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J. A. Klieger

J. Bareta

C. H. Altshuler

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J. A. Klieger, M.D. — J. Bareta, M.D. — C. H. Altshuler, M.D.

Thoughtful and responsible persons concerned with providing medical care for a community have been confronted in recent years with some very real problems. Because medical knowledge and technology have proceeded at an unprecedented pace and because medical costs have risen precipitously, an onerous social dilemma has developed. While resolution of this difficulty may appear to be fairly straightforward, subtle ramifications of it concern the very future of medical practice. It is difficult to persuade some physicians and individuals not trained in medicine of the essential role that realistic teaching and research programs play in the development and maintenance of good medical care in a community. Yet, without them, the quality of medicine in a given institution and in a given community must deteriorate. Some of the reasons for this conclusion have recently been outlined by Morrison who offered the following arguments:

Dr. Klieger is chairman of the Research Committee and Dr. Bareta and Dr. Altshuler are pathologists at St. Joseph's Hospital, Milwaukee, Wisconsin.

Morrison, Robert S., M.D., Clinical Research in the Community, *Canad. Med. Ass. J.*, Jan. 25, 1964, Vol. 90, p. 335-340.
Gardner, John W., *Excellence. Can We Be Equal and Excellent Too?* Harper & Rowe, New York, 1961.
Gardner, John W., *Self-Renewal. The Individual and the Innovative Society*, Harper & Rowe, New York, 1964.

First, many of the advances in medical care involve extremely complex procedures which cannot be readily applied without the abilities normally developed in a research laboratory. To acquire these skills is expensive — expensive in time, expensive in effort and expensive in money. Because of the complexities involved, the development of these capabilities is a continuous evolutionary procedure. One needs to grow up with the procedure.

Secondly, unless creative individuals are given adequate support and recognition, a community runs the risk of losing its best medical brains to areas where the opportunity for intellectual satisfaction is greater. No community is so rich in talent that it can afford this type of drain.

Thirdly, the opportunity to do research is an essential element in the preparation of young physicians and in the continuing education of the older doctors. It is apparent that this type of activity with its demand for flexibility, critical analysis and re-analysis are essential to the process of self-renewal to be mentioned below.

It would appear that the basic philosophic considerations involved in this situation are of general applicability and have been beautifully discussed in two provocative books written by John W. Gardner, the current Secretary of Health, Education and Welfare. The first book entitled, *Excellence, Can We Be Equal and Excellent Too*, deals with the difficulty of developing and maintaining high standards of performance in an egalitarian society. The second book, *Self Renewal*, concerns itself with the individual and the innovative society.

In a democratic society there is a natural reluctance to give recognition to a creative individual — an individual who is different from the norm. Unconsciously, and sometimes consciously, an attempt is made to force the individual to conform and to accept criteria of competence which most practitioners may satisfy. The eventual result of this phenomenon is mediocrity.

It must be obvious that excellence once obtained is not necessarily a lasting thing for as new knowledge accumulates the criteria for excellence must change. The physician and the institution in which he practices, therefore, must be flexible and ready to alter the standards for competence. They must abjure mediocrity in all of its forms. Perpetual self re-evaluation and self-renewal, then, are essential for the maintenance of excellence and we must be ready to discard even old trusted ways when they are no longer the best available.

Self-renewal is difficult because it involves the avoidance of many common behavioral patterns. How does one avoid the inertia of complacency generated by previous success? As we become established, too, and because we believe it to be in the interests of good care, we develop an elaborate body of rules governing our procedures and conduct, even to the point of "organizational senility." This rigidity may be stultifying to a creative individual.

To insure a continuing self-renewal, optimism for the future and an orientation to it are important. There must be confidence that the individual not only can understand but can also participate in the changing medical pattern. It is essential that the physician and the institution must help in the accumulation of knowledge, i.e., contribute creatively. They cannot afford either passivity or resistance to change. Passivity of spirit can lead only to sloth and smugness. While it is easy to render lip service to teaching and research activity in a community hospital, the inseparable difficulties and consequences of realistic programs are not always palatable to physicians, to hospital administrators or to the community.

The physician is the focal point. He must act as a stimulus and as a driving force. These programs can only be effectively created and maintained when they are activated by the ferment of the physician. In the words of Cardinal Stritch, he must be "calmly discontent" with our inadequacies. The physician needs to be aware and enthusiastic to overcome the deadening inertia created by the overwhelming demands on his time, by his relative opulence and by the apparent lack of interest of the community.

The administration and the community must be convinced that the very nature and adequacy of the

present and future medical care (and the near future, at that) will be dependent on these developmental programs. To reiterate, these programs are expensive — and they cannot be carried out by the physicians or the hospitals alone. They need the active participation, recognition and support of the community. These are community projects.

In a realistic way, therefore, we as physicians must sedulously adhere to the ideals and dreams which attract us to medicine and not be influenced to the point of surrender by attempts to entangle us in a morass of mediocrity, or by the distractive cries of "we must be business-like," "let's avoid waste by reduplication," and "we must pay off the interest on the capital debt." Certainly these are important practical matters but medicine cannot be run by business techniques and in accord with business criteria.

Medicine is not a business. If it were, we would only do t se procedures which provide tl greatest financial return. As app d to the laboratory, for example, e would perform urinalyses and b od counts only and not be bothere by things like aldosterone determ tions or immunoassays of insulin. ow many members of the commu ty expect or would tolerate a phy cian who behaved professionally a that type of business man who i notivated only by the desire fo financial reward?

We — both the resp sible lay person and the physician — must be particularly careful no to allow unimaginative hospital rea planning commissions, h pital lay boards, medical scho faculties, county or state medical ocieties or medical executive cor nittees to create repressing and restrictive planned rigidities, for that path surely leads to early ntellectual and moral bankruptcy.