2-1-1955

Medical Advisory Committee to Assist Catholic Hospitals: A Report

Catholic Physicians' Guilds

Follow this and additional works at: https://epublications.marquette.edu/lnq

Part of the Ethics and Political Philosophy Commons, and the Medicine and Health Sciences Commons

Recommended Citation
Available at: https://epublications.marquette.edu/lnq/vol22/iss1/4
Medical Advisory Committee to Assist Catholic Hospitals

S omething is being done to evaluate and to assist all hospitals, but the purpose of this action was criticized by the majority of the committee members. Rather, it was recommended that interested be assigned to men who were capable and willing to teach such that they would be responsible for a limited number of patients so that they could follow them through from the writing of the history to discharge.

Most of the members of the committee favored a rotating internship with a minimum assignment of 12 to 16 weeks. The issues discussed affected many of our Linacre Quarterly readers in a professional capacity and they might well be encouraged to go to work in a hospital and try their hand at reading reports which follow. The issues included those of the various hospitals and the educational policies to be affected.

The first meeting of the committee was held in October at the central office of the Association in St. Louis. The following who had been asked to serve as members were present: Edward H. Belcher, M.D.; St. Louis, Missouri; Joseph V. Finnegan, M.D.; St. Louis, Missouri; Raymond J. Bigon, M.D.; Washington, Missouri; Frank E. Gilhooly, M.D.; School of Medicine, Creighton University, Omaha, Nebraska; William J. Lacey, M.D.; St. Louis, Missouri; Education, St. Francis Hospital, Hartford, Connecticut; Sister Loretta Marie, R.S.M., administrator, Mercy Hospital, Chicago, Illinois; Rev. John J. Hoenschen, diocesan director of hospitals, Cleveland, Ohio; and Robert S. Myers, M.D., F.A.C.S., assistant surgeon, American College of Surgeons, Chicago, Illinois.

In the meantime, the problem of internship in Catholic hospitals had been discussed at the annual business meeting of the Linacre Quarterly readers in various cities and hospitals. Many hospitals could not accommodate the Linacre Quarterly readers in their hospitals, and the problem of who should be assigned was discussed in the form of a workshop for medical staff and administrators.

RECOMMENDATIONS

1. The Catholic Hospital Association should encourage hospitals to foster medical education programs, even though it is an expensive item, it will contribute to improved medical practice.

2. The Catholic Hospital Association should encourage hospitals to foster medical education programs, even though it is an expensive item, it will contribute to improved medical practice.

3. The Catholic Hospital Association should set up conferences or workshops for medical staff and maintain a consultant service.

RESEARCH

Comment was made on the question of research being done in Catholic hospitals and the small number of Catholic hospitals engaged in research. It was thought many hospitals are discouraged because it is the opinion that all research is expensive and that the time is spent in writing a paper. It was pointed out that there are two kinds of research: basic research and hospital research. The former does require extensive laboratory, full-time staff, special equipment and adequate funds. Clinical research is less expensive and can be carried out even in a small hospital by any specialist or general practitioner. The attitude of medical men and hospitals is the most important factor. The desire to improve in the work is the foundation of the whole project and it is this desire that leads to cooperate and to provide facilities and environment to make research possible.

February, 1955
1. Hospitals should be encouraged to attempt only the type of research adapted to each institution. Community hospitals should be cautious about engaging in expensive research projects.

2. The Catholic Hospital Association should publish the sources of grants for research.

3. Research must originate with doctors, but administration should be alert to encourage and to cooperate with efforts of physicians by giving space and some secretarial assistance.

4. Research for its own sake is dangerous.

5. Promulgate the principle that better patient care will result from:
   a) A review of principles
   b) A good educational program
   c) The research that will be the concomitant result.

6. Hospitals should be cautious about hospitals that medical staff and administration make certain that the required functions are being carried out.

7. Although the five following committees are essential in a well-organized staff—executive, credentials, joint conference, tissue, and medical records—a small hospital staff can satisfy requirements by demonstrating that the functions of these five committees are being carried out by one committee or by the staff as a whole.

8. In large hospitals it is very helpful to rotate members of committees as much as possible so that more members of the staff may become familiar with the functioning and the importance of the committees.

9. In some instances, administration in Catholic hospitals moves too rapidly and takes drastic action without consulting the medical staff. This statement led to the topic which came up frequently in the deliberations of the committee, the need for better liaison between the medical staff and the governing boards of Catholic hospitals.

10. It was pointed out that the joint conference committee is an excellent device to remedy this situation. It was suggested that the Mother General of the Holy Name or Mother Provincial might well be a member of that committee or at least attend a meeting of the committee when she visits the hospital.

11. There was a feeling that hospital administrators should be careful to seek advice from well-qualified and progressive members of the staff rather than from one who is pleasing and popular and diplomatic.

ETHICAL STANDARDS

A fear was expressed that some Catholic hospitals are concentrating only in preventing abortions and sterilizations and do not realize the ethical and moral implications involved in ghost surgery and the unnecessary removal of organs. It was felt that hospitals should be advised regarding the morality involved in ghost surgery, unnecessary surgery and fee splitting.

It was recommended that the individual hospital require that those who participate in consultation sign as consultant and that when a surgeon performs an operation recommended to the attending physician, the surgeon be introduced to the patient and his function explained. It is also recommended that the latest amendment of the A.M.A. code be publicized among all hospitals.

THE GENERAL PRACTITIONER

Discussion revealed that an increasing number of people prefer the services of the general practitioner. However, in some sections of the country the general practitioners have difficulty receiving appointments to the staff of hospitals. In large staffs, the general practitioner seems to be overlooked and gets least consideration.

Representatives of the staff of the Catholic Hospital Association informed the committee that the members of the Association were on record through a convention...
resolution recommending that all Catholic hospitals make provisions for a general practice section in their staff or organization. It was also pointed out that the model by-laws suggested by the Catholic Hospital Association include provision for a general practice section.

The committee recommended that an annual review be made of medical staffs with a view to eliminating those who do not avail themselves of privileges and thus make a place for those who are more worthy, including qualified general practitioners. Most general practitioners realize that merit should determine a physician's status on a staff.

The committee hoped that people could be educated to consult a family physician who will refer them to a specialist if necessary. A fear was expressed that some specialists are attempting to act as general practitioners and that this could be a medical hazard. The increasing number of specialists is such that doctors do not wish to make house calls, and if a specialist does make a house call, the fee is usually $25.00.

The committee concluded that discussion by stating that hospitals and doctors have a responsibility to see that the general practitioner is encouraged and recognized in the all-important capacity of a family physician.

NURSING

The committee recognized that there is a shortage of graduate nurses. Nurses' salaries have not kept pace with other salaries. The member of the Committee felt that there are too many instances of inadequate care, of carelessness and errors. However, it was admitted that the attitude of nurses paralleled the attitude of the doctor. Nurses do not write good notes, because the doctors are not faithful in keeping up charts and nurses become careless because doctors do not take time to read notes or to supervise and check on the nurses' work.

SPIRIT OF CHARITY

The members of the committee were asked to comment on the spirit of charity in Catholic hospitals. They expressed a concern that the spirit of charity does prevail, but that the public does not realize it. It was pointed out that no mathematical amount can be set for charity. In times of financial depression, the need for charity is greater and the need will vary from community to community.

Dysmenorrhea and Stilbestrol

by John J. Lynch, S.J.

Among generally accepted procedures in the management of primary dysmenorrhea, the administration of estrogen receives rather frequent mention in medical literature.1 The calculated effect of this hormone, commonly prescribed in the form of diethylstilbestrol tablets, is to achieve painless menstruation through temporary suspension of the ovarian function, since usually "primary dysmenorrhea does not occur in the absence of ovulation." 2 If it is true that one effect of the medication is to inhibit ovulation, and that it is only through the attainment of this first result that painless flow is achieved, then immediately a question can arise regarding the lawfulness of the temporary sterility which necessarily occurs. It may in fact appear at first sight that the use of stilbestrol would have to be condemned for the very reasons which have been adduced against hysperin as an antifertility factor.

There is, however, a distinct and important difference between fertility control as previously discussed and estrogen therapy in the present instance. First of all, it is clear that the natural function of the ovaries is at least two-fold, generative and endocrine. Hence whenever ovarian activity is suspended, two immediate results are necessarily produced: the subject is rendered sterile, temporarily at least; and the system is deprived of certain glandular secretions which are usually beneficial, but sometimes harmful, to bodily health. Now it is entirely conceivable that either one of those results could be desired and intended without the other. One might, for example, intend sterility while disclaiming completely any deliberate intent to affect secondary sex characteristics. Or, by the same token, one might be intent on preventing metastasis of breast carcinoma and repudiate all direct intention to bring about sterility. Of those two examples involving the same morally indifferent act (suspension of ovarian activity), we recognize the first as illicit and the second as potentially permissible, since in the one case the direct intention is illicit, whereas in the other all direct intent is legitimate.

And that is why we condemn fertility control as commonly understood. There the directly intended object of medication is sterility itself, and any other possible consequences are incidental by-products as far as subjective intention is concerned. Since the

February, 1955