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I believe that it is our mission to prove that these can be fused with scientific excellence and professional excellence to produce the type of care which the health field is hungry for. Our job is to develop this balanced program in a limited number of Catholic centers which will serve as training centers and demonstration centers so that the world will turn to these institutions to see Christian medical care in its fullest spiritual and professional expression.

If each of our large sisterhoods would make one of its hospitals outstanding in these respects, then we would have a leaven for the entire Catholic system. We cannot preach to the world, we cannot teach unless we do so from positions of professional strength.

In the course of this meeting we will see that some Catholic hospitals are doing this and we can learn from them and their experience.

Religiously affiliated institutions and religious men and women have a role to play in America. It is not to reach into every hamlet, it is not to do all the appendectomies or gall bladders. But it is to exemplify in the world the excellence of religion, the excellence of science and the greater excellence to be achieved when these are joined in unselfish service to mankind.

Major Problems of Catholic Hospitals in Medical Education

CHARLES U. LETOURNEAU, M.D.

A survey of the educational and research programs of about 25 hospitals during the past five years reveals certain problems that are common to all hospitals in this area and some that occur more frequently in Catholic hospitals than in non-Catholic hospitals.

Most Catholic hospitals are of the voluntary service-to-humanity type which were not primarily designed for teaching or research. Very few of such hospitals are affiliated with medical schools and in the affiliated institutions, the arrangement has left something to be desired on both sides.

Emphasis is placed on service, rather than teaching or research although the latter goals are receiving much more attention than they ever did in the past. Service to humanity is in the best tradition of the Catholic Church and it is not surprising that our hospitals should follow such a tradition. Emphasis on service is further enhanced by the attitude of the medical staff of the hospital which, in its advisory capacity to administration sets the tone for the policies to be followed.

Where there is any conflict of objectives between service, teaching and research, the choice is made invariably to provide service, even at the expense of the other two objectives. This is not surprising since the charter of the hospital usually provides that the aims and objects of the hospital corporation shall be to provide service to the people of the community. Almost universally, therefore, Catholic hospitals have developed as family-doctor types, for service to people of the community. In more recent times, medical specialties have infiltrated into these hospitals, as might be expected, to keep up to date with medical discoveries and new medical techniques and procedures.

It would be unfair to attempt to generalize about all Catholic hospitals or, for that matter, all voluntary ones. Some voluntary hospitals are outstanding in the types of medical service that they offer but, unfortunately, the majority of them are still dominated by general practitioners who feel a growing insecurity in the face of modern medical scientific services which they are not equipped to provide for their patients. There is a tendency, therefore, on the part of the less qualified doctors of medicine to resist the growth and development of specialized services in their hospitals if these are not to be within the purview of their privileges.

In many hospitals, the retarding view of the general practitioner has been communicated to the adminis-
The days of MacEachern were the days of the uncontrolled medical fee where a physician was free to charge whatever his conscience dictated and the law of supply and demand was expected to take care of the medi­cal staff. Physicians were expected to fill in the time between slow promotion that was char­acteristic of those days and were expected to fill in the time between surgical operations in doing teaching and research. The chief was expected to refer patients who could not afford his fee to the younger doctors. The younger doctor was similarly expected to show a great interest in his own development by doing teaching and research. If he did not manifest enough such de­sire, he might not ever become the chief himself.

But times have changed and, in this day, anyone who charges $1,000.00 for a prostatectomy might find himself in front of a Grievance Committee, no matter how wealthy the patient might be or how much he could afford to pay. Fees are now set by Relative Value Schedules so that the most experienced sur­geon in the country may not charge more than the least experienced. The R.V.S. has become the great leveller of medical quality in our times.

It is true that there are still a very few physicians with worldwide reputa­tions who can and do charge more than the Relative Value Schedule allows but these are the exception rather than the rule. Third party payors dare not attack such out­standing men.

The net result of this development has been to curtail the teaching time that a physician would devote to the development of young physi­cians. In this day, the chief of sur­gery is now obliged to work at least five times as much as he did for­merly to obtain the same income as he did 30 years ago. Time formerly spent in teaching and research is now spent in earning money from the practice of medicine.

By thus limiting the teaching time of the senior physicians, the burden of teaching and research must now be spread over a large number of physicians in order to achieve the same number of teaching hours that were given by a chief of surgery 30 years ago.

As one chief of surgery explained it, a surgeon can perform three opera­tions in a morning period of five hours if he does them himself. At an average income of $200.00 per operation, the surgeon could derive $600.00 for a morning’s work in the operating room. But if the surgeon were to spend the time showing a resident how to perform the opera­tion or employed his time in super­vising him, the maximum number of operations that he could hope to accomplish would be one major operation and one minor operation which would divide his income in half. A physician who has independ­ent means can afford to indulge in such prestigious activities as teaching and research, but a man who has to earn a living cannot afford to give away very many of his working hours in non-remunerative activities such as teaching.

In some non-Catholic hospitals a rule has been imposed on the prac­ticing physicians, obliging each to give a certain number of teaching hours in return for privileges to prac­tice medicine in the hospital. Some physicians consider this rule harsh and many prefer to work in non­teaching hospitals where the work­ing hours are financially rewarding.
if not as prestigious or rewarding in knowledge as the teaching hospital.

Most administrators of Catholic hospitals recall at the idea of exerting economic pressure upon a physician in order to assure a teaching program. As a result, many Catholic hospitals have fallen behind in their programs of training young physicians.

Another problem which is not confined to Catholic hospitals is the attitude that has been taken by certain courts of law toward the teaching physician. Particularly in those states where hospitals enjoy immunity from lawsuit, the rule has been developed that an intern or a resident is a borrowed servant of a teaching physician. Such a situation arises in the state of Pennsylvania where hospitals enjoy immunity from lawsuit. The cases of Yorston v. Pennell and McConnell v. Williams, illustrate the hazard that may be faced by a teaching physician who may not even have seen the patient. In the Yorston case, the physician had sent a bill to the patient and this was considered to be evidence of accepted responsibility.

Many voluntary teaching hospitals have an arrangement whereby the work performed by an intern or an under the supervision of a licensed physician is considered to be the work of the licensed physician himself so far as billing the patient is concerned. The licensed physician also assumes responsibility for the case but the money is generally deposited in a fund for the education of interns and residents. The teaching physician then assumes all of the responsibility for the acts of interns and residents and receives no payment in return. The courts ordinarily do not look at the manner in which the money is spent but assume that the money sent the bill accepts responsibility for the care. This problem still has not been resolved and teaching interns and residents may be hazardous undertaking in some voluntary hospitals.

It is a well recognized fact that the practicing physicians can no longer afford the time necessary to do a good job in a teaching program. Many voluntary hospitals have recognized that the help in teaching must be bridged by a man or men who must be remunerated in some way for the time they spend in teaching.

Some hospitals have now acquired directors of medical education and directors of medical, surgery and obstetrics on a full-time or part-time basis. These men are remuneraed by the hospital for their teaching obligations. The full-time director of medical education and the full-time heads of departments seem to have been more successful than those who function part-time. The full-time men are in competition with practicing physicians of the hospital and, theoretically, they should expect to obtain the highest degree of cooperation from practicing physicians. In some hospitals, this cooperation has been a fact but in other hospitals, practicing physicians have tended to oppose and even to sabotage the teaching program of the hospital by non-cooperation. Opposition to teaching programs by practicing physicians is mainly based on economics.

Although the practicing physicians may not have personal objections to chiefs of departments who do not compete with them for patients, they may object to the size of the teaching program because of the number of hospital beds that are required to maintain an adequate number of patients for teaching purposes. Each bed has a certain monetary value to the practicing physician. Each bed is worth something in consultations, hospital visits, surgical operations, obstetrical deliveries and other procedures which, in turn, can be translated into monetary values.

Consider the internist, for example, who visits his patient daily. The fee for the average daily visit in the hospital ranges from $20.00 for the first day to $5.00 for an average routine visit. Assuming that the average is $10.00 per day, every occupied bed is worth $10.00 per day to that internist. In a high occupancy hospital where beds are occupied on an average of 330 out of 365 days, the hospital bed is worth approximately $1,300.00 per year to the internist. Conservatively, most internists feel that they have to control about ten beds to make a reasonable annual income. Although the income of the surgeon in the hospital appears to be disproportionate compared to that of the internist, it should be remembered that income from office practice for a surgeon is minimal but availability of beds and surgical operating time is a matter of paramount importance to his survival. Obstetricians and other types of specialists similarly have an economic stake in a hospital.

Theoretically, therefore, a 500 bed hospital can support 50 physicians of all kinds of specialties if we calculate ten beds per physician. Obviously, this figure would require adjustment because some specialists cannot confine all of their activities to one hospital but they choose to work in several hospitals because of the limited number of patients referred to their specialty in each hospital.

Although the teaching head of a department may not be in financial competition with his practicing colleagues, the fact remains that a certain number of beds must be allocated to him for use in teaching of
residents and interns or the program of residency and internship will be disapproved by the American Medical Association. Reducing the total number of available beds for private practice creates economic pressure on the practicing physicians of the hospital and each physician must reduce his practice in proportion to the number of beds lost or some physicians must go elsewhere to obtain the beds that they need for a reasonable income.

In all hospitals, physicians have an enlightened self-interest and an economic stake in the hospital bed which is worth protecting. One of the major problems, therefore, concerns the determined efforts made by practicing physicians to protect hospital beds for their own use, even at the expense of sacrificing a teaching and research program. This attitude of practicing physicians is normal and understandable. There seems to be no reason why public education should be carried on at the expense of a physician's family and his way of life. Were the future of teaching and research in Catholic hospitals to be left entirely in the hands of the practicing physicians, there seems to be no doubt that the existing mediocrity in the majority of our hospitals would continue indefinitely to the eventual total deterioration of the quality of care in the hospital.

In some hospitals, physicians dedicated to preservation of mediocrity have become an entrenched oligarchy dedicated to resistance to change.

In some hospitals, this oligarchy takes the form of a gerontocracy fighting a rear guard action against progress until they are ready for retirement.

Blame for mediocrity cannot be placed entirely upon the physicians who practice in the hospital. The major share of the blame must be placed on the shoulders of the administrators who are responsible for maintaining the highest possible quality of care in the hospital. Too many Catholic hospitals have suffered from weak administration. In most instances, administration is weak only because of the system in which it functions.

In the first place, the policy-making body may be located at some considerable distance from the hospital and completely out of touch with what has transpired in recent times. All too often the hospital representative on the general council is a person who once served as operating room supervisor and got all of her advice from the chief surgeon of the hospital whom she knew many years ago, thus bypassing effectively the administrator. Examples of bypassing which weaken the position of the administrator are delegations of medical staff representatives to the Motherhouse to complain about the administrator, delegations to the local Bishop to ask for his good offices to intercede on behalf of the physicians and pressure upon religious sisters who work in various departments of the hospital to attempt to influence the administrator directly in the convent.

Arguments frequently used by physicians are that the hospital owes them a living in return for all of the favors that they have conferred on the hospital over the years. Generally the major argument is that certain physicians have treated religious sisters, priests and even Bishops free of charge for a number of years at great personal sacrifice to themselves.

Another argument is that the development of a teaching program will attract young well qualified physicians to compete with the existing practitioners resulting in serious economic loss to themselves.

In altogether too many hospitals, these arguments and representations have been successful and have maintained the level of mediocrity that they sought to achieve. In other hospitals, the administrator took a more enlightened view that the hospital owes no more to the physician than the physician owes to the hospital. As noted above, a hospital bed has a great economic value to a physician and the fact that he enjoys the use of such beds free of charge is ample reason for him to do everything in his power to serve the hospital.

However, even in those hospitals where the voluntary physicians have been willing to undertake teaching of residents and interns free of charge and have been willing to devote time, a major problem is lack of competence in the teacher. It has been well established by the specialty boards that a general practitioner is not sufficiently well qualified to teach a specialty. The answer to this problem is obvious. If a major teaching program is to be maintained in the hospital on a voluntary basis, qualified specialists will have to be brought into the hospital and since there are only a limited number of beds available, the general practitioner will have to go elsewhere.

Finally, there is the problem of money. Educational programs cost money and under the existing voluntary hospital system, the education of physicians and other professional personnel in hospitals must be paid for with the sick man's dollar. The fact that the dollar may come from the third party payor makes relatively little difference. The fact is that a certain additional charge must be made per patient day for the educational programs. Research, it is usually possible to get a grant from the government or some foundation but at the present time, very little financial support exists for education.

In hospitals which have a good system of accounting money is budgeted for education, and full-time or part-time teaching physicians have been acquired to meet the needs of the program.

There are numerous other minor problems of education and research in Catholic hospitals but before these problems can be attacked, solutions to the major problems must be found and these will not be easy.