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Medical-Hospital Relationships

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It is not the truth). The daughter of a patient of mine after two years on the pill has had two ovarian cysts removed and is now sterile. She has had bouts of increased intracranial tension. I would not have taken notice of this but for two cases of post-pilar pseudo-tumor cerebri reported by Arben (Schweiz Med. Wschr. November 27, 1965); it is a sign of hyperadrenalinemia postcortisr and reported by Earl Walker (J.A.M.A. June 1, 1964).

In my ruggedly rhyming review of The Time Has Come (L. Walker 1964) I wrote in ignorance of the careful physician was law. If a doctor hears about a “side effect” from a patient or a friend it cannot be chance; it must mean that ill-effect is common (I put side effect in quotes to show I am in an even better position to know that it was a tablet failure, not a patient failure... more doctors recently are believing women rather than the manufacturers implications that failures are always due to patients forgetting doses.

I should have known excessive doses of ovarian hormone would cause ovarian atrophy, even excessive doses of adrenal hormone cause adrenal atrophy.

April, 1966. Michael Kelly, M.D.

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Editor's Note: Father Flanagan, Executive Director of The Catholic Hospital Association, addressed the paper which follows to members of The National Federation of Catholic Physicians' Guilds and guests at a breakfast meeting in Chicago on June 29. This was the second annual Father Gerald Kelly Lecture which has been established to honor the noted Jesuit moral theologian who died in August, 1964. As a fellow Jesuit and associated with Father Kelly through the mutual interests of the hospital Association, it was most appropriate to ask Father Flanagan to give this Lecture. For some fifteen years Father Flanagan served as editor of the LINACRE QUARTERLY and has been friend and adviser to the National Federation equally as long. Since 1947 he has been the executive director of CHA and through his efforts the organization has become a most effective force in the health field.

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LINACRE QUARTERLY
I believe he was a pioneer — I believe he initiated a trend which has been refreshing and stimulating and has been an encouragement to a science which must adjust itself to an endless stream of newly discovered scientific data.

Because of his human understanding, because of his love for Catholic physicians and Catholic hospitals, I think he would be a sympathetic friend and adviser to all of us today. I hope that, at this moment, he is looking over my shoulder and guiding me in the thoughts I wish to present to you today. His great contribution was that he could fit changing moral principles into a world of changing medical facts. He would wish Catholic hospitals and physicians to solve their individual and mutual problems, not by backing back to an earlier era or maneuvering against a purely historical background. He would remind us that we live in the Twentieth Century; that we are to serve people in the Twentieth Century, and that we must use the education, the progress, and the environment in which we live.

I have deliberately chosen a topic of mutual interest to hospitals and physicians because I am much concerned about; because I think it should be a matter of concern to the Church in America and because there are at stake certain patient care values.

In this period of time when traditional patterns of services to people are being questioned, the role of Catholic hospitals is being questioned by members of the laity, by some of the clergy, and by some Catholic physicians. At the same time, the traditional manner of delivering medical care is being challenged by the consuming public. If private voluntary hospitals and the private practice of medicine are to survive, if the values of patient care under these arrangements are to continue, then we must honestly and courageously face up to the social, economic, and scientific facts that surround us and devise a future role which fits the decade in which we live. We must be able to justify our existence in a period of time when the consumer public and the paying public is able to recognize the values of the free enterprise system in competition with less costly socialized services which cater more to the convenience of the medical and hospital consumer. Perhaps we shall be forced to recognize the Christian dignity of the tax-paying, for-paying and contribution-paying citizen for what he really is and not continue to look down upon him as a professed or even a successful practitioner, they are to support the practitioner by taking the burden of medical administration and supervision.

What are some of the changes we must face and what are some of the problems we must solve if we are to serve people in the name of the Church and in a Christian way? Catholic hospitals must plan in such a way that they will not be competing with each other; they must participate in overall area planning so that their existence and services meet needs and do not unnecessarily overlap with other institutions. (This is a delicate situation which must be carefully studied, keeping in mind the interests of the Church and the needs of people.)

The management and governing bodies of our Catholic hospitals must be released from isolated monastic moorings and brought closer to the realities of civic community life. Ownership may not change, but most certainly lay people will have greater participation in governing boards and in administration. The gulf of misunderstanding between hospital management and the medical staff must be eliminated — physicians must be consulted and their advice followed; physicians must assume a greater role in policy-making, and in sharing responsibilities of directing and supervising medical care. Hospital administration and our governing boards now recognize this need. The Catholic hospital must exist as a professional institution under Catholic auspices and not be a construction which dabbles in health care as a sideline. These changes we are facing from the hospital administration point of view. I would like to be brazen enough to mention a few changes which physicians must face up to. In large hospitals the administration and supervision of medical care and medical staff organization cannot be adequately dealt with by the busy, practicing chief of staff. We need a medical director, full time. Roger or later in the good large institutions we must have full-time chiefs of service. These men are brought in to compete with the private practitioner, they are to support the practitioner by taking over the burden of medical administration and supervision.

The quality of care in our emergency services is disgracefully jeopardized today because of the inadequate medical coverage and disorganized medical supervision. In many instances, emergency departments are being overwhelmed by patients who do not need emergency care but who seek relief from the built-in weaknesses and grave inconveniences connected with solo office practice. Outpatient clinics are developing in hospitals and are unnecessarily encroaching on office practice because too much offiice practice is antiquated. The busy practitioner with an office full of paying patients may be unaware of the frustrations of people who resent being referred by general practitioners to specialists, to subspecialists, each in a separate building, each with a parking problem and each with a long waiting period. Physicians forget that we live in a shopping center age. In due time the long suffering patient will learn that there are medical shopping centers where the family can visit the family physician, the surgeon and the pediatrician by parking once, seeing all the specialists in the same building, perhaps in the same building complex. He will not forever be frightened by a label of specialization.

I am hoping that physicians and hospitals will use some imagination and ingenuity to solve some of these problems. I would hope that hospitals would provide or help members
of their staff provide a doctor’s office building adjacent to the hospital so that the physician is at his office and on call to the bedside. I would hope that in this type of arrangement many so-called emergency cases could be referred to a planned private care system in the office building or could be staffed more easily by the private physician and paid medical care could be kept to a minimum. I would hope that the physician closely based to the hospital could more easily and more frequently see his hospitalized patients. I would hope that patients, particularly families, could see the necessary number of physicians in one building and on one visit. Specialization and subspecialties are necessary and have contributed to the improvement of medicine. But we must make them readily accessible to the patient.

I have one last “please” to Catholic physicians. Please use your Catholic training to restore the term medical ethics to a position of respect and moral significance. Today it is a term which is abused and prostituted to protect medical etiquette and is overridden by hypocrisy and fiction to protect selfish and some times purely financial vested interests. Ethics originally referred to moral responsibility of physicians in respecting the rights of patients. It would be interesting to review all the cases which come before the A.M.A. Judicial Committee to see how many were concealed with patient welfare.

One of the important cases in a mid-western city dealt with the heavy issue of whether or not a physician was unethical because his name appeared in bold print in the yellow pages of the telephone directory. I think there is a moral problem connected with corporate practice of medicine. Historically, there must have been a need to protect patients from institutional decisions and lay people doing therapy. I urge that we attempt to determine the need for unethical and dangerous aspects of corporate practice of medicine and that the hospitals must join you in supporting your position.

I firmly believe that there is a future role for Catholic hospitals and the private practice of medicine, and I believe that working together, physicians and institutions can preserve this and give it a value and a dignity because it will serve the needs of people. But we must work together.

We must not become parental because of fear and apprehension or because traditions practices are challenged. We must not become sterile in our thinking. We must use our God-given intelligence and imagination to structure a better health care system which will give greater care to people and be a credit to the Church.

Letter From Ireland

This Easter time we celebrate the 50th anniversary of the Insurrection which was the first step towards our gaining independence. It is fashionable at this time to review progress in the past fifty years. Granted, enormous strides have been made in the field of medicine, but the students’ course in University has remained about the same length. The subjects have become much more complex and seem less oriented to the production of the embryo general practitioner. Proportionately fair teaching in all branches of the art and science of medicine is given, but these lectures have been given by specialists, who cannot fail to emphasize their own subject. This may give the most up-to-date knowledge to the student, but it leaves him wondering what the “compleat doctor” does in his practice. In an effort to help in this matter most colleges now have one or two lectures in the final year by family doctors on the broad principles of general practice.

The new graduate is required to be an “intern” for one year before registration and license to practice. His troubles begin immediately. There is a chronic shortage of house officers and consequently long hours of duty. In most cases few facilities are available for public health and general medical attention to those whose incomes fall below a certain level. He has many other duties, but basically this is a salaried post with pension and permission to engage in private practice. This gives a great start in life to any young doctor, and many train particularly for this.

Several surveys have been published in the past year showing the reduction in the number of new doctors going into general practice. This trend is worldwide. The Southern Irish Faculty of the College of General Practitioners has published a very detailed analysis of the Career and Migration of Medical Graduates from University College, Cork. Before 1950, 60% of graduates settled outside the Irish Republic, mostly in the United Kingdom, and 60% of these went into general practice. Since then, more than 75% go abroad, more than half of whom are not in the United Kingdom, and only 40% in general practice. The remaining 50% are almost all in the United States of America or Canada.

The trend to specialize abroad and the lack of post-graduate teaching in this country are shown clearly by these figures (43% of returning doctors are specialists).

Most general practitioners would aim for a public appointment as a District Medical Officer, who is given an area where his services are available for public health and general medical attention to those whose incomes fall below a certain level. He has many other duties, but basically this is a salaried post with pension and permission to engage in private practice. This gives a great start in life to any young doctor, and many train particularly for this.

A recently issued Government