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Organizational Structure N ded to Support an Educational P gram

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It seems quite clear that the excellence of any educational program is directly related to the strength and enlightenment of the Board of Trustees and management of the institution.

Although it is only a part of the recipe, it is without question as fundamental as yeast.

Recently, the President of one of America's great universities, while giving a paper at Yale, made the statement that, "In the twenty-four years that I have been a hospital Trustee, I have never been asked to pass upon a single matter of educational philosophy or of educational planning, and yet these hospitals have had, and do have, large obligations and activities in the educational field."

Shocking as this statement may be, it unmistakably describes management as having the opinion that education is really none of the Trustee's business, or that trusteeship of our hospitals must remain pigeonholed in the narrow and pedantic concern only for financing and the balance sheet — not with the wisdom, imagination and quality of the educational programs of the hospital. Such an indictment needs challenge!

Our center of attention will be the community teaching hospital with its educational responsibilities, its commitment to c nunity service, and its relationsh the practicing profession. Not th iversity owned hospital where co unity service is incidental to edu ion. Not the community hospita here education is incidental to ser .

We are talkin bout an immensely complex i itution, vastly more complicated t n its counterpart of twenty y s ago, and I would suggest, evc nore sophisticated. It is now fac with the obligation to reconcile ducation with service when bo cry out for preference.

The fact is, that e hospital no longer exists solely t rovide a place where physicians c for the sick. The relationship of d tor to patient is no longer exclusiv nor is the relationship of the ho tal to the patient an exclusive or What today's patient experiences our hospitals is a delicate balanc f meaningful relationships with a m of collaborating health profess als.

How can this delic e balance become the framework the organizational structure need d to support an educational progra , and at the same time function as an efficient, effective, organization for service?

The initial consider tion demands an answer to this basic question:

What are we willing to sacrifice to insure good educational programs?

Are we willing to sacrifice some of our management prerogatives? Yes, even some of our traditional professional freedoms?

No matter how benevolent the intentions, the solution to the problem threatens our cherished freedoms to act and manipulate as we choose, for the private practice of medicine and the management of the hospital are not mutually exclusive.

W. M. Dickson writing on "The Human Condition," queries: "Have you ever asked yourself why men have fought for liberty? Not for amusement. Freedom they must have, whether they know or not what to do with it. Freedom to choose cause or party, order or disorder, the good or the bad, to steer each his own vessel to the port of his desire. Take away his choice and you make of him for all your benevolent intentions, a slave."

It is, therefore, very apparent that freedom and duty may be at odds with one another from time to time. It is also very apparent that, if one threatens a man's freedom, he will fight.

The bridge between scientific knowledge and its application in an orderly accepted and efficient course, is the job of management.

By management we mean the total management of the institution, not merely the administrator, but also his professional counterparts.

Uniquely true in hospitals, the executive officer (administrator) is a catalyst.

A catalyst is defined as a substance to accelerate or, in a negative sense, to retard a reaction. Then goes on, "and may be recovered practically unchanged at the end of the reaction." It goes without saying that few executive officers recover practically unchanged at the end of a reaction, but catalytic we must be, even though certain trauma results.

It seems important for all to understand the variety of executive officers, each to be dealt with differently, but most of all to be understood for what they are. There is, (1) the Bureaucrat, who regulates and lives by the rules; (2) the Autocrat, who directs and makes the rules; (3) the Democrat, who invents and humanizes the rules; and (4) the Diplomat, who manipulates and bends the rules.

Now the hospital, the physician, and the patient are subject to all the natural human traits, especially that familiar trait known as "status quoism" or resistance to change. Few are not enslaved by it and none go unaffected by it.

Because of this tendency, hospital administration, physician, and patient will always tend to cling to their historical notions and images of each other. However, in an even brief exposure to the hospital as it functions as an educational institution, it has become apparent that, as in life itself, change continues to be relentless.

Traditions are regularly shattered, customs are overturned, and these events never fail to be painful to those intimately involved, leaving behind them the apprehension,

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resistance, and insecurities which always accompany revolution.

It is a good deal like the situation of the Australian native of the Outback, who was justly proud of the new boomerang he had just carved, but was having one impossible time throwing the old one away. Few periods in written history have demonstrated so much change, social, economic, or political. Therefore, we have referred to this period as revolution, not evolution.

Within this environment there are three kinds of organizations:

1. Those who initiate change — make it happen.
2. Those who wait for change to happen.
3. Those who don't even know when change has happened.

As the focus of health care in our communities, and as the crucible in which the new metal, "health care in the 70's" will be fabricated, we must be the initiators of change. We cannot survive as a strong and healthy medical care system by merely adjusting to the environment — we must change it or be changed by it.

We must be able to not only communicate better, but to recognize that the world, as our late President suggested in his now famous speech to the American University, that "the world is not all black and white, but rather it is a world of grey, and we must learn to live in it." Not words, but deeds are the order of the day, for the tree is known by its fruit, and the public is examining the tree.

Performance i ns change — change creates p lems, conflict, and rumor. It ma the individual participant's con crucial. It forces us to the re ition that one must be understo o be effective.

Conduct seems be determined by two forces:

1. The duty c he individual, which is the uff that holds society togeth giving it law and order;
2. The freedom act personally, which is inh nt in a free society.

Conflict arises wh the individual tries to fit his or h need to be an acceptable social mal, with his need to act as a fre nan.

It is crucial that l who participate in this ma ement system need to be predict le and a great deal of attention ds to be paid to the developmen of the simple formula:

Behavior=the fo of personality x environment.

It is also importa that the principles of manageme or the rules of the game, so to sp k, are applied and studied as to th ir applicability.

It seems to us tha the basic principles of manage nt are either totally lacking, or are in many respects, inappropriate within the patient care and teaching environment.

The problem then becomes one of trying to answer the question of, "How can an organization survive when it violates the principles of management so recklessly?" We would like to suggest that perhaps a hospital is a unique institution,

and that therefore, it has a set of principles which have evolved from its own body of knowledge. Therefore, it becomes necessary for a hospital to seriously violate one of its own principles before survival is truly in jeopardy.

What are these principles? Could they be the old fashioned virtues of Loyalty, Faith and Charity? Have they become too virtuous for us to recognize — too embarrassing to write about?

We have established the hospital as the crucible. The ingredients are already present (Patient — Medical Staff — Nurse — Administration). If Loyalty, Faith and Charity are common among them, they just might be the elements that fuse the various disciplines together into the only environment for quality health care and education. The constant companion to virtue is sacrifice. For example, there are inherent pitfalls in loyalty. Its introduction into the crucible, like any catalyst, may hinder the reaction if it is not introduced in appropriate proportion.

These pitfalls are:

1. Loyalty to one's self (Profession).
2. Loyalty to the organization.
3. Loyalty to the patient we serve.

These often come into conflict with each other. It is this conflict which will undermine the greatness of our efforts. Administrator's responsibility is to so direct the management affairs — both medical and non-medical, so as to insure that loyalty to the organization is compatible to the other two, without compromise, with principle.

However, to find loyalty, which is so paramount a quality, one must accept its problems and its pitfalls. Without it, any profession becomes meaningless. Without it, few can be trusted. Without it, success is a prelude to failure. Without it, one carries his own precipice around with him.

The fear of the untrusting is the beginning of chaos in any organization.

It seems to us that here are at least some of the factors, important to such an environment:

1. The presence of those who are in the hospital environment is by privilege, not right.
2. There is a stewardship that must be felt by each of us, concerning the financing of health care as it is related to the vital nature of the service we perform.
3. Each of us needs a *proper* understanding of our role. Interpretation and explanation of medical problems by non-medical people can be damaging and dangerous.
4. The policies and philosophy of Management must be clearly understood.
5. There must be a required absence of pettiness and personality cliques.
6. Prejudice, like a wad of gum, must be placed on the door mantle before entering our place of work, and may be picked up again on the way out. This includes the prejudice of religion, race, politics, age and sex.

We require no crusaders or evangelist — our business is "PATIENT CARE."

7. We are in a partnership; along with partnership goes responsibility.

Responsibility to the patient means:

1. When absent — you are missed.

2. When unsympathetic and intolerant — you fail to recognize mistakes as a price of true learning.

3. When disinterested — you frighten.

4. When inconsiderate — you offend.

5. When impatient — you frustrate, for you cannot live realistically with your circumstances.

6. When undisciplined—you may never know the difference between discontentment and dissatisfaction, for discontentment breeds contempt — while dissatisfaction breeds progress and hope.

7. When faithless—you will never know the substance of things hoped for, and the conviction of things not seen.

However, to show clearly in the hospital that it is not always necessary for a member of the staff to feel that he is not lost in a cooperating group where his individuality loses identity, it is sometimes important that competition and, in fact, conflict, may be very beneficial to good patient care. For example, one of the early writings of Florence Nightingale stated:

"Great have been the 'scrimmages' from time to time between administration and the orders; and great have been the benefits to the sick from such scrimmages . . . Now the balance is most happily established. The administration[illegible]plains of the Sisters, and the doc[illegible]s wish the Sisters were 'complet[illegible]under them.' The Sisters compla[illegible]f the administration and wish[illegible]at the Order had it completely [illegible]er itself. And all are the best pos[illegible]e friends, and the collision and [illegible]mpletion does the greatest possib[illegible]ood. And all work much better [illegible]it, and none know how much [illegible]l it prevents, how much good it [illegible]ures."

Management is [illegible]longer a unilateral thing, but [illegible]hared responsibility.

If the true natur[illegible]f the partnership is ignored, t[illegible]the question may yet be Manage[illegible]nt vs the Physician, but the by[illegible]oduct of this fight is chaos and [illegible]lls disaster to our system.

Let there be con[illegible]t—healthy exchange . . . but let [illegible]outside force, no unqualified jud[illegible]arbitrate our differences and th[illegible]determine our destiny.

The third party [illegible]itrator may be good for labor-ma[illegible]gement problems, but inappop[illegible]te, inept and destructive in the [illegible]alth care system, where Manag[illegible]ent and physician should and c[illegible]ld resolve their problems to present *all* the recommendations of the [illegible]rofessional.

Our hospitals, con[illegible]antly burdened with the cost of n[illegible]w medical technology and daily faced with the problem of medical [illegible]ducation versus service to the comm[illegible]nity, struggle to do well in all their responsibilities. However, as education has become more appropriately a university function, some plan must be devised

to utilize the hospital as a clincal laboratory for the university, while at the same time making patient care and service of paramount consideration.

It is still believed and, I believe, that medicine must be practiced to be learned. Our hospital provides such an environment.

Therefore, a necessary reconciliation between the responsibility for excellence in medical education and for the highest level of patient care is the goal of our hospitals — a goal infinitely more difficult to reach than simply one or the other.

We need to be worthy of our educational responsibilities, while at the same time to be the pride of our community for the patient care with which we are entrusted.

What about the organization itself? These are my own opinions and do not necessarily reflect those of my sponsor!

The first question must be — how are the chiefs of departments assigned their responsibility? Election, or appointment? I believe the basis of any good and lasting educational program depends on the appointment of the chiefs, not an annual election.

Two types of medical staff organization exist in every hospital:

1. The classical variety of medical organization, which requires no explanation, for it does not change, and has been proven. It is in this environment that the chiefs of surgery, medicine, etc., function as an individual physician, with no other rights and privileges because of his office.

2. The executive responsibility for professional management is that peculiarly given to the chiefs of any department, and in this respect, he does function outside of the classical variety of medical staff organization and peculiarly functions within the classical variety of management. He is, in fact, part of the Management of the institution, as surely as if he were called Administrator.

The chief cannot abdicate such responsibility, nor even purchase it away by the hiring of a Director of Medical Education. This went out with the Civil War when one could pay another to go in his stead.

Unfortunately, too many hospitals think that the Director of Medical Education is the solution to the intern problem. "After all, he is paid to teach — let him teach."

I am neither opposed nor critical of the Director of Medical Education as a position. I simply say that here is *not* the organizational answer. Too many of our excellent D.M.E.'s have been expected to carry the burdens of medical education in our community hospitals, as if they have some unique power to make this responsibility successful without the participation of the private practicing physician.

I would, however, suggest that with the appointment of chiefs, doing their appropriate jobs, and part-time physicians within each department, we may begin to place the responsibility for medical education appropri-

ately in the hands of the individual departments. Young men coming into an area to practice may be encouraged to enter a hospital system through part-time employment in education within the various departments. I would like to make clear that it is not required of every institution to have full-time paid chiefs of service in order to have a good educational program. It is, however, required that those men responsible for so important a task, be given opportunity and convenience to get the job done.

Therefore, it would seem that a geographic arrangement for full-time presence in the hospital would be reasonable. Their presence is mandatory. Offices can be provided in the hospital where he can carry on his private practice while at the same time, making himself available for management decisions.

It would seem that if a chief appointed by the Board of Trustees, with an executive responsibility to manage, fails in this responsibility, he may be relieved, while at the same time, not seriously affecting his private practice; a practice which is his and not the hospital's — for it is through this practice that he maintains his livelihood.

A practice can be moved—a salary cannot.

We tend to look into the looking glass and ask, "Mirror, mirror on the wall, who is the fairest of them all?" The answer is obvious — we are!

We would suggest that, like Alice, of *Alice in Wonderland,* we step through the looking glass and discover the world of l lvement—not just the world of re tion. And like Alice, we will find a topsy-turvy world, requiring al! our skills and statesmanship.

It is fundament hat appropriate financing be d oped in support of the educ nal program. Here Trustee invol ent is crucial.

It is becoming i asingly more apparent that a arate budget, with separate finan g is to be required if we are to tain our large educational progra and to justify them to the patient l the community that we serve.

Endowment, supp ental financing, and an appropr share of hospital expense must documented and clearly underst by all.

The most import ingredient in any organizational ucture in the development of an o standing educational program is participation of the practicing pro ssion.

The practice of m icine, as suggested, must be p cticed to be learned and it is or through the physician and his co ant guidance, as well as backup of he young men in training, that we hall maintain a level of high educat nal endeavor.

The practicing p fession must always be available to give additional thought and guidance, always available to reinforce the student at times of doubt, in periods of confusion, and even panic. Only in an environment where quality care is given, can a student learn. It is, as a matter of fact, the hallmark to an environment of learning.

The Practitioner as the Essential Partner in Education and Research

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Vannevar Bush has said succinctly, "All professional men are confronted with the dilemma that there is too much they need to know and too little time to do it." Most of us are in agreement that there is a widening gap between medical knowledge and its application in medical practice. To bridge the gap a physician may read much or little. He may attend meetings. He may enroll in any one of the currently listed 1,200 or more postgraduate courses. Some do these things all the time, some occasionally, others never.

There is a change needed not only to benefit the practitioner, but equally as much the medical schools. The cost of facilities, the demands of research, the often sheltered life of the full-time faculty member makes it essential that there be a change in the intrinsic structure of the medical school and equally as much, if not more, of a change in the attitudes and goals of the practitioner.

There are several areas in which the university hospital and practitioner can become more profitably united. One area is medical education and the other research. The atmosphere of the university hospital dealing with the most complex patients, the unusual, and the dramatic, may find itself training young men best equipped to suspect the rare disease entity without giving concern to the common. I am reminded of an experience only a few days ago when on my morning rounds an excited, enthusiastic house staff and group of students anxiously awaited my arrival because of an interesting problem of diabetes insipidus in a middle-aged woman who had just been admitted the previous day. All of the classical historical information and symptoms (thirst, excessive water, excessive urination) supported this diagnosis. I shall not forget the disappointment and disbelieving countenance of the house officer of whom, after hearing this story and all the findings, I asked a question. The question was not about the pituitary x-ray, the response to pitressin, the visual fields or other similarly pertinent questions. I asked: Does the woman wear dentures? Do they fit? This was a disturbing question to be asked by the professor when he should have been talking about anti-diuretic hormone, nicotine stimulation of ADH and the effects of alcohol on ADH. The important point to be made was that oral conditions — such as ill-fitting dentures (which turned out to be the case) or inade-

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quate saliva — are among the most common causes of excess fluid ingestion and subsequent excessive urine output.

Every practitioner knows he must be practical and think of the common and not the rare or the unusual. He must be a percentage player in the continuing game of diagnosis. He has to be. Should he resort only to considering the unusual, only using consultants, he would soon be a pretty poor physician — medically and financially. But this is the very point I wish to make and emphasize — the very nature of medical practice conducted by the general practitioner or internist who sees patients in his office can be valuable to medical colleagues and medical students. The character of his work places him in intimate contact with a special kind of medical experience frequently quite unknown to full-time faculty members of a medical center complex. This knowledge should be imparted to others. This can be done by his taking an active part in the teaching functions of a medical school or teaching hospital. I do not have in mind the outmoded practice of having preceptorships but rather the practitioner participating directly in the intra-university and intra-hospital programs where students and house-officers will benefit.

The other important reason for our encouraging the participation of practitioners in medical center objectives is to further medical research. He can be given an opportunity to do clinical research and to contribute to i tant medical developments that ld be impossible or extremely likely during the life of his mc academic colleagues. The ideal position of a team conducting cl al research is: one, a seasoned ve n in research who is usually ac mic full-time; two, a cautious, tical, experienced, devoted p itioner, and; three, a querulous, usiastic, spirited young house er. This is a team that does for ical research what the Four H men did for Notre Dame. The development of our knowledge garding oral hypoglycemic agen was delayed because all the ear studies were carried out in uni sity hospitals by full-time investi ors. The excellent effects of th drugs were attributed to their a ity to control insulin secretion a glucose metabolism. Its failure were often ascribed to a loss of dr effectiveness. Some even considere initially that these agents were b er than insulin since many diab cs previously poorly controlled b insulin were now well controlled by taking these pills. Some even thou at these drugs must cause the indivi ual to produce a better insulin or his own insulin was made more effective. It remained for a practitioner to learn from his office patients given these drugs that the reason for the better control of many diabetic patients was not the remarkable properties of the drug, nor that a better insulin was produced nor that their endogenous insulin was made more active, but the simple observation that one reason such drugs were so effective was that for the first time diabetics so treated were adhering strictly to their prescribed diets. Diabetics were doing better with their diets and being better regulated because they knew that unless they remained well-controlled on the pills they had only one recourse—to return to taking injections of insulin—which they did not have any wish to do if it could be avoided.

Many young physicians seek university hospital positions. They want to conduct some research and do some teaching, but mainly they want to practice medicine. This is admirable. They are not dissuaded from following such a plan, but the number of them who follow through with this intent after the first year is remarkably small. The hospital is there; the research and teaching need is there; the full-time academician is there; but, the practicing physician is not. He has defaulted. He has let slip a great opportunity and chance for gratification.

It is my firm conviction that no university-directed or community hospital-directed program—whether in education or research — can continue a high standard without the direct participation of practicing physicians. Conversely, unless he is a part of teaching and education pursuits of such institutions he not only becomes a progressively obsolescent physician, but he is missing the most exciting, pleasurable, and continuing experience of his life. Each needs the other. Let us not wait too long to realize it.