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Major Problems of Catholic Hospitals in Medical Education

CHARLES U. LETOURNEAU, M.D.

A survey of the educational and research programs of about 25 hospitals during the past five years reveals certain problems that are common to all hospitals in this area and some that occur more frequently in Catholic hospitals than in non-Catholic hospitals.

Most Catholic hospitals are of the voluntary service-to-humanity type which were not primarily designed for teaching or research. Very few of such hospitals are affiliated with medical schools and in the affiliated institutions, the arrangement has left something to be desired on both sides.

Emphasis is placed on service, rather than teaching or research although the latter goals are receiving much more attention now than they ever did in the past. Service to humanity is in the best tradition of the Catholic Church and it is not surprising that our hospitals should follow such a tradition. Emphasis on service is further enhanced by the attitude of the medical staff of the hospital which, in its advisory capacity to administration sets the tone for the policies to be followed.

Where there is any conflict of objectives between service, teaching and research, the choice is made invariably to provide service, even at the expense of the other two objectives. This is not surprising since the charter of the hospital usually provides that the aims and objects of the hospital corporation shall be to provide service to the people of the community. Almost universally, therefore, Catholic hospitals have developed as family-doctor types, for service to people of the community. In more recent times, medical specialties have infiltrated into these hospitals, as might be expected, to keep up to date with medical discoveries and new medical techniques and procedures.

It would be unfair to attempt to generalize about all Catholic hospitals or, for that matter, all voluntary ones. Some voluntary hospitals are outstanding in the types of medical service that they offer but, unfortunately, the majority of them are still dominated by general practitioners who feel a growing insecurity in the face of modern medical scientific services which they are not equipped to provide for their patients. There is a tendency, therefore, on the part of the less qualified doctors of medicine to resist the growth and development of specialized services in their hospitals if these are not to be within the purview of their privileges.

In many hospitals, the retarding view of the general practitioner has been communicated to the adminis-

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tration with the result that the hospital has fallen behind the pace in providing high quality of medical services and chooses instead to provide a mediocre service.

In some hospitals, administration has shown a vigorous leadership in recognizing that the expanding scope of medical science requires an expanding outlook on the part of the hospital toward meeting the challenge of new developments in medicine. In these hospitals, special efforts have been made to develop the specialties in medicine and to develop the educational and research programs that are so necessary to maintain quality in the specialties.

Such an administration requires a great deal of courage because the attitude of the medical staff may be one of hostility towards the development of any kind of program that might encroach upon the economic stability of the practicing physician. At one time, however, Catholic hospitals were in the forefront of service, teaching and research.

The late Dr. Malcolm T. MacEachern took it for granted that the obligation of the medical staff in a hospital, in addition to service was also to undertake teaching programs as a matter of the highest priority, second only to the obligation of service. Physicians were expected to give a considerable amount of their time to the teaching of interns, residents, nurses and, in teaching hospitals, to medical students — for which they received no financial reward.

The days of MacEachern were the days of the uncontrolled medical fee where a physician [illegible] free to charge whatever his consc[illegible]e dictated and the law of supply [illegible] demand was expected to take c[illegible]of the mediocre and the inexpe[illegible]ced physician. The most experien[illegible] physician, the chief of surgery fo[illegible]ample, would charge fees that we[illegible]igh enough to allow him to do a [illegible]imum amount of surgical work o[illegible]rivate patients and to devote the [illegible]aximum of his time to the traini[illegible] of apprentice physicians and resi[illegible]ts and interns.

The voluntary sy[illegible]m of the practice of medicine [illegible]s based upon the right to charg[illegible]fees according to experience, educ[illegible]on, reputation, training and recogn[illegible]on such as fellowships and certifi[illegible]ons in specialties. Thus, the chief [illegible] surgery might charge anywhere f[illegible]n $1,000.00 to $5,000.00 for such [illegible] simple operation as a prostatect[illegible]y, based upon the ability of the p[illegible]ient to pay for his service. Using [illegible]is fee schedule the chief of surgery [illegible]need only perform seven or eight [illegible]uch operations in each month and [illegible]ould afford to spend the rest of h[illegible] time teaching and doing research. Many of the great teachers and researchers in voluntary hospitals [illegible] the past functioned in exactly this way.

Nor was teaching relegated only to the chief. The younger physicians, who were serving their time as apprentices had a great deal of time on their hands while awaiting the slow promotion that was characteristic of those days and were expected to fill in the time between surgical operations in doing teaching and research. The chief was

expected to refer patients who could not afford his fee to the younger doctors. The younger doctor was similarly expected to show a great interest in his own development by doing teaching and research. If he did not manifest enough such desire, he might not ever become the chief himself.

But times have changed and, in this day, anyone who charges $1,000.00 for a prostatectomy might find himself in front of a Grievance Committee, no matter how wealthy the patient might be or how much he could afford to pay. Fees are now fixed by Relative Value Schedules so that the most experienced surgeon in the country may not charge more than the least experienced. The R.V.S. has become the great leveller of medical quality in our times.

It is true that there are still a very few physicians with worldwide reputations who can and do charge more than the Relative Value Schedule allows but these are the exception rather than the rule. Third party payors dare not attack such outstanding men.

The net result of this development has been to curtail the teaching time that a physician would devote to the development of young physicians. In this day, the chief of surgery is now obliged to work at least five times as much as he did formerly to obtain the same income as he did 30 years ago. Time formerly spent in teaching and research is now spent in earning money from the practice of medicine.

By thus limiting the teaching time of the senior physicians, the burden of teaching and research must now be spread over a large number of physicians in order to achieve the same number of teaching hours that were given by a chief of surgery 30 years ago.

As one chief of surgery explained it, a surgeon can perform three operations in a morning period of five hours if he does them himself. At an average income of $200.00 per operation, the surgeon could derive $600.00 for a morning's work in the operating room. But if the surgeon were to spend the time showing a resident how to perform the operation or employed his time in supervising him, the maximum number of operations that he could hope to accomplish would be one major operation and one minor operation which would divide his income in half. A physician who has independent means can afford to indulge in such prestigious activities as teaching and research, but a man who has to earn a living cannot afford to give away very many of his working hours in non-remunerative activities such as teaching.

In some non-Catholic hospitals a rule has been imposed on the practicing physicians, obliging each to give a certain number of teaching hours in return for privileges to practice medicine in the hospital. Some physicians consider this rule harsh and many prefer to work in non-teaching hospitals where the working hours are financially rewarding

if not as prestigious or rewarding in knowledge as the teaching hospital.

Most administrators of Catholic hospitals recoil at the idea of exerting economic pressure upon a physician in order to assure a teaching program. As a result, many Catholic hospitals have fallen behind in their programs of teaching young physicians.

Another problem whch is not confined to Catholic hospitals is the attitude that has been taken by certain courts of law toward the teaching physician. Particularly in those states where hospitals enjoy immunity from lawsuit, the rule has been developed that an intern or a resident is a borrowed servant of a teaching physician. Such a situation arises in the state of Pennsylvania where hospitals enjoy immunity from lawsuit. The cases of *Yorston v. Pennell* and *McConnell v. Williams,* illustrate the hazard that may be faced by a teaching physician who may not even have seen the patient. In the Yorston case, the physician had sent a bill to the patient and this was considered to be evidence of accepted responsibility.

Many voluntary teaching hospitals have an arrangement whereby the work performed by a resident or an intern under the supervision of a licensed physician is considered to be the work of the licensed physician himself so far as billing the patient is concerned. The licensed physician also assumes responsibility for the case but the money is generally deposited in a fund for the education of interns and residents. The teaching physician thus assumes all of the responsibility for the acts of interns and residents but receives no payment in return. The courts ordinarily do not look at the manner in which the money is spent but assume that the man who sent the bill accepts responsibility for the case. This problem still has not been resolved and teaching interns and residents may be a hazardous undertaking in some voluntary hospitals.

It is a well recognized fact that the practicing physician can no longer afford the time necessary to do a good job in a teaching program. Many voluntary hospitals have recognized that the gap in teaching must be bridged by a man or men who must be remunerated in some way for the time they spend in teaching.

Some hospitals have now acquired directors of medical education and directors of medicine, surgery and obstetrics on a full-time or part-time basis. These men are remunerated by the hospital for their teaching obligations. The full-time director of medical education and the full-time heads of departments seem to have been more successful than those who function part-time. The full-time men are not in competition with practicing physicians of the hospital and, theoretically, they should expect to obtain the highest degree of cooperation from practicing physicians. In some hospitals, this cooperation has been a fact but in other hospitals, practicing physicians have

tended to oppose and even to sabotage the teaching program of the hospital by non-cooperation. Opposition to teaching programs by practicing physicians is mainly based on economics.

Although the practicing physicians may not have personal objections to chiefs of departments who do not compete with them for patients, they may oppose the size of the teaching program because of the number of hospital beds that are required to maintain an adequate number of patients for teaching purposes. Each bed has a certain monetary value to the practicing physician. Each bed is worth something in consultations, hospital visits, surgical operations, obstetrical deliveries and other procedures which, in turn, can be translated into monetary values.

Consider the internist, for example, who visits his patient daily. The fee for the average daily visit in the hospital ranges from $20.00 for the first day to $5.00 for an average routine visit. Assuming that the average is $10.00 per day, every occupied bed is worth $10.00 per day to that internist. In a high occupancy hospital where beds are occupied on an average of 330 out of 365 days, the hospital bed is worth approximately $3,300.00 per year to the internist. Conservatively, most internists feel that they have to control about ten beds in the hospital to make an adequate income of about $33,000.00 per year.

Surgeons are paid, not by the hospital day, but by the surgical procedures that they undertake. Fees for surgery range widely but it is generally agreed that the average is $200.00 for each major surgical operation. If we assume that the average stay per surgical operation is 12 days, then a surgeon may expect to get 30 operations out of each bed so that each hospital bed is worth about $6,000.00 per year to him. Like the internist, most surgeons agree that they require control of about ten beds to make a reasonable annual income. Although the income of the surgeon in the hospital appears to be disproportionate compared to that of the internist, it should be remembered that income from office practice for a surgeon is minimal but availability of beds and surgical operating time is a matter of paramount importance to his survival. Obstetricians and other types of specialists similarly have an economic stake in a hospital.

Theoretically, therefore, a 500 bed hospital can support 50 physicians of all kinds of specialties if we calculate ten beds per physician. Obviously, this figure would require adjustment because some specialists cannot confine all of their activities to one hospital but they choose to work in several hospitals because of the limited number of patients referred to their specialty in each hospital.

Although the teaching head of a department may not be in financial competition with his practicing colleagues, the fact remains that a certain number of beds must be allocated to him for use in teaching of

residents and interns or the program of residency and internship will be disapproved by the American Medical Association. Reducing the total number of available beds for private practice creates economic pressure on the practicing physicians of the hospital and each physician must reduce his practice in proportion to the number of beds lost or some physicians must go elsewhere to obtain the beds that they need for a reasonable income.

In all hospitals, physicians have an enlightened self-interest and an economic stake in the hospital bed which is worth protecting. One of the major problems, therefore, concerns the determined efforts made by practicing physicians to protect hospital beds for their own use, even at the expense of sacrificing a teaching and a research program. This attitude of practicing physicians is normal and understandable. There seems to be no reason why public education should be carried on at the expense of a physician's family and his way of life. Were the future of teaching and research in Catholic hospitals to be left entirely in the hands of the practicing physicians, there seems to be no doubt that the existing mediocrity in the majority of our hospitals would continue indefinitely to the eventual total deterioration of the quality of care in the hospital.

In some hospitals, physicians dedicated to preservation of mediocrity have become an entrenched oligarchy dedicated to resistance to change. In some hospitals this oligarchy takes the form of a gerontocracy fighting a rear guard action against progress until they are ready for retirement.

Blame for mediocrity cannot be placed entirely upon the physicians who practice in the hospital. The major share of the blame must be placed on the shoulders of the administration which is responsible for maintaining the highest possible quality of care in the hospital. Too many Catholic hospitals have suffered from weak administration. In most instances, administration is weak only because of the system in which it functions.

In the first place, the policy making body may be located at some considerable distance from the hospital and completely out of touch with what has transpired in recent times. All too often, the hospital representative on the general council is a person who once served as operating room supervisor and gets all of her advice from the chief surgeon of the hospital whom she knew many years ago, thus bypassing effectively the administrator. Examples of bypassing which weaken the position of the administrator are delegations of medical staff representatives to the Motherhouse to complain about the administrator, delegations to the local Bishop to ask for his good offices to intercede on behalf of the physicians and pressure upon religious sisters who work in various departments of the hospital to attempt to influence the administrator directly in the convent.

Arguments frequently used by physicians are that the hospital owes them a living in return for all of the favors that they have conferred on the hospital over the years. Generally the major argument is that certain physicians have treated religious sisters, priests and even Bishops free of charge for a number of years at great personal sacrifice to themselves.

Another argument is that the development of a teaching program will attract young well qualified physicians to compete with the existing practitioners resulting in serious economic loss to themselves.

In altogether too many hospitals, these arguments and representations have been successful and have maintained the level of mediocrity that they sought to achieve. In other hospitals, the administrator took a more enlightened view that the hospital owes no more to the physician than the physician owes to the hospital. As noted above, a hospital bed has a great economic value to a physician and the fact that he enjoys the use of such beds free of charge is ample reason for him to do everything in his power to serve the hospital.

However, even in those hospitals where the voluntary physicians have been willing to undertake teaching of residents and interns free of charge and have been willing to devote the time, a major problem is lack of competence in the teacher. It has been well established by the specialty boards that a general practitioner is not sufficiently well qualified to teach a specialty. The answer to this problem is obvious. If a major teaching program is to be maintained in the hospital on a voluntary basis, qualified specialists will have to be brought into the hospital and since there are only a limited number of beds available, the general practitioner will have to go elsewhere.

Finally, there is the problem of money. Educational programs cost money and under the existing voluntary hospital system, the education of physicians and other professional personnel in hospitals must be paid for with the sick man's dollar. The fact that the dollar may come from the third party payor makes relatively little difference. The fact is that a certain additional charge must be made per patient day for the education and research programs. For research, it is usually possible to get a grant from the government or some foundation but at the present time, very little financial support exists for education.

In hospitals which have a good system of accounting money is budgeted for education, and full-time or part-time teaching physicians have been acquired to meet the needs of the program.

There are numerous other minor problems of education and research in Catholic hospitals but before these problems can be attacked, solutions to the major problems must be found and these will not be easy.