater burden on the public hospitals.

**GARBER:** I think I read someplace that the implementation of Medicare helped hospitals straighten out their chart of accounts.

**PETASNICK:** It helped hospitals learn how to bill. For the first time there was the development of a chart of accounts to aid hospitals in determining their cost structure. The AHA took a leadership role in the development of tools to improve their billing practices and begin the process for creating a structure to measure quality. The notion of “back room functions” was just beginning and there was a steep learning curve to fully understand the maze of regulations.

**GARBER:** You had mentioned segregation. It amazes me that ending segregation could have been included in the Medicare legislation – and that it passed.

**PETASNICK:** You have to credit the role of Lyndon Johnson. I was a great fan of John Kennedy, and I remember to this day sitting in a classroom in high school when the principal announced the president's death over the loudspeaker. The Kennedy assassination set Johnson in motion. He had the ability to dig down and get the votes needed to make profound changes. I'm not sure it would have happened otherwise.

**GARBER:** You mentioned that in a segregated hospital there would be a nursing unit that would only be for people of color. Another nursing unit would only be for white people.

**PETASNICK:** The cafeteria was like that, too. I was at the University of North Carolina, a very progressive organization in a progressive state, but up until Medicare, the units were segregated. The cafeteria was segregated. Fifteen years later people would still refer to units, “Oh, yeah, that was the black unit.” That was the prevailing way. It was wrong. Medicare was the driver – if you want to get paid, you've got to change what you're doing.

**GARBER:** Operationally, there would have been an impact, too, because you would have had to have more beds.

**PETASNICK:** Right, and staff. It was not a pretty picture. It was a struggle in progressive organizations. That was the way things were.

**GARBER:** How long did it take for hospitals in the south to say, yes, we would like to participate in Medicare and therefore we're willing to desegregate?

**PETASNICK:** Money is a great stimulator. It stimulates the necessity of making some changes quickly. That transition was over a three-year to five-year period.

**GARBER:** That's pretty fast.

**PETASNICK:** It was, but the alternative was, you weren't going to get paid. It was a perverse incentive but it worked.

**GARBER:** Before we move on to your career, is there anything else you wish to say about your years in school?

**PETASNICK:** Being at the university was eye opening. My life would have been different had I not been exposed to that.

**GARBER:** You received your master's degree. Did you go to work for the federal government next?

**PETASNICK:** I was able to get a draft deferment with the understanding that I was going to go into the service as a medical service officer. I was able to do that through the Public Health Service.

My parents had grown up in Sheboygan and never moved. As I was growing up, the only big cities I ever went to were Milwaukee and Chicago. I wanted to broaden my experiences. I had this opportunity to go to Washington for two years and to be part of the National Center for Health Services Research at a time when nobody knew what health services research really was. Even more incredibly, there was money available. Part of my role was to help fund and evaluate grant applications from programs in health administration. I was this young whippersnapper, and I was reviewing grant applications to help establish and provide seed money for programs in health administration. One of my responsibilities was to visit programs around the country. I was able to visit top programs at UCLA, at the University of Colorado, at Yale and meet some of the major players in health care administration. It was an incredible two years. We were young and didn't have any children at that time. Living in Washington was like working in a candy store in terms of being exposed to all of this. People talked to each other then.

**GARBER:** You had the opportunity to meet George Bugbee and undoubtedly some other lions in the field. What was George Bugbee like?

**PETASNICK:** George Bugbee<sup>7</sup> had played a major role in the development of the AHA and then ran the program in health care administration at the University of Chicago. His wife had passed away and he had just stepped down from the program. He retired and was spending time at the

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<sup>7</sup> George Bugbee (1904-1995), served as the executive director of the American Hospital Association from 1943 to 1954, later becoming director of the Graduate Program in Hospital Administration at the University of Chicago from 1962 to 1970. His oral history: Weeks, L.E., (Ed.). (1983). *George Bugbee in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

National Center for Health Services Research. I was his staffer. George was an incredible individual. He was always impeccably dressed in a suit or a sport coat – with everything perfectly tied. I learned how to tie a tie from George. For two years, I worked with him and drove him places. He knew everyone.

He was a door opener. I was working on a grant involving Ray Brown,<sup>8</sup> also a giant in the field, who ran the Duke program of health administration. At that time, he had moved to Chicago to take over a consolidation that was underway between Passavant and Wesley to form Northwestern Memorial.<sup>9</sup> I remember going late on a Thursday afternoon and meeting and talking to a legend. We ended up talking for almost two and a half hours.

After two years, my time was done and I had to decide what I wanted to do. Did I want to go back to graduate school and get a Ph.D. and ultimately run a program in health administration? Did I want to return to the hospital setting? There was an opportunity to get a grant to get a Ph.D. I elected to return to Ann Arbor to focus on the steps that would lead to becoming a CEO. I decided to be where the action was – with those who ran the institutions, those who would have an impact.

**GARBER:** You went back to the University of Michigan Hospital for a couple of years.

**PETASNICK:** Yes, I worked with the physician practice groups that were being formed at the time. Medicare was causing a shift in how physicians were being paid. I remember Ed saying, “What you need to do is to get exposed to different elements because they’re going to have an impact on what you’re doing.”

My role was to help form the medical practice group of the university physicians. Before that, the billing systems were not in existence. I had an interest in research. We were trying to form a health research center there, blending the hospital as a laboratory and the university program. Having met John Griffith, I was able to be a part of that process. I had two things going on. One was understanding and working with physicians and on the formation of a practice group, and then continuing to look at how we could use the hospital as an operating laboratory for health services research.

I got a call out of the blue from a friend who was then the acting director at the University of Wisconsin. He was building a management team and was calling to see if I was interested in coming to interview for one of the vice superintendent positions.

**GARBER:** About that time, you wrote an article having to do with young administrators and their interests and ability in doing research. Now I can see why you were asked to write that article.

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<sup>8</sup> Ray E. Brown (1913-1974), served as a hospital administrator at the University of Chicago Clinics and Hospitals as well as director of the Graduate Program in Hospital Administration at the University from 1951 to 1962. [The American Hospital Association’s 1963 Distinguished Service Award to: Ray E. Brown. (1963, May 1). *Hospitals, J.A.H.A.*, 37(9), 44-49.]

<sup>9</sup> In 1972, two nearby hospitals in Chicago’s Streeterville neighborhood merged to form Northwestern Memorial Hospital. Chicago Wesley Memorial Hospital and Passavant Memorial Hospital, both faith-based hospitals, consolidated to become the largest private not-for-profit hospital in the region and serve as the primary teaching hospital for the Northwestern University Medical School, now known as the Feinberg School of Medicine. [Northwestern Medicine. (2017). Northwestern Memorial Hospital history. <https://www.nm.org/about-us/history/northwestern-memorial-hospital-history>]

**PETASNICK:** Yes, I've had a lifelong interest in health services research and understanding it. It's hard to believe that then, it was a new concept. What is it? Is it survey research? Is it medical sociology? There were a lot of different terms being floated around.

**GARBER:** That was a nice opportunity for you at Wisconsin. You had been staff at Michigan and then you became a vice-superintendent.

**PETASNICK:** It was. It was at a time when that organization was going through a restructuring and a new person was coming in to lead the university hospital— Gordon Derzon.<sup>10</sup> I had taken a risk by going there without knowing who was going to be the permanent director of the hospital. Going back to that statement in the yearbook, "I try all things. I achieve what I can" – I didn't worry about it. I thought it would work out, but it was risky. At that time, we had two children. Our son was born as we were leaving Washington. He was born at Bethesda Naval Hospital. I ended up getting a ticket. The ticket cost me more than it cost to have the baby. At that time, if you were in the military, which we were, you paid for the food that your wife consumed, the formula, and the rest was part of the government plan. Our daughter was born just as we were leaving Ann Arbor.

**GARBER:** You were taking a risk but you were young.

**PETASNICK:** Right. We didn't know better.

**GARBER:** It turned out that Gordon Derzon ended up staying 26 years in his position.

**PETASNICK:** Yes, exactly. He had, at a very young age, run Kings County Hospital Center. We were all nervous in terms of what was going to happen. Gordon has the ability to keep a very serious face and to a young administrator this was quite unnerving. The initial impression among the staff was that he would be a tough individual to work for. While Gordon was a tough and demanding individual, once you met his requirements he was a real human being with a sensitivity for people that you might not see on first encounter. I had a serious health problem and was hospitalized for several weeks. I will never forget that Gordon stopped by every day to see how I was doing. I greatly benefitted from my years of working for and with him.

While at the University Hospitals and Clinics, I met Gary Mecklenburg,<sup>11</sup> who was also one of the assistant superintendents. To this day we have retained a close personal and professional relations. Gary became one of the top CEOs in the field.

**GARBER:** You stayed at Wisconsin for about seven years. What were you responsible for?

**PETASNICK:** At that time, I had become the associate senior vice president for all the operations. At the end, I was functioning as the chief operating officer. I had responsibility for all of

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<sup>10</sup> Gordon Derzon served as president and CEO of the University of Wisconsin Hospital and Clinics from 1974 until his retirement in 2000. Prior to coming to the University of Wisconsin, he had been executive director of Kings County Hospital Center (Brooklyn, New York). [University of Wisconsin-Madison Libraries. (2002). *Oral history program interview with Gordon Derzon, 2002*. <https://search.library.wisc.edu/catalog/999935784202121>; and, Hospital director disputes charges of city officials. (1971, December 19). *The New York Times*. [http://www.nytimes.com/1971/12/19/archives/hospital-director-disputes-charges-of-city-officials.html?\\_r=0](http://www.nytimes.com/1971/12/19/archives/hospital-director-disputes-charges-of-city-officials.html?_r=0)]

<sup>11</sup> Gary A. Mecklenburg served in leadership positions at St. Joseph's Hospital (Milwaukee), Franciscan Health Care and at Northwestern Memorial Hospital in Chicago. [University of Chicago Booth School of Business. (2017). *Gary A. Mecklenburg*. [https://www.chicagobooth.edu/daa/past\\_honorees/gary-mecklenburg](https://www.chicagobooth.edu/daa/past_honorees/gary-mecklenburg)]

the operating departments, for example, the laboratories, radiology and plant engineer. Those duties led me to where I was competitive in being recruited as a chief operating officer.

**GARBER:** Did you have direct reports?

**PETASNICK:** Yes, I was responsible for a lot of people. My day consisted of meeting after meeting. I remember my second-grade daughter telling one of her friends that all her dad did was attend meetings. When parents were asked to come to school to tell the students what they did at work, I remember her saying, “Dad, they’re never going to understand what you do as a hospital ‘adminirator’. Why don’t you just tell them you’re an artist?”

**GARBER:** Your next opportunity was at North Carolina Memorial. Is there anything else you’d like to say about Wisconsin before we move on?

**PETASNICK:** It was hard to leave because we had family and an incredible network of friends in Madison. That’s a problem in health care leadership – you move. If you want different experiences, you are forced to move. There might be levels in the organization you can get to, but many times getting promoted to the next level means you have to move. It was a tough transition because my wife, who was a teacher, had a network of friends. Our kids had a network of friends. It was the first tough place to leave. We got in our car and we were all crying.



Chapel Hill turned out to be a great learning experience that set the stage for the next part of my life. We were there long enough that

our kids felt that was their place. They grew up in Chapel Hill. It was one of the most productive periods of my life and it gave me the opportunity to work with a great boss, Eric Munson.<sup>12</sup> Both of us were Yankees from the north. One of the early challenges was to eliminate smoking in the hospitals. This was a big issue in North Carolina, given the role of tobacco in the state. The board chair at that time said, “I’m supportive of this, but you Yankees need to get someone else to be at the forefront on this.” The legislature was already making noise about cutting off funding because they heard we were going to eliminate smoking and get rid of all the cigarette vending machines and the like. The culture was different.

Chapel Hill was called the “southern part of heaven.” Culturally, Chapel Hill was a great place to live and raise a family. Our kids had developed a southern dialect with a midwest twang! Talk about tears when we left! When I announced to my family that we were going to move to Iowa City, our kids were in high school. My son said, “Dad, I thought you loved us.” For a couple of years, every time the James Taylor song, “Carolina on My Mind” came on the radio, everybody would start crying.

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<sup>12</sup> Eric B. Munson served in leadership at North Carolina Memorial Hospital (Chapel Hill, NC) from 1980 until 2004. [UNC Health Care. (2004, March 15). Eric Munson named president emeritus of UNC Hospitals. *Press release*. [http://news.unchealthcare.org/news/2004/Mar/munson\\_emeritus](http://news.unchealthcare.org/news/2004/Mar/munson_emeritus)]

My wife would start crying. My kids would start crying. The dog would look at me and growl.”

**GARBER:** How did your next opportunity at Iowa come about?

**PETASNICK:** I got a call from Sam Levey,<sup>13</sup> who was running the program in health administration at the University of Iowa and was chairing the steering committee, to see if I would be interested in being part of the senior staff at the University of Iowa. The last thing I had in mind was leaving Chapel Hill and returning to the midwest and the cold. The opportunity to work for John Colloton<sup>14</sup> and be a part of one of the premier academic medical centers in the country was something I could not pass up. The timing was right for me to move and be exposed to a different cultural environment, a new set of issues and challenges. University of Iowa Hospitals & Clinics was a unique environment.

There was also the challenge of moving high school age kids. I wouldn’t advise it, although our kids now look back as if it was a great experience because they were able to start over and meet new friends. They knew that they could deal with change. My wife didn’t want to move because she was teaching. This was disruption but I felt that I needed this move because of the experience.

We made the move. To this day, John and I keep in touch. He was a demanding individual to work for and he challenged you constantly. John’s focus on attention to detail was powerful and something that I needed to have a greater appreciation for. I learned at Iowa what it would take to be a strong and effective CEO. I’ve learned a lot from John. My years at Iowa prepared me to become a better chief executive officer when the opportunity presented itself.

Being at Iowa also allowed me to be a faculty member at the University of Iowa with Sam Levey. Sam was a true academic and well known in the field. He was an incredible individual and we developed a lifelong relation. Sam died about a year ago and I miss his friendship.

At 45, I was getting impatient about not running my own show as a CEO. I had this internal drive, this wanting to run something – maybe it goes back to my dad, who said the important thing is to be your own boss. After being a COO for almost ten years I felt the time was ripe.

Lo and behold, I got a call to see if I would have an interest in coming back to Wisconsin and putting my hat in the ring for the CEO job in Milwaukee at Froedtert Hospital. Interestingly, I had been at the University of Wisconsin years earlier when the first certificate of need application was submitted for state approval to build the Froedtert hospital. I had been on the staff at UW when we wrote a negative opinion, arguing that the state didn’t need another academic tertiary institution. Then I left Wisconsin, so I lost track of what happened. My first response when I got that phone call was, “They actually built the hospital!”

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<sup>13</sup> Samuel Levey, Ph.D. (1932-2015) was professor emeritus at the University of Iowa’s Department of Health Management and Policy, where he was chair of the program beginning in 1977. [Samuel Levey. (2015, December 30). *Iowa City Press-Citizen*. <http://www.legacy.com/obituaries/press-citizen/obituary.aspx?page=lifestory&pid=177070549>]

<sup>14</sup> John W. Colloton served for 44 years at the University of Iowa Hospitals and Clinics, starting as an administrative intern, becoming director in 1971 and continuing in this top leadership position until 1993. [M.C. native John Colloton to get honorary doctorate. (2012, December 8). *Mason City (Iowa) Globe Gazette*. [http://globegazette.com/news/local/m-c-native-john-colloton-to-get-honorary-doctorate/article\\_696626a2-4106-11e2-838a-001a4bcf887a.html](http://globegazette.com/news/local/m-c-native-john-colloton-to-get-honorary-doctorate/article_696626a2-4106-11e2-838a-001a4bcf887a.html)]



**GARBER:** Before we move on to Milwaukee, I'd like to ask more about John Colloton, who was a legend at Iowa. You mentioned some of his characteristics were that he demanded attention to detail, that he was a forceful leader. Could you say anything else about his leadership style?

**PETASNICK:** He could be forceful and intimidating to work for, but he wanted strong people around him. I did feel at times he was overbearing and would challenge him –but I always felt his heart was in the right place. His focus on being overly prepared was something that made me a more effective leader. For example, John never went into a meeting without being fully prepared. His “briefing books” were notorious for their thoroughness. He was always able to flip to a page in the briefing book and say, “You’re wrong, here are the facts.” He had an incredible ability to retain information.

He was demanding on himself. His whole life revolved around the UIHC. It was an all-consuming part of his life, and he expected that it would be that way for the staff. He expected the staff to be available in the evenings and on weekends, if necessary. If you were easily intimidated, you would not do well working for John.

**GARBER:** What graduate program did he come out of?

**PETASNICK:** University of Iowa. He grew up in Iowa. I think he is from Mason City. He knew everyone in the state and was highly respected throughout the state.

**GARBER:** In the early ‘90s, you made another career move to Milwaukee, as mentioned earlier. What is the story of the founding of Froedtert Hospital?

**PETASNICK:** Kurt Froedtert,<sup>15</sup> ran the largest malt company in the world. When he died in the early ‘50s he left funds in his estate for the creation of a hospital that would play a role in teaching and research and advancing medical science. He himself had had a long-time interest in health care. A trust was established, but the hospital didn’t open until 1980. Why did it take so long? The state of Wisconsin had an extensive certificate of need process especially for anything that involved building new hospitals or adding new beds.

Milwaukee is a community of around 650,000, and when you add in the surrounding area, maybe a million. There was a sense that there were too many hospitals already, so the state refused approval of a certificate of need and said that the proposed hospital should be consolidated with an existing hospital. There was a lot of scurrying around with regard to linkage with another hospital.

This was going on at the same time that Marquette University decided to close the medical school due to the high cost of running a freestanding school of medicine. Luckily, Milwaukee city leaders felt that having an academic center was important if they were going to develop a robust community. There was a group called the Greater Milwaukee Committee that went on site visits around the country to look at cities that had medical schools. They became enamored with the University of Texas Medical Center in Houston, which is built upon a common campus that housed several medical institutions. Community leaders felt this model could also work in Milwaukee on

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<sup>15</sup> Kurtis R. Froedtert (1887-1951), head of the Froedtert Malting Company, bequeathed money for the building of the Froedtert Memorial Lutheran Hospital in Milwaukee. [Froedtert Hospital. (2005). *Celebrating 25 years of hope and spirit.*]

county land west of the city.

The notion of a regional academic medical center anchored by the Froedtert Hospital began to emerge. However, there were several regulatory challenges ahead. Wisconsin was a certificate of need state at that time. Milwaukee was deemed “overcrowded” with hospital beds. The land that the county was proposing also housed the Milwaukee County Medical Complex. In order to get through the certificate of need process, a complex set of agreements would be required. First and foremost, Froedtert Hospital would be built adjacent to the county hospital. Secondly, certain clinical services would be divided between the two hospitals. The trauma center would stay at the county hospital along with orthopedics and cardiology services. The transplant program and specialty services would be at Froedtert. Finally, there would be a jointly operated “bridge building” that would house radiology and laboratory services. These two entities would work together under the guise of what was called the Milwaukee Regional Medical Complex.

The agreement was a regulatory dream but became a management nightmare. The hospital opened in 1980 and soon began struggling. As a result of the complex patient mix, its price structure was too costly to remain competitive in the market place. Numerous joint governance arrangements were tried to create greater functionality between the two institutions – none of which worked. This was also a time where managed care was coming into the marketplace. To do a managed care contract, one needed to negotiate with Milwaukee County as well as with Froedtert, which was a private entity with private governance. There was a realization that a new governance structure was going to be needed.

I was called by a search consultant and by Tom Smallwood, who was an attorney in Milwaukee and was chair of the Froedtert board, to explore my possible interest in becoming the president & CEO of Froedtert Hospital. Tom was a dynamic guy, an incredible individual – also an Iowa graduate. We bonded immediately.

The University of Iowa Hospital & Clinics is one of the premiere medical centers in the world, highly regarded, modern facilities, vibrant in terms of patient care programs and resources. Froedtert was complex and a fiscal disaster waiting to happen. There was disruption everywhere. For me these disruptions provided a great opportunity to build something from the ground up. The challenge at the University of Iowa Hospital & Clinics was essentially – don’t screw things up. In Milwaukee, the opportunity was to build a comprehensive academic medical center in partnership with the Medical College of Wisconsin. The challenge was to develop a strategy that would enable Froedtert to achieve its potential. The pieces were there, but the real challenge was how to redefine the role of Milwaukee County.

I arrived in February 1993. Every CEO usually thinks that the world begins with their arrival. I wanted to be careful of that. Dean Roe,<sup>16</sup> who was the long-term president of Froedtert, was an outstanding individual. He was a true gentleman. Dean had done the heavy lifting to create a semblance of a framework but the alignment with the county hospital (now called Doyne Hospital) was a real impediment.

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<sup>16</sup> Dean K. Roe (1929-2014) was the founding president of Froedtert Hospital (Milwaukee). [Uebelherr, J. (2014, May 30). Roe used patience, determination, vision to open Froedtert Hospital. *Milwaukee Journal Sentinel*. <http://archive.jsonline.com/news/obituaries/roe-used-patience-determination-vision-to-open-froedtert-hospital-b99281077z1-261287131.html>]

**GARBER:** Who were some of the players from Milwaukee County?

The biggest challenge was to get Milwaukee County to realize that they were not on a sustainable path. Thankfully, many of the county supervisors were beginning to recognize this including Tom Ament<sup>17</sup>, county executive, and Bob Jackson, county board chair. In my first meeting with these two individuals, I had prepared an extensive briefing book. John Colloton would have been proud of it. To my surprise, Bob Jackson opened the meeting by saying, “We need to get out of the hospital business. There needs to be one entity operating the two hospitals and that entity needs to be Froedtert and its board of directors.” The next challenge was to get the 26-member board of supervisors to agree with Bob’s position.

There were lots of individuals telling me we were wasting our time. With the help of John Petersen, M.D.,<sup>18</sup> long-time medical director of the county hospital and Tom Brophy,<sup>19</sup> a well-respected executive within Milwaukee County government. The County Board agreed to a special study. The study was an important document reinforcing the point that the existing framework was not sustainable.

To the surprise of everyone, an agreement was reached with Milwaukee County in the fall of 1995. The county board voted to sell the county hospital to Froedtert Hospital and end its role as a direct provider of health services. It was a courageous move by Milwaukee County and a significant risk by the board of Froedtert Hospital. After many hours of negotiations, on December 24, 1995, the doors of Milwaukee County Hospital closed and simultaneously a new Froedtert Hospital was created.

It was a crazy time for the management team of Froedtert. Overnight, a full service hospital was created. It was a significant opportunity but a major challenge to our team. New IT systems were needed, staff had to be recruited, a comprehensive facility plan was needed and, most importantly, we needed a financial plan that would keep us afloat over the transition. We developed a different affiliation arrangement with the medical college that allowed us to start acting like an institution that had the three-part mission of teaching, research and patient care. I felt like a kid in a candy store, because we could start anew on things that had been issues in other places.

It was a great opportunity to put together a strong management team. We were going from 150 beds to over 500. We had to bring on a whole new staff because Doyne closed and we did not want to become a successor organization. We built a staff and recruited some 2,500 people in a short period. The county hospital would close and we would take over the next day. It was a fly-by-night as we were trying to do this, but it was an exhilarating thing professionally.

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<sup>17</sup> F. Thomas Ament (1937-2014), an attorney, was elected to the Milwaukee County Board of Supervisors in 1968 and became board chair in 1976. He was later elected to be County Executive. [Milwaukee Historical Society. *Milwaukee County. County Executive. F. Thomas Ament.* <https://milwaukeehistory.net/milwaukee-county-county-executive-f-thomas-ament-1968-2002/>

<sup>18</sup> John R. Petersen, M.D. (1929-2009) served as director of medical services at the Milwaukee County Medical Complex for 27 years. [Milwaukee County Historical Society. *Petersen, John R. papers.* <https://milwaukeehistory.net/wp-content/uploads/2017/09/0749.John-Petersen-Papers.pdf>]

<sup>19</sup> Thomas A. Brophy began his career as a social worker before moving into leadership positions such as serving as administrator of the John Doyne Hospital starting in 1994. [Medical College of Wisconsin. Doctor of humane letters honorary degree recipient conferred in 2013. <https://www.mcw.edu/History-of-MCW/Honorary-Degree-Recipients/Thomas-A.-Brophy.htm>]

**GARBER:** The new arrangement was described as a half hospital. Have you heard of any other examples of half hospitals?

**PETASNICK:** I have not heard of others. This is something that only a policy person could put together. The county hospital ran the Level 1 trauma center – we would leave that in the county hospital. Froedtert would become more of a specialty boutique institution where all the medical and surgical subspecialties – transplants for example – would be at the new Froedtert. Orthopedics and general surgery and cardiac surgery would stay at the county hospital. Neurosurgery, ENT would be at Froedtert. There were certain clinics that ran at Froedtert that didn't run at the county hospital. It made no sense.

**GARBER:** Froedtert was a brand new bricks-and-mortar facility that was built adjacent to the county hospital?

**PETASNICK:** Think of it as East and West Berlin – that's how the staff used to refer to it.

**GARBER:** Which was East Berlin?

**PETASNICK:** East Berlin was the county hospital. West Berlin was the Froedtert facility. They were two separate buildings with a connector built later.

**GARBER:** Do you mean a bridge?

**PETASNICK:** A bridge, although there were some places where the bridge didn't go through. I remember getting a call from my engineer asking if I wanted to come over as we broke down the wall to this one connector.

There were certain services that were shared. There was a connecting bridge that had, for example, radiology. It didn't make sense to operate a radiology department in Froedtert and not in the county hospital. They had built an ancillary building that was called United. It was the only thing that was united, but it required separate governance. There were all these workarounds trying to create this ability to have this institution. It was the craziest thing that I had seen. I did ask some of the staff at the AHA and at AAMC to see if they knew of other half hospitals. Nobody did. There were situations where there were two full hospitals operating in close proximity and sharing some services, like at the Houston Medical Center, but there was nothing like this in terms of the governance structure or this model.

**GARBER:** Was it a united medical staff?

**PETASNICK:** They were all faculty of the Medical College of Wisconsin.

**GARBER:** Were there physicians who had privileges at one hospital and not at the other?

**PETASNICK:** Yes, which complicated things, as you can expect. There were some community physicians, too, but what was evolving was a full-time faculty. This had not been the model to that point because they had used community doctors for clinical practice sites. What we were talking about was creating a full-time, unified faculty. This raised a cultural issue because there were some physicians who were very committed to the mission of the county hospital, and who were concerned that Froedtert would close the Level 1 trauma center and walk away from some of those

services that were financially not able to cover their cost.

There was a lot of ambivalence coming from the faculty as to whether this consolidation was a good thing or not. Working through that process with the leadership of the medical college was important so that we could become unified in terms of our vision. How to define what we meant by an academic medical center was key.

**GARBER:** What is the definition of an academic medical center (AMC)?

**PETASNICK:** It has a three-part mission. One, it's a site for teaching the next generation of physicians and nurses and other health professionals. Two, it's an ability to apply the latest technology in patient care. The ability to focus on patient care and manage multi-specialty capabilities under one roof, in one organization, would have an impact. That was different from a community setting. Three is the research side. People got the idea that the medical school was involved in doing research but how does that apply to the patient – what does that mean to me? We were able to get stories out about the clinical capabilities that we were able to have by applying research.

We spent a lot of time defining our mission to our surrounding communities. We also wanted to avoid the traditional town-gown conflicts. We needed the support of the local physicians. We needed a referral source because, like most academic centers, we didn't have a very big primary care base. We were dependent upon referrals. We were balancing trying to create a full-time faculty, clinical capability, while at the same time not wanting to generate a town/gown conflict. That always was a difficult dance. It was difficult at North Carolina. It was difficult at Iowa. It was difficult at Wisconsin.

**GARBER:** What you describe as an academic medical center sounds like the classic three-legged stool concept that has been around for decades. As we look into the future is that three-legged stool model going to continue or will it evolve?

**PETASNICK:** It's fragile because it adds a level of complexity and cost. Teaching is an expensive commodity. The National Institutes of Health, Medicare and Medicaid are important sources of financial support for the educational efforts that go on in these institutions. That's vulnerable. One of the big uncertainties being debated today with the concept of repeal-and-replace is what's going to be the impact on teaching programs and the research programs at NIH.<sup>20</sup> They're part of the core of what these institutions do. It is vulnerable and requires strong societal support to be successful.

When I was starting out, people would talk about the "aging dinosaur" in reference to academic centers. Their governance structure was in many ways non-existent. Their ability to move quickly and make decisions, unlike the competitors, was limited because of needing to get all the other players together. Many of the academic centers, instead of having a unified practice for all of the physicians being part of one organization, had formed their own corporation. Radiology was a separate corporation. The department of surgery was a separate corporation. They couldn't move quickly in terms of responding to contractual obligations, building networks, bringing in other players

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<sup>20</sup> Repeal-and-replace refers to ongoing political activity related to The Patient Protection and Affordable Care Act (P.L. 111-148) which was signed into law in 2010 by President Barack Obama. [Retrieved from <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html>]

because these governance structures were flawed and they were self-limiting.

There's a lot that has changed to make these institutions more effective. Governance is still a big issue in terms of the nature of whether boards can respond to the needs of both the medical school, which has different needs and requirements, versus that of the clinical enterprise. There is greater movement now to try to integrate these while still maintaining the separate roles and functions of each of the organizations.

Our competition was able to move quickly, but we were like a covered wagon train. When we needed to, we would surround the wagons, but shoot within. There was a lot of time that was lost, as opposed to being able to compete in the market where quickness was important. The ability to do single-signature contracting for managed care was limited by some of the governance structures that were in place in these settings. The last ten years that I was involved, we were trying to figure out how do we move more quickly? How do we become more responsive to the marketplace? How do we build partnerships? How do we bring in community players? How do we link and create a different structure that would create integrated care? In many of the academic centers, it just wasn't structured that way. Profound change is still going on in terms of how academic centers continue to be leaner, more focused and able to respond more quickly to market dynamics.

**GARBER:** Who are the nimblest competitors?

**PETASNICK:** There are a number of integrated settings that have evolved from some outstanding community organizations. In Chicago, there is Advocate, which has built a strong, geographically distributed model of care. They've been able to do it at a faster pace than Rush or Northwestern, for example.<sup>21</sup>

In Milwaukee, we had a very strong competitor – Aurora<sup>22</sup> – that had developed a broad network while we were “Johnny-come-lately” to the scene. We ended up developing a relationship – an integrated structure. Health care is still local. You can be part of a large system and still know what's going on in your community and how to relate to that which is a critical factor in being successful. So you may say, “We needed to create an integrated structure.” By that I mean physicians and hospitals working together in a coordinated way. These are being done in different settings, and each plays out differently based upon the local situation.

We would kid that running an academic center is like trying to turn an aircraft carrier. It takes a long time to turn while other ships are more nimble and can move faster to take advantage of things. That was the constant challenge.

**GARBER:** I'd like to circle back to the subject of town/gown issues, which have been around for a long time. Which of the various academic medical centers that you worked for was the best at

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<sup>21</sup> Advocate Health Care (Downers Grove, Illinois), Rush Health (Chicago) and Northwestern Medicine (Chicago) are all not-for-profit health systems operating hospitals in Illinois. [Advocate Health Care. *About Advocate*. <https://www.advocatehealth.com/about-advocate/>. Rush Health. *About Us*. <https://www.rush-health.com/RHAWeb/AboutUs/>. Northwestern Medicine. *Northwestern Medicine History*. <https://www.nm.org/about-us/history>.]

<sup>22</sup> Aurora Health Care (Milwaukee) is a not-for-profit health system operating 15 hospitals in Wisconsin. [Aurora Health Care. *Overview & History*. <https://www.aurorahealthcare.org/about-aurora#More-to-Explore>.]

resolving this?

**PETASNICK:** It's still a challenge for most academic medical centers because of the different cultures. Of the 125 AMCs, it seems everyone is exploring new alignment models either through outright acquisitions or through clinical integration. Institutions like the University of Wisconsin faculty practice foundation, Duke, Penn, UNC and UPMC, among others, have been at this for some time. At Froedtert, our health system was built around aligning community institutions and medical practice groups into a common clinically integrated alignment with the Medical College of Wisconsin faculty practice.

The nature of those debates is different because the doctors have become part of the academic environment by setting up separate divisions or entities to accommodate community-based practice in a big way. I mean, we created a unified structure that all of our primary care physicians were under one entity controlled by the health system, and that was a prevailing model that has been utilized.

**GARBER:** In five or ten years will there be independent physicians?

**PETASNICK:** Those days are over now. Milwaukee was known for a variety of clinics. They're now all part of health systems. In Chicago, private independent physician groups now are a small minority. It doesn't mean they have to be employed, but through clinical integration, physician networks can be aligned so that one can deal with quality issues, have some consistency in terms of clinical protocols, and have some consistency in terms of standards. Advocate is the best example of that. They've created a large network of community physicians, many of who continue to view themselves as private, but are part of the Advocate system. They have to manage within the protocols that Advocate has established. They're part of integrated clinical medical record systems. The independent physician is not a sustainable model, whatever the health practice requirements are going to be. I think those days are gone.

**GARBER:** What is your prognosis for the stand-alone hospital?

**PETASNICK:** I think it's going to be very tough being a stand-alone hospital. As I talk to my colleagues around the country, it's clear that size does matter in terms of access to capital and creating integrated delivery systems.

These critical access hospitals in rural areas have a lot of political strength with key members of Congress who support them. They're not going to give up and not continue to support a critical access hospital. It may not be called a hospital. Critical access hospitals may evolve into community health centers and move away from traditional inpatient care, or become more involved in terms of chronic disease management under a different framework.

**GARBER:** Is there anything else you'd like to say about your time at Froedtert or individuals you worked with there?

**PETASNICK:** It was a great time to be the president & CEO of Froedtert Hospital and work with a great management team. Key members of this team included Blaine O'Connell,<sup>23</sup> chief

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<sup>23</sup> Blaine O'Connell served as chief financial officer at Froedtert from 1993 until his retirement in 2011. [Froedtert CFO O'Connell to retire. (2010, March 10). *Milwaukee Business Journal*. <https://www.bizjournals.com/milwaukee/stories/2010/03/08/daily33.html>]

financial officer; Cathy Buck,<sup>24</sup> chief operating officer; Peter Pruessing,<sup>25</sup> senior vice president for regional development; Charlie Runge,<sup>26</sup> senior vice president for clinical integration; John Balzer,<sup>27</sup> vice president for facility planning and development; and, Andrew Norton, M.D.,<sup>28</sup> senior medical officer. In an environment where there can be tension between the hospital and the medical school over funds flow and resource allocations, I had a close working relationship for ten years with Mike Dunn, M.D., dean of the Medical College of Wisconsin.<sup>29</sup> Michael Bolger,<sup>30</sup> president of the Medical College of Wisconsin, was also a great partner.

It was important to have a supportive board willing to take risks. Here we were, a 150-bed hospital taking over an institution three times our size. One of our board members, Don Schuenke, sent me a cartoon of the dog catching the car. If our board had not been willing to take risk and buy into the vision we were trying to achieve, this never would have occurred. What has evolved is a robust academic medical center that is flourishing. It has tripled in size. It's a viable community resource.

I remember distinctly the first time that I met with some of the insurance players in Milwaukee. Someone from Humana said, "We don't view you as a resource. Your organization could be gone tomorrow – we don't need you to sell our product." One of the greatest things was, ten or fifteen years later, the same person said, "Was I wrong! Today we could not sell our product without having Froedtert and the Medical College as a part of it."

**GARBER:** I've been thinking about the combination of the hospitals. You had mentioned that there was a huge staff change, that you brought in a lot of new people, so a lot of people then lost their jobs?

**PETASNICK:** They lost their job as a county staffer but many became part of Froedtert. We spent a lot of time in terms of cultural development. County Hospital was heavily unionized. Froedtert was private and had a non-unionized workforce. I have to give the union leadership credit. They recognized that they were on a death spiral in terms of sustaining employment for their people at the county hospital. In the end, they took a supportive position which resulted in a smooth

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<sup>24</sup> Cathy Buck became president of Froedtert Hospital in 2011. [Froedtert & Medical College of Wisconsin. (2017). Cathy Buck biographical summary. <http://www.froedtert.com/about/leadership/cathy-buck>]

<sup>25</sup> Peter S. Pruessing was an executive with Froedtert Health and later served as CEO with Integrated Health Network of Wisconsin. [Kurt Janavitz succeeds Peter Pruessing as Integrated Health CEO. (2015, January 8). *Milwaukee Business Journal*. <https://www.bizjournals.com/milwaukee/news/2015/01/07/kurt-janavitz-succeeds-peter-pruessing-as.html>]

<sup>26</sup> Charles W. Runge (1957-2012) served in various positions at Froedtert beginning in 1995, including senior vice president for planning and service line management. [Charles W. "Charlie" Runge. (2012, November 6). *Milwaukee Journal Sentinel*. <http://www.legacy.com/obituaries/jsonline/obituary.aspx?pid=160897488>]

<sup>27</sup> John A. Balzer, who started his career as an award-winning school teacher, serves as vice president, facility planning and development at Froedtert Health. [Froedtert & Medical College of Wisconsin. *Froedtert Health executive leadership*. <http://www.froedtert.com/about/executive-leadership>]

<sup>28</sup> Andrew J. Norton, M.D., served as chief medical officer at Froedtert from 1997 to 2011. [Main Line Health. (2017). *Chief medical officer*. <https://www.mainlinehealth.org/about/senior-leadership/andrew-norton>]

<sup>29</sup> Michael J. Dunn, M.D., served as dean and executive vice president of the Medical College of Wisconsin from 1995 to 2008. [Medical College of Wisconsin. *Portrait of Michael J. Dunn*. <http://mcwlibraries.digital.mcw.edu/cdm/ref/collection/p16123coll1/id/4>]

<sup>30</sup> T. Michael Bolger, an attorney, served as the fifth president of The Medical College of Wisconsin from 1990 until his retirement in 2010. [Medical College chief to retire. (2009, July 14). *The Milwaukee Journal Sentinel*. <http://archive.jsonline.com/business/50807002.html>]



transition.

Creating a patient-oriented culture was a consistent focus of our team. Academic medical centers are notorious for long waiting times, for fragmented care, for not communicating effectively. We were focused on the patient and continuity of care. That didn't happen by chance. It happened because Cathy Buck and her team worked with our staff to create a patient friendly environment.

**GARBER:** How they did they do that?

**PETASNICK:** It's scripting. It's creating and defining scenarios – situations and how that should be managed.

**GARBER:** These were communicated in staff meetings?

**PETASNICK:** Staff meetings, training sessions, bi-weekly meetings, quarterly meetings. Everyone had to go through a common training course in terms of customer service and expectations and scripting. For example, the simple practice of walking into a patient room and introducing yourself and giving a little brief bio goes a long ways of creating a patient friendly environment. . "I'm Nurse Smith. I've been practicing nursing for x number of years. We're going to take good care of you."

Academic medical centers have a lot to learn in this area. Patients are subject to all these different people coming into the room. Many of them don't introduce themselves and it's confusing. We wanted to make sure that the doctors introduced themselves and told something about themselves to the patient. Adding the phrase, "We're going to take good care of you," was because of a focus on scripting, training, sensitivity to these issues, and it had a profound impact on our campus.

**GARBER:** Could you talk about your time working with AHA?

**PETASNICK:** Ed Connors was very involved in the Association. He was a member of a task force that produced the Perloff Report.<sup>31</sup> It was one of the classic studies done by the AHA in terms of the future of health care and how it needs to be organized into health care corporations and some other topics. I was support staff to Ed, indirectly. George Bugbee also exposed me to the AHA. We would talk a lot about his days at the AHA. It sounded like something important to be a part of.

There wasn't a lot I could do as an assistant or as an associate, although I did become involved in the state hospital organizations in North Carolina, Iowa and Wisconsin. I always had an interest in the AHA because of my mentors. Stan Nelson<sup>32</sup> was a great one as well. I saw people I respected become very active and involved with the AHA. I myself became involved through various work groups, study sections, essay sections, task forces and a Regional Policy Board. Exposure to Dick

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<sup>31</sup> *Ameriplan: A proposal for the delivery and financing of health services in the United States, Report of a Special Committee on the Provision of Health Services*. Chicago: American Hospital Association, 1970. Also known as the Perloff report after committee chair Earl Perloff.

<sup>32</sup> Stanley R. Nelson (1926-2012), was CEO of Parkview Hospital (Fort Wayne, Ind.), Abbott Northwestern Hospital (Minneapolis) and Henry Ford Hospital (Detroit). His oral history: Weeks, L.E., (Ed.). (1987). *Stanley R. Nelson in first person: An oral history*. Chicago: American Hospital Association, can be found in the collection of the American Hospital Association Resource Center.

Davidson,<sup>33</sup> Rick Pollack,<sup>34</sup> Carmela Coyle<sup>35</sup> and the entire AHA staff was energizing.

I learned a lot and I could take information back to our own staff and share with them things that were going on. We were talking about system fragmentation coming from this work group and task force in the mid-'90s, before it was on anybody's agenda. Another advantage of connecting with AHA was a goal that we had of making people aware that there was this entity called Froedtert Hospital. It's a difficult name to spell, let alone pronounce. It was a way of getting our institution known.



**The Petasnick family**

I became involved in the Regional Policy Board, which was exhilarating. It was like a firehose of information, but being able to transfer and use that firehose was very helpful. I never dreamed I would ultimately be a chair of the AHA. During my nominating process, I remember talking to the committee and stepping back after the formal interview. I said, "I can't believe I'm actually here. I grew up in Sheboygan. I can't believe that a kid from Sheboygan is competing for the chair of the AHA." I find it an incredible honor. It was humbling.

I look back with pride at being able to serve the organization, working with outstanding staff at the AHA and making a difference. During my tenure, we were starting to work on health reform – this was 2008. We spent a lot of time in terms of building a framework called "Health for Life" and beginning the heavy lifting towards the enactment of the Affordable Care Act was something that ordinarily I never would have been exposed at that level.

I was doing this at the same time that my brother was chair of radiology at Rush and was very active in his association, the Radiological Society of North America. He was President of the RSNA when I was chair of the AHA. Two guys from Sheboygan. Isn't this a wonderful country? That was an interesting time.

**GARBER:** The chair year involves a phenomenal amount of travel. How did your organization fare with you on the road all the time?

**PETASNICK:** I was lucky to have a supportive management team and board. I remember talking with my board about this opportunity. All were supportive and encouraged me to pursue it.

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<sup>33</sup> Richard C. Davidson (1936-2016) served as president and CEO of the American Hospital Association from 1991 to 2007. His oral history: Garber, K.M. (Ed.). (2015). *Richard C. Davidson in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <http://www.aha.org/research/rc/chhah/Davidson--090310--FINALFINAL.pdf>

<sup>34</sup> Richard Pollack has served as president and CEO of the American Hospital Association since 2015. [American Hospital Association. (2015, May 4). Rick Pollack named president and CEO of the American Hospital Association. *Press Release*. <http://www.aha.org/presscenter/pressrel/2015/150504-pr-rickpollack.shtml>]

<sup>35</sup> Carmella Coyle was part of the policy staff at the American Hospital Association until 2008, when she was named president and CEO of the Maryland Hospital Association and later of the California Hospital Association. [California Hospital Association names new CEO. (2017, July 7). *Sacramento Business Journal*. <https://www.bizjournals.com/sacramento/news/2017/07/07/california-hospital-association-names-new-ceo.html>]

By this time, I'd had a team in place for almost fifteen years. Several people reminded me that being chair of AHA is different than being the CEO of the AHA. Your key responsibility is still back to your core institution. Dick Davidson reinforced that. I was able to do this at a time when I had stability in the organization. I made sure I was around a day or two so that I had some ongoing interaction. Technology makes this a lot easier.

It's a great honor. The board saw that it was an honor for me personally but, more importantly, it was an honor for our organization to be identified as a part of that process. Our entire organization benefited because I was able to come back and give presentations based on what I'd learned. The broader management team felt a part of this process.

**GARBER:** Part of your broader management team was Catherine Jacobson,<sup>36</sup> who you brought on board a year and a half before you retired. She was hired from the outside. I'd like you to talk about succession planning. You had given your board a very long notice.

**PETASNICK:** Yes. There was a lot going on in my life. My wife had passed away from breast cancer. I always said that I didn't want to be like Brett Favre, who threw the last pass and it was intercepted. I knew that I wanted to leave and do it in a way that left the organization stronger than I found it.

My CFO also was retiring. I went to the board and worked with Rich Gustafson in putting together a two-year plan in which we would use this as an opportunity to bring someone in that could assume my role although this was not necessarily guaranteed. We were fortunate in being able to recruit Cathy. The two of us had a wonderful relationship. We were able to make this a gradual transition. It allowed me to leave and begin a new life and brought in continuity to our organization.

While succession planning gets a lot of attention, there aren't a lot of good examples. I think there's been a greater focus in the last couple of years on this, and I've spoken with professional groups about this. It's got to be deliberate. It's got to be viewed as a board action. It's got to be viewed in a way that provides an opportunity to recruit someone and then do a logical transition.

**GARBER:** Are there succession planning consultants?

**PETASNICK:** There are but in the end it is a discussion that has to occur first with your board chair and then in executive session with the board. You've got to have a relationship with your chair that allows you to have those kinds of one-on-one discussions, and then moving from that into an executive session. It doesn't happen by chance – it could play out over a year or so. It also involves an assessment of your current team. The first step is to figure out if there are people who logically want to or could assume this role.

In our case, we made a couple of changes. I had the title of CEO of the health system as well as president of Froedtert Hospital. We separated those titles. Cathy Buck was a terrific chief operating officer and felt comfortable in the operational focus. She assumed the role of president of the hospital. Cathy Jacobson came in as our chief strategy officer and chief financial officer. I moved up to the title of president and CEO of the health system. There were a lot of different things going on, but it

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<sup>36</sup> Catherine A. Jacobson joined the executive team at Froedtert Health in 2010, becoming president and CEO in 2012. [Froedtert & Medical College of Wisconsin. (2017). *Catherine A. Jacobson, FHFMA, CPA, President and CEO, Froedtert Health*. <http://www.froedtert.com/about/executive-leadership/jacobson>]

was a deliberate thoughtful process. Timing was key.

**GARBER:** Could you talk more about governance generally and how you build a relationship with your board chair?

**PETASNICK:** Effective governance is still the greatest challenge. It's still the Achilles' heel and a lot of organizations have ineffective governance. Role definition is very important. It does start with having a direct relationship with your chair. A chair also recognizes what his or her role is. It's not running the institution. Governance is different than operational accountability and stewardship.

It begins with clarity in terms of what these roles are. I've seen a setting where the board chair had an office right outside the chief executive's office. This board chair was very much into detail. He was retired and this was his thing. That model, unfortunately, is more prevalent than one would think. That's the total opposite of what good governance is. Governance is about making sure the organization has a well-defined vision and is moving towards that vision and has an understanding of the complexity of what we're doing.

I was lucky. I've had three board chairs over my 20-year experience, starting with three community icons – Tom Smallwood, Mike Mahoney and Richard Becker; and then my last couple of years with Dave Lubar, who is a young, dynamic leader in the community. Each of these individuals was an icon in one way or another, and they were well respected in the community. Tom and I used to have scheduled meetings to the point where it was redundant. It became, let's just constantly connect. We created a relationship that was trustworthy and it was open and it was ongoing, but it wasn't the in-your-face kind of thing that some CEOs have ended up getting into.

We had a self-sustaining model for appointing new members to the board. A lot of academic medical centers have complex governance structures with people there because of their position – like the dean of the medical school or the president of the university. We have been able to avoid such a complex governance structure. Although we have a strong affiliation agreement with the Medical College of Wisconsin, our board was independent from the medical school. A lot of boards are unsure of who they're ultimately accountable to but my board knew what they were focusing on. There can be confusion in terms of – if I'm dean and I'm now also a board member, what hat am I wearing? Am I speaking as a representative of the medical school, or am I here because of my expertise? Am I here to function in terms of assuring the good stewardship of the hospital in its multiple roles?

There are a lot of transitions going on where physicians are being moved into chief executive officer roles because the board feels they need to have a physician, as opposed to getting an individual who has the right leadership skill set. It's not whether you're an MBA or an MD. The real question is whether you possess the necessary leadership skills to assemble an effective team and move the organization? What troubles me is what I'm seeing a lot of positions being recruited by board members to put in a physician who doesn't have the training – maybe the physician is a great clinician or a great researcher, but doesn't have the skill set to be an effective chief operating, chief financial or chief executive officer.

**GARBER:** Are you retired?

**PETASNICK:** I would say I'm semi-retired. I'm very involved in a number of different activities. I have become very involved with startup companies, especially those focusing on digital

technologies.

**GARBER:** You've mentioned disruption during this interview – for instance when you said that you were somewhat attracted to the concept of change for change's sake.

**PETASNICK:** Right.

**GARBER:** You like change?

**PETASNICK:** Yes, it's exciting. Change creates uncertainty which must be managed carefully. There are some people who go through their lives not wanting to deal with uncertainty. They feel very uncomfortable with uncertainty and change. Others see it as invigorating because it opens up new and exciting opportunities. I also wanted to be a "change agent" and can look back at my many years of being thankful for being able to play this role.

**GARBER:** How did you manage work/life balance?

**PETASNICK:** My kids spoke at my investiture. That was an interesting opportunity – ordinarily you're not alive to hear those kinds of remarks. They said that I was always there when needed. They would be playing something and they'd look up and I was there. I always felt the opposite as there were many times when I couldn't be there to lend my support. I always felt that I was letting my kids down – that I wasn't there. There were the long dinner meetings and they would be asleep when I came home. There were the vacations that had to be canceled at the last moment and so on.

I've always thought that family came first. Unfortunately, it didn't always happen that way. I remember when my son was in a golf match for his high school team. Because of a meeting I didn't get there. To this day I have no idea what that meeting was about, but it pains me that I missed that golf match. I've known people where work came first. I'm glad I wasn't one of those individuals.

One of the great things that happened to me while at the University of Wisconsin was that I met my future wife. There was a graduate library on the fourth floor at the University of Wisconsin Library. We were undergraduates. I was sitting there at a desk, and this young lady walked in, sat down across from me, took out all of her books and laid them down nicely, then put her head down and fell asleep for an hour and a half. Then she got up, repacked her things and left. I figured that was someone who I needed to get to know. It was those little experiences that you happen to run into. By chance, I ran into Ed Connors; by chance, I ran into my future wife, who had a great night's sleep in the graduate library.

My wife, Bobbe, passed away after a ten-year struggle with breast cancer. We had a great relationship and were married for over 42 years. She was a teacher and a great one at that. She had a great sense of humor. She had the ability to walk into a room and know everybody by the time she left, and was loved by all. She displayed remarkable courage. At the darkest period of my life, Irene Thompson entered it. Irene was a professional colleague and a mutual health services CEO. We were married in 2011 and life began again. I firmly believe when God closes one door, He opens another.

**GARBER:** Do you have any final comments?

**PETASNICK:** This field is vastly different today than when I entered it. Back then the focus

was on hospitals, which were referred to as the doctors' workshop. Today the focus is on population health and the formation of integrated health systems. For me personally, it has been a great run. I'm energized about all the changes occurring in our field, as energized now about being a part of this field as I was then I entered it. I've met and worked with some outstanding individuals. A few years ago George Lynn<sup>37</sup> coined the phrase, "it's the work we do not the business we're in that is important." This quote highlights the social mission we all have as health care leaders.

**GARBER:** Thank you very much for your time today.



**Irene and Bill**

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<sup>37</sup> George F. Lynn is the president emeritus of AtlantiCare (Atlantic City, NJ). His oral history: Garber, K.M. [Ed.], (2014). *George F. Lynn in first person: An oral history*. Chicago: American Hospital Association, can be retrieved from <http://www.aha.org/research/rc/chhah/Lynn%20-%20121614%20-%20FINAL.pdf>

## CHRONOLOGY

- 1946 Born March 2, 1946 in Sheboygan, Wisconsin
- 1968 Married June 10 to Bobbe Ann Malkin of Chicago  
Children: David, Ellen
- 1968 University of Wisconsin, Madison  
Bachelor, Political Science
- 1969-1970 University of Michigan Hospitals (Ann Arbor)  
Administrative Resident
- 1970 University of Minnesota  
Master of Healthcare Administration
- 1971 U.S. National Center for Health Services Research  
Public Health Officer
- 1972-1974 University of Michigan Hospitals (Ann Arbor)  
Director, Medical Services
- 1974-1981 University of Wisconsin Hospital & Clinics (Madison)  
1974-1977 Assistant Director  
1977-1981 Associate Director
- 1981-1988 North Carolina Memorial Hospital (Chapel Hill)  
Director, Operational Services
- 1988-1993 University of Iowa Hospitals & Clinics (Iowa City)  
Administrator/Chief Operating Officer
- 1993-2012 Froedtert Memorial Lutheran Hospital (Milwaukee)  
President/Chief Executive Officer
- 1993 University of Iowa  
Adjunct Associate Professor
- 2011 Married to Irene M. Thompson
- 2012 Rush University (Chicago)  
Adjunct Associate Professor of Health Management
- 2012- Petasnick & Associates, LLC  
Principal
- 2012- AVIA  
Executive-in-Residence

## SELECTED MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives  
Fellow

American Hospital Association  
Chairman, Board

American Hospital Association, Health Forum  
Chairman, Board

Association of American Medical Colleges, Council of Teaching Hospitals  
Chairman, Board

Blood Center of Wisconsin  
Member, Board

Downtown Rotary Club of Milwaukee  
Member, Board

Froedtert Health (Milwaukee)  
Member, Board

Greater Milwaukee Committee  
Member, Board

HealthSystem Consortium  
Member, Board

Metropolitan Milwaukee Association of Commerce  
Member, Board

Wisconsin Hospital Association  
Chairman, Board



## AWARDS AND HONORS

- 2005 Distinguished Service Award, Wisconsin Hospital Association
- 2006 Person of the Year, Downtown Rotary Club of Milwaukee
- 2007 Doctor of Health Management, hon. caus. from University of Wisconsin – Milwaukee
- 2015 Doctor of Medicine, hon. caus. from the Medical College of Wisconsin (Milwaukee)
- 2016 Distinguished Service Award, American Hospital Association

## SELECTED PUBLICATIONS

Petasnick, W.D. (1989, Summer). Expectations of what an entry-level manager should know about the application of health services research methods: Perspectives of an administrator of a university teaching hospital. *The Journal of Health Administration Education*, 7(3): 567-572.

Petasnick, W.D. (2002, January-February). A community approach to free care. *Healthcare Executive*, 17(1), 64-65.

Petasnick, W.D. (2007, Fall). Hospital-physician relationships: Imperative for clinical enterprise collaboration. *Frontiers of Health Services Management*, 24(1), 3-10.

Grayson, M. (2008, October). Grounded in community: An interview with AHA chair-elect William Petasnick. *HE&HN*, 80(10), 41-42, 44, 46.

Petasnick, W.D. (2008, July). Can seniors afford care? *HE&HN*, 82(7), 148.

Interview with William Petasnick, FACHE, President and Chief Executive Officer, Froedtert Hospital and Froedtert & Community Health System, and 2008 Chair, American Hospital Association. (2008, November-December). *Journal of Healthcare Management*, 53(6), 352-355.

Goldberg, A.J., and Petasnick, William D. (2010, May-June). Managing in a downturn: How do you manage in a global financial recession? *Journal of Healthcare Management*, 55(3), 149-153.

Petasnick, W.D. (2011, March-April). It's time to get on with the work at hand. *Journal of Healthcare Management*. 56(2), 95-98.

Petasnick, W.D. (2011, November-December). End-of-life care: The time for a meaningful discussion is now. *Journal of Healthcare Management*, 56(6), 369-372.

Petasnick, W.D. (2012, November-December). Increasing access to care for the underserved. *Healthcare Executive*, 27(6), 56.

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**The grandchildren**