The Linacre Quarterly

Volume 30 | Number 4 Article 4

November 1963

Hospital Relations ... Medical Education

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HOSPITAL RELATIONS . . .

MEDICAL EDUCATION

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There is no other activity like a hospital in the United States — nor in the world for that matter. It is a *private institution* affiliated with an *organized group* engaged in private enterprise. The one is a voluntary health institution; the other, a rather informally organized group of private practitioners of medicine who voluntarily associate themselves with the hospital and do much of their work in the hospital. This represents a cooperative effort directed to the welfare of the citizens of a community.

This joining together of private institutions and physicians engaged in the private practice of medicine represents one of the most significant developments in the history of health care. The chief benefactors of this system are the American people. For out of this cooperative relationship has developed a type of care which cannot be paralleled in any other country in the world.

All persons involved are proud of this achievement in American medicine and among American hospitals. This record is excellent, but historical achievement alone will not sustain this cooperative activity in the future. In the years ahead, hospitals must structure careers and fashion their services in terms of the medical and social needs of people today. In the past, pioneer sisters and physicians were progressive and imaginative in developing services with much more meager resources than we have today.

This discussion concerns itself with the preservation and continuation of the kind of medical and hospital care which we appreciate so much. It will not speak of threats which are external. Emphasis is directed to weaknesses that are internal and which, if not corrected, can weaken the fabric of our private endeavors and lead to the ultimate dissolution of our system.

Let us consider first the relationships between hospitals and physicians. Each group is, to a great extent, suffering from success and from too much professional self-satisfaction. Each takes the existence of the other for granted — and each is inclined to measure its importance at the expense of the other. Together, both represent a magnificent professional activity and service. Separated, each would dwindle into insignificance — the one to become a mere nursing home; the other, to revert to a disorganized and haphazard practice of home and office medicine. It behooves both, therefore, to make special efforts to understand each other and to think of mutual support rather than any appearance of distrust or opposition.

There must, therefore, be a sharing of information and a sharing of objectives. It is often true that busy practitioners know very little about the hospitals in which they practice; at the same time, hospital administrators and governing boards have failed to communicate to their medical men and to the public the significant facts and features of hospital operations. How many medical men know the number of employes in their hospitals? Do they have any idea of the monthly payroll? What payroll amounts to in a year? What does it mean to keep the hospital staffed three shifts a day, seven days a week? These figures can be staggering.

Much more significantly, hospitals have failed to explain to the public the values of a good hospital; the values of good medical care. What would it mean to a community if there were no hospitals — no doctors? The public takes emergency service for granted. How many understand the teamwork necessary and the resources kept in reserve to handle the emergencies at midnight on Saturday?

How many physicians really understand the value of accreditation in terms of better patient care? Is it still looked upon as a conspiratorial device foisted upon them by "eggheads" in Chicago? If so, very probably the physicians, the hospital, and above all, the patients, are failing to derive the full benefit of accreditation.

Hospital administrators frequently fail to understand the problems of doctors and the frustrations they sometimes experience in attempting to practice the best possible medicine in the hospitals. Sometimes parking lots, gift shops and stainless steel equipment have priority over good diagnostic services, qualified technicians, and ready availability of people and good equipment. Some administrators lean too heavily for advice on the wrong doctors — the gladhanders.

There is available, fortunately, a device to help solve these problems of misunderstanding. It is the Joint Conference Committee which has been recommended by the American Medical Association and is required by the Joint Commission. It is a committee made up of representatives from the medical staff and from the governing board. How many doctors understand it and its purposes and functioning? Does it really function in the hospital or is it a mere paper committee? Does it boldly study problems of mutual concern with a desire to develop constructive policies — or does it meet occasionally in a perfunctory manner just to satisfy requirements? It is sad to report that it is too little understood and too little utilized. It *could* accomplish so much and could produce a greater unity of pur-

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Father Flanagan, Editor of this journal, is Executive Director of The Catholic Hospital Association. The above is adapted from his address at a dinner for the Medical Staff, Divine Providence Hospital, Williamsport, Pa., May, 1963. It is reprinted here with permission of *Hospital Progress*, the Association's official publication.

pose and a more efficient development of services for patients. Doctors who have enough interest to study it will learn of its values for medical care.

There is a second point of mutual concern for doctors and hospitals. It is continuing medical education. The classical definition states that one of the objectives of a hospital is education. This has long been accepted, but too seldom fully understood. It is commonly believed that the educational objective of a hospital is fulfilled with programs in nursing education, internship and residencies, programs for training of x-ray technicians and medical technologists. But thousands of hospitals do not have these programs. Should they be without educational objectives? Did Dr. MacEachern in his definition of hospitals mean to exclude these hospitals? Did he mean that an educational objective could be fulfilled only through the formal programs mentioned above?

Obviously, he and all the other writers have envisioned every hospital as having an educational function. This would be one which is interwoven into the very fibers of the institution and integrated into the bloodstream and personality of every physician, nurse and technician. There are certain sources of new knowledge; certain centers producing or discovering valuable scientific information and techniques which could be of great value to the practicing physician in any hospital or in any office. Frequently this information fails to reach the service points of contact until after years of delay. Perhaps it may be ineffective because it is not communicated through a medium which can explain and demonstrate.

The United States Public Health Service has published a pamphlet which explains regretfully the time lag between scientific discoveries and their application in practice. The American Medical Association has recognized this problem as a result of a study it sponsored. The report on this study recognized the great need for continuing education for physicians. The report recommends that the AMA seek funds to support an intensive educational program to reach every physician; it further recommends that it employ every medium of communication and teaching to achieve this goal. This report of the Joint Study Committee in Continuing Medical Education is called *Lifetime Learning for Physicians* or a university without walls. It sees every hospital and every medical society cooperating in this great plan to enrich the quality of medical care. This very ambitious plan may never be realized, but it does very forcefully pinpoint a need.

Regardless of the outcome of this plan, one would hope that every hospital would become a distributing point for medical education. One would hope that it would deliberately establish channels of communication with medical schools and medical centers. One would hope that each hospital might become a real educational institution by becoming a demonstration and dissemination center for the newer and better things in medicine. The members of the medical and nursing and technical staff would benefit. But one would also hope that this educational institution would be community-minded enough so that doctors from other hospitals and doctors who do not have staff appointments would be invited to participate. Isn't it time to eliminate institutional pride and snobbishness and become, in a Christian sense, a truly community hospital? If they could see themselves in this role, hospitals would not be unwisely seeking interns who do not exist. They would not be foolishly competing for the limited number of interns available. Think of what this kind of educational spirit would mean to patients — to general care in the community.

There are certain barriers to the development of this attitude toward education. One of the most insidious is the unreasonable antagonism which has been built up between university medical centers and the practicing physician, the clash between academic medicine and medical practice. Are there two types of medicine — one academic and one less dignified? Medicine should be seen as one stream, beginning with and flowing from basic education. This stream is continually added to and fed by scientific discoveries and developments regardless of sponsorship; it is a stream which God and human wisdom would have flow uninterruptedly to its logical destination, suffering humanity, to countless men, women and children in each community. No group or individual dedicated to service may in conscience dam up this stream, divert it, or close minds to its benefits. God has been good to us in America — has given us so much — so much that we feel free to reject at will. In the underdeveloped and underprivileged nations we would not find this sophisticated self-satisfaction. The Tom Dooley's and the Dr. Schweitzer's should inspire us all.

Another barrier to general improvement in medical care is the nasty interprofessional bickering. This includes the bickering and petty competition between the specialties, but most of all the devastating feud between specialists and general practitioners. It is a feud which confuses and dismays the lay person and undermines the prestige of the profession. It would take a Solomon to judge where the greatest blame belongs. Some specialists are unnecessarily disdainful and intolerant of the general practitioner. Some of them are also attempting to engage in general practice for which they are not prepared.

I would like to express myself in a rather brash way about general practitioners. Although they are the greatest in number, although they could be the pride and joy of families, they are floundering in a sea of professional frustrations and self-pity. They feel they have lost status; that they have lost economic advantages. I feel they *have* lost something. They have lost their sense of destiny; they have lost sight of their true goals. Emotionally, they speak of the importance of the family physician. But at the same time they seek status by attempting to be little surgeons — by being partially an O.B. specialist, or by staking

a small claim in pediatrics. Seldom do they see their goal or seek their satisfaction in terms of pure general practice. Perhaps the real goal of the family physician is too high and demands too much to reach.

The family physician ordinarily should be the first medical contact for the patient; he should be the first to diagnose and he must be alert to many symptoms. Paradoxically, the real family physician *should* be the best trained and the most skilled in the arts and sciences of medicine. The specialist is limited to a part of man and he knows this part in depth. The general practitioner must see man in his entirety and be sensitive to a multitude of symptoms. Instead of being the least prepared in medicine he should be the best prepared. I am convinced that the family physician of the future will be the best prepared. When general practitioners see their real goal and work toward it, they will control family practice; they will become so valuable that a hospital and a medical staff cannot do without them. They will not seek privileges under the tent of some specialty. They will be specialists in their own field; they will capture affection and confidence of American families.

There is a final thought as hospitals and medicine look forward to an expanding and demanding future. Some will surely be anxious to embark on some educational activities. This will not be easy; efforts which are too ambitious and too diffuse can result in colossal failure. Education is a slow process, it is basically an individual endeavor which demands strong motivation. Mass education is seldom successful. It is not humanly possible to involve a total staff in educational pursuits. Some are getting too old to be up under the physical demands; others are enjoying competent security with a captive practice and cannot be influenced. This need not defeat the movement.

A SUSTAINING CORE

If only a handful band together to make a start, and if they can mutually encourage and sustain each other, a core will be established. From this small group will emanate a spirit of search for professional excellence which will grow. Americans can learn from the Communists who achieve great results by use of the cell working in a group — they for evil and destruction — we for the good of society. Such leaders deserve the support of hospital administration.

If the organized hospital staffs of the community, the County Medical Society and the administration and governing boards of the hospitals unite in the one common and sacred purpose of serving the sick with all their resources and talents, they will have strengthened themselves in the best possible manner to protect our great system of medical care. God has been good to us in America — education, buildings and equipment, great financial resources — ours is the sacred responsibility to use them for the people who are entrusted to our care.