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A Successful Hospital Program

Mother Mary Michael

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Ten years ago Misericordia Hospital embarked on an intensive medical education program. Why did we undertake such an expensive and controversial step? Because of a deep conviction shared by the Board of Managers, the Administrator, the Medical Director, and leading members of the medical staff — a conviction that well-conducted graduate training programs inevitably lead to excellence in all functions of the hospital. This conviction did not develop overnight, but over a period of time covering the transitional post-war years. While working toward replacement of a preceptorship method of surgical training with a formal training program, we came to believe that proper residency programs would improve patient care, including that of private patients, stimulate investigative activities, and better community relations.

The over-all goal of the hospital since its opening in 1918 has been excellence — excellence in all aspects of patient care. Through the years the academic tradition prevailed—in medicine, in nursing, and among the paramedical groups. Therefore, it came as a shock to the sisters and doctors to learn, through regional meetings of the Catholic Hospital Association in the late 1940's, that Catholic hospitals in general were not meeting the goal of excellence in the medical care of the patient and in the preparation of the medical specialist, despite the devotion and hard work of all concerned, apparent patient satisfaction, new building programs, and ever-increasing student nurse enrollment. The criticism leveled against Catholic hospitals in general was a valid criticism of Misericordia Hospital at the time.

Misericordia had experienced a long tradition of training specialists, particularly in surgery, by the preceptorship method. During the war years with many of the young surgeons away in military service, the Program lagged. After the war the preceptorship method of training practically disappeared throughout the country and while the debate went on at Misericordia regarding the superiority of the preceptorship method of training, the young men went off to other hospitals to take their residency training. Finally, agreement was reached on the need for establishing formal residency programs and after concerted effort on the part of the surgical staff provisional approval was obtained from the conference committee on graduate training in surgery. One year later the approval was withdrawn, with a statement that "the educational aspects of the service do not meet the standards of the committee." (Reference to *Essentials of Approved Residencies and Fellow-*

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ships). All concerned were obviously disappointed. After considerable correspondence with the accrediting authorities it became evident that approval was not going to be restored. Our efforts to secure approval seemed fruitless. While the clinical material was adequate and the surgeons well qualified, in fact, eminent clinicians, a lack of interest in academic medicine hampered our efforts to provide the type of program specified in the *Essentials*.

Before revising the Program and again reapplying for approval, a decision was made to determine: first, is it in the best interest of all concerned to have a Surgical Residency Program; second, is it feasible for such a program to be established in this hospital, and if so, what steps should be taken to accomplish the goal.

It seemed self-evident that patients receive better care in the teaching situation which is present in a well-conducted residency program. The Medical Director and the surgical staff were convinced that, as then organized, our Surgical Training Program left much to be desired. It was apparent that we needed an authoritative opinion on whether we should pursue the idea of a Residency Program. One of or own surgical specialists suggested that an experienced consultant, a Professor of Surgery from another city, be requested to come to Philadelphia to discuss with the Medical Director, the Director of Surgery, and the Administrator the problems concerned with the loss of the approval of the surgical residenc nd also the advisability of conti ng to seek approval.

This was agreed up and the history and the facts of e case were presented to the cc ltant. The Program and the respondence with the accrediting g ups were reviewed, as were the sical set-up and the surgical st tics. Ward rounds were made w the surgical resident. Following t the consultant discussed ideal r dency training viewed by a si patient, an eager student, and expert surgeon. He emphasiz the expert should be the best p on available for the patient. The aff must be organized to provide e expert and to make him availa to the resident on all occasions This requires thought and planni which, at times, runs counter established ideas. He also broug out that occasionally seniority d length of service may be supers ed by ability and special preparatio and further, that the objectives of e hospital as a whole are paramou to the objectives of individual su ons.

The consultant bel ved that with proper provision for taff appointments and staff or nization, an outstanding Residency Training Program could be deve ped. On the basis of his experience, he suggested that a competent committee interested in the problem be organized to advise us. He judged that the committee best suited for the job should have an academic or medical college background and be thoroughly familiar with residency training. In

the interest of objectivity, which he believed to be very important in our case, he recommended that the committee be composed of Philadelphia physicians interested in the problem, but not connected with Misericordia Hospital.

Subsequently, by invitation of the Archbishop of Philadelphia, a committee, consisting of four Professors of Surgery, was formed and after reporting their observations on residency training they made the following recommendations:

1. Misericordia Hospital reorganize its surgical staff and place responsibility for direction of this staff in a highly qualified surgeon. This surgeon should be one who is thoroughly familiar with modern surgical training methods. He should have participated in such methods both as a resident and as a responsible staff member. His background should be academic. He should have an established reputation and authority as a technical surgeon. He should consider Misericordia Hospital and its future as his primary and full-time occupation, and administrative measures to assure this dedication should be taken. Complete jurisdiction over surgical activities in the hospital with direct control of ward beds and supervisory control of private patient policy should be his responsibility. He should have nominating power for staff appointments made by the Board of Directors. He should have an office in the hospital with facilities for private practice.

2. Further, the committee believes that such reorganization is incomplete unless the medical service has similar objectives. Whereas, the major work in a community type hospital is surgical, in a teaching hospital the intellectual leadership is shared with internal medicine. The organization of clinics, the long term study of disease in ambulatory patients, and the investigation of fundamental processes are all dependent on a high class medical service.

A copy of the full report of this advisory committee was sent to each member of the surgical staff and the report was reviewed very carefully at several surgical meetings. The chairman of the advisory committee and another member of the committee, met with the Director of each department of the medical staff and the Administrator and through discussions and explanations helped greatly in securing acceptance of the report by the staff.

The final paragraph in the Medical Director's detailed memorandum on this meeting states:

"As a result of this meeting, a pattern is being set for the development of residency programs in this hospital, and I feel certain that time will prove this is the correct procedure to follow, and with its institution, over-all problems of the medical staff will become minimal; the internship will be raised to a very much higher standard; patient care will automatically greatly improve; and every member of the Institution will take a greater pride in the work of the hospital."

I might add ten years later that the above statement has proven to be prophetic.

Subsequently, a committee, consisting of the Medical Director, who was a surgeon, the Director of Surgery, a Chief of Surgery (senior attending), an attorney member of the Board of Directors, and the Administrator interviewed applicants for the position of Director of Surgery. Contact with the applicants was established through the surgeons on the original advisory committee. The Director selected was an Associate Professor of Surgery at a university. Within one year the reorganized Surgical Residency Program received full approval. The Surgical Program furnished the stimulus and pattern for the successful development of residency programs in the other specialties of Obstetrics/Gynecology, Pathology, Internal Medicine, Radiology and an affiliate Residency in Pediatrics. At present we have a full quota of fifteen interns and nineteen residents.

The year following approval of the first Residency Program, an affiliation was established with a medical school. A short time later a Research Laboratory opened its facilities for the purpose of encouraging independent and investigative thinking throughout the entire staff. The Research Laboratory was busy immediately; federally financed and privately financed projects were undertaken. Findings were reported at meetings, in scientific publications, and in our own *Hospital Medical Bulletin*, a journal published by the Director of Surgery enable the staff to review what t were doing, evaluate their results, l determine the effectiveness of th progress.

When plans were nulated for the development of a idency Program in Medicine, th Director was selected through the s e procedure as the Director of Su ery. Subsequently, the Residen Program in Medicine was approve nd a medical school affiliation c blished.

Unquestionably, pa nts are receiving better care b use of the educational program. he hospital, too, has been aided im asurably by the educational prog in attaining its secondary goal f education and research. Our go for the future continue to be co ered on the level of patient care a the level of the educational progr s.

Unquestionably, too we encountered many problems developing these programs. Some f the problems were not as weigh as others—changes and adjustmen ccompanying the reorganization f schedules, provision of adequat conference room facilities, develop ent of cooperation in attendance a conferences, education of supervi ry nursing personnel to accept the changes necessary to carry out the program, segregation of medicine and surgery, etc. Financing of the educational program posed an immediate and a long-range problem — salaries of full-time directors, increased intern and resident staff, housing, rising numbers of free care patients, and over-all increase in use of services.

Dealing with the physical and financial problems proved to be minor compared to coping with the problem of medical staff relations. Physical facilities and financial problems are like the poor — always with us. However, medical staff relationship problems are delicate, but weighty, and frought with pitfalls.

From the inception of the program a small, but vocal, minority of the medical staff manifested persistent opposition. Leaders of the opposition labelled the program as a step toward socialized medicine which lead to an usurpation of the rights of the individual physician. On the other hand, this vigorous opposition did not dim the interest of the other members of the staff — some 90%, and actually may have stimulated interest.

Leaders in the teaching program and the active supporting staff believe that this type of program provides a level of patient care that will insure the future of private medicine. From the hospital management point of view, the continued improvement in patient care, the well-formed organization, the leadership offered by the medical staff, department directors, and supporting medical staff, and the response to that leadership by the hospital family have enriched the experience of all those associated with the hospital, have stimulated nursing and paramedical groups, and have made Misericordia an exciting place in which to work.

Personally I am deeply indebted to the "new breed in medical education" and inspired by them to strive diligently, within the framework of our Catholic philosophy, to "continue to be leaders in providing total patient care on a level of academic excellence in medicine, nursing, and administration." We count on the leadership of the doctors, nurses, and administrators to plan, organize, develop, and implement our tradition of educational excellence and compassionate care.

June 25 - Catholic Physicians' Day-

THE VATICAN PAVILION (NEW YORK WORLD'S FAIR) HAS DECLARED JUNE 25 AS CATHOLIC PHYSICIANS' DAY AND SCHEDULED A SPECIAL MASS FOR 12 NOON.

CHAPEL SPACE IS LIMITED AND THOSE INTERESTED IN PARTICIPATING ARE ASKED TO INQUIRE ABOUT DETAILS AT THE NATIONAL FEDERATION TICKET AREA OF THE AMA CONVENTION IN THE NEW YORK COLISEUM.