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The Transition Era in Medical Education: A Critical Period for Loyola University School of Medicine

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LOYOLA UNIVERSITY CHICAGO

THE TRANSITION ERA IN MEDICAL EDUCATION:
A CRITICAL PERIOD FOR LOYOLA UNIVERSITY SCHOOL
OF MEDICINE

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

DEPARTMENT OF EDUCATIONAL LEADERSHIP AND POLICY STUDIES

By

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CHICAGO, ILLINOIS

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In many ways this research has been a family project, and I have many to thank: my sisters-in-law, Sherry and Terry have shared my joys and frustrations and have always given me their total support as only sisters can do; my husband, Anthony, has always been a shining example of determination and a constant source of encouragement; my children, Mark, Anthony, and Amanda have

allowed me the dual pleasure of being their mother and a student at the same time; my brothers, Phil and Greg, are my best friends and my heroes; and to my dad, who used to take my brothers and me to visit a new medical school whenever we went on vacation, thank you for the good genes, your faith, and your inspiring life.

Preface

By the early 1900's, the public was becoming increasingly aware of the woeful state of medical education in America. Proprietary schools and "diploma mills" had given the country a plethora of poorly trained physicians. There was, however, a growing reform movement, spurred by the influential Flexner Report, that called for higher admission standards, laboratory instruction in the sciences, and hospital-based clinical teaching. The new instructional system became the model for the nation; it became not only desirable but absolutely mandatory if the medical school was to survive. Within a few years, the proprietary schools disappeared.

However, laboratory-based instruction in small student groups under trained scientists, clinical work in hospitals, and a lengthened curriculum resulted in enormous increases in the cost of medical education. Loyola University School of Medicine was typical of a smaller, less well-established, private university that did not have access to the support of the large foundations and philanthropic trusts and without strong departments of biology, physics and chemistry. Such institutions had considerable difficulty meeting these new standards. Many of these schools were placed on academic probation, and a number went out of existence.

The remolding of medical education was slowed by World War I, the Great Depression, and World War II. There followed, however, an era of unprecedented change in society, as medicine and all the world moved inexorably into the modern era. The twenty years from 1940 to 1960 were years of transition and of critical importance in the history of medical education. During this transition era many medical schools were still struggling to implement the mandated changes called for in the Flexner Report when there began a new age characterized, in part, by an exponential growth in scientific knowledge, unprecedented federal funding, a research epidemic, and explosive growth in both size and complexity of medical schools and medical centers. This was, then, a transition period in U. S. medical education, especially for an institution such as Loyola University with no endowment, lesser program emphasis in the sciences and a struggling medical school. To describe how Loyola University School of Medicine survived the constant threat of dissolution during this critical period and to analyze the complex factors involved in this struggle, are the primary purposes of this dissertation.

To view the Loyola saga in context, it is necessary to trace the development of American medical schools, in general, as well as their universities (with which they were closely associated). Because of the inevitable relationship of American medicine to medical education, this researcher also believes it relevant to trace, at least briefly, these changes

during the transition era and in the preceding and subsequent periods. The transition era of medical education is characterized by epochal changes in American medicine and medical education. The history of Loyola University School of Medicine during this era is undoubtedly the most tumultuous in the school's existence. The story is a complex one involving administrative difficulties at the school itself, a strong role played by Cardinal Stritch of Chicago, a desperate struggle by the university to overcome financial difficulties, and the frustrating efforts to develop the necessary teaching hospital affiliation. The survival and eventual success of the medical school is a tribute to the effort and persistence of a small group of extraordinary individuals.

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CHAPTER I

DEVELOPMENT OF THE MODERN MEDICAL SCHOOL IN AMERICA

From Colonial Times to the Civil War

Henry Sigerist, the noted medical historian, suggested that American medical education may be roughly divided into two periods, pre- and post-Civil War. The practice of medicine during the pre-Civil War era, except for a few European-trained physicians, was primitive. This might be anticipated in a nation carving out its destiny in the wilderness. The second or the post-Civil War period began when the frontier came to an end and American medicine began its rise to world significance.¹

When the first European colonists landed in the New World, among the earliest problems facing them were those of severe illness and epidemic disease. From the first arrival at Jamestown (1607 to 1625), about 6500 individuals migrated to the Virginia Colony but only about 1025 survived. Similar statistics existed for the Plymouth Colony in Massachusetts. Epidemic disease wreaked havoc. The early immigrants were mainly economic, social, or political outcasts and included criminals sentenced to migration. Only a very few qualified physicians chose such a non-remunerative and dangerous

¹Henry Sigerist, Foreword to Medical Education in the United States Before the Civil War, by W. F. Norwood (Philadelphia: The University of Pennsylvania Press, 1944).

life. Thus medical practice was mainly in the hands of poorly educated apprentices who, in turn, had learned their trade under other apprentices with equivalent training.²

Medicine was considered no different than any other trade such as blacksmithing, coopering or printing. The medical apprenticeship was fully in line with the European example; though in Europe it was usually preceded by graduation from a university. In the colonies, a father with sufficient funds would apprentice his son to a craftsman for three to five years. The craftsman would teach him the trade in exchange for a fee and the labor of the youth. The apprentice served as an assistant and performed chores while he “read medicine” from his “master.” Some apprenticeships were with university-trained physicians, but the great majority received only rudimentary training.³ There were many instances of abuse such as the cobbler who transformed himself into a physician without even an apprenticeship education. In addition, early physicians not only diagnosed and treated ailments but also worked as pharmacists selling medicine to their patients.⁴ They enjoyed the trade of selling commodities as well as providing medical advice. A number of well-educated clergymen also took up

²Martin Kaufman, American Medical Education--The Formative years: 1765-1910 (Westport, Connecticut: Greenwood Press, 1976), 3-4; Kenneth M. Ludmerer, Learning to Heal: The Development of American Medical Education (New York City: Basic Books, 1985), 9-11.

³W. F. Norwood, Medical Education in the United States Before the Civil War (Philadelphia: The University of Pennsylvania Press, 1944), 11.

⁴Lester S. King, “Medicine--Trade or Profession?,” Journal of the American Medical Association 253 (May 10, 1985): 2709; Kaufman, 6-7.

medicine. Clergymen were well-suited to serve as the town doctors because, in the colonies, there was much disease and illness yet few known cures, hence often the most that anyone could offer a patient was sympathy and kindness which was frequently best provided by the town's clergymen.⁵

First Medical Schools

With the start of the eighteenth century, the early colonial “starving period” had ended. The colonies became prosperous and a number of European-trained physicians began to migrate to America. The first substantial step toward improvement in medical practice came with the establishment of the first American medical college in Philadelphia in 1765 and another school shortly thereafter in New York City. The Philadelphia School, which was part of the University of Pennsylvania, was established by John Morgan, William Shippen, Benjamin Rush and Thomas Bond, all University of Edinburgh graduates. These were outstanding physicians who had widespread influence on American medicine. Thomas Bond was particularly adept at clinical teaching utilizing a technique he learned at the University of Edinburgh. For the first time in an American hospital, Bond had his medical students “walk the wards” with him. John Morgan has been called the father of medical education in the U.S. and Benjamin Rush, the godfather.⁶

⁵Robert J. Glaser, “Teaching Hospital and the Medical School” in The Teaching Hospital (Cambridge: Howard University Press, 1960), 11.

⁶Norwood, 2-4, 46, 70; Erwin H. Ackerknecht, M. D., A Short History of Medicine (Baltimore: Johns Hopkins Press, 1982), 221; John K. Crellin, Medical Care in Pioneer Illinois (Carbondale: Pearson Museum Southern

Benjamin Franklin, among his other multiple activities, played an important role in assisting with and encouraging the fledgling Philadelphia Medical School. In 1752, Thomas Bond and Benjamin Franklin also established the Pennsylvania Hospital in Philadelphia, which became the first incorporated hospital in the U.S. and remains today as one of the outstanding hospitals in the country. Several years later in 1767, Dr. Samuel Bard and colleagues, many of whom were graduates of the University of Leyden, in the Netherlands, established the second American medical school in New York City. This was King's College, later to become the Columbia University College of Physicians and Surgeons. Other schools were then established at Boston (Harvard), New York City (Cornell), and New Orleans (Tulane). Eventually, additional medical colleges were begun in upstate New York and in some of the newer territories of Ohio, Illinois and in some southern states.⁷ In reality, as Glaser pointed out, very early American physicians actually obtained their medical education in the rudimentary institutions that

Illinois University Press, 1982), 93. Benjamin Rush was the most influential physician in the United States; his ideas, nevertheless, were highly controversial. His belief in the curing power of bloodletting and purging with calomel were extreme even in his day. He was, however, highly regarded for his humane and advanced treatment of mentally ill. In addition, he established the first free dispensary in the United States. A man of considerable influence, his contributions extended far beyond the scope of medicine as he helped found the first American anti-slavery society, was a founder of Dickinson College, served as a member of the Continental Congress, signed the Declaration of Independence, was Surgeon General of the Continental Army, and served as treasurer of the U. S. Mint from 1797 to 1813. He also espoused numerous causes including the emancipation of slaves, anti-alcoholism, abolition of the death penalty, and money reform.

⁷Norwood, 44, 109, 304-76.

existed. He noted that in the early part of the nineteenth century “only ten percent of the physicians of the time were graduates of the existing medical schools and eighty percent had had no formal course work whatsoever.”⁸

After the Louisiana Purchase in 1803, there was a large westward migration by wagon, on horseback and on foot; hordes of Americans, including trained and untrained physicians, traveled westward. The conditions were primitive. Physicians treated wounds with boiling oil and bled patients for a variety of ills ranging from headaches to yellow fever.⁹ They would go directly from conducting an autopsy to performing a vaginal examination on a pregnant woman “stopping only to wipe their hands and scalpels on their frock coats.”¹⁰

Among these early pioneers was a physician, Daniel Brainard, a graduate of Jefferson Medical College in Philadelphia. Brainard migrated to the village of Chicago (renamed from Fort Dearborn--population about 1,000). In 1837 he obtained a charter for the establishment of the city’s first medical school which later became Rush Medical College. One of Rush’s most prominent faculty members was Nathan Davis, who would break away from

⁸Glaser, 11.

⁹Kaufman, 40; Norwood, 285. A typical incident occurred in 1809 when an ovariectomy (removal of an ovarian tumor) was performed by a Kentucky physician who attended one term at Edinburgh but never attained a degree. This was the doctor’s first attempt at this type of surgery and was carried out without benefit of antiseptic or anesthesia; nevertheless, the hardy patient survived.

¹⁰William K. Beatty, “Why Study Medical History,” Journal of the American Medical Association 264 (December 5, 1990): 2816.

Rush, and begin what would eventually become Northwestern University Medical School.

The "Heroic Age" of American Medicine

After the War of 1812, the new medical schools tended to be proprietary. It became a matter of local pride as well as a good source of income for physicians to open a medical school. Schools began to multiply and since there were no licensing restrictions, the level of instruction deteriorated. While some Eastern schools were of high standard, the great majority of American medical schools were of inferior caliber. There was open competition and sometimes physical warfare between competing schools. Rivalry between schools was fierce, often featuring open confrontation with knives and pistols. In 1856, one such battle broke out over control of the Eclectic Institute in Cincinnati; one combatant was Professor Buchanan who led his side with a six pound cannon.¹¹

Thus what was known as "the Heroic Age of American Medicine" began. The methods of therapy, even by the best physicians, consisted mainly of bleeding, blistering, leeching, cupping, purging and sweating. Benjamin Rush's "thunderbolt" (a combination of Jalap and Calomel) was used as late as 1878. "Heroic medicine" was rampant in the U.S. prior to the Civil War and undoubtedly contributed to the high mortality of the day.¹² Probably in response to this situation, many unorthodox methods (e.g. homeopathy) as

¹¹Kaufman, 27-46.

¹²Ibid., 57-63.

well as a wide variety of patent medicines and nostrums were introduced by “faith healers” and “traveling practitioners.” These remedies had the decided advantage that they were less harmful than the conventional healing methods. Self-treatment books were also popular.¹³ It was indeed an inglorious chapter in American medicine.

From the Civil War to 1910: Reform Begins

The Civil War, the bloodiest war in American history, brought to light the woefully inadequate state of medical practice. It has been estimated that of the 335,000 Union deaths about two-thirds were due to disease and one-third to wounds. On the Confederate side, of the 200,000 deaths, about three-quarters were due to disease. Sanitary conditions were deplorable; dysentery, malaria, measles, typhoid fever, small pox, pneumonia, scurvy and other diseases were rampant. The great majority of physicians were graduates of proprietary schools. These schools were small with seven or eight teachers, were owned by the professors, and medical teaching was a part-time activity. Entrance requirements were lower than for a good high school. The medical course consisted of two terms of sixteen weeks each. Instruction was by lecture only and graduation was practically assured. Discipline was a problem and drunkenness and pranks were common.¹⁴ Blacks, women, and the lower economic classes had little chance of admission. Ackerknecht explained that the westward expansion of the country along with the absence of educational

¹³Ackerknecht, 224; Kaufman 64-73.

¹⁴K. M. Ludmerer, Learning to Heal: The Development of American Medical Education (New York City: Basic Books, 1985), 9-16.

standards gave “free rein to ruthless commercialism,” and that at times diplomas were awarded from “diploma mills” which did not even pretend “to give even the lowest grade of instruction.”¹⁵

As described above, there were some European-trained physicians and some graduates of the first Eastern medical schools well-grounded in the elements of physics, chemistry, biology, but they were in the distinct minority. Much of the American medicine practiced at that time was well below the standard of instruction at leading European medical centers. In Europe as in America, however, there was a tremendous disparity between the instruction offered at a leading medical university and the other available institutions. Unfortunately, only a relative few physicians (in Europe or America) had the benefit of superior medical training.

Early Reform Efforts

There had been some efforts at medical school reform even before the Civil War. From 1825 to 1846, several states proposed an increase in degree and license requirements and some medical societies had conventions in which efforts were made to increase admission and graduation requirements. In 1847 the American Medical Association, newly formed, also tried to increase standards without success.¹⁶ At that time, it was considered un-American for the government or any agency to interfere with business or regulate a profession. While some of the medical colleges tried to instigate

¹⁵Ackerknecht, 224-5.

¹⁶Kaufman, 78-82.

increased standards, they were boycotted by the majority of schools so it became evident that neither the schools nor the medical profession could regulate medical education. Since medical schools were lucrative and new territories were opening up, there were no restrictions, and the number of medical schools ballooned from ninety in 1880 to one hundred sixty-one in 1906.¹⁷ This resulted in an even greater number of inferior schools. Thus, while there was an increased availability of medical care throughout the country, the new physician was most often very poorly trained and ill equipped to treat the unsuspecting patient.

Johns Hopkins--a Reform Leader

During the late nineteenth century, there were interesting developments in medical education. In 1893, a new university and medical school, Johns Hopkins, was established with a large endowment and enlightened leadership. Hopkins was to become the model for the next century. Under the "big four" outstanding clinicians, i.e. Welch (Pathology), Osler (Medicine), Halsted (Surgery) and Kelly (Obstetrics), this group established new American precedents. There were full-time clinical teachers, modern laboratories for instruction in anatomy, physiology and other basic sciences, a hospital under the direct control of the clinical faculty, increased entrance requirements, ample financial resources, and inspired leadership.¹⁸

¹⁷Ibid., 119-120.

¹⁸Kaufman, 145-150; Glaser, 12; Ludmerer, 57-63; W. Bruce Fye, "The Origin of the Full-time Faculty System," Journal of the American Medical Association 265 (March 27, 1991) : 1555. The original idea of full-time clinical physicians has been attributed to Carl Ludwig, a German scientist who had a great influence on the medical reform movement in America. Welch, who

It was now shown that a superior medical college could be developed in America.

The European influence was apparent; the medical college became closely integrated with the university (following the German precedent) and there was an increasing tendency within the staff toward specialization. The Johns Hopkins experiment was successful and was soon copied at Harvard by President Elliot, who forced it on his medical faculty over the objections of Henry Bigelow and Oliver Wendell Holmes.¹⁹ Reform followed at Pennsylvania, Cornell (New York), Michigan and elsewhere.

Growth in Science and Call for Change

During the late nineteenth century, there was another significant development for medical education: the scientific revolution had begun and the medical field was a great beneficiary. Between 1876 and the turn of the

became the first dean of the medical school at Johns Hopkins, was a pupil of Ludwig and helped bring his ideas to the U. S. medical schools. An interesting aside to the Johns Hopkins story is that in order to get the funds necessary to open the medical school, the early administration had to accept conditions imposed on them by a group of wealthy Baltimore ladies who insisted that the school admit women which was an anomaly in the early history of medical education (in chapter III of this dissertation there will be a further discussion of the early attitudes toward female medical students). It is also important to note that the main goal of the full-time system was to stimulate research not to improve the medical teaching.

¹⁹Ludmerer, 53-60; Kaufman, 61, 121; Glaser, 13-15. Glaser discusses Harvard's President Eliot's distress over the woeful state of American medical care and quotes his 1871's Presidential Report when he regales that "the ignorance and general incompetency of the average graduate of American medical schools, at the time when he receives the degree which turns him loose upon the community, is something horrible to contemplate."

century, Koch had isolated the bacterium for tuberculosis, and Pasteur, the bacterium for pneumonia. Diphtheria, cholera, tetanus, typhoid and bubonic plague were under control or close to it.²⁰ The unprecedented development in the biological and physical sciences had begun and was to continue to the present day. It was to permanently change life on the planet. These advances in science led to an increased public belief that many other diseases could be controlled and also increased the dissatisfaction with the state of medical practice.

Finally, by 1896, twenty-three states had stiffened their regulations for medical licensing and the newly formed Association of American Medical Colleges and the American Medical Association finally discussed increased national accreditation standards for medical schools.²¹ However, as the noted medical historian, John Bowers, observed, “these voices alone were not capable of instigating the radical reform that was essential.”²² Nevertheless, the stage was now set for a reputable outside agency, the Carnegie Institute for the Advancement of Teaching, to play a critical role.

²⁰Kaufman, 121.

²¹Ibid., 143; Glaser, 16.

²²John Z. Bowers, “Changes in the Supply and Characteristics of American Doctors in the Twentieth Century,” in Medical History and Medical Care (London: Oxford University Press, 1971), 20.

Reform in Full Swing: 1910-1940

The Flexner Report

In 1910, at the request of the AMA (American Medical Association) and the AAMC (Association of American Medical Colleges), the independent and prestigious “Carnegie Commission for the Advancement of Teaching” agreed to undertake an analysis of American medical education. Henry Pritchett, president of the commission, appointed Abraham Flexner, an educational expert, to lead the investigation and develop recommendations. Although unacquainted with medical education, Flexner, a professional educator, and not an M.D., steeped himself in the existing literature and visited the leading medical schools including Johns Hopkins University and Hospital, with which he was very impressed.²³ Flexner already had a first hand acquaintance with American and European universities and later wrote a treatise on the subject.²⁴

Flexner launched a vigorous study. He visited all 155 existing medical schools in less than two years, talked to administrators, faculty and students, carefully inspected all facilities, and diligently examined all records including credentials of faculty, student applicants, and graduates.²⁵ An interesting and

²³Kaufman, 167-170; Andrew D. Hunt, Medical Education, Accreditation and the Nation's Health--Reflections of an Atypical Dean (East Lansing: Michigan State University Press, 1991), 29.

²⁴Abraham Flexner, Universities, American, English, German (Oxford: Oxford University Press, 1930).

²⁵Ludmerer, 173-8.

fortunate circumstance was that the medical schools misunderstood his mission. They believed that since the Carnegie Institute was known to be an affluent organization, Flexner's survey would probably result in grants, so they were more than candid in demonstrating their inadequacies and thus hopefully increasing the likelihood of financial aid.²⁶

The report was a devastating indictment of the overwhelming majority of the schools.²⁷ It portrayed the poor quality of institutions, the inadequate preparation of students (even some Harvard students could barely write English), the lack of standards of some schools which were outright "diploma mills," and the obvious rigging of the schools for financial gain by the owners. It was all documented in great detail. The result was a shock to the nation. The press and public were aroused to the lamentable state of the medical schools. The result was a far-reaching revolution in medical education--perhaps the greatest and most significant of any professional educational system in the history of the country.²⁸ It was the death knell of the proprietary medical schools which rapidly went out of existence, and set the pattern for American medical education which has lasted to the present

²⁶Kaufman, 168.

²⁷Abraham Flexner, Medical Education in the United States and Canada Report to the Carnegie Foundation for the Advancement of Teaching (Boston: Merrymount Press 1910).

²⁸Association of American Colleges Report, Physicians for the 21st Century: Report of the Panel on General Professional Education of the Physician (Washington, D. C.: AAMC, 1986); R. V. Christie, "Trends in Medical Education" Journal of Medical Education 38 (Sept., 1963): 662-6; Ludmerer, 184-190.

day. From 1910 to 1925, the number of medical schools declined by nearly 50 percent.²⁹ While some proprietary institutions were forced to close outright, others sought to survive by affiliating with universities. An example of a new university medical school created from the ashes of failed proprietary institutions was Loyola University School of Medicine which was formed in the early 1900's from four failed proprietary schools.

Several factors, already existent, were important in bringing about this startling closure of so many existing medical colleges: a) For a number of years, many of the leading medical schools, the AMA and the AAMC and the state licensing boards had been actively attempting to reform medical education. In 1907 the Council on Medical Education of the American Medical Association developed a rating system for medical schools; they were classified as Class A, acceptable; Class B, doubtful and Class C, unacceptable; b) The Scientific Revolution which had begun in the latter part of the nineteenth century and the general increase in public education had improved life expectancy and expectations for the medical sciences which, however, contrasted sharply with the poor reputation of the medical profession; c) An increasing number of physicians and educated individuals were now aware that nineteenth century American medicine lagged profoundly behind that of the medical centers in Europe; d) Some leading physicians returning from studies in German universities were much influenced by European teachers; and e) The disastrous accounts of military

²⁹Edward C. Atwater, "Clinical Education Since Flexner or Whatever Became of William Osler?" in Beyond Flexner (New York: Greenwood Press, 1992), 37.

medicine in the Civil War were still fresh in the public consciousness.³⁰

While these were important factors in the response to the report, there is little question that the character and force of the report itself played a major role. According to Ludmerer the report was a “classic example of muckraking” to be ranked with the exposé by Ida Tarbell of Standard Oil or Upton Sinclair of the meat packing industry--and of equal importance.³¹

The Primary Objectives and Results of the Reform Movement

Because of the sweeping ramifications of the Flexner report and the subsequent reform movement, it is important to summarize the main principles which guided Flexner in preparing his report and recommendations, as well as some specific results.

The central feature of the newly proposed medical education process was “laboratory based learning,” i.e. “learning by doing,” and not through lectures. One educator termed this “self-learning under guidance.” This was actually progressive education similar to that advanced by John Dewey. The two movements developed independently of each other, although Flexner was undoubtedly aware of Dewey's work.³² The experimental laboratory

³⁰Morris Fishbein, History of the American Medical Association: 1847-1947 (Philadelphia: W. B. Saunders, 1955), 892-900. The ratings of B and C were rarely given in the beginning although Loyola in 1919 held a B rating and sought to affiliate with Mercy Hospital in order to hopefully attain an A ranking. Later, by the 1940's, when the public was much more aware of the significance, a B or C ranking could be catastrophic.

³¹Ludmerer, 167, 180.

³²Ibid., 167.

method (borrowed from the German universities) meant that the student became an active participant in the learning and not just a passive observer. The theory held that knowledge is always evolving, and the student must be a life-long scholar. The common view of the day on the two general ways to obtain knowledge could be summarized as: 1) to watch natural events as they occur or 2) to arrange conditions so events will change, appear or disappear. Method one was generally favored by French scientists and adopted by some early American physicians who studied in Paris. The second or “experimental laboratory” approach, which was taught primarily by German universities, came to be the favored approach of later American physicians and was the method admired by Flexner.³³ It is also noteworthy that some of the leading French medical scientists (Pasteur, Bernard and Magendie) were not associated with universities. However, German research was almost exclusively university centered.³⁴

It should also be pointed out that while laboratory-based teaching methods became the standard in American medical schools, there was in some places strong opposition to these proposals such as the previously mentioned turf battle at Harvard between President Eliot and Drs. Holmes and Bigelow. Holmes and Bigelow, both Harvard faculty members of considerable influence, opposed the laboratory-based instruction method; however, President Elliot prevailed and the Hopkins approach was adopted at

³³Ackerknecht, 155; Atwater, 34-47; Hunt, 30-31.

³⁴Ludmerer, 22-23.

Harvard.³⁵ There was also opposition by medical practitioners to the idea that full-time clinical teachers, who were leaders of this movement, were becoming the intellectual elite of medicine.³⁶ A nation, traditionally egalitarian, did not take kindly to elitism. However, the opposition was unable to stem the tide, and the Hopkins model became the standard to which all medical schools aspired.

What was the specific legacy that Flexner and the reform movement bequeathed to American medical education? Reform resulted in several marked changes in the educational process and in American medicine and medical sciences.³⁷ For example:

1. The university was placed at the center of the medical education process. This idea was based on the German university-dominated educational system. (However, as noted in subsequent sections, this proposed union never really materialized in America).
2. Laboratory-based learning contributed greatly to the rising importance of medical research in the U.S.
3. Clinical teaching was now centered in the hospital. While this had existed in some European countries for centuries, it was new to America since medical colleges and hospitals had developed more or less independently.

³⁵Glaser, 13-15.

³⁶Kaufman, 129-130; Ludmerer, 40-50.

³⁷Ludmerer, 153, 176-78.

The clinical clerkship, i.e. individual or small group instruction in the hospital centering on a diseased patient, became the clinical teaching mode. Although relatively new to the U.S., this feature had also been in vogue in some western European cities for some decades.

4. Johns Hopkins became the model medical teaching unit. It had a closely knit faculty, a teaching hospital under the control of the university (which gave all students "bedside" experience and responsibility for patients), laboratory-based instruction in the basic and clinical sciences, a full time basic and clinical faculty, strict admission and graduation requirements, and an emphasis on medical research.³⁸

These were now to become the objectives to which all medical schools in the United States must aspire if they were to endure. While these changes undoubtedly helped propel the nation to eventual dominance in medical research, there were also unintended consequences, and, as described in the following, some of the ultimate consequences were less than favorable.

The American University and Its Medical Schools

Since the growth and development of American medical education were heavily influenced and closely associated, at least initially, with the American university, it is important to summarize the development and status of the American university from the latter nineteenth century until the 1970's.

³⁸Atwater, 38.

During this time, American higher education, especially the universities, grew enormously in size, enrollment and influence, sparked to a considerable extent by the scientific revolution. The natural, biological and social sciences as well as medicine and engineering boomed. Spurred by private philanthropic contributions and later by government largesse, the universities became research centers and experienced unprecedented growth. However, in this process of growth, the university underwent considerable change in its character, its general purpose and its role in society.

The university began as a vehicle to ensure an educated clergy and enlightened political leadership.³⁹ Inherent in that was the belief of Jefferson, Newman and many Western educational philosophers that the pursuit of knowledge by communities of scholars would yield a higher educational value system and a “liberating spirit” to the student citizen of a free society.⁴⁰

Beginning with the end of World War II and the resultant influx of new students into higher education, the function of the American university slowly evolved; it no longer merely served as the stepping stone for an elite few, but now broadly served the needs of a diverse society. While many large and medium-sized universities continue to revere the research ethic, there has been, at the same time, a growing trend toward more practical and vocationally oriented courses. This change in role has caused much criticism

³⁹John S. Brubacher and Willis Rudy, Higher Education in Transition (New York: Harper & Row, 1968), 6.

⁴⁰A. Whitney Griswold, “American Education’s Greatest Need,” Address of the President of Yale University to the graduating class (New Haven: Yale University Press, 1952), 4; Brubacher and Rudy, 239.

as some educators bemoan the perceived abdication of the liberal arts curriculum as the education core of higher education. This view was summarized by Robert Hutchins, a former president of the University of Chicago, when he noted, "the object of an educational system is not to produce hands for industry or to teach the young how to make a living; it is to produce responsible citizens."⁴¹ A number of educators have voiced criticism of this tendency in university education on two closely related features: 1) A rising tide of vocationalism and specialization with undue emphasis on technical and scientific courses at the expense of liberal arts; and 2) An increasing splintering of university purpose, instruction and the fostering of electives.⁴²

As will be described in the succeeding sections, the general tendency toward vocationalism, specialism and splintering of departments of instruction has also become manifest in the medical schools. In many ways, this is an inevitable consequence of the exponential increase in scientific knowledge since World War II. Scientific fields have, with the information

⁴¹Robert M. Hutchins, The University of Utopia (Chicago: University of Chicago Press, 1953), 3.

⁴²Mark Van Doran, Liberal Education (New York City: Holt and Company, 1943); William J. McGucken, S. J., Philosophy of Catholic Education Chapter VI, Philosophies of Education, 41st yearbook of the National Society for the Study of Education (Washington, D. C. American Press, 1953); R. Q. Marston and R. M. Jones, Eds. Report of Medical Education in Transition: The Science of Medical Practice (Princeton, N. J.: Johnson Foundation, July, 1992), 2; L. J. Evans, The Crisis in Medical Education (Ann Arbor, Michigan: University of Michigan Press, 1965), 22; Paul Westmeyer, A History of American Higher Education (Springfield: Charles C. Thomas, 1985), 86-87.

explosion, moved inexorably toward specialism; if universities and medical schools were to remain citadels of scientific knowledge, they were forced to specialize.

While a consensus seems to exist that this splintering of educational effort is common in many universities, it should be recognized that some institutions, e.g. Harvard, Kentucky, New Mexico, Duke and others, have made serious efforts to combat this tendency in their medical schools by restriction of certain types of vocational and professional training, through promoting organizational unity with liberal arts as the central focus, and by the institution of "honors programs" to better fit the pace of instruction to those gifted and willing.⁴³

The Catholic University and Medical School

The question might be asked whether Catholic institutions of higher learning--especially medical colleges--differ significantly from non-Catholic institutions. It is not this researcher's intention to explore this complex subject in depth but only to the extent that it might have a bearing on this dissertation. The evidence suggests that Catholic universities were no more successful in avoiding vocationalism, specialism and splintering of academic departments and curricula than were non-Catholic institutions; however, they were less successful in developing centers of academic excellence.

The early Catholic institutions were established for three main reasons: to educate seminary students, to establish a center for missionary activity and

⁴³Marston and Jones, 93-99.

to inculcate moral values.⁴⁴ Newman and Ward state that both faculty members and students must embody the intellectual and moral virtues to an equal extent, but they note, however, that the development of intellectual faculties is the primary objective of any university, Catholic or non-Catholic.⁴⁵ In addition, Ward relates that the original objectives of Catholic universities were mixed--intellectual and moral, scientific and religious--and an ordering of these purposes was at no time achieved. He related that Catholic higher education has been satisfied with mediocrity, and quotes Gilson as follows: "the Catholic church might have done without scholars and universities, but once we decided to have them, we cannot be easily forgiven for a love of less than excellent."⁴⁶ John Tracy Ellis--a leading Catholic intellectual leader--has stated that the Catholic preoccupation with immigrants accounts for their meager contribution to the American intellectual climate and remarked that as in so many other ways, Catholics have been thoroughly American in their lack of disposition to foster scholarship and honor intellectual achievement.⁴⁷

⁴⁴F. Michael Perko, "Religion and Collegiate Education" in the Encyclopedia of the American Religious Experience (Scribners, 1988), 1611; Edward J. Power, Catholic Higher Education in the United States (Milwaukee: The Bruce Publishing Co., 1958), 35.

⁴⁵J. H. Newman, The Idea of a University (New York: Longmans and Green, 1931) xii; Leo R. Ward, Blueprint for a Catholic University (St. Louis: Herder and Co., 1949), 226-229.

⁴⁶Ward, 228.

⁴⁷John Tracy Ellis, American Catholics and the Intellectual Life, Annual Meeting of the Catholic Commission on Intellectual and Cultural Affairs, (St. Louis: Maryville College, May 15, 1955), 5.

Catholic Medical Education

At mid-twentieth century, there were five Catholic medical schools in America--all Jesuit--Georgetown (Washington, D. C.), Creighton (Omaha, Nebraska), Loyola (Chicago), Marquette (Milwaukee) and St. Louis (St. Louis). While each school has its individual characteristics and it is perhaps an oversimplification to consider them as a group, they have certain features in common. As Catholic institutions they profess a double purpose--spiritual objectives in common with their parent universities and academic objectives in common with other medical schools. How effective were these schools in achieving their spiritual objectives? It has been suggested that such assessment cannot be made with real assurance.⁴⁸ But whether or not their teaching of Christian ethics and morals has been less than forceful, and whether or not these principles have gained a wide-spread and receptive audience, Drummond believes that in an era of continuous decline of interest in the spiritual aspects of humankind, Catholic medical schools have openly proclaimed and seriously cultivated these values and "bore witness" to these important truths.⁴⁹ There has been some concern that as the Catholic medical schools strive to gain increasing respect they may become more secular in their philosophy and present an education that is not appreciably different from that offered in non-Catholic medical schools.⁵⁰

⁴⁸James J. Smith, "The Catholic Medical School--Performance and Potential, Linacre Quarterly (August, 1966): 2.

⁴⁹E. J. Drummond, "Why a Catholic Medical School" Linacre Quarterly 32 (1965): 294-297.

⁵⁰Dr. Richard Matré, interview by author, Wilmette, Illinois, October

What about the academic performance of the Catholic medical school? While there have been outstanding scientists, clinicians, and teachers and even Nobel laureates, the general performance has been very uneven and some of the Catholic medical schools have at times teetered on the brink of extinction.⁵¹ Perko felt that “the general inability of Catholic schools to develop outstanding graduate programs has prevented their movement into the first rank of American universities.”⁵²

Why do Catholic medical schools have such an undistinguished record? The answer to this question lies in the rather mediocre performance of many Catholic universities. The record of Catholic universities with their sometimes uninspiring leadership and lack of vigor in fostering academic distinction has been documented by Ellis and Greeley.⁵³ Greeley's evaluation of Catholic higher education could leave graduates with a distinct inferiority complex, “This is not to argue that Catholic colleges and universities are all that good, but simply that they are not so bad as to notably impede the academic growth or notably impair the academic effectiveness of the students

2, 1994.

⁵¹Smith, 2.

⁵²F. Michael Perko, “Religion and Collegiate Education” in Encyclopedia of the American Religious Experience (ed.) Charles H. Libby and Peter W. Williams, (New York: Scribners, 1988), 1619.

⁵³Ellis, John Tracy, American Catholics and the Intellectual Life. Annual Meeting of the Catholic Commission on Intellectual and Cultural Affairs, Maryville College Saint Louis May 14, 1955. 5; Andrew M. Greeley, From Backwater to Mainstream (New York: McGraw-Hill Book Company, 1969.)

who attend them . . . on balance, they are in some instances worse and in a few instances little bit better than average.”⁵⁴ There is a absence of studies on the relative quality of Catholic medical schools, but it is axiomatic that strong universities spawn strong medical schools, and the reverse is also undoubtedly true.

World Events and Medical School Changes 1910-1940

Progress in medical education reform was painfully slow. Reform was delayed by events that occupied the attention of all Americans. In the thirty years following the Flexner Report, Americans would be preoccupied by the events of World War I, the Great Depression and World War II. By 1940, although Flexner’s Report had ended the proprietary school, reform provisions that provided for closer university--medical school ties, full-time clinical faculty, a university-controlled hospital, improved research, and laboratory facilities were slow in coming except for a few prestigious institutions. However, the next twenty years, from 1940 to 1960, are regarded as pivotal transition years in American medical education. This transition era would see great advances in science, increasing financial demands, and the growing struggle of many medical schools to cope with the rapidly changing dynamics of post-World War II America. In addition, medical reform would

⁵⁴Greeley, 97-98.

wind through a period of often painful adjustment as medical education wrestled with tremendous changes in both the size and complexity of its operation as it moved into the modern era.

CHAPTER II

DEVELOPMENT OF THE MEDICAL SCHOOL IN AMERICA 1940-PRESENT

The Transition Era

This was undoubtedly the most eventful period in the history of the American medical school. The method of instruction, as well as the basic character of the medical school, had by this time tended to deviate from its original and sole purpose of training undergraduate students for the M. D. degree. These significant changes became widespread, fixed and perhaps irrevocable during this transition period.

The years 1940-1960 also proved to be, for many medical schools, an almost never-ending struggle of adjustment to a number of basic forces in medicine and in society which had become evident prior to 1939 but received great impetus during World War II. These forces, and the academic reaction to them, were to change the character of American medical education. These forces included the scientific revolution and the increasing preoccupation of the faculty with research, the necessity for schools to own or control their teaching hospitals, the curricular reform which now became mandatory, the growth of clinical specialty boards, the expansion of graduate education in the basic sciences, and

the increasing preoccupation of medical schools with medical practice in their own hospitals. ¹

All of these forces were, in a sense, distractions since they were often peripheral to undergraduate medical education. Yet the medical schools, in their efforts to cope with these forces, developed into large, multi-purpose institutional bureaucracies with almost exponential increases in the cost of medical education which over the years proved to be the greatest burden of all. But first, educational institutions, like the rest of society, were required to deal with the effects of World War II.

World War II

From 1929 to 1941, the U.S. and much of the Western world suffered from a severe economic depression which induced hardships on universities and medical colleges as well as the rest of the country. World War II (1939-1945), immediately following, had its own profound effects on institutions of higher learning.

The establishment of comprehensive military training programs in the universities relieved, to some extent, the financial losses stemming from the decline of student enrollment and helped these institutions to survive. American universities were forced into a willing dependency on the federal government. Students specializing in areas vital to the war effort--such as medical students--were deferred from immediate military service. After the draft age was lowered

¹Ludmerer, Learning to Heal, 5-8.

to eighteen in 1942, massive Army Specialized Training Programs (ASTP) and Navy (V12) programs were established at colleges and universities for special training in a wide variety of technical fields. Student-soldiers spent thirteen weeks at a military basic training facility before reporting to their college. The university curriculum emphasized engineering and technical studies but the program also required English, history and other basic academic courses. The fifty-seven hour-a-week program was not easy but successful completion often led to officers candidate school. Most army trainees ended up as non-commissioned technicians. By 1944 about 400,000 persons were enrolled in the various training programs, and by war's end, more than one million servicemen and women had earned college credits--and in some cases degrees. It was a big step toward mass higher education and set an important precedent for post-war federal government financial-aid to American higher education.²

Education and World War II

Education was generally speeded-up. Forty-nine medical schools accelerated their programs, and as a result, the average length of medical training in the war-time U.S. was reduced to three years. It is difficult to assess the effect of such acceleration on the quality of the programs, but it is doubtful that the education was improved by the war.³ It was noted that for Loyola University School of Medicine the accelerated curriculum improved the school's financial situation, but the administration viewed the speeded-up curriculum as a poor

²Willis Rudy, Total War and Twentieth Century Higher Learning (Cranbury, New Jersey: Associated University Presses, 1991), 60-84.

³Ibid., 84.

education policy.⁴ Many faculty participated in the war effort either in one of the military services as consultants, or in government-sponsored research (e.g. in the Office of Research and Development (OSRD) or in organizations such as the National Defense Research Committee (NDRC)). OSRD and NDRC together had spent over \$540 million by the end of fiscal 1945 on contracts with universities and large corporations. The best known of these enterprises was the Manhattan Project, a giant enterprise centered on the development of atomic energy. Ultimately, the Manhattan Project expended over \$2 billion, employed some 150,000 persons and created whole new cities practically overnight at Oak Ridge, Tennessee; Hanford, Washington and Los Alamos, New Mexico.⁵

One of the more significant government educational programs in American history was the Serviceman's Readjustment Act of 1944 (the G.I. Bill), which provided a broad range of benefits. However, its most lasting effect was in education, in which it proved to be a remarkable success. By the fall of 1946, more than a million veterans were enrolled in post-secondary education; when the benefits ran out in 1953, 7.8 million veterans had taken advantage of the G. I. Bill. The veterans did remarkably well, and colleges testified to their academic achievements. The impetus to college attendance turned into a tidal wave;

⁴Minutes, Loyola University School of Medicine Academic Council, June 7, 1945, Loyola University of Chicago Archives. Office of the President. Fr. James Hussey. Box 3. Folder 15.

⁵Rudy, 84-99.

college enrollments doubled between 1940 and 1960 and more than doubled again in the 1960's.⁶

Medical Education in The Post-War Years

By the 1940's, the reform of medical education had essentially run its course. The Flexner Report had now been accepted as the ideal of how medicine should be taught. Furthermore, bolstered by public support, the AMA Council on Medical Education and the Association of American Medical Colleges established a joint accrediting commission which regularly inspected all medical schools, graded them and, in effect, determined whether they would or would not continue. State licensing boards officially confirmed the arrangement.⁷

This action meant that all medical schools were now required to conduct laboratory-based instruction in all basic sciences with prescribed minimum student-faculty ratios. In addition, schools were required to develop inpatient and outpatient clerkship programs, at least in the major clinical specialties and to own or control at least one teaching hospital. The cost of medical education was greatly increased in order to provide for the expanded faculty required, the necessary laboratory space, equipment and facilities, and the added hospital instructional costs. Many schools had considerable difficulty meeting these added costs, and some did not survive.⁸ Loyola Medical School in Illinois was

⁶Lazerson, American Education in the Twentieth Century, 26-29; Brubacher and Rudy, Higher Education in Transition, 236-238, 263.

⁷Ludmerer, 235-8; Fishbein, History of American Medical Association, 907.

⁸Ludmerer, 234-54.

typical of the small, unendowed, academically unexceptional institution whose financial woes put its survival in jeopardy.

To carry out this required program, schools expanded both their basic science (first two years or pre-clinical) faculty and also the clinical (second two years) faculty. The increase in full-time clinical faculty was a new and notable addition to the medical school scene. The full-time clinicians, who divided their time between teaching, research, and medical practice, became an important and permanent feature of medical education; their presence, however, caused tension with the existing medical practitioner, who had previously provided medical teaching on a voluntary, part-time basis. The practitioner now resented the increasing importance of the full-time scientist-clinician, a prime member of a growing academic elite. Thus began a long-lasting struggle within the medical profession.⁹ A survey in 1951 of seventy-one medical schools showed there was an average of twenty-nine full-time faculty members in the clinical departments.¹⁰ However, the less affluent schools were unable, for financial reasons, to match this; for example, in 1950 Loyola Medical School had only one full-time clinician on its faculty-- the Associate Dean for Clinical Studies.¹¹

An interesting facet of medical education in the U. S. was the teaching of basic sciences by Ph.D.'s. Although basic science in European medical schools is

⁹Ibid., 130-1.

¹⁰Ronald V. Christie, "Trends in Medical Education," Journal of Medical Education 38 (Sept., 1963): 663-4.

¹¹James J. Smith, interview by author, Milwaukee, Wisconsin, April 15, 1994.

taught predominantly by M.D. scientists, in the U. S. beginning in the 1920's, Ph.D.'s were recruited as basic science teachers after the Flexner Report. The relationship between the Ph.D. basic scientists and the M. D. clinical scientists was generally cooperative; however, as clinicians became more specialized the research interests of faculty M.D.s and Ph.D.s increasingly diverged. One group was trained as scientists, the other was essentially trained in the practice of medicine.¹² In addition, students were not taught by a faculty member holding the degree they sought, and so in these instructors, students did not readily see a role model. Currently, less than 5 percent of basic science faculty in the United States medical schools are M. D.s.¹³

The University and the Medical School

As described in previous sections, one of the prime objectives of the revolution in medical education, begun at Hopkins in 1893 and strongly fostered by the Flexner Report of 1910, was to tighten the unity between the university and the medical school. But, while the two have usually remained in the same organizational framework, the union was never really consummated.¹⁴ One reason offered was that there was frequently a geographic separation between the two such as occurred at Harvard and Johns Hopkins. Loyola University

¹²V. P. Lippard, The Changing Medical Curriculum (New York: Josiah March Foundation, 1972), 65.

¹³Robert Q. Marston and Roseann M. Jones, Eds. Medical Education in Transition (Princeton: Robert W. Johnson Foundation, 1992), 125.

¹⁴W. C. Anylan, The Future of Medical Education (Durham: Duke University Press, 1973), 43.

School of Medicine was a typical example which, in its west side Chicago location, was ten miles from the main Loyola University campus. However, it is likely that the more important reason is that the medical schools never really sought a close union. Some observers decried the intellectual isolation of these two elements from each other and suggested that a number of university disciplines including psychology, sociology, epidemiology, nutrition and genetics should be incorporated into the medical curriculum to produce physicians more able to deal proactively with patient care issues.¹⁵

The Medical School and the Teaching Hospital

The demand of the accrediting agencies for closely monitored clinical clerkships--outpatient and inpatient--and for junior and senior medical students to have "practice patients" under the direction of clinical faculty, was a very significant step in the development of the important role for the hospital in medical education.¹⁶ This necessity and Loyola's own tenuous relationship with Mercy Hospital, its main teaching facility, placed the medical school in a precarious position for much of the transition era.

In general, for teaching purposes (as well as for research), there were certain requirements for a proper number and distribution of patients to provide

¹⁵Marston and Jones, 3-6; Suzanne W. Fletcher, "Clinic in Epidemiology --One of the Basic Sciences for Modern Medical Education" in Medical Education in Transition (Princeton: R. W. Johnson Foundation, 1992), 79-82; David Barnard, "Relation of Ethics and Human Values to the Sciences of Medical Practice" in Medical Education in Transition (Princeton: R. W. Johnson Foundation, 1992), 100-101; L. J. Evans, The Crisis in Medical Education (Ann Arbor: University of Michigan Press, 1965), 42-44.

¹⁶Ludmerer, 152-55.

a sufficient variety of disease types. If the clinician had a research interest in a specific disease, the hospital often attempted to increase accommodations for such patients. Thus the vast and complicated machinery of the hospital, i.e. nursing care, diagnostic and laboratory facilities as well as house staff, needed to be mobilized not only for patient care but also for teaching and research purposes.¹⁷ The medical school, therefore, needed to be able to appoint its faculty to the staff, to be able to assign patients to students for study purposes, and be able to use hospital lab and diagnostic facilities for teaching and research. This, of course, amounted to a considerable control over the hospital. While the presence of outstanding physicians on their staff enhanced their prestige, hospital boards were often reluctant to grant the degree of control required by the medical school.¹⁸ The relationship between Mercy Hospital and Loyola typified the tension that could exist between a medical college and its major teaching hospital; one viewed its primary function as medical training while the other saw itself as providing a service for clients whose good-will was necessary for the hospital to flourish. Furthermore, patients did not always take kindly to frequent examinations and demonstrations for junior doctors. In addition, the non-full-time attending staff often resisted the take-over of the hospital by the full-time medical scientists. For a number of medical schools, obtaining the necessary clinical facilities was their most vexing problem. Increasingly, the universities needed to take over or build their own hospitals to obtain the

¹⁷J. H. Knowles, (ed.), "Concerning the Need for Behavioral and Social Science in Medicine" in The Teaching Hospital (Cambridge: Harvard University Press, 1966), 24-25, 27-30; Ludmerer, 152-155.

¹⁸Knowles, 76-80; Ludmerer, 155-65.

complete control they needed.¹⁹ However, this step entailed large financial expenditures which the institution was often unable to meet. In 1910, Dr. William Welch of Johns Hopkins said that a good teaching hospital under proper control was the most urgent need of medical education; yet, it was not until 1968 that Loyola University had, for the first time, a genuine teaching hospital under its proper control.²⁰

The hospitals were large, free standing business enterprises with their own problems, and tensions sometimes developed between the hospitals and the medical school. Pollack called for better accounting methods and a separation of hospital costs from those of teaching and research.²¹ Cope said there was a shortage of people protecting the interests of the teaching hospital and that the medical school administration and clinical staff often resisted collective responsibility for the teaching hospital. These two entities had separate purposes; hospitals worked to meet the needs of the patients and the communities, and the medical school sought to meet the needs of the curriculum.²²

The case might be made that the takeover of the hospital was the most critical step in creating the dilemma of the modern medical school. Through this step, the school became involved with a large and complex non-academic

¹⁹Ludmerer, 152-60.

²⁰Ibid., 156.

²¹J. Pollack, "Teaching and Research Costs in the Teaching Hospital" Journal of Medical Education 36 (July 1, 1961): 807.

²²Oliver Cope, "The Endicott House Conference on Medical Education" in The Teaching Hospital (Cambridge: Harvard University Press, 1966), 139-145.

organization which greatly increased its general financial obligations and caused it to be involved in an ever-growing administrative bureaucracy. In this regard, one observer noted that medicine is the only profession which required the incorporation of its entire workshop and associated paraphernalia for the training of its members.²³ In a sense, this would be comparable to law schools having their own courtrooms and halls of justice and engineers incorporating bridges, sanitation plants and nuclear reactors within their own walls to train their engineers.²⁴

The Costs of Medical Education

In the early part of the twentieth century, there were proposed changes in medical education that would greatly increase its cost: laboratory-based instruction (in contrast to the status quo didactic lecture method), a need for great increases in numbers of faculty, and the necessity for a medical school to control its own teaching hospitals, all caused medical education to become very expensive. But caught up in the enthusiasm of reform and with the considerable encouragement of Flexner, the Carnegie Institute, and the universities and medical schools themselves, there followed what might be termed the philanthropic era of American medical education. The first two philanthropic organizations that significantly donated to medical research were the General Education Board founded by John D. Rockefeller in 1903 and the Carnegie Foundation for the Advancement of Teaching which began in 1905 with a donation from Andrew Carnegie and which, five years later, would sponsor the

²³Pollack, "Teaching and Research Costs," 808.

²⁴Evans, The Crisis in Medical Education, 25.

Flexner Report. Both Rockefeller and Carnegie were deeply religious men who felt that they served their religion best by distributing their wealth.²⁵ Through the generosity of the Rockefeller and other foundations, as well as, individual donors, large bequests were made to Johns Hopkins, Yale, Cornell, Harvard, University of Pennsylvania, Columbia and other universities to meet the considerable costs necessary to improve their medical schools. In subsequent years, large bequests to the University of Chicago, Vanderbilt, Washington University (St. Louis), Duke, Stanford, and others also provided these schools with the important boost they needed to build first class institutions.²⁶

Federal Assistance

By the 1940's, there was increasing concern that private philanthropy was not sufficient to provide the funds necessary to assure America's position as a world leader in research. These concerns led to a dramatic increase in federal involvement. Just before 1940, the total amount expended on research in the United States had been \$250 million, and, of that, less than \$50 million came from

²⁵John Z. Bowers, "Changes in the Supply and Characteristics of American Doctors in the Twentieth Century" in Medical History and Medical Care (London: Oxford Press, 1971), 20. Flexner, after he finished his study, devoted much of his life to raising funds to improve medical schools. He joined Rockefeller's General Education Board and assisted in distributing over \$78 million to twenty-four medical schools. In the book, Beyond Flexner, Robert Hudson relates the story of Flexner convincing George Eastman to give \$5 million dollars to create the University of Rochester School of Medicine and that, "In raising money for medical education, Abraham Flexner had no peers." Robert P. Hudson, "Abraham Flexner in Historical Perspective" in Beyond Flexner (New York: Greenwood Press, 1992), 13.

²⁶Ludmerer, Learning to Heal, 146-151, 191-206.

the federal government, but by 1944 the federal government alone was spending \$600 million annually on research. The elite Eastern medical schools were no longer the exclusive beneficiaries as government funds became available to all medical schools with the expectation that all medical institutions develop their research capabilities.²⁷ The National Institutes of Health (NIH) under the direction of the U.S. Public Health Service established a research grant program which became the largest health investment in history; by 1978 more than \$3 billion had been spent by the NIH primarily in the nation's medical schools.²⁸ In addition, beginning in 1946, the Veterans Administration began a great expansion of their hospital and medical research programs to accommodate returning veterans. By 1962, the V. A. had 169 hospitals with 125 beds (10 percent of the nation's total). Many of the finest hospitals were built within medical school complexes. These hospitals along with an annual medical research expenditure (by 1962) of \$27 million, provided an enormous boost to the teaching and research programs of the nation's medical schools.²⁹

Understandably, in this unprecedented expansion, the stronger schools--mainly Eastern universities--which had benefited from initial grants gained the most. They had stronger staffs and better facilities and were able to show better past records and greater likelihood of being able to use additional funds to

²⁷Hunt, Medical Accreditation, 84-85.

²⁸Andrew D. Hunt and Lewis. E. Weeks, Conference on Medical Education Since 1960 (East Lansing: Michigan State Press, 1979).

²⁹M. J. Musser, and R. I. McClaughery, "Affiliation of Veterans Administration Hospitals with Medical Schools," Journal of Medical Education 38 (July, 1963): 531-8.

greater advantage. So strength begot strength and the older, larger, more established schools became giant medical research and teaching centers. State institutions, with civic pride on the line plus state taxing authority, also were able to mobilize large sums of money and gradually build imposing state medical teaching and research centers. However, the smaller private medical schools of the Midwest (such as Loyola), West and South, which developed later, did not have such initial advantages, had lesser past traditions of philanthropic giving and so had a much more difficult time meeting these financial needs even with the opportunity for federal funding.³⁰ A considerable gulf therefore developed between schools on the basis of physical and financial resources.

The Science Explosion and Specialization

Fueled by the military demands of World War II, the entire Western world experienced during this period an unprecedented growth of the natural sciences of physics, chemistry and engineering as well as the biological and medical sciences. Both the universities and the industrial world participated. The growth of scientific technology extended also to the social and behavioral sciences such as sociology, anthropology, psychology, biometrics and, in fact, to every field in which quantitative measurement was possible. This exponential growth of knowledge required the development of new methods of recording, translating, storing, and retrieving scientific information.³¹

³⁰Ludmerer, 229-230; Hunt, 82.

³¹D. S. Ruhe, "Communication in American Medical Centers" Journal of Medical Education 38 (April, 1963): 252.

During World War II, there were notable medical advances in surgery, in trauma methodology, rehabilitation, treatment of burns and shock, treatment of psychiatric stress in aviation and submarine medicine, blood substitutes, and immunization techniques. The incorporation of this additional scientific information into an already crowded curriculum put a further strain on medical education. Medical schools resisted the idea of further lengthening an already prolonged period of study, so the medical curriculum became further overrun.³²

Subsequently, this information explosion saw the development of additional medical specialties during this era, e.g. thoracic and pulmonary surgery, neurosurgery, plastic surgery, radiation, and colon and rectal surgery. These fields have had continued growth to the present day. The increase in the number of medical specialties and the increased length of specialty training to three to five years added substantially to the size and complexity of the clinical departments, the teaching hospitals, and of course, the medical schools themselves.

Evans termed these two or three decades just preceding 1960, a critical period in American medical education, not only because it was a time of momentous change (as described above) but also because he felt that in the adaptation to these changes, certain tendencies developed which did not bode well for medical education. In a perceptive analysis, he stated his belief that the medical school had ceased to be an academy of learning but instead had become a collection of graduate, post graduate and specialty medical training programs. Above all, similar to changes in the university, it had become a Mecca for

³²Evans, The Crisis in Medical Education, 7, 34.

research which engrossed clinical and basic scientific faculty alike. The era of publish or perish had arrived at the medical school. He believed that such growth fostered bureaucracy, that the education had become disease-oriented rather than patient-oriented and that the objectives of the schools had become blurred.³³ In addition, patient expectations changed. The public now looked at quality health care as a right and not a privilege and thus placed increased demands on medical care facilities. One example of this is reflected in statistics that show that 50 percent of the people who come to Massachusetts General Hospital for emergency care do not have life-threatening illness.³⁴ Glaser noted, "The fact that in many urban areas, and especially in less affluent ones, the number of physicians is decreasing, tends to increase the dependence of the populace in such areas on the teaching hospital, not only for consultation and major problems, as was formerly the case, but also for less serious medical needs." ³⁵

1960 to the Present

The general pattern of medical education which had developed by 1960 continued into the ensuing decades, including the emergence of the academic medical center, the continual expansion of medical research, and increasing specialization. These changes have also brought with them further progression

³³Ibid., 33-37.

³⁴Glaser, The Teaching Hospital, 29.

³⁵Ibid., 30.

of some problems of medical education which had appeared in the transition period.

Academic Medical Centers

One of the more manifest signs of the change in medical education was the physical size of the establishment. From the usual medical school and its teaching hospital, there has now grown a mammoth conglomerate of concrete and steel which might include, in addition to the schools of medicine and nursing and the affiliated general teaching hospitals, schools of dentistry, veterinary medicine and pharmacy, special hospitals such as pediatric, orthopedic and psychiatric, and special institutes for cancer, heart disease and rehabilitation. It was here at the regional center where complicated medical problems were referred.³⁶ By 1977, there were 110 academic health complexes, usually numbering eight to ten subdivisions, but sometimes having as many as thirty separate organizational units.³⁷ It became the national norm for universities to build an academic medical center. A typical example was the construction of four-year schools of medicine, dentistry and nursing as well as a 550 bed general hospital in 1958-60 for the state of West Virginia. The entire

³⁶Bowers, 60; Robert H. Ebert, "Medical Education at the Peak of the Era of Experimental Medicine," Dae Dalus 115 (Spring, 1986): 79.

³⁷John Z. Bowers and E. F. Purcell eds., The University and Medicine--the Past the Present and Tomorrow (New York: Josiah Marcy Foundation, 1977), 163-5.

complex was built from scratch at a cost of \$31 million to serve a community of 385,000 people in the vicinity of Morgantown, West Virginia.³⁸

Since many of these special hospitals and institutions built within medical centers had their own specific and independent purposes, conflicts often developed between the affiliated institutes and the medical school. While it was entirely logical to locate medical care institutions in geographic proximity to the professionals who serve them, the medical school, originally organized for the training of undergraduate medical students, seemed to be physically overwhelmed by the multi-purpose units which composed the center.³⁹ As that well-known historian and sometime student of architecture, Winston S. Churchill, once remarked, "At first we fashion our buildings, then they fashion us."

Because of the population boom of the 1950's, a national physician shortage developed. Through federal capitation and state grants, new medical schools were created and existing schools were encouraged to increase their enrollment. Between 1920 and 1960 the number of medical schools had remained constant at about seventy-six, but by 1971, the number had increased to 103. Most of the new schools were built in smaller cities and emphasized community and family medicine and comprehensive care.⁴⁰

³⁸Kenneth E. Penrod, "A Modern Medical Center is Born" Journal of Medical Education 36 (June, 1961): 397.

³⁹Bowers and Purcell, 163.

⁴⁰Hunt, A. D. and L. E. Weeks, Conference on Medical Education Since 1960 Michigan State University, 1979.

Increasing Importance of Research

The scientific revolution continued through the late twentieth century on a broad front. Those physical and biological science projects which were deemed in the national interest received federal funds. While pharmaceutical and other industries contributed, the universities and medical schools played the major role in the growth of biological sciences. The funds were given primarily for research purposes and a decreasing fraction for research training. The bulk of the funds went to universities and medical schools with stronger science programs and better previous records of scientific achievement. This resulted in even greater emphasis on research in the medical schools.⁴¹

Research was king. In the triumvirate of duties of the medical faculty there was no question that research was first, teaching last and medical practice somewhere in the middle. Moreover, it became evident that much of the research was of doubtful quality. As Barzun noted in his book House of Intellect, "Research has acquired an inherent sanctity; the quality of the work and its results are secondary. To do research is deemed nobler than to teach . . . it is not necessary to discover, if only one 'produces', production being defined as publication."⁴²

The academic medical centers had multiple purposes: medical education, research, and patient care. They were, however, supported largely by income

⁴¹Evans, 51.

⁴²Jacques Barzun, House of Intellect (New York: Harper Brothers, 1959), 192-200.

from faculty clinical practice and research. When federal funds were given for research purposes, they were given to individuals and not to universities (although the university did receive a small percentage to cover overhead expenses). Faculty members have therefore, “tended to think of the goals of their own academic specialty and department rather than the education goals of the school as a whole.”⁴³ Some thought that this practice helped create schisms between faculty members and between faculty and university administrators. Few, however, ever spoke out and objected to the growing dependence of all medical schools on the federal government in general or National Institute of Health specifically. Robert Ebert, former dean of Harvard University Medical School, summarized the problem, “the critics were in a distinct minority; their arguments were declared simplistic; they were accused of being anti-science, anti-government, and against progress. Finally, their voices became so faint that their message was completely lost in the noise of the applause from the majority, who rejected any argument against more and larger grants for research and research training. There was no debate, there was no planning and no thought was given to the consequences of a profound change in the way medical school would be financed.”⁴⁴

The decade of the 1960’s would also bring increased federal funding for the construction of new medical and hospital facilities, but of equal importance, was the passage of Medicare and Medicaid in 1965 which gave further support to

⁴³Cam Enarson and Frederic D. Burg, “An Overview of Reform Initiatives in Medical Education 1906 through 1992” Journal of the American Medical Association, 268 (September 2, 1992): 1142.

⁴⁴Ebert, 59.

teaching hospitals.⁴⁵ These funds would be instrumental in ensuring the success of Loyola's own medical center.

There began in the 1950's and continues today--the growth of specialties and subspecialties as the volume of new medical information made it increasingly more difficult to master and stay informed of all the current developments in a broad field. The academic medical center became the repository of tertiary care specialists and sub specialists and not primary care givers. So as medical care is redesigned for the twenty-first century large academic medical centers are seeking to affiliate with community hospitals which have a large base of primary care patients.

The Curriculum

Beginning in the early 1960's, there was increasing criticism of the medical curriculum on the basis that the courses (especially the first two or pre-clinical years) were overloaded, placed too much reliance on the lecture method and memorization, and had too little integration between the basic scientific and clinical material.⁴⁶ Hunt noted, "It was after World War II, with the explosion in research funding, that the problems developed. The amount of new information, which under the traditional curriculum had to be learned by

⁴⁵Ibid., 61.

⁴⁶Robert Q. Marston and Roseann M. Jones, Eds. of Medical Education in Transition (Princeton, New Jersey: R. W. Johnson Foundation, 1992), 2; Darwin J. Prockop, "Basic Science and Clinical Practice: How Much Will a Physician Need to Know?" in Medical Education in Transition (Princeton: R. W. Johnson Foundation), 51-57; W. C. Anylan, The Future of Medical Education (Durham: Duke University Press, 1973), 43-50.

students, became overwhelming and the first two years became nightmarish for faculty as well as students."⁴⁷

Criticism centered not only on the quantity of material but the quality of the faculty. Some observers believed the faculty were unimaginative in their presentations, that most had no formal training in pedagogy and little interest in teaching their subject.⁴⁸ Some critics claimed that the medical faculty had very limited ability to teach, seemed to gear their material to the lowest common denominator of ability, and as a result, student unrest seemed to be widespread and genuine.⁴⁹ Frustration sometimes gave way to humor; one student commenting on the curriculum wrote, "listening to a basic science lecture is like trying to take a drink from a firehose."⁵⁰ One common suggestion was that the basic material needed better integration across disciplines and greater incorporation of information from behavioral and social sciences; some critics commented that in the last fifty years at least eight commissions had made similar recommendations without much result.⁵¹

⁴⁷Hunt, Medical Education, Accreditation, 31.

⁴⁸J. Romano, "Comparative Observations of Medical Education" Journal of American Medical Association, 178 (Nov. 18, 1961): 742.

⁴⁹J. R. Krevans, Reform of Medical Education: The Effect of Student Unrest (National Academy of Science Printing Office, 1970).

⁵⁰J. Romano, "Comparative Observations of Medical Education" Journal of American Medical Association 178 (Nov. 18, 1961): 742.

⁵¹Joseph E. Johnson, III, and Anne Lea Shuster, "Preparing Physicians for the Future" in Medical Education in Transition (Princeton: R. W. Johnson Foundation, 1992), 26-40.

After the medical school expansion of 1940 to 1960, there followed a remarkable standardization and rigidity in the medical curriculum. Schools emulated one another in the design of laboratory experiments, in hours spent on different courses and in total hours of instruction.⁵² Perhaps the most important reason for the standardization and rigidity of the medical curriculum was the examination system. The National Board of Examinations, which developed in the 1950's, became the national standard against which all schools measured the performance of their students and their own courses. This scientifically-based exam became the dominant factor in determining course content, maintaining or acquiring prestige, and was a strong force in maintaining the curricular status quo.⁵³

Recent Trends in Medicine and Medical Education

It is abundantly evident that in the last 50 years, universities and their medical schools have made tremendous contributions to the scientific advance of medicine; as a result, America unquestionably leads the world in its standard of medical care. This is the lasting endowment of American medical education to world medicine. Yet in spite of this magnificent achievement, certain trends have manifested themselves in the last twenty to thirty years which have raised concerns for the future of American medical education; some of these concerns are as follows:

⁵²Ludmerer, Learning To Heal, 88-89; 249-250.

⁵³A. D. Hunt and L. E. Weeks, Conference on Medical Education Since 1960 (East Lansing: Michigan State Press, 1979).

1. The research euphoria that began after World War II gave way in the 1970's to the realization that research funds could not continue to increase at an annual rate of 15 percent; so the 1980's began an era of cost containment that has continued throughout the 1990's for academic medical centers.⁵⁴ How cuts will be made, who will be affected, how will the medical education component of the medical center be effected are all concerns that need to be addressed.

2. Medicine itself has declined rapidly in public esteem in the last two decades; this may be due in part to a resurgence of anti-intellectualism and an anti-science sentiment that are perhaps associated with the mounting cost of medical care as well as the mandatory costs of "big science." It may also be associated to some extent with some disillusionment with the uses to which scientific expenditures have been put.⁵⁵

3. There has been a decline in the attractiveness of a medical career for young Americans. For many decades, admission to medical school was both highly competitive and highly selective, but neither medicine nor basic science graduate work are as much sought after as they once were. In succeeding generations this will have a profound influence on the demographics of both medicine and medical science in the U.S. Escalating medical tuition costs have also had its effect on student career choice.⁵⁶

⁵⁴Ebert, 76.

⁵⁵Bowers and Purcell, The University and Medicine, 69.

⁵⁶J. V. Warren, Medical Education for the 21st Century 1984 Ohio State College of Medicine Symposium.

4. The decreasing income from research grants has forced clinical departments into increasing dependence on income from medical practice to finance clinical and house staff salaries, research and clinical teaching. This has in many cases resulted in higher medical care costs. There is, however, an unwillingness of federal funding agencies to provide additional support for medical educational purposes. But, some observers believe that there is a fundamental incompatibility of fee-for-service medicine with medical education and that the continued pressure to contain costs will adversely effect medical education.⁵⁷

5. There is a recent tendency for some hospitals and medical schools to merge and become incorporated into large health care centers. For example, in 1993, two Pennsylvania medical schools (Medical College of Pennsylvania and the Hahnemann University Medical School) merged with seven acute care hospitals in Pittsburgh and Philadelphia resulting in a \$1.5 billion organization governed by a five person corporate board of directors. The chair of the new board said this type of consolidation was essential to reforming the health care system of the U.S. ⁵⁸ There is always a question, however, whether the medical educational needs will be properly met in such an organizational framework. Also, there is still a possibility of government mandated universal health care, and the impact of such a monolithic change on medical education can only be hypothesized.

⁵⁷S. Jones, Medical Mystery (New York: W. Norton and Company, 1978), 55.

⁵⁸Daniel Winship, Financial Problems of Medical Teaching Centers, Address to Milwaukee Academy of Medicine, Oct. 22, 1993.

It would appear, therefore, that a convergence of national economic, social and political forces has placed medical schools in a difficult situation. The clinical years of medical school are financed to a considerable extent by medical practice income of the clinical faculty and the basic science years to a great extent by research grants. But, the fact is that both of these sources of income are somewhat uncertain, and in neither case does there seem to be a firm commitment to the purposes of education. Thus student fees and institutional endowment would appear to be the only certain income sources for education, but it is doubtful if these sources will be adequate for present needs.

Obviously, there are many forces at work in this complex situation, and medical schools cannot be held responsible for all of these problems. However, it appears that a considerable portion of the current income to the average medical school is primarily non-educational. This is disadvantageous in the sense that it requires a large fiscal and administrative effort to deal with an immense budget; yet it leaves the school very limited jurisdiction to plan and execute its own educational programs. Thus the school does not, in effect, control its own faculty for educational purposes. Although it may appear impractical in the light of present-day university finance, it nonetheless seems likely that medical schools will be unable to carry out effectively their primary job of undergraduate medical education until they control their own destiny, that is, both receive and dispense funds for strictly educational purposes. Only when this occurs will the administration and faculty be able to act together to draw up an educational program for the students relatively free of non-educational objectives.

The evolution of medical education continues. The early days of apprenticeship, blood letting, and proprietary schools have given way to giant bureaucratic edifices. To further illustrate the evolution in medical schools, this dissertation will examine, in detail, one institution--Loyola University School of Medicine (which was renamed the Stritch School of Medicine of Loyola University in 1948). Specifically, this research concentrates on the pivotal years from 1940 to 1960, the transition era, when medical education, in general, and Loyola, in particular, moved from an embryonic state into the modern era. Chapter III will review the early development of Loyola University Medical School; Chapter IV and V will detail the significant events of the transition era at the medical school; Chapter VI will summarize significant post-transition era events and look to the future of Stritch School of Medicine.

CHAPTER III

LOYOLA AND OTHER CHICAGO MEDICAL SCHOOLS IN THE EARLY TWENTIETH CENTURY

At the beginning of the twentieth century, Chicago was a growing metropolis with a population of nearly 1,700,000 and twelve daily newspapers; it had an elevated rail transportation system, the Chicago Sanitary and Ship Canal had just opened, and Carson Pirie Scott and Co. department store began doing business. The city had evolved from a struggling mud-covered outpost to an important Midwest trade center.¹

The effects of the Industrial Revolution were now felt everywhere. Recent inventions included the diesel engine, wireless telegraph, modern submarine, photographic film, radio vacuum tube, escalator, tractor and in the medical field the electrocardiogram and x-ray machine. In the medical

¹Department of Development and Planning, Lewis W. Hiss Commissioner, Chicago a Chronological and Documentary History (Dobbs Ferry, New York: Oceana Publications, 1976), 64. The sanitary and ship canal was a twenty-eight mile long symbol of the enterprising spirit of Chicago. It was hailed as the most important municipal and engineering undertaking of its time. The part of Lake Michigan that bordered Chicago had no outlet for waste and was actually a repository for the excess from Michigan, Indiana, and Wisconsin. This caused severe health problems for Chicago--tuberculosis and typhoid were common. In 1891 alone 10,000 died of typhoid. To solve this problem, the innovative city engineers proposed the previously unheard of course of action. They would change the flow of the Chicago River. The old canal was lowered to draw in more water from Lake Michigan. Sewage and pollution could now be treated and carried away from Lake Michigan and eventually into the Mississippi River.

education field, proprietary institutions were still the norm, and medical education was characterized by an ever increasing number of third-rate, poorly equipped institutions which were allowed to issue medical degrees.

Medicine in Chicago

The state of medical affairs was not much different in Chicago than in the rest of the country. Doctors were feared more than respected, and the preferred course of treatment by many physicians was still bleeding and the use of mercury, and calomel. Thus it is understandable that many people turned to such remedies as Dr. Foord's Pectoral Syrum and Wishart's Pine Tree Tar Cordial which were recommended as a cure for the elderly's "sour or thin blood" as well as for those of the younger generation afflicted with "adolescent humor in their veins."²

Despite the generally dismal state of medical affairs, there was no lack of medical schools. As their number grew, their quality became more suspect. In 1889, there were ten medical schools in Chicago. Medical historian, Thomas Bonner, reported that by 1900 the number of medical schools was increasing, but "Chicago was suffering from an even more bewildering assortment of schools: night and correspondence, missionary and sectarian, homeopathic and regular, osteopathic and chiropractic, each of which sent dozens or even hundreds of graduates into the practice of

²Thomas Neville Bonner, Medicine in Chicago 1850-1950 (Urbana: University of Illinois Press, 1991), 231.

medicine each year.”³ Many of these were evident diploma mills which provided little or no medical education, but nonetheless, enabled the graduates to practice medicine on their unsuspecting patients.

Three Quality Medical Schools

In 1900, ten years before the Flexner Report would be released, there were three Chicago medical colleges, all with university affiliations, which attempted to upgrade the quality of the medical professional. Their history is significant in understanding the evolution of medical education in Chicago.

Daniel Brainard--and Rush Medical College

It was hard to imagine that the tall, thin, twenty-two year old man arriving in Chicago in 1836 by horseback would change forever the character of medicine in this nascent city. Dr. Daniel Brainard was only twenty-two when he moved from New York. The village of Chicago was also a neophyte, incorporated only four years earlier, but during that brief time its population had grown tremendously from one hundred to thirty-five hundred. This population explosion caused a myriad of difficulties including a lack of housing, streets of mud, inadequate sanitation, and an overabundance of disease. Since there was insufficient housing for all the new arrivals, warehouses were opened to provide shelter. Homes were poorly built and often stood on stilts to avoid sinking into the mud or snow. The ubiquitous mud, aside from making travel extremely difficult, served, along with its sewage content, as an incubator for disease. Public health was abysmal; there

³Ibid., 111.

were no hospitals, no provisions to care for the poor, no sewage system and no suitable clean water supply. A majority of the new citizens were immigrants, some of whom brought diseases from their homeland. Many succumbed to small pox, cholera, or scarlet fever. ⁴

The need for good medical care was obvious, and Daniel Brainard a graduate of the well-respected Jefferson Medical School in Philadelphia, brought a vision of a city served by well-educated and skilled physicians. Although not a specialist, Brainard received early acclaim for performing only the second surgery ever recorded in the city. The patient was a canal worker whose badly injured leg was deeply infected; the skillful surgery was witnessed by a number of physicians, and Brainard's reputation was established.

Brainard soon became an influential leader in the city. Tall and impressive, his manner was serious and direct although some considered him cold and remote. He was described as a "renaissance man" who loved studying literature, geology and botany. A scientist by nature, he meticulously recorded the results of his work and would often travel to Paris to learn new surgical techniques. His civic accomplishments were many: he served as the city's first health officer, organized the first hospital (Mercy Hospital), became editor of Chicago's first newspaper (The Chicago Democrat) and in 1858 ran (unsuccessfully) for mayor. However, his most lasting

⁴Kathleen M. Allard, Orthopedics at Loyola University: Heritage and Legacy (Washington: Color Press, 1984), 12.

contribution was undoubtedly the establishment of Rush Medical College, the first medical school in the city. ⁵

Discouraged with the pathetic state of medicine in Chicago, Brainard immediately saw the need for quality medical education, and thus set out to establish a medical school with high standards. Although it was chartered in 1837, the first class was not enrolled until 1843. When Brainard opened the college he stated, "we believe the school we have begun this day is destined to rank among the permanent institutions of the state. It will pass in time into other and better hands, but it will live on identified with the interests of a great and prosperous city." ⁶ In 1898, Rush joined forces with the new, yet already well-respected, University of Chicago. This union would last for forty-four years.

Dr. Nathan Davis and Lind Medical College

Subsequently, Dr. Brainard was responsible for the establishment of Chicago's second noteworthy medical school. In his search to bring the best

⁵Allard, 14; Chicago Medical Society, History of Medicine and Surgery and Physicians and Surgeons of Chicago (Chicago: The Biographical Publishing Corporation, 1922), 189; James Bowman, Good Medicine: The first 150 Years of Rush Presbyterian-St. Luke's Medical Center (Chicago: Chicago Review Press, 1987), 2-18. In 1866, soon after returning from a trip to Paris, Brainard, while working on a lecture to be given that night on cholera, was stricken with galloping cholera and died within hours. Students at Rush panicked and wanted to suspend classes for several months. The faculty worked frantically to successfully stop the exodus. They recognized that if the medical staff fled it could start a panic that could effect the whole city.

⁶"Chicago Medical Schools--Rush Medical College," Chicago Medicine 76 (April, 1973), 261-4.

faculty available to Rush Medical College, he recruited a distinguished physician from New York who in 1847 was one of the founders of the American Medical Association. Dr. Nathan Smith Davis was brought by Brainard to teach physiology and pathology at Rush. They both strongly believed in the need to promote quality medical care and medical education, and the newly formed medical societies, but their strong personalities often conflicted. Davis wanted to strengthen the curriculum; he campaigned for a longer course of study, more rigor, graded courses, and more stringent entrance requirements. Brainard worried that Rush would lose too many students to other schools if such proposals were implemented. When Brainard cast the deciding vote that sent Davis's plan down to defeat, Davis felt that he had little choice but to leave Rush and establish a new medical school more consistent with his own beliefs. He and six associates from Rush constituted the nucleus of the newly formed Lind Medical School. Here, Davis would eventually implement his reforms and extend the college term, increase the number of professorships, add daily clinical experience at a hospital, and become the first medical college in the country to have a graded course of study. Thus their feud, far from injuring medical education, led to progress and Chicago in 1859 had two medical schools of high caliber. Lind was reorganized in 1863 as the Chicago Medical College and in 1869 affiliated with Northwestern University.⁷

⁷Bonner, Medicine in Chicago, 52; Chicago Medical Society, 190.

The Third Medical College

The third medical college from this era to survive was the College of Physicians and Surgeons of Chicago which opened in 1881 and six years later became affiliated with the University of Illinois. Typical of the early associations between universities and medical schools, this was a very loose association, and it wasn't until around 1913 that the College of Medicine became an integral part of the University of Illinois. The medical college began as a proprietary institution, but by the early 1890's, it gained renown for its innovative curriculum that emphasized laboratory work and clinical practice long before it was the national norm.⁸ In 1969, it was renamed the Abraham Lincoln School of Medicine.

Not only were the early medical pioneers, Drs. Brainard and Davis, responsible for the establishment of the first two medical schools in the city, but they were instrumental in the founding of the first hospital--Mercy Hospital which would be of vital importance to the growth of Loyola University Medical School.

Sisters of Mercy at Work in Chicago

Mercy Hospital has a long history dating back to the very beginnings of the city. Accepting an invitation from Bishop William Quarter to come and help the people in "the garden city of the West," the Mercy Sisters arrived in Chicago in 1842, six years after Dr. Daniel Brainard. Thus this brave band of Irish women became first women religious order in the state. The Sisters of

⁸Bonner, 111.

Mercy were founded in Dublin by Mother Catherine McAuley, a wealthy woman, who renounced her fortune and dedicated her life to fighting poverty. Mother McAuley sent Mother Frances Warde, one of her first disciples, to Pittsburgh to open the first convent in the United States; three years later Mother Warde brought five other nuns to Chicago to work in this pioneer settlement.⁹

The sisters did not let the deplorable conditions discourage them in their mission of health care and education. They soon erected the first parochial school in the city and in 1846 opened St. Xavier Academy, the forerunner of St. Xavier University. Assuming a role as educational leaders in the emerging city, the Mercy nuns established a parochial high school ten years before the city opened its first public high school. They operated both free and tuition schools; the latter enabled them to support the former. They are also credited with opening the first orphanage in Chicago. In addition, the Sisters of Mercy turned out to be very shrewd real estate investors. They owned their convent, several schools in the downtown area, and purchased property on the outskirts of the city for future development. There were several disputes with early bishops over the right of their order to hold title to property. In a preview of their stubborn negotiating talents, the Sisters held firm. In 1867, while the Archdiocese of Chicago was still deeply in debt, the Sisters of Mercy owed no money on any property they owned, and their

⁹Mary Ildephonse Holland, R. S. M., Lengthened Shadows (New York: Bookman and Associates, 1952), 52-54; Joy Clough, R. S. M., In Service to Chicago a History of Mercy Hospital (Chicago: Mercy Hospital and Medical Center, 1979), 9-11.

school and convent at Wabash Avenue and Madison Street were valued at over a quarter of a million dollars.¹⁰

Chicago's First Hospital

In addition to the schools and orphanages, the Sisters of Mercy chartered the first general hospital in the Illinois. Aside from the sisters, Mercy Hospital, undoubtedly, owes its professional origin to the two pioneers of Chicago medicine, Dr. Daniel Brainard and Dr. Nathan Smith Davis. Dr. Davis had only been on staff for one year at Rush Medical School when Dr. Brainard offered Davis the position of Chairman of the Department of Principles and Practice of Medicine. Davis, however, hesitated because there was no facility that provided clinical bedside instruction for the students.¹¹ The need for a hospital was obvious; the problem was how to finance and staff such a facility. Dr. Davis came up with the financing solution. He would offer a lecture on the deplorable sanitary conditions of the city. A date was set and arrangements were made for Dr. Davis to speak at South Market Hall, the largest auditorium in the city. Tickets were sold for twenty-five cents each; the proceeds amounted to \$100 and Chicago's first hospital had its start. Brainard and Davis used this stake to open a makeshift facility at Michigan Ave. and Rush Street. The facility served well as a clinic for Rush Medical

¹⁰Ellen Skerett, Edward R. Kantowicz and Steven Avella, Catholicism, Chicago Style (Chicago: Loyola University Press, 1993), 143.

¹¹ Chicago Medical Society, 235; Bonner, 52; One of the major problems for medical students in the mid-to-late 1880's was the lack of bodies for students to use for dissecting. The gallows apparently was the only source for legally available bodies which made body snatching was a serious problem around the middle 1800's.

Students, but finding people to provide continual care to the sick became an increasing problem.

When the Sisters of Mercy came to Chicago, they had built a small convent next to St. Mary's Church on the corner of Madison and Wabash. Their fenced-in yard was adjacent to the home of Dr. Daniel Brainard. He was familiar with their work in Pittsburgh, and while he was searching for just the right people to manage the nursing care at his newly established hospital, it occurred to him that the solution to his problem might be just across the white picket fence. The early band of sisters, although only few in number, willingly took on the challenge. So in 1847 they assumed the nursing duties at a flimsy former hotel, the Lake House. Under the care of the sisters, the hospital grew quickly, and they soon needed additional space. When a cholera epidemic swept the city in 1849, the sisters realized that there was a great need for hospital care, and thus in 1850 they chartered the first general hospital in the state--the Illinois General Hospital of the Lakes and moved to larger facilities at Wabash near Van Buren.¹²

Many of the inhabitants in this fast growing city were suspicious of hospitals. In the 1800's, hospitals were viewed as "vestibules of death." They were refuges of the homeless and friendless. The importance of cleanliness and germ control was not yet understood. Dr. Philip Smith in a lecture on the early hospital conditions in America related that at Bellvue Hospital in New York City at this time the "sick were cared for by inmates, epidemics

¹²Chicago Medical Society, 235; Allard, 43; Clough, 11.

were frequent and terrible.”¹³ In the 1800’s, a student still thought his teacher excessively fussy if he prohibited spitting in the wards. Infection and cross infection were frequent; several diseases became so common in hospitals that they were identified as “hospital diseases,” and surgeons prided themselves on the degree of blood left crusted on their coats.¹⁴ It was not until antiseptic techniques were incorporated into the hospitals in the 1880’s and 1890’s that public confidence in hospitals increased.

Mercy on the Move

The success of the Mercy Sisters’ early hospital forced them to again search for larger quarters. So in 1869 Mercy Hospital was relocated to Twenty-sixth and Prairie Avenue which seemed, to some, distant from the main part of the city. It was, however, a fortuitous move. Only two years later, on March 4, 1871, the Great Chicago Fire raged through the center of town, burning for twenty-seven hours, destroying three and a half square miles of the heart of the city, incinerating most of the city’s famous stores, churches and buildings, and leaving one-third of the population (over 100,00 people) homeless. ¹⁵ Six hospitals were destroyed, but Mercy Hospital, in its new

¹³Philip W. Smith, M.D., “Infection Control Through the Ages,” Harold Rose Memorial Lecture, Froedtert Memorial Hospital, Milwaukee, Wisconsin, September 16, 1994. Dr. Smith also noted that it wasn’t until the late 1800’s that doctors stopped reusing bandages and began to wash their hands and instruments before and between surgeries.

¹⁴Bonner, 147- 152;

¹⁵Department of Development and Planning, Historic City-- Settlement of Chicago (Chicago: Department of Development and Planning, 1976), 42.

location, was spared and was able to offer assistance to the homeless and injured.¹⁶

After the fire, the area south of the loop, where Mercy Hospital was located, became the most fashionable in the city--home to the rich and famous Chicagoans including Marshall Field, George Pullman and Phillip Armour.¹⁷ When they moved to the south side Mercy Hospital also began an affiliation with Northwestern University which would last fifty years. Mercy would establish itself as a premier hospital during that era, and its location in the most exclusive section of the city made it the hospital used by the wealthy and powerful. They could cater to the needs of the very affluent patients offering rooms "en suite" which Mercy prepared for patients who demanded, even in sickness, elegant accommodations.¹⁸

The Birth of Loyola Medical School

In the early 1900's, Chicago had three medical colleges affiliated with universities. Many felt that Chicago had a sufficient number of university medical schools. Consequently, it is understandable that when Loyola proposed to become the fourth university to incorporate a medical school that suggestion was met with little enthusiasm and even open hostility in the medical community.¹⁹

¹⁶Clough, 35.

¹⁷Herman and Rick Kogan, Yesterday's Chicago (Miami: Seemann Publishing Inc., 1976), 65.

¹⁸Clough, In Service to Chicago, 55.

¹⁹Allard, 39.

The year 1909 was an epic one in the history of Loyola University. Its predecessor, St. Ignatius College, saw its enrollment drop to only seventy-six students causing the college administration to seek additional members by expanding to a university and accepting graduate students. At the same time, a proprietary medical school, Illinois Medical College, sought to avoid extinction by affiliating with the newly named Loyola University. Loyola hoped to establish itself as a major university in the Chicago so, in November of 1909, Loyola took over the three-story building on the southwest corner of Halsted and Washington and Illinois Medical College became part of Loyola University.²⁰ Shortly afterwards in 1910, Abraham Flexner published his prestigious report on the state of medical education; his verdict on Chicago medical schools was short and decisive, calling it the “plague spot of the country.”²¹ He suggested that if the State Board of Health enforced its law requiring four years of secondary education for admission into medical school only Rush, Northwestern and the College of Physicians and Surgeons would survive. The eleven other medical colleges in the city were substandard and offered nothing resembling a proper clinical training. Over the next seven years, four of these substandard colleges would join to form the Loyola University School of Medicine.

²⁰Henry S. Spalding, S. J., “The Beginning of the Loyola University Medical School and an Account of the School During the First Ten Years,” Undated Material, Loyola University of Chicago Archives, Department and Professional School Histories, 2; Edward J. Power, A History of Catholic Higher Education in the United States (Milwaukee: Bruce Publishing Co. 1958), 247.

²¹Flexner, Medical Education in the United States, 216.

One of the intentions of the Flexner Report was to greatly reduce the number of medical schools. He noted that "for the past twenty-five years there has been enormous over-production of uneducated and ill trained medical practitioners." In the United States, physicians were "four to five times as numerous in proportion to population as in older countries like Germany."²² This overproduction of ill-trained physicians was due in a large part to the existence of mediocre commercial schools. After the Flexner Report, many inferior schools throughout the nation desolved; still others survived by joining forces with a university.

Two of these failing institutions Bennett--an eclectic institution--and Reliance--a night school--joined Illinois Medical School in becoming part of the Medical Department of Loyola University. This arrangement was formalized in 1915 which is given as the official year for the founding of Loyola University School of Medicine. Flexner, however, had little positive to say about these schools: Bennett's school building "was in wretched condition"; its clinical facilities were "utterly inadequate," and it operated, to Flexner's utter disdain, "a vigorous advertising and soliciting system." His review of Illinois Medical College and Reliance Medical College provided little reason for optimism. They were scrutinized together because at the time of Flexner's Report they were different aspects of one college; one shift of students attended during the day the other at night. Their entrance requirements were the "usual for a commercial medical school," and it had

²²Ibid., X.

only fair laboratories and inadequate clinical accommodations.²³ Thus the nascent Loyola University School of Medicine, with no endowment and few resources, had little in its favor except a determined spirit and a strong belief that it had a mission to train Catholic physicians. Some felt that Chicago already had the nucleus of a quality medical education environment and there was pressure on Loyola to desist in its efforts to form yet another medical school; others felt "Loyola did not have the resources to conduct a medical school," that Bennett was only a "cheap, commercial college, that numerous medical schools in the country had been closed and that it was useless . . . to try to hold out against so strong an association."²⁴ Loyola University faculty members did not hesitate to state their belief that "medical schools were expensive luxuries for universities, and non-medical members of faculties were often jealous of the vast expenditures for medical departments, especially if they were not scientifically minded."²⁵ Fr. Spalding related in his early history of the medical school, "Many of our own felt that the medical school was injuring the good name of Loyola; nor can I blame them for so thinking, but Loyola fought the odds, holding to the belief that there was a great need for a Catholic presence in medical education."²⁶

²³Flexner, Medical Education in the United States, 210-212.

²⁴Spalding, 6.

²⁵R. M. Strong "A History of the Stritch School of Medicine of Loyola University," 1951, LUCA, Department and Professional School Histories, 5; Most of the information on the early history of the medical school is in the folksy account of the first ten years of the school by Fr. Spalding, S. J. and the more detailed reminiscence of Dr. R. M. Strong who wrote in 1951, after serving 28 years as Chairman of the Department of Anatomy.

²⁶Spalding, 11.

What was the advantage to Loyola of keeping this school that was seen as an “expensive luxury”? With the addition of Bennett and Reliance came larger facilities (albeit still woefully inadequate) and a student body of nearly four hundred. Dr. John Dill Robertson, the owner of Bennett, essentially gave the school to Loyola as a gift. He noted, “I have given ten years of my life to this school and I have not received one dollar of remuneration. I have done my best. I brought it up to where it is; take it and make it a Class A.” Father Spalding stated that the gift of Dr. Robertson was the real beginning of Loyola as a university and that the medical school and the large medical faculty “gave the university a standing in the city.”²⁷ Despite the questionable future of the new college, Loyola had succeeded with these acquisitions in establishing itself as a legitimate university.

The Last of the Four Proprietary Schools

The next step toward permanence for the medical college was the purchase of the Chicago College of Medicine and Surgery in 1917. This was a

²⁷Ibid., 17; Allard, 36; As was mentioned previously, there was a variety of types of medical schools existing in the late 1800's and early 1900's. Bennett began as Bennett Eclectic Medical School and Allard notes that although the regular physicians claimed that eclectics were incompetent charlatans, the schools they founded were at least on a par of the “regular” schools when evaluated on their “faculty, facilities, length of term and time devoted to clinical instruction and anatomical dissection.” At the turn of the century irregular sects weakened. Allard believes that this was not because of their incompetence, but the result of “revolutionary medical discoveries which changed the practice of both the regular and irregular physician.” In 1907 three years before merging with Loyola University, Bennett changed its name from Bennett College of Eclectic Medicine and Surgery to Bennett Medical College. Medical science was growing so rapidly that medical schools based on nonstandard methods such as eclecticism (which advocated the use of indigenous plants to cure illness) quickly became obsolete.

proprietary institution that was offered to Loyola for \$85,000 by its owner Dr. Roe. The industrious Fr. Spalding, the medical school's first regent, (a regent was the representative of the Jesuit community who served as an intermediary between the university president and the medical school) believed that it would take hundreds of thousands of dollars to duplicate the equipment and the building, and most importantly, the new facilities were far superior to the current structure that housed the medical school. So one busy Sunday afternoon, Fr. Spalding hurriedly convinced several influential Chicagoans that loaning money to the Loyola Medical School was a very safe investment. It happened so quickly that there was only a one day notice for students to report to the new college building. Loyola took over the facilities at 706 S. Lincoln (in 1936 the street name was changed to Wolcott), strategically located directly across from Cook County Hospital. Amazingly, the combining of these schools gave Loyola University School of Medicine the largest graduating class in the country.²⁸

Quantity has certainly never been a guarantee of quality, and this fourth piece of the Loyola medical school puzzle was held in no higher regard

²⁸Spalding, 21; The Bulletin of Loyola University Stritch College of Medicine for 1956-57 (Chicago: Loyola University, 1956), 25; The bulletin put its own interpretation on the early history of the medical school. "After extended consultation and serious consideration, it was decided that medical education in general, and Loyola's aim in particular could be served best by gradual evolution through affiliation and absorption of a few of the leading and existing medical schools. The assimilation and combination of four independent, proprietary schools into one institution which became an integral part of Loyola University proved to be a marked contribution to the raising of standards of medical education in Illinois and throughout the Midwest."

than the first three. Flexner explains the large size of Chicago College of Medicine and Surgery class as being, "largely due to the fact that advanced standing has been indiscriminately granted to students who had previously attended low grade institutions." In addition, he stated that the "equipment throughout is ordinary" and clinical facilities "are inadequate."²⁹

The young medical school came under question by accrediting agencies, not only for its inadequate facilities, but also for apparent violations of state admission requirements. Fr. Robert Hartnett, S. J., former dean of Loyola's College of Arts and Sciences, related the story of a crisis that arose over admission policies during World War I. Apparently, during Fr. Spalding's tenure as regent some applicants forged high schools credits "in some cases as a draft-dodging technique"; still others were apparently given "special consideration" by Fr. Spalding. When these improprieties were discovered, the medical school accrediting agencies selected a panel to investigate the charges and recommend possible disciplinary action. A Chicago ophthalmologist, Dr. William Noble, cast the deciding vote that saved Loyola. In Fr. Harnett's retelling of the story, he noted that when Dr. Noble was a young man he had read about the Jesuits and was impressed with their "heroic virtues and high intelligence." So with the medical school's fate in his hands Dr. Noble reasoned, "How the hell can a struggling new medical school get back on its feet after a misfortune like this when it's on probation?"

²⁹Flexner, Medical Education in the United States, 209-210.

These people have been in business for nearly four hundred years. If they say they'll straighten things out, they will."³⁰

Early Issues

Besides accreditation problems Loyola would face monumental difficulties of financial instability, inadequate facilities, and hospital affiliation that would plague the medical school not merely in its infancy but throughout the first fifty years of its existence.

706 S. Wolcott

When Loyola moved in 1917 into the facilities of the former Chicago College of Medicine and Surgery, it was relocating into three buildings which were once used to house the Women's Medical College of Chicago. Loyola's new medical school was originally built in 1877. Eventually, additions were made and when the Women's Medical College was absorbed into Northwestern University in 1902, it was sold to the Chicago College of Medicine and Surgery.³¹ These three buildings, which were once private

³⁰Robert C. Hartnett, S. J. , "How Historian Francis Parkman Helped save the Med School," Stethoscope, (January 16, 1976), 3.

³¹Chicago Medical Society, 212; Bonner, 60; The Women's Medical College was founded in 1870 as a direct result of medical schools' refusal to admit women. The only female student during Rush's first sixty years was dismissed in 1852 and Rush was censured by the Illinois State Medical Society for accepting a female. This prevailing prejudice can be seen in Dr. Alfred Stille's inaugural address to the American Medical Association: " On the whole, then, we believe that all experience teaches that woman is characterized by a combination of distinctive qualities, of which the most striking are uncertainty of rational judgment, capriciousness of sentiment,

homes, now provided much needed additional space for the fledging Loyola. It was, however, not nearly enough for adequate research and laboratory areas.³² This edifice was a temporary solution until the university could build its own school. Even though the three buildings were extensively remodeled in 1925, a long stay at Wolcott Avenue was not anticipated.

Hospital Affiliation

In order for Loyola to gain a Class A ranking, it needed to affiliate with a respected hospital. And so, for the first of many times Loyola was to become the beneficiary of the influence of the Archdiocese of Chicago. The regent of the medical school, Fr. Patrick Mahan, asked the then Archbishop of Chicago, George Mundelein, to assist the medical college in locating quality hospital facilities, and although Mahan knew that the Flexner Report advocated a hospital under the complete control of the medical school, this was an impossibility for this financially strapped institution. Chicago's Catholic leader recognized the importance of a strong Catholic presence in the medical field. Therefore, to assist Loyola, the archbishop (he became a cardinal in 1924) used his persuasive powers to convince the established and highly respected Sisters of Mercy that it was in their best interest, and that of the Catholic community, to join forces with the upstart Jesuit medical school. So in 1919, Mercy Hospital discontinued its fifty-year affiliation with Northwestern University Medical School and began a long term, frequently

fickleness of purpose, and indecision of action, which totally unfit her for professional pursuits.”

³² Allard, 36; Strong, 16-21.

acrimonious relationship with Loyola. Other Catholic hospitals in the city (St. Bernard's, St. Elizabeth's, St. Anne's and Columbus) joined Mercy in providing clinical facilities and clinical faculty for Loyola.³³ In 1920, after establishing a relationship with Mercy Hospital, Loyola received the Class A ranking it sought.

Archbishop Mundelein's initiative was motivated by two main forces:

First, American Catholics placed great importance on Catholic education. From the earliest days of Chicago, Catholics set up a parochial school system; even before churches were built, schools were established. There was a firm belief that whenever possible an individual should have the "benefit of a Catholic education" As early as 1876, Chicago's Bishop Foley established that precedent when he stated that Catholic parents had an obligation to give their children the advantages of Catholic education.³⁴ It was a natural extension of this belief that compelled Archbishop Mundelein to ensure the availability of Catholic education at the medical school level.

Secondly, it was the desire of the Catholic hierarchy to increase the self-esteem of American Catholics. Historian Edward Kantowicz reported that well into the twentieth century American Catholics did not feel equal to other

³³Sally Brozenec, "The Development of Nursing Education at Loyola University of Chicago" (Ph.D. diss., Loyola University of Chicago, 1991), 34.

³⁴Laurence J. McCaffrey, Ellen Skerrett, Michael F. Funchion, and Charles Fanning, The Irish in Chicago (Urbana: University of Illinois Press, 1987), 35.

Americans or even to other Catholics elsewhere in the world. ³⁵ In the American Catholic Church there was a paradox, “supremely confident ideologically, the Church knew that it was right and everyone else was wrong. Yet, as a church of immigrant outsiders, it showed an acute lack of confidence socially.”³⁶ It was the goal of Archbishop Mundelein and his colleagues to overcome this lack of confidence and to put the Catholic Church and people “on the map.” To combat the lack of self-esteem, American bishops initiated giant building programs and operated conspicuously under the principle of “going first class.”³⁷ Believing a Catholic medical school would be a source of great pride for Chicago Catholics, Archbishop Mundelein exerted his influence to ensure Loyola's early success. Mundelein was widely respected for his business acumen, and he did not hesitate to use his influence in an attempt to raise the Catholic self-esteem of his community.

Mercy's position in the city was undisputed; it was both the oldest hospital and the largest Catholic hospital in Chicago. Also occurring in the early 1900's, in the medical field, was improved antisepsis and anesthesia which made intricate surgical procedures a reality. This led to the emergence of the surgeon star who had a large following and added considerably to the

³⁵Skerrett, Kantowicz, Avella, Catholicism, Chicago Style, 65.

³⁶Ibid., 67.

³⁷Ibid., 67-71; Archbishop Mundelein (he became a cardinal in 1924) build St. Mary's of the Lake Seminary which is an example of this “giantism” philosophy of Catholic American hierarchy. It was built on 950 acres; a sprawling , multibuilding opulent complex, with imported marble, individual seminary rooms with private baths and 80 acres set aside for a golf course.

prestige of a hospital. Arguably the most brilliant, but certainly the most colorful surgeon of the time was John Murphy for whom Mercy built a separate amphitheater to showcase his talent. Upon seeing Dr. Murphy in the hall, one sister reported that “he wore an overcoat with a cape, one of the points thrown up over his left shoulder; he held a silk hat in his left hand.” He had graying red hair, blue eyes, a sandy complexion, and a parted beard. This flamboyant genius was the doctor to whom Teddy Roosevelt turned to after being shot in 1912, just before delivering a campaign speech in Milwaukee. Roosevelt remained hospitalized for eight days at Mercy before resuming his campaign.³⁸ Sr. Sheila Lyne, R. S. M., and Dr. Lloyd Nyhus stated, in the foreword to The Remarkable Surgical Practice of John Benjamin Murphy, “It has been said that in the early years of Mercy Hospital in Chicago, the trials and triumphs of the hospital parallels those of the city itself. We could also say that the progress and prominence of Mercy Hospital

³⁸Clough, 50-55; Bonner, 87; Chicago in the 1880's was gaining a reputation as a Mecca for prominent surgeons. Besides Murphy, another physician who had almost a cult like following was the Danish surgeon and pathologist--Christian Fenger, “his influence on the development of surgery and general medical practice was such that the evolution of scientific medicine in Chicago is often dated to his arrival.” He was a colorful character who, despite a speech impediment and a gruff exterior, was admired for his integrity, stamina and his thoroughness of preparation. Before he undertook a major operation, he would often review the literature in three or four languages. A tireless worker he would occasionally take a break during his six to ten hour surgeries and offer beer and pretzels to nurses and students who gathered to watch. Devoted to him were a group of young doctors and medical students “whose devotion and loyalty to their master has few parallels in modern medicine.” Another of Chicago's high schools is named after the surgeon star of Rush at this time--Nicholas Senn, who also had a reputation as an indefatigable surgeon, writer and researcher.

in that early period were launched by the intensive study, pioneering surgery, and inspirational teaching of John B. Murphy."³⁹ It was also noted that John Murphy may have had his detractors, but "the leaders in medicine and surgery seem to have considered him a genius."⁴⁰ Dr. Murphy's reputation did much to add to the prestige of Mercy Hospital .

The prominence of Mercy in the city was unquestioned. It is understandable, then, that its reluctant 1919 decision to leave Northwestern University Medical School and affiliate with the neophyte Loyola University School of Medicine would be viewed by the hospital as a sacrifice, made to ensure the existence of a Catholic medical school in the city and to accede to the wishes of the local Catholic hierarchy. ⁴¹

Loyola 1920-1940

Administration

Despite affiliating with Mercy Hospital, Loyola's medical school was still struggling to improve its financial stability and reputation while being served by a very limited administrative staff. A strong influence in a Catholic

³⁹Sr. Sheila Lyne, R. S. M., and Lloyd Nyhus, Foreword to The Remarkable Surgical Practice of John Benjamin Murphy, by Robert L. Schmitz and Timothy T. Oh (Champaign: University of Illinois Press, 1993).

⁴⁰Robert L. Schmitz and Timothy T. Oh, The Remarkable Surgical Practice of John Benjamin Murphy (Champaign: University of Illinois Press, 1993), 165.

⁴¹Sr. Gwendolyn Durkin C.E.O. of Mercy Hospital, interview by author, Mercy Hospital, Chicago, Illinois, October 21, 1994.

medical college was embodied in the position of regent. The regent was the representative of the Jesuit university president at the medical school. He was there to foster the religious purpose of the university. Furthermore, since the dean was most often a part-time administrator (as he was at Loyola), the regent was the only full-time administrator at the school, the only one with authority on day to day decisions. As Strong points out, "until 1946, except for the period (one year) when Dr. Braceland was at the school, the deans were busy clinicians who did not devote much time to the routine of the school, and who only occasionally came to the offices of the school. Such a system tends to lessen the authority of the dean whether he likes it or not." On the other hand, the regents of the school "have been handicapped by taking office with no experience in medical education, and, as a rule, with no scientific training."⁴² The lack of a full-time administrative team certainly contributed to the slow progress in implementing medical reform at the medical school.

At Loyola there were several regents during this era: Father Spalding left in 1918, after an army inspection questioned the quality of the school; he was succeeded by Rev. Patrick Mahan, S. J. who was "grim and rather reserved"; he was followed by Rev. Terrence H. Ahearn who seemed to have difficulty in allowing admittance to "Negro" students;⁴³ Fr. George L. Warth

⁴²Strong, 25-27.

⁴³Samuel K. Wilson, S. J. to Fr. Finnegan, S. J., February 26, 1937, Loyola University of Chicago Archives (hereafter LUCA). Office of the Dean. Francis J. Braceland. Box 4. Folder 5. Fr. Wilson discusses the policy of Fr. Ahearn, "The reason I make this statement is because of the case of Lucius Davis (a "colored lad") was bitterly fought by Father Ahearn and every year we were compelled to force Father Ahearn to continue Lucius Davis in the

served from 1936-42 and while according to Dr. Strong he “had high ambitions for the medical school,” the early regents did not effect major changes in the direction of medical education.⁴⁴ While the position of regent changed every five or six years, the medical school had one dean, albeit a part-time dean, for over twenty years.

Dr. Strong reports in his history of the medical school that in 1918 Fr. Mahan, the new regent, introduced a young intern from Cook County Hospital whom he had taught in high school. Dr. Louis B. Moorhead would serve one year as acting dean and then twenty years as a dean of the medical

Medical School.” There is another letter in the archives also dated February 26, 1937 addressed to Father Warth, the regent, that deals with Lucius Davis. Samuel K. Wilson, S. J. to Fr. Warth, S. J., February 26, 1937, LUCA. Office of the Dean. Francis J. Braceland. Box 4. Folder 5. The name of an individual has been deleted in conjunction with the previous letter; it is perhaps possible to make an educated guess as to whose name has been removed. “Since you did not bring this case up to me in September, I presume that the arrangements under which we compelled (name deleted) to accept Lucius Davis as a clinical student have been met in some way or other. (Name Deleted) had a very deep prejudice against all colored students and I am not so sure that his opposition to Lucius Davis beginning in the School and continuing in it was motivated rather by prejudice than by difficulties in securing clinical experience.” In correspondence from George Warth to Wilson on June 27, 1938, Warth expresses a different policy at the medical school, “I see no difficulty in accepting colored Catholic student . . . as long as they do what they are told in their clinical years.” George L. Warth, S. J. to Rev. Samuel K. Wilson, S. J., 27 June 1938, LUCA. Office of the Dean. Francis J. Braceland. Box 4. File 7; Although Loyola's policy was not atypical of the era in which it existed, Dean Francis Braceland's letter to the National Association of Colored People in 1942 seemed a trifle hollow, “I don't suppose the Colored Race has a friend as good as the Catholic Church. A rather careful investigation would prove that to you.” Francis Braceland to Mr. Ira W. Williams, January 6, 1942, LUCA. Office of the Dean. Francis J. Braceland. Box 4. File 5.

⁴⁴Strong, 26.

school. Strong talks about his ability as a speaker, his tack, and pleasant personality, but noted, "it was a pity that he could not give more time to the works of the school." Others remember Dr. Moorhead for his arrogance.⁴⁵ A surgeon with no administrative experience, he would remain dean, in a part-time (which during this era would require only several hours a week) capacity until 1940. It is also understandable that Moorhead would have little time for medical school matters since, besides his active private practice, he would serve from 1928 -1941 as President of the Staff at Mercy Hospital. One clinical professor, in discussing Moorhead's tenure noted, "Our dean, Louis Moorhead, was personal physician to Cardinal Mundelein as was his father before him. In 1939 he spent nearly a year in Rome with Cardinal Mundelein electing a new Pope. Considering Dr. Moorhead's contributions to medical education, I am not certain that he was missed."⁴⁶ His influence with the Archdiocese of Chicago, however, would continue long past his tenure as dean as he would serve as private physician for Cardinal Stritch and advise him on many matters relating to the medical school.

⁴⁵Dr. Paul Fox, interview by author, River Forest, IL., November 29, 1993; Dr. James J. Smith, interview.

⁴⁶Frank W. Newell, M. D. to Reverend Raymond Baumhart, S. J., 20 January 1978. LUCA. Office of the President. James Maguire. Box 2. File 1.

A Remodeled Facility

Loyola was elated in September, 1917 when it acquired its fourth medical college, the Chicago College of Medicine and Surgery. This meant it would have a new building which was larger and better equipped than its predecessor but still with precious few facilities for research. Its laboratories were too small to even accommodate entire classes. Its location, however, across from Cook County Hospital, in the heart of the west side medical center added to the prestige of Loyola. Strong notes, "the building was quite well suited for a school with part-time faculty members who were often not in the building except for teaching." In 1925, the building was totally remodeled. Since an enlargement was necessary and there was only one direction to go, the front wall was moved twenty feet closer to the sidewalk and a common front for the three buildings was added. Classrooms were reconstructed to meet the city ordinance for twelve foot ceilings. Almost all interior walls had to be removed. The remodeling was a vast improvement over the old facility, but it was still an accepted fact that the building was much too small and quite inadequate for a quality medical school. Strong stated that "the president of the university asked us if the building could serve for ten years." No one anticipated the coming economic crisis.⁴⁷

⁴⁷Strong, 21.

Financial and Accreditation Concerns

The 1930's brought the worst depression the country had ever experienced, and Chicago was one of the hardest hit of the major American cities with unemployment reaching 750,000.⁴⁸ If the university had plans to build a new medical facility, or to add full-time faculty, such plans were put on hold, and it became a primary concern to provide for the growing daily costs of the university and the medical school. The clinical needs for the medical school were being met by Loyola's affiliation with several hospitals in the city, but they had no hospital directly controlled by the university as Flexner had advocated. Thus providing proper opportunity for students to secure sufficient patient or clinical time was always a concern. One of the principal opportunities for students to gain clinical experience was provided by a hospital's dispensary which distributed free medical service for those in need. Since 1919 when Archbishop Mundelein negotiated a working relationship with Mercy Hospital for Loyola, the Mercy Free Dispensary, which served the needs of tens of thousands of Chicagoans, and also provided a laboratory of clinical teaching for Loyola medical students. Hospitals, however, were also suffering great financial losses at this time, and Mercy was forced to close its dispensary during the depression from 1935 to 1938. To fill this clinical void, Loyola opened its own small dispensary at 706 South Wolcott. This temporary solution highlighted Loyola's failure to control its

⁴⁸Howard B. Furer, Chicago a Chronological and Documentary History (New York: Oceana Inc., 1974), 66.

own teaching hospital. In an attempt to appease accrediting agencies, the university sought a formal agreement with Mercy hospital. Such an arrangement was signed on October 25, 1937, when Mercy Hospital became the university hospital of the medical school. In this document, it was stated that the “medical direction and policy of the hospital was now vested in the University.”⁴⁹ This vague phraseology makes it unclear just how much of the authority to select staff and department chairs the Mercy sisters were willing to relinquish. As will be discussed later in this document, Mercy never really operated as a true university hospital but rather as an affiliate of Loyola retaining its autonomy. This inability to secure a true university hospital placed Loyola in serious jeopardy of losing its accreditation.

From its earliest days, money was a problem. In 1921 Fr. John Furey, S. J., the university president, remarked, “During the past two years the deficit in the medical school has become a serious question; we cannot go on this way; we must close the medical school or get some subsidy.”⁵⁰ The college had few financial resources other than tuition; with the move of medical education from the didactic lectures to an experimentally-based curriculum, and the increasing need for newly developed scientific equipment to stay competitive, costs were naturally spiraling. The deficit for 1938 alone was

⁴⁹Bulletin of Loyola University School of Medicine for 1945-46 (Chicago: Loyola University, 1945); “History,” Undated paper on the early years of the medical school, LUCA. Office of the Dean. Louis B. Moorhead. Box 4. Folder 7.

⁵⁰ Fr. Raymond Baumhart, S. J., Talk to Staff of McGaw Hospital,, December 7, 1977.

\$52,000. The university was relying on profits from other divisions to cover the losses connected with the medical college.

Equally troublesome was the 1935 action by accrediting agencies that placed Loyola "on something called confidential academic probation; it continued that way for a good many years."⁵¹ Although this action was kept relatively secret, it officially notified the university that its facilities, full-time faculty arrangements, financial resources, and hospital affiliations were inadequate, and consequently, the medical school's very existence was in peril.⁵² Thus as it moved into the critical transition era of medical education, to even survive, Loyola would need enlightened leadership, tenacity, a financial savior, and an unwavering commitment to maintaining a Catholic presence in medical education.

⁵¹ Ibid.

⁵² Samuel K. Wilson, S. J. , to Dr. Louis Moorhead, Feb. 28, 1936, LUCA. Office of the President. James T. Hussey. Box 2. Folder 1. President Wilson fought to ensure the secrecy of this A.M.A. decision "Consequently I am writing to you along with the other two members of the medical school staff who are cognizant of the decision, warning you all not to communicate this news to any one, whether members of the medical school faculty, members of the archdiocese, or all other persons whatsoever. If this decision is divulged before I communicate it myself I shall investigate the source of the information and be compelled to take steps to indicate effectively my extreme displeasure at this violation of confidence."

CHAPTER IV

THE TRANSITION ERA AT LOYOLA UNIVERSITY MEDICAL SCHOOL: 1940-1950

A Period of Uncertainty

Almost since its inception the Loyola University School of Medicine had been a continual albatross for the university. The accrediting problems were a source of embarrassment, and its financial insolvency was a continual drain on the rest of the university. So in 1940 after the very part-time dean, Louis Moorhead, resigned, the university hesitated before hiring a replacement as the Loyola University Board of Trustees seriously contemplated closing the medical school. Fr. McCormick, one of the university trustees, succinctly explained their reasoning, "there are so many contingencies that the circle is rather vicious; we are to take the dean if we are to continue the medical school, and if we take the dean we must continue."¹ It appeared as if the university administration never knew how to proceed in its governance of the medical school. No long-term policy was discussed nor outside advice solicited as the all-Jesuit board of trustees faced the continual dilemma of judging the viability of its medical school. In deciding whether to close their medical college in 1941, Fr. Egan, another trustee, spoke of seeking support from sources that they would turn to often during the transition era,

¹Board of Trustee Minutes, Loyola University of Chicago. January 21, 1941.

"We can't go on as is. We can't drop the medical school right now. Let us get Braceland (candidate for the dean's position) and trust to the province of God and the help of the Archbishop."²

A New Dean and New Hope

Dr. Francis J. Braceland was a distinguished psychiatrist from the University of Pennsylvania. As Loyola sought to improve its administrative team, Braceland was hired as the first, full-time dean. In him the trustees felt that they had a harmonizer.³ A gracious and sensitive man, the medical school had great hope that his thoughtful style would serve him well in dealing with the various factions at the medical school and at Mercy Hospital.

In the interim between the resignation of Dr. Moorhead and the hiring of Dr. Braceland, the regent, Fr. George Warth, S.J., provided continuity; but, when Dr. Braceland assumed his position in June of 1941, he soon found that the conditions at the medical school were far worse than he had imagined. University President, Rev. Samuel Wilson, S. J., tried to encourage his new recruit, "may I say that I hope the difficulties you are running into, difficulties created by a lack of supervision extending over many years, will not unduly alarm you. After all, no one can accomplish more than just a

²Ibid.,

³Board of Trustee Minutes, Loyola University of Chicago. January 21, 1941.

certain degree in correcting long standing abuses, and the correction of such messes can only be achieved over a course of years."⁴

Wilson would never know, however, if Braceland was the person to rectify the situation and point the medical school in a new direction because in less than a year after his appointment he was called to active duty by the U. S. Navy. In reviewing his one year as dean, Braceland stated, "the school was a little farther ahead scholastically and not a bit farther ahead financially".⁵ Despite Braceland serving in the navy, the medical school kept his position vacant for three years hoping that he would return to Loyola after the war. The medical college was further depleted when the Assistant Dean, Stewart Thomson, was also activated into the service. In the interim, policy decisions would be left to a new regent, Fr. Edward Maher, S. J., and starting in 1943 to an executive committee of physicians. From a policy perspective, little was being accomplished to upgrade the standards of the school.

⁴Samuel K. Wilson, S. J. to Dr. Francis Braceland, August 19, 1941. LUCA. Office of the President. Fr. James T. Hussey. Box 5. Folder 6.

⁵School of Medicine, Councils, Committees and Boards, May 26, 1942, LUCA. Faculty Council Minutes 1941-1945. Box 1. File 12.

Continued Financial and Administrative Difficulties

With an absent dean and a mounting deficit, the trustees once again considered closing the medical school. Meanwhile, the university's activist president, Fr. Samuel Knox Wilson S.J., turned to the new Chicago archbishop, Samuel A. Stritch, for assistance. The archbishop, while personally very interested in the cause of Catholic medical education, was dismayed to report to Wilson that he had approached ten people who could "lift the medical school out of trouble and not one was interested."⁶ With no help on the horizon, the board of trustees had little choice, but to vote, at their March 18, 1942 meeting, to close the medical school.⁷ With Braceland advising them in absentia, the board members proceeded with a plan to announce the school's discontinuance in the fall of that year. However, for the first of several times in his reign as head of the second largest Catholic archdiocese in the country, Archbishop Stritch rescued the medical school from certain extinction. He agreed that all special collections at the parish closest to Loyola, St. Ignatius Church (with the exception of the Peter's Pence Collection), would be given to the medical school; the archbishop also agreed to supplement this amount to ensure a collection of \$10,000. In addition, the archbishop approved the request of the new university president, Fr. Egan,

⁶Board of Trustee Minutes, Loyola University of Chicago. January 13, 1942.

⁷Board of Trustees Minutes, Loyola University of Chicago. March 18, 1942. The vote was unanimous, but there was also a discussion of closing the Law School and the School of Social Work; the feeling was, however, that "neither of the other two jeopardized the existence of the university."

for \$100 from each of the 250 parishes in the archdiocese.⁸ This financial support amounted to an influx of \$35,000 which enabled the medical school to continue. The actual amount received was certainly not enough to permanently sustain the medical college in the face of growing needs; nevertheless, it set an important and unique precedent for the archdiocese to serve as financial benefactor for a private Jesuit university, and it firmly established the pivotal relationship between that university and Samuel Stritch.

In February of 1944, Braceland tendered his formal resignation; there would be, however, still efforts made until 1946 trying to entice him to return to Loyola. To fill the deanship vacancy, the president of Loyola, Rev. Joseph Egan S. J., accepted Dr. Braceland's suggestion and turned to Dr. Italo Volini, chairman of the Department of Medicine, to accept the position of acting dean. Volini who preferred the title of "Dean for the Duration" took over the position that had been vacant for two years. There was concern among the board of trustees regarding this selection, since, in their view, "Volini, though a good man, would not get along with all the faculty and Mercy Hospital."⁹ The medical school, furthermore, was once again led by a busy clinician who was expected to devote only several hours a week to his dean's duties.

⁸Board of Trustee Minutes, Loyola University of Chicago, September 21, 1942. The financial needs of the medical school were so great that Fr. Egan took time to individually write each of the contributors.

⁹Board Of Trustee Minutes, Loyola University of Chicago, March 30, 1943.

War Years

Because of the need for doctors in the war effort, the medical school curriculum was accelerated. At the urging of the Association of American Medical Colleges, the average length of medical training was reduced from four to three years as students continued their studies throughout the summer. This caused a hardship for many students as they relied on summer employment to earn their tuition money for the year. In addition, because the amended Selective Service Act made all physicians under the age of forty-five subject to active duty, Loyola saw its faculty depleted as many were called to serve in the armed forces. In the minutes of the Academic Council on June 7, 1946, Dean Volini discusses the effect this had on the school, "This depletion left the School of Medicine with older type of teachers, men who are busy in practice . . . the men who are teaching are worn out by their private work and this condition has contributed to absenteeism and to an improper student attitude."¹⁰ This depleted faculty and the "speeded-up" curriculum did provide an unanticipated financial upswing for the school as it went from a deficit of over \$64,000 in 1942 to a surplus of \$38,716 in 1943 and a surplus of \$44,113 in 1944.¹¹ The administration recognized that this was a temporary situation and not an indication that the overall financial situation was improving.

¹⁰Minutes of the Meeting of the Academic Council, June 7, 1945. LUCA. Office of the President. Fr. James Hussey. Box 3. Folder 15.

¹¹Board of Trustees Minutes, Loyola University of Chicago. May 23, 1945.

The Crisis of 1945

With Fr. Egan's health failing, James T. Hussey, S. J., was appointed university president in 1945 and soon found himself embroiled in the overwhelming financial difficulties of the medical school. The archdiocese, since the time of Cardinal Mundelein (the 1920's), had been supportive both financially and in terms of lending its prestige to the cause of Loyola Medical School, never hesitating to speak out and encourage all Catholics to give their support to Catholic medical education. This occasional infusion of funds was not nearly enough, nor dependable enough to address the mounting financial needs of the medical school. With the post-war era on the horizon, Loyola had still not met the standards of the Flexner Report. It had inadequate facilities, no full-time clinical faculty, no teaching hospital under its control, no endowment to meet the needs of research; it was holding on by a string.

By June of 1945, Germany had surrendered; servicemen and women were returning home to America, and with the help of the G. I. Bill, colleges and universities anticipated sharp increases in their enrollments. Thus for Loyola there were many pressing needs not just for the medical school but for the university at large as it needed to find faculty, classroom space, and facilities to accommodate the enormous influx of undergraduate students. Not wanting to abandon the medical school, the university's president Fr. James Hussey S. J., pleaded his case to Archbishop Stritch for a large endowment to build new medical and dental school facilities. Archbishop Stritch after thoughtful analysis responded:

It seems to me that, facing the post-war period, we must plan the future development of Loyola University and ask the support of our people for the execution of our plans. In the making of them we must think boldly and courageously and realistically. Such resources as we may hope to have at our command we must use to the very best advantage. Largeness of undertakings must not injure the excellence of our achievements. If we make a good plan, possible of realization within the limits of our foreseeable resources, in future years we shall be able to enlarge its reaches. The prudent thing at this time is to plan to do excellently the possible.

The development of Loyola must be first and before everything else in its Schools of Arts and Sciences.

Archbishop Stritch continues,

I have given very much thought to your Medical School over a period of years. Realizing the good that such a School can contribute to Religion. All my thoughts have been centered on finding a way to conduct it on a high standard. Presently the difficulty in conducting this School is financial. In the past, to meet the unavoidable difficulties in conducting a Medical School without an adequate endowment or adequate annual appropriations, the University has used the surpluses of its general income and the income of many of its Schools. The effect has been to hamper the development of the other Schools of the University.

After a full study of the facts, I am forced to the conclusion that in planning the immediate development of Loyola University we ought to suspend the operation of the Medical School.¹²

This could not have been the response that Fr. Hussey expected; he took the crisis to the Loyola University Board of Trustees who had voted

¹²Archbishop Samuel Stritch to James T. Hussey, S. J., June 5, 1945. Archives of the Archdiocese of Chicago (hereafter AOC). Chancery Correspondence 1945. Box 10662.

twice previously to close the medical school.¹³ The trustees were given two options: close the school immediately or accept a freshman medical class and immediately begin an intensive fund-raising effort; if the fund-raising proved unsuccessful, the medical school would refuse candidates for the term beginning October 1, 1946. The vote among the trustees was unanimous; the school would continue and Fr. Hussey would start an intense search for contributions, personally canvassing the alumni.¹⁴

Fr. Hussey selected Fr. Gerald Grant to lead the fund raising efforts and informed Archbishop Stritch of the trustees' resolve. The archbishop expressed total support for their decision, "I think it is clearly understood that the statement which I made in my letter on this matter does not in any way militate against my desire to have the Medical School if it proved possible to provide the necessary finances for conducting it on a high standard."¹⁵

Their hope of securing funds from alumni was quickly dashed as Fr. Grant reported in September of 1945 that he had only received pledges for

¹³Dr. Richard Matré, interview by author, October 1, 1994, Wilmette, Illinois. Dr. Matré has served Loyola in many different capacities, Dean of University College, Dean of the Graduate School and Vice-President of the Medical Center. He noted that in searching of the Board of Trustees minutes he never found them rescinding the votes to close.

¹⁴James T. Hussey, S. J. , to Samuel Cardinal Stritch, June 19, 1945, LUCA. Office of the President, James T. Hussey. Box 10. Folder 4.

¹⁵Samuel Cardinal Stritch to Fr. James T. Hussey, June 30, 1945, AOC. Chancery Correspondence. Box 10662.

\$8,000 and \$2,000 of that came from Dr. Volini. Alumni had never previously been asked to support their alma mater, and Fr. Wilmes (the regent in the 1940's for the dental school and the chaplain for the medical school), noted that very few expressed any interest; students felt they had paid their tuition and thus contributed all that was needed from them¹⁶. Fr. Hussey informed Archbishop Stritch of the dismal failure of the medical school fund-raising attempts, "the reaction on the part of the medical alumni to Fr. Grant's campaign for funds for a medical school endowment is in no sense encouraging."¹⁷

Thus as 1945 drew to a close, and the future of the medical school once again appeared problematic; the medical school, however, would be saved thanks to the interest, tenacity and generosity of three men: Samuel Stritch, James Hussey and Frank Lewis (the medical school's first great benefactor). The year's end brought about two milestones for the university: Archbishop Stritch offered to the medical school "to meet the deficit of the Medical School in the sum of \$50,000 a year as long as it is needed,"¹⁸ and Frank J. Lewis donated the Tower Court Building at 820 North Michigan Avenue to Loyola. This building would be used a Loyola's downtown campus and help house the influx of students

¹⁶Fr. Robert Wilmes, S. J., interview by author, Chicago, Illinois, March 13, 1994.

¹⁷James T. Hussey to Cardinal Stritch, 1945, AOC. Chancery Correspondence. Box 10659.

¹⁸Samuel Stritch to James T. Hussey, S. J., January 8, 1946, AOC. Chancery Correspondence. Box 10659.

returning from World War II. Of great importance to the medical school, however, was Fr. Hussey's statement that Frank Lewis's main interest was in the medical school.¹⁹

The archbishop's monumental contribution breathed life back into the medical school just when all seemed lost. Despite the size of the archbishop's gift, the board of trustees once again vacillated, hesitating to commit itself to unconditional support as the minutes from the board of trustees' December 12, 1945 meeting shows:

The question was then discussed whether we should keep the medical school open on this basis. The motion was voted to accept the funds and Fr. Egan stated that, if in another four or five years, we faced the crisis again the matter could be reopened for discussion.²⁰

Cardinal Stritch

Samuel Stritch was an amiable and unpretentious man who was born and raised in the South and who "remained indelibly Southern in his speech and life-style."²¹ Priests who worked in Chicago viewed him as a "permissive and tolerant figurehead," and as "the bishop who said

¹⁹Board of Trustees Minutes, Loyola University of Chicago, December 12, 1945. Negotiations for Tower Court Building were often difficult as the building would be jointly occupied by Loyola (using floors one through nine) and Mrs. Julia Lewis's group the Illinois Club for Catholic Women (who would occupy the top seven floors).

²⁰Board of Trustees Minutes, Loyola University of Chicago, September 15, 1945.

²¹Steven M. Avella, This Confident Church (Notre Dame: University of Notre Dame Press, 1992), 35.

yes.”²² Msgr. Quinn related that Archbishop Stritch allowed administrators to do what they wanted with only the admonition, “well, Father, just do your best.”²³

Before coming to Chicago in 1940, he served as Archbishop of Milwaukee for ten years. There, Stritch is remembered as the generous prelate who, during the Depression, passed out dollar bills as he walked down the town's main street,²⁴ and who distributed to the poor of Milwaukee the money the archdiocese had been saving for the purpose of building a cathedral in the city.²⁵

Philosophically, Samuel Stritch was very much a product of the theological milieu of the times which exhibited a great fear of heresy. He believed that real power was centralized in Rome, and he fretted about continual Catholic exposure to non-Catholic philosophies. Understanding his beliefs helps explain his intense interest in maintaining a Catholic medical school since for him it was vital to ensure that future physicians be trained under the auspices of Catholicism.

²²Edward Kantowitz, Foreword to This Confident Church, by Steven Avella, (Notre Dame: University of Notre Dame Press, 1992), 11.

²³Father John Quinn, interview by author, Chicago, Illinois, November 30, 1994.

²⁴Steven Avella, interview by author, Milwaukee, Wisconsin, February 14, 1994.

²⁵Fr. Quinn interview.

Archbishop Stritch had a strong interest in medicine (he even read medical journals) and a strong belief in the importance of Catholic medical practitioners. He would be of valuable assistance to Loyola in two main areas: financially and in dealing with Mercy Hospital. Dr. Steven Avella, who has written extensively on the life of Cardinal Stritch, explained his relationship with Mercy and Loyola as that of a marriage counselor, constantly going back and forth between the two warring factions trying to keep both parties negotiating. This entanglement in the affairs of the medical school and Mercy was in direct contrast to his normal managerial style in which he generally functioned as a "hands-off" administrator. The parish priests operated with a lot of autonomy, but the medical school was as, Dr. Avella noted, "his thing;" he did not delegate authority for the medical school and Mercy Hospital decisions to his subordinates, but rather he dealt with all the principals personally. ²⁶

Besides providing for the viability of two important Catholic concerns, Stritch was also interested in maintaining Mercy's presence on the south side of Chicago. The neighborhood was changing rapidly, and the Mercy nuns were seeking to move from their location in the once fashionable Prairie Avenue District to an area they considered safer.

Equally important to Loyola was Archbishop Stritch's role as financial savior. When Loyola Medical School faced a near collapse in 1945, and Fr. Hussey had little success with soliciting medical alumni: Stritch brought the prestige and clout of his office to save the institution; it

²⁶Dr. Avella interview.

seemed only natural therefore that several years later the board of trustees would vote to rename the college The Stritch School of Medicine of Loyola University.

Post-War Era at the Medical School

Now that the medical school did not face the imminent threat of bankruptcy or foreclosure, it could turn its attention to the ruefully neglected academic conditions at the school. The post-war era in medicine was one of great opportunity: large federal grants were available, research would rise in prominence, clinical teaching became an increasingly vital component of a medical student's training, and discoveries made during the war years led to new specialties. When medical education was beginning a great push to absorb radical changes, Loyola was unprepared. It had spent the last several decades merely trying to survive; it was ill-equipped in many ways: financial, faculty, facility, and administratively to move into the modern era of medicine.

A New Dean - James Smith

The year, 1946 brought several important changes: Archbishop Stritch would be elevated to cardinal by the pope, and the medical school hired a new full-time dean. The medical school's new chief administrator, James J. Smith, was only thirty-two years old and was the youngest medical school dean in the country. Dr. Smith had an M. D. from St. Louis University and a Ph. D. in physiology from Northwestern University so he was quite well versed in the basic and clinical aspects of

medical education. He was also just returning from five and a half years of military service where he was a Lieutenant Colonel in the U. S. Air Force Medical Corps and Commanding Officer of the Air Force Medical Research Department in England during World War II. Dr. Smith brought with him high expectations for the school, an intense drive, youthful optimism, and a degree of brashness. At the same time, Fr. Michael I. English, a man of great charm and wit, was brought in to serve as regent in the hopes that he would also help as an important fund-raiser for the medical school. After several months on the job, Dr. Smith wrote a detailed report on the conditions at the school. He stated that Loyola Medical School had done a fairly good job in medical education considering its financial resources; he went on to discuss the future,

under the present income, however, it will be impossible for Loyola Medical School to maintain a high standard of medical education. It operates at present on an expenditure budget which is less than one-third of any of the other three approved medical schools in Chicago. This discrepancy points out a nationwide trend in medical education involving tremendous expansion of physical plants, operating budgets, research and operating facilities. Unless Loyola Medical School receives its share of these physical advantages, our caliber of medical graduates will steadily decline on a comparative basis. ²⁷

Dean Smith also delineated four specific needs for the school:

²⁷Memorandum to the President from Dean James J. Smith, November 20, 1946, LUCA. Office of the President. James Hussey. Box 7. Folder 1.

1) re-organization of the entire curriculum, particularly of the clinical curriculum; ²⁸ 2) a university hospital physically adjacent to the school with a highly selected closed staff; 3) a large increase in the current operating income; and 4) a new medical school and dental school building. ²⁹

These were lofty goals and ambitions, certainly in line with the recommendation of Flexner and the A.M.A., but in light of current conditions at the medical school, they appeared to be somewhat unrealistic.

Growing Frustration with Mercy Hospital

Loyola University School of Medicine seemed to be in a continual fight for respectability. If it ever hoped to be taken off of its secret probation (the medical school would be on secret probation most of the time from 1935 to 1966) status, it would need to strengthen its clinical teaching program, but since the school did not control its own hospital this was a task of monumental difficulty. Although the large municipal hospital--Cook County--would have patients available for clinical teaching, its subservience to the whims of county government made it impossible for Cook County Hospital to function in a prime teaching role.

²⁸Despite the curricular changes called for in the Flexner Report, the medical school curriculums throughout the nation were very slow to change. Rush's program in 1924 was essentially the same as it was in 1898; Bonner, Medicine in Chicago, 116,

²⁹Ibid.

Mercy Hospital, the other main teaching hospital of Loyola, seemed to be the obvious choice. The cardinal had wanted it and put the power of his office behind this choice. In his view it seemed natural that two prominent Chicago Catholic institutions should work together to form a powerful and influential force in the city and one in which all Catholics could take pride. But, this union's success was improbable because the needs of the two institutions were too divergent and the personalities too unbending to ever consummate such a marriage. For practical and accreditation purposes, Loyola needed to have control of the selection of the staff and department chairs as existed in the other three main Chicago medical schools and in the great majority of schools in the country.

The staff at Mercy had no real interest in affiliating with the medical school. The administration at Mercy saw themselves as custodians of a well-established private hospital whose primary job was to provide skilled service to private patients. Success for them was manifest in a higher occupancy rate. Their staff was understandably loyal to Mercy--not Loyola.³⁰ Loyola needed Mercy for clinical clerkship opportunities which did little to fill Mercy's beds and thus was a very low priority for the hospital administration. Additionally, Mercy had previously been affiliated with Northwestern University Medical School, and its credibility was an established fact.

³⁰ Dr. Robert Schmitz, former head of surgery and Chief of Staff at Mercy Hospital, interview by author, Chicago, Illinois, November 16, 1994.

Frustrations continued for Loyola Medical School administrators as they tried to negotiate with Mercy for more favorable teaching conditions. Much of the source of conflict with Mercy surrounded the financial arrangements for the Mercy Free Dispensary. The dispensary was visited by hundreds of patients a week; it was a major source of both clinical teaching and rancor over finances. As Dr. Schmitz noted when discussing the relations between Mercy Hospital and Loyola, "I was aware of the annual battle between the nuns and Loyola over who paid for what in that dispensary; there was always screaming about the budget."³¹ In the late 1940's, Loyola contributed \$550 per month to help defray the expenses of the dispensary; expenses, nevertheless, often exceeded \$1500 per month. Budgetary differences and differing goals were not the only sources of contention. There was the feeling among the administrators of Loyola that they were treated like second class citizens by Mercy³² and the sense by the Mercy sisters that Loyola had no real interest in their welfare. Excerpts from notes taken by the sisters of a meeting, December 19, 1949, between Dean Smith and Sr. Dolorosa, the Irish nun who was head of Mercy Hospital, clearly illustrates the difference between the two parties,

Dr. Smith felt the real problem is that we have been talking about two different things. He stated it was fantastic how much medical science and medical education has advanced in the past 16 years. . . . He knows the sisters feel that a hospital that has a long tradition should maintain its identity and independence. That is the view of the sisters. On the school side--due to the advances in medical education--we need a university hospital--a

³¹Ibid.

³²Lad Grapski, interview by author, Osprey, Florida, March 19, 1994.

teaching hospital--which is entirely different from what you want. The sisters feel this is an independent hospital. He stated that today a university hospital requires such strong control of the medical school, administration, finances, etc. that the other will not suffice.

Sister Dolorosa advised she feels this is complete domination and who wants that? She said that Mercy Hospital could never be a university hospital and that the sisters can not turn their hospital over to Loyola.

She said that no matter how much Mercy gives it is always give and give more.

Sister Dolorosa told Dr. Smith that she feels he is thinking only of the medical school and not the hospital.³³

The strong-willed Mercy nuns had for over a hundred years ministered to the needs of Chicagoans. They had not been deterred by streets of mud, cholera epidemics, the Great Fire nor pressure from the Jesuit community to join forces. The needs of these two institutions were so different that it was virtually impossible that they join forces and retain their respective autonomy.

Cardinal Stritch recognized the needs of Mercy for a new hospital building and Loyola for a new medical school and hoped to effect a compromise that would result in the two institutions building together. That seemed impossible when on May 7, 1947, the Chicago Tribune informed Chicago and surprised Loyola with the information that the Mercy Sisters had purchased property near the downtown campus of Northwestern University for the purpose of building a new hospital.

³³Notes of December 19, 1949 Meeting between Sr. Dolorosa and Dr. James Smith given to author by Sr. Gwendolyn, C.E.O. of Mercy Hospital.

Dual Fundraising Drives

At a Loyola University Board of Trustees meeting on May 13, 1947, Loyola came to the obvious conclusion that Loyola and Mercy would have to separate. Mercy could continue to function as an affiliate of Loyola (a hospital that provides some clinical clerkship opportunities for students), but it was apparent that Mercy had officially served notice that it did not want to serve as the main university hospital for Loyola. The board evaluated the situation "Mercy prefers to go it alone which would make it an affiliate rather than the teaching hospital of Loyola. The situation is really critical; here now we find ourselves without a hospital without a staff." ³⁴ At this time only three of the seventy-seven medical schools in the country did not have control of their own teaching hospital and only a few were not adjacent to their medical college facility.

Both institutions would now begin major fundraising drives, both headed by Cardinal Stritch, and both needing to solicit from the same Catholic community. Despite the seeming impossibility, Cardinal Stritch, throughout the drive, had hopes that the Mercy-Loyola marriage could be salvaged, and in spite of his leadership position in fund raising for the new downtown location of Mercy, it was his goal that they remain on the south side of Chicago. The impasse continued, but Stritch kept working to ensure a Mercy Hospital--Loyola union with Mercy building at their

³⁴Board of Trustees Minutes, Loyola University of Chicago, May 13, 1947.

present site, and Loyola erecting a new medical and dental school in the developing West Side Medical District.

Heading Mercy's fund drive for six million dollars was Mayor Edmund Kelly, and lending their public support to the Mercy cause were 150 prominent citizens of the city including Henry Crown, E. I. Cudahy, Richard J. Daley, Marshall Field, Joseph P. Kennedy, Werner Wieboldt and Arthur Wirtz. Meanwhile, Loyola was having difficulty even finding a prominent alumnus to spearhead its drive.³⁵ There seemed little doubt that Mercy was viewed as the institution of prominence, and that Loyola's campaign, though reflecting the wants of an equally needy institution, was not seen as an equally worthy institution by these prominent Catholic Chicagoans. The letter from Bishop James Griffin of Springfield to Fr. Gerald Grant typified the feelings of many,

While the general aims of the Loyola University Foundation from which I received a soliciting letter today, are laudable in the main, I feel that the University is in exceedingly bad taste by instituting its appeal for funds for the Medical and Dental units at a time when the Sisters of Mercy in Chicago are inaugurating a general drive for their new Hospital.

The two aims are so parallel in their scope that there cannot help but be a series of overlapping conflicts in the lists of proposed subscribers to each. Both drives will suffer. I happen to be acquainted with the extent to which the Sister of Mercy plan to canvas such prospective donors, and I cannot help but feel that your drive will cause a division of loyalties -- and a consequent diminution of individual contributions--on the part of those donors.

³⁵Board of Trustees Minutes, Loyola University of Chicago, June, 13, 1947.

It likewise seems to me that the people of Chicago owe a far greater debt to the Sisters of Mercy in their work in the medical field than they do to Loyola University. In the days when Chicago was beginning to struggle out of the mud and primitive conditions which characterized her early years, the Sisters of Mercy were on hand to provide their ministrations to the sick and infirm. Now, when they finally have a chance to garner a substantial reward from the descendants of those early Chicagoans, they are suddenly faced with competition from another source, a source which would do the cause of Catholic Medical advancement in Chicago a greater service, not by a competitive drive for funds, but by a generous contribution from Loyola University Medical and Dental Schools to the Sisters of Mercy's new Hospital.³⁶

Undaunted, the newly hired fund-raising firm of the American City Bureau began its solicitation of funds for Loyola in 1948. It delayed its drive, called the "Fulfilment Fund," until then so as not to directly conflict with the major portion of Mercy's appeal. Their ambitious initial goal of \$12 million dollars for the medical school would finance a much needed new building for the medical and dental schools and establish an endowment fund to be used for maintenance, equipment and research facilities all centered in the Medical Center District in the near west side.³⁷ Loyola's drive would attain its legitimacy in June of 1948, when Fr. James Hussey announced at the kick-off dinner for the Fulfilment Fund that the

³⁶Bishop James Griffin to Fr. Gerald Grant, S. J., June 25, 1947, AOC. Chancery Correspondence. Box F-16.

³⁷While the goal the medical school was twelve million dollars, the overall goal for the fund was twenty-four million. The additional twelve million would be used to meet the needs of the other colleges in the university.

newly named Stritch School of Medicine had received a one million dollar donation from its first great benefactor: Frank J. Lewis.

Frank J. Lewis and Fr. James Hussey, S.J.

Mr. Lewis's reputation as a generous Catholic benefactor was already well established in Chicago. He had previously donated the Tower Court Building (now Lewis Towers) to Loyola in 1946, and he donated funds to establish both Lewis College and Lewis Maternity Hospital. But, his largest donation occurred the night of June 15, 1948, and brought new hope that the medical school would survive. Mr. Lewis was born in Chicago in 1867, four years before the Great Fire. As a child he lived at La Salle and Adams, and the family farmed the land where the Merchandise Mart now is located. His plan had always been to go to medical school, but his father's death forced him to leave school and help support his mother and nine siblings. By the age of twenty, he had formed a successful tar company that would later grow to be the largest in the country. Just before the Depression, Lewis sold his company and for the remaining thirty-three years of his life devoted himself to philanthropy. His philosophy was simple; he felt that God had given him success so that he could share it with others. Many Catholic institutions in the city would benefit from the generosity of Mr. and Mrs. Lewis. For Loyola, Fr. Hussey played a pivotal role in securing this prodigious donation. The negotiations for the Tower Court building had been protracted and at times acrimonious, but Fr. Hussey never forgot an early statement by Lewis that his chief interest was

in medical education, and over the years Fr. Hussey would continue to remind Mr. Lewis of the great needs of the medical school.

Fr. Hussey was a slow-talking, easy-going, unpretentious man, who didn't let his wooden leg (the result of a childhood injury) slow him down.³⁸ He had a most difficult task; the demands on his office were many and his resources were few. His tenacious spirit kept the hope of the medical school alive even when members of the board of trustees and the archbishop suggested its closure. He was both a peace-keeper and a salesman as he kept philanthropist Frank Lewis and Archbishop Stritch interested in the welfare medical school while encouraging contentious factions at the medical college and Mercy Hospital to continue in their tenuous affiliation.

University Hospital

In 1948, a unique opportunity was given the medical school. Mrs. Marshall Davison, the widow of a prominent Chicago physician, contacted Fr. English and Dr. Smith asking if Loyola would be willing to take over a small private hospital at 432 Wolcott Avenue near the medical school. The hospital was slated to be torn down in several years for the Congress Expressway, but in desperate times, it was viewed as a unique opportunity to determine if the Stritch School of Medicine could support its own hospital. Presented with this option and faced with continual discord at Mercy Hospital, Dr. Smith rationalized the opportunity as follows:

³⁸Smith interview.

It was an old building that was destined to be condemned to make way for a new highway, but this would not happen for two or three years maybe more, and we thought that it might be a good place to start a good small university hospital and to try out the idea of our faculty getting used to teaching in a hospital of our own. Ultimately, it was our theory that this could grow into a later to be built true university hospital which the university so badly needed.³⁹

Loyola hired a young, very competent Catholic administrator who was a graduate of the University of Chicago School of Hospital Administration, Mr. Lad F. Grapsky. Dr. Smith had hoped with this hospital acquisition to strengthen the much maligned clinical teaching facilities of the medical school. To do this and to make the newly named University Hospital a success, he would need the cooperation of the clinical faculty (who were full-time physicians) to steer their patients to the new facility. After approximately a year's trial, Dr. Smith realized that the results were not what he had hoped for,

It ultimately didn't really work very well primarily because we had to rely, as all hospitals do, on the staff to fill beds to keep the hospital economically solvent. Almost the entire Mercy Hospital staff really were not interested and sort of boycotted the hospital, provided no patients, and thought that the University Hospital was going to be a threat and a competitor to Mercy.⁴⁰

Fr. Hussey became a man in the middle on this issue. The cardinal, the contributor of \$50,000 a year to the school, wanted the Mercy-Loyola relationship to work. Dr. Smith, who firmly believed that the relationship

³⁹Ibid.

⁴⁰Ibid.

would never sufficiently satisfy the accrediting agencies which expected medical schools to control their own hospital, fought for the viability of University Hospital. In the meantime, the medical school's Associate Dean for clinical teaching, Dr. Charles Thill, whose job it was to recruit staff for the University Hospital, was surreptitiously writing Fr. Hussey voluminous reports critical of Dr. Smith's policies and administration. Since these reports covered an extended period of time, it appears that Fr. Hussey did not discourage this correspondence. Dr. Thill's motivation was ostensibly distress that some new faculty members were hired at a higher salary, the desire to let Fr. Hussey know that he disapproved of the dean's policy which favored clinical teaching at the University Hospital, and the fear that if the pending inspection by the accreditors found the clinical teaching to be inadequate, he would be held responsible.⁴¹ Dr. Smith's very difficult task of convincing clinicians to support a new facility was obviously destined to fail when his primary associate worked so feverishly behind the scenes to erode any possible support.

Mr. Lad Grapski, the first administrator of the University Hospital, discussed the dilemma of University Hospital for university administration:

I wasn't really 100% sure that the university officials, and by that I mean the board and the university president, really knew what they wanted in the hospital and the medical school. To them it was a dream, but I don't think they knew how they were going to realize it, and they were using this as a mechanism to do it. I think there were some who felt they should have their own

⁴¹Charles Thill to Fr. James T. Hussey, LUCA, Office of the President. Fr. James Hussey. Box 11. Folder 7.

hospital and their own facilities to operate, and there were others who felt, no, maybe we should listen to the Cardinal and do something with Mercy. ⁴²

University Hospital was a festering sore for Fr. Hussey. It was a source of conflict with Cardinal Stritch and amongst the faculty; and yet somewhat a surprise in that it was operating in the black. ⁴³ Symptomatic of the quandary that University Hospital caused was Fr. Hussey's response when Dr. Smith received the medical school's first large federal grant from the National Institute of Health (\$450,000 to be used to develop the teaching and research facilities of University Hospital), "Fr. Hussey seemed disappointed."⁴⁴ Dr. Harry Oberhelman, the head of surgery for Loyola, succinctly summarized the situation at a faculty council meeting,

Policies change, administrators change, and as long as administrators cannot get together, I see no hope for the school. That is why the school is thirty years behind. Unless we can have a hospital that we can control, I don't see how we can go ahead.

Dr. Thill responded,

I agree with what has been said. I certainly feel that our problem is two-fold. We have an immediate problem for the next five years and a future problem, and I think it is absolutely essential that we have our own university hospital. In the immediate

⁴²Grapski interview.

⁴³Ibid.

⁴⁴Smith interview

problem, we do not need a teaching hospital and I think Mercy Hospital will meet our problem for the next five years.⁴⁵

Although perceived as a threat by some, the hospital succeeded in establishing the fact that financially a university-owned hospital, even under these very difficult circumstances, could be a profitable enterprise. Fr. Michael English wrote to Dr. Smith in 1951 and stated that "The University Hospital is filled; the time of financial stress is past; the profits will hit a high of \$10,000 this month."⁴⁶

For Dr. Smith, however, the University Hospital situation came to a crisis point at the close of 1949. Dr. Smith wrote yet another letter to Fr. Hussey encouraging him to commit to the development of a small university hospital with university control because the alternative of "depending on Mercy Hospital as the main teaching facility for private beds will certainly consign us to a permanent role of a second rate medical school giving second rate education."⁴⁷

Meanwhile, the cardinal was becoming increasingly agitated with Dr. Smith's dreams for the medical school. Remarks from the following letter that Cardinal Stritch sent to Fr. Hussey clearly indicate the cardinal's

⁴⁵School of Medicine, Council Committee Boards, June 10, 1949, LUCA. Box 1. Folder 14.

⁴⁶Michael I. English to James J. Smith, May 17, 1951, Personal Correspondence File of James Smith.

⁴⁷James J. Smith to Fr. James T. Hussey, December 15, 1949, Personal Files James J. Smith.

preference for Loyola to continue an association with Mercy and not develop their own university hospital

I know that there is an ideal in working out the program for the Medical School. The question in my mind is that we simply cannot foresee where we can get the money to realize in full this ideal. A good artist takes the media which he has at hand and does a masterpiece. It is all the greater because he does it with imperfect media. I think that we ought to try to use what we have at hand and succeed in working out our program. ⁴⁸

Faced with mounting pressure from the archdiocese, Fr. Hussey informed Dr. Smith:

It is the mind of the Board of Trustees that the means for working out plans which would result in a University Hospital are neither on hand or in the prospect. Accordingly, the Trustees believe that we have no alternative but to work out our problems at Mercy. Furthermore, it is the wish of the board that we comply wholeheartedly with the desires of His Eminence in this matter. ⁴⁹

The following are selected sections of Dr. Smith's articulate reply to Fr. Hussey's directive:

It is with the greatest regret that I must tender my resignation as Dean of the Stritch School of Medicine of Loyola University. I know that my purpose and yours is the same; that is, to develop a Catholic Medical School of which we may be justly proud. We have come a long way toward that goal in the last three and a half years through persistent hard work, risks, disappointments and many good breaks. However, from our recent discussions and your letter of Dec. 20th, I realize that you and the Board of Trustees cannot agree with my belief that the greatest need of our Medical School is

⁴⁸Samuel Cardinal Stritch to Fr. James T. Hussey, July 15, 1949, AOC. Chancery Correspondence. Box 10699.

⁴⁹James T. Hussey, S. J. to Dr. James J. Smith, December 20, 1949, Personal Correspondence File of James J. Smith.

real University Hospital and that an all out effort must be made to develop one at this opportune time.

The main point at issue, of course, is policy on the University Hospital. A medical school today needs , not as an eventual ideal but as a practical necessity, at least one small, true university hospital. The fact that practically all schools have it, is strong evidence of its need. Mercy Hospital does not, and in my opinion, never will meet this requirement, no matter how valuable it may be as a teaching adjunct. It is an independent hospital which in its own right has a long tradition. The Sisters, quite reasonably, will never cede to any other body the full control of their own hospital that is required.

Looking to the future of the school, I am sure that there has never been a time when I hoped more fervently that I was wrong. A good Catholic Medical School is truly a dire need of the Catholic educational system. Because they are so few, and currently beset by so many difficult problems, the welfare of the Stritch School of Medicine in the prominent Archdiocese of Chicago is of the utmost importance, not only to the Church and Catholic Education, but to the survival of the few remaining Catholic Medical Schools. There is no better reason than this why it must succeed; but also because in the last years its problems and its fate have been close to my heart, let me wish and pray with you for the very best success of the Medical School. ⁵⁰

When he came to the medical school, Dr. Smith had high hopes that Loyola could develop into a medical school on a par with the other Chicago medical institutions. These goals were probably unrealistic given the financial and affiliation constraints that burdened the school. His military background and relative youth left him impatient and ill-prepared for the delicate diplomacy this position required. He was not the

⁵⁰James J. Smith to Fr. James T. Hussey, S. J. , Personal Correspondence File of James J. Smith.

first at the medical school to trumpet the necessity for university control of a teaching hospital; he was, however, the first to resign his job defending that principle.

CHAPTER V

A CONTINUED SEARCH FOR SOLUTIONS: 1950-1959

For the nation, the post-war era was a time of economic growth and rising income. The populace had an inbred sense of confidence and optimism that this period of progress and prosperity would continue indefinitely. It was also a time when people believed that education was the key to success and that education and the hallowed research ethos could cure all problems.¹ In Chicago, the city development caused both prosperity and difficulty, as this still emerging metropolis would face serious post-war issues involving racial tensions, housing shortages, and difficult decisions regarding plans for neighborhood redevelopment and slum clearance.

The Stritch School of Medicine was exiting from the 1940's shrouded in uncertainty: financial, academic, accrediting, and affiliating. The prior ten years had been a continual struggle, not merely for respectability but for survival. At the mid-century mark, there was still no permanent university hospital, very few full-time clinical faculty and a facility that had been labeled inadequate as far back as 1917. The medical school was secretly on academic probation, had virtually no endowment, and had little hope of obtaining a firm financial base. Yet at the conclusion of the 1940's, there were some reasons for optimism: e.g. Frank Lewis' donation, Cardinal Stritch's annual

¹Richard J. Jensen, Illinois A Bicentennial History (New York: W. W. Norton and Co., 1978), 153-155.

assistance, the first federal grant, and an attempt at a university-controlled hospital. Indeed, despite significant handicaps, Loyola was responsible for providing 23 percent of the Chicago physicians.²

Changes at the Medical School

A New Dean - John Sheehan

When Dr. Smith left the Loyola Medical School deanship in January of 1950, Fr. Hussey turned to Dr. John Sheehan, a prominent pathologist on the staff of Mercy Hospital. Since much of the previous dissension stemmed from a distrust by administration and clinical faculty at Mercy toward the medical school administration, Fr. Hussey sought to allay fears by selecting a faculty member who was on Mercy's staff. Also Dr. Sheehan himself believed that his Jesuit training at both Holy Cross for undergraduate and Georgetown for medical school, had made him especially adept at understanding the Jesuit administrators and philosophy at Loyola University.³ As a teacher he was widely respected; as an administrator he was described as ascorbic, caustic, autocratic, and a despot; his domineering manner caused either total devotion or utter frustration.⁴ This totalitarian style served him well in his early term (he served as acting dean from

²Talk by Fr. Michael English, S. J., Regent of Loyola Medical School to Pastors in Archdiocese of Chicago, April 21, 1948, AOC. Chancery Correspondence. Box 10694.

³Dr. Matré interview.

⁴ Fr. Raymond Baumhart, interview by the author, Chicago, Illinois, October 1, 1994; Dr. Richard Matré interview, Dr. Paul Fox interview.

January, 1950, to July, 1951), as he was seen as a steadying force who fought to bring the school back from probation in the pursuit of improved academic standards.

Dr. Sheehan would serve the medical school for the next eighteen years. He faced, throughout the 1950's, continued questions of affiliation, accreditation, financial survival and relocation. Many felt that despite a personal style that some found offensive, he was very much responsible for the survival of the medical school through this continually turbulent era. The most striking observation about the decade of the 1950's, however, was how little the problems had really changed from the previous thirty years. The board of trustees was still all-Jesuit and determined to continue the medical school but without the ability to find long term solutions. Board members still sought financial solace from the cardinal. In the final analysis, the board still yearned for a relationship with Mercy, but Mercy still coveted the role of premier private hospital and thus resented the intrusion of Loyola.

The Closing of University Hospital

The University Hospital served as a continual reminder of the previous administration. Lad Grapski had proved to be an able administrator who turned a weak link into a financially successful institution. The trustees gave no indication that they saw this successfully run hospital to be a precursor to a hospital which, on a larger scale, might support a medical school teaching program. There was some indication that Dr. Sheehan and Fr. Wilmes (the regent for the Dental School) saw potential for a permanent

university controlled hospital for Loyola when, at a board of trustees meeting in February, 1950, they reported on their visit to Georgetown Medical School which operated a profitable private hospital in conjunction with its medical school. The board, nevertheless, felt that it did not have the financial resources to consider establishing its own hospital and thus dismissed the idea with little discussion.⁵ The University Hospital would close on August 15, 1951; however, Fr. Hussey noted at the March 9, 1950, meeting of the Board of Directors of the University Hospital, "At the University Hospital we have done something we did not know was possible. I am sure the Administration of the Medical School will work out plans to continue the good work at the University Hospital."⁶ Much of Fr. Hussey's dilemma concerning the success of this tiny hospital emanated from his dependence on Cardinal Stritch and the cardinal's concern that the physicians and administrators at Mercy viewed any attempt by Loyola to establish a clinical teaching situation under their own control as an attempt to undermine Mercy's position as the predominant teaching hospital for Loyola. So while the medical school needed the benevolence of the cardinal to continue, it found itself in a Catch-22 situation because that generosity limited the school's options in searching for other clinical possibilities. Fr. Hussey continued, "Whether we want to or not--we must work at Mercy. It is the express wish of the cardinal to work at

⁵Board of Trustees Minutes, Loyola University of Chicago, February 2, 1950.

⁶Minutes of the Eighth Meeting of the Board of Directors of the University Hospital an Illinois Corporation, March 9, 1950, LUCA. James F. Maguire Files. Box 22. File 8.

Mercy.”⁷ The same day that University Hospital closed Fr. English was transferred to Loyola University High School. He would, however, serve as a member of the Loyola Board of Trustees until 1955 and was one of the first of the trustees to have had direct experience in medical education. Although he spoke eloquently of the needs of the university to be aggressive in planning for the future of the medical school rather than reacting to each individual crisis, in reality, despite his legendary charisma, he was unable to effect real change after he left the medical school. When Fr. English departed, the position of regent was discontinued.

New Fund Raising Help

Despite the annual contribution of \$50,000 from the Archdiocese of Chicago and \$50,000 from the Frank Lewis Trust Fund, the school continued to be a financial drain on the university which contributed \$75,000 to cover its deficit in 1949. In 1950, the closing of the school was still a possibility as the school searched frantically for additional funds. Again board members sought assistance from their most reliable source--Cardinal Stritch. At a meeting at the cardinal's residence attended by the cardinal, Fr. Hussey, Fr. English, Dr. Sheehan and Dr. Moorhead (the former dean, personal physician and longtime medical school advisor to the cardinal), the discussion centered on different ways to stave off financial disaster. Cardinal Stritch suggested a charity dinner with the proceeds used to retire the annual medical school deficit. The nascent plan received enthusiastic support, and with the strategic

⁷Minutes of the Eighth Meeting of the Board of Directors of the University Hospital an Illinois Corporation, March 9, 1950, LUCA. Office of the President. James R. Maguire Files. Box 22. File 8.

help of the cardinal's staff and Dan Conroyd (of the Development Office of Loyola), the "Cardinal's Dinner" succeeded in annually generating large enough funds to cover the medical school's deficit for many years. This donation would range from \$100,00 in 1952 to \$230,000 in 1957, the year before the cardinal died. Another important consequence of the dinner was to raise the level of recognition for the medical school in the city. As Fr. Maguire (who became university president in 1955) pointed out, "I feel that the annual Cardinal's Dinner has proven to be a most effective method of deepening the appreciation on the part of well-informed Catholic laymen and women of the archdiocese of the importance of the Stritch School of Medicine in the apostolate of the church."⁸ There were, however, some individuals who expressed concern that the major amount of medical school revenue was coming from an impermanent source, Cardinal Stritch. No one doubted Cardinal Stritch's devotion to the medical school. There was, nevertheless, no guarantee that these monies would continue after Cardinal Stritch's tenure. Fr. Michael English stressed that point when he relayed his concerns to the board of trustees, "History shows that the archdiocese was generally indifferent until the time of the present cardinal." Fr. English, the minutes reveal, suggested that the board consider the question of what would happen to the school if this aid should stop, and also consider the relationship between diocesan control and help.⁹ There is no indication in the board of

⁸ Father James Maguire to Samuel Cardinal Stritch, November 25, 1958, AOC. Chancery Correspondence. Box 5618.

⁹Board of Trustees Minutes, Loyola University of Chicago. January 12, 1952.

trustee minutes that this issue or others concerning long-range plans were addressed.

Issues During the Fifties

Financial Difficulties--a National Problem

The fiduciary issues inherent with medical schools were complex, and these problems became more vexing in the 1950's as all medical schools, private and state supported, faced concerns of rampant inflation and the spiraling cost of medical education. In a report published in 1950 by the National Fund for Medical Education (headed by Herbert Hoover), the high cost of medical education, and the inability of most medical schools to meet this cost were recounted in great detail.¹⁰ In 1910, the tuition fees for medical school covered 75 percent of the cost of medical education; by 1950, tuition only covered 25 percent of the cost. In addition, of the seventy-eight medical colleges active in 1950, forty-eight operated with a deficit. Twenty-six of those schools operating in the red had deficits of over \$100,000.¹¹ Aside from this, the financial climate of the medical schools was effected by the post-war reality of the decline in individual philanthropy, the increasing burden of taxes, and a sharp rise in operating costs.¹² Parenthetically, in a separate report on Catholic medical education, the statistics showed that all five

¹⁰Lester Grant, Medical Education in the United States, (New York: National Fund for Medical Education, 1950).

¹¹Ibid., 16.

¹²Ibid., 7.

Catholic medical schools had deficits of over \$100,000: Creighton, \$171,425; Georgetown, \$148,000; Loyola, \$163,000; Marquette, \$131,329; and St. Louis, \$114,809.¹³

What was happening, therefore, at Loyola was symptomatic of a national crisis in medical education that threatened not merely the individual medical school but also the associated university. The rising deficits of the medical schools acted as drains on the universities as a whole, siphoning off funds from other parts of the institutions to sustain the medical portion of higher education. The Hoover Commission Report joined a growing chorus of voices which prompted the federal government to increase its presence in medical education. It was becoming increasingly evident that medical education was entering the modern era where change would be rapid, necessitating new and expensive equipment, facilities, techniques and training. Traditional sources of income would be insufficient to sustain the escalating costs. Furthermore, in the 1950's the Russian launching of Sputnik increased the demands placed on research to satisfy the national goal to excel in scientific exploration. All these factors were leading to the inevitable conclusion that the financial source for the future must be the federal government.

Results of Fund-Raising Drives

By the early 1950's, it became apparent that Loyola and Mercy's respective attempts to raise funds from individual donors would fall far short

¹³ Report Catholic Medical Education in the United States., Undated, LUCA. Office of the President. James Maguire. Box 31. Folder 7.

of their goals. In the 1940's both Mercy (Friends of Mercy) and Loyola (Fulfilment Fund) launched individual fund-raising campaigns, and even though these were their first such efforts to raise a large amount of money for their needs, both institutions had, at best, only moderate success. In 1952, Mercy announced the discontinuance of its Friends of Mercy Drive and its plan to build a hospital in the Fairbanks Court near north section of Chicago. In announcing the decision, the Sisters of Mercy noted physician concern about the location, parking issues, and expenses and the decision of the Veterans Administration to build a 1,000 bed hospital one block away as the reasons for abandoning this plan.¹⁴ The primary need to replace Mercy's outmoded facility still remained. The sisters would therefore place the \$2.5 million raised into an escrow account while the religious order continued to search for a new construction site.¹⁵ The tepid response to their campaign would force the sisters evaluate their options and several years later, once again, discuss with Loyola the goal of jointly building a hospital and medical school complex.

Shortly after Mercy had begun its Friends of Mercy campaign, Loyola undertook its own fund-raising efforts with an initial goal of \$12 million for the medical school and a long term goal of \$24 million to build additional classrooms and facilities on its other campuses. This inaugural, university-wide fund-raising attempt similarly yielded only lackluster results. According

¹⁴Ibid.

¹⁵Clough, *In Service to Chicago*, 75. They would sell this site to Continental Insurance Company for \$1.5 million (50 percent above their purchase price).

to a 1959 report, the total pledges amounted to \$5,114,489, including the \$1 million donation from Frank Lewis. The net cash figure in the Fulfilment Fund at that time was \$2,615,021.

The Frank Lewis donation was given to the medical college with only one stipulation: that Mr. Lewis, himself, would invest the money for the school.¹⁶ The original gift of \$1 million would be distributed in the first ten years (1948-1958) at a rate of \$50,000 per year, and for the remaining ten years (1958-1968), the medical school would receive quarterly checks of one-fortieth of the corpus. The generosity of Lewis was magnified by his shrewd insistence that he handle the investment. By the time the fund was closed-out in 1968, nearly \$7 million had made it into the needy coffers of the medical school.¹⁷

Continued Accrediting Issues

Accreditation was a constant problem from the 1930's through much of the 1960's. The accrediting agencies by this time had a tremendous amount of power; it was, of course, their mission to try to upgrade the standards of all the medical colleges. Every few years the Council of the American Medical Education of the American Medical Association and the Association of American Medical Colleges jointly inspected and accredited the Stritch School of Medicine. It became increasingly critical to obtain a favorable rating

¹⁶ Fr. James Maguire, S. J., interview by author, Chicago, Illinois, December 3, 1993.

¹⁷Ibid.

because the alternative was certain closure. The report by the Joint Commission reviewing the Stritch School of Medicine in November of 1952 stated, "The general status of the school is better today than in 1949. Nevertheless, there remain many real causes for concern." There were further notes on different aspects of the school's operation:

1. Financial--the school depends too heavily upon the funds raised by Cardinal Stritch. They noted that since this sizable donation (in excess of \$100,000) in 1952 continues now at the behest of the current cardinal. If the cardinal's successor discontinued the annual dinner, it would "constitute a serious blow which would jeopardize the whole educational program of the school."

2. Clerkship Training--third-and fourth-year students on varying rotations at affiliated hospitals (but principally Mercy and Cook County Hospitals) were not always supervised sufficiently, the main problem being, "lack of day to day supervision of students by experienced teachers of senior rank who are familiar with modern methods of medical clerkship training."

3. The facilities--described by those familiar with the Wolcott Avenue building as dilapidated, totally inadequate, dingy, and cramped,¹⁸ the reviewers stated the obvious: "It is evident that the school vitally needs new facilities if its healthy development is to continue."

4. Hospital--used by medical schools as the base of their clinical teaching, Loyola's situation had been inadequate from its beginning, "there is

¹⁸Fr. Wilmes interview.

an equal need for a modern well-staffed hospital which could serve as the major base for clinical teaching.”

5. Staff--the joint commission points out the very real consequence of a medical school burdened by obsolete facilities, lack of hospital and research possibilities. “It is difficult to obtain well qualified, seasoned teachers to fill vacancies in the full-time faculty, and it may be necessary to fill these appointments with young men who have only recently completed their graduate training.”¹⁹ Flexner, in 1910, set a standard of full-time clinical faculty, but Loyola’s many needs relegated this issue to a low priority.

In summary, the joint commission commended Dr. Sheehan for the gains made over the past several years, but, while its members felt that it was not necessary at this point to return Loyola to probationary status, it would monitor the school closely and hold another inspection in three years hence. If the clinical clerkships were not “developed to a point where they were more nearly comparable to the well developed clerkships that exist in most other medical schools today, serious questions will again have to be raised concerning the adequacy of this school’s teaching program.”²⁰ After each accreditation report the medical college and the administration either breathed a collective sigh of relief or scampered frantically to shore up

¹⁹Survey of Stritch School of Medicine of Loyola University by the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges, November 18-20, 1952, AOC. Chancery Correspondence. Box 10720.

²⁰Ibid.,.

defenses. Despite many areas of grave concern, there were apparently two main reasons why the accrediting agencies never forced the college to permanently shut its doors: First of all, the administration was continually and actively struggling to remedy its financial, facility and clinical problems. Dr. Richard Matre explained that “they fended it off time and again; they were always going to build a new center, first at the West Side Medical Center and then at Touhy and Carpenter. Then they would fend off the accreditors who would say it was okay since you are going to build. It wasn't that they were lying because they actually intended to move.”²¹ Secondly, from the agencies' perspective, they wanted very badly for the school to succeed. There was a perceived shortage of medical doctors, and since there were positive aspects to the medical school (for example, the teaching of the basic sciences), there existed the possibility that the problems could eventually be resolved. Thus the accreditors continued in their hope that the school would find the means to successfully address and remedy its areas of concern.

Possible Building Sites

The search for a permanent home for the medical school was a continual quest throughout the 1950's. What made that search so troublesome were the unknown factors, such as the location of the school, its connection with Mercy Hospital and the manner in which it would be financed.

²¹Dr. Richard Matré interview.

Chicago had set aside an area encompassing Cook County Hospital and the associated institutions known as the West Side Medical District. It was the hope of some city planners that this slum area would be revitalized by the development of a large medical center including the University of Illinois Medical School, the Stritch School of Medicine, Cook County Hospital, Presbyterian Hospital, Illinois Departments of Public Health and Welfare and other medical institutions. This site was never favored by Loyola or by the accrediting agencies, which pointed out the dangers inherent in concentrating medical facilities and "making them a vital target in case of atomic warfare."²²

Other sites were considered and rejected: the Clarendon Beach area was deemed unsuitable; the northside Loyola campus was too small; a golf course near Addison and Western was also discussed and dismissed. One additional location given serious consideration was the Mercy Hospital area where Cardinal Stritch, Frank Lewis and later Mayor Richard J. Daley all campaigned to have Mercy and Loyola build jointly.²³ Some speculated that if the medical school had built on the south side, Mr. Lewis would have contributed additional millions of dollars.²⁴ Finally, the selection process received a strong impetus when Fredrick Specht, president of Armour Co., and a member of Fr. Hussey's President's Council, paid for a professional

²² Loyola University Medical Center Information, LUCA. Office of the President. James Maguire. Box 15. File 15.

²³ Fr. Maguire interview.

²⁴ Dr. Schmitz interview.

survey of all suitable sites in the Chicago area. The study concluded that the ideal location was a fifty-six acre tract of land in Skokie on the west side of Carpenter Road south of Touhy Avenue. After prolonged contentious dealings with the local citizenry, which didn't want a medical school and hospital built in its suburb, the property was annexed by Chicago and rezoned. Eventually, Mercy Hospital agreed to move and build on this site, and plans for a medical school-hospital complex materialized. Once again there appeared a genuine possibility that Loyola and Mercy would join forces in erecting a Catholic medical center. For the next four years (from 1954-1958), Loyola and Mercy would negotiate over the specifics of a new contractual relationship.

Cardinal Stritch's behavior as a mediator may appear to be contradictory. While his chief goal had been to fashion a coalition between the venerable Catholic hospital and one of the five remaining Catholic medical schools in the country, he also recognized the importance of not abandoning the south side of Chicago where so many Catholics still resided. So while it would have been his choice to have both institutions housed on the south side to add to the area's stability, his *laissez faire* management style allowed both institutions the latitude to explore other options as long as they ultimately remain affiliated. Fr. Egan explained that the enigmatic Cardinal Stritch often appeared to vacillate and that, "you sometimes didn't know where he stood."²⁵

²⁵Fr. John Egan, interview by author, Chicago, Illinois, December 5, 1994.

From Loyola's perspective, there were several advantages to the northwest side location: the government considered this area in need of a hospital, and so Loyola would qualify for newly available federal funds for hospital construction. In addition, the proximity to the suburbs would make the site attractive for physicians and patients. In contrast, the West Side Medical Center, where some local politicians still wanted them to build, was crowded with hospitals and other medical care facilities and surrounded by an unattractive, run-down neighborhood. Dr. Sheehan had never been an enthusiastic supporter of building in the Mercy location. In a letter sent by Dr. Sheehan to Cardinal Stritch, he discussed the decision of another local hospital, Chicago Memorial, to leave the south side of Chicago, "This decision of the Chicago Memorial Hospital to move out of the blighted south side is, in my opinion, further indication of the doubt in many peoples' minds of any effective reconstruction in the area near Mercy Hospital."²⁶ In addition to concerns of safety and the future of this south side neighborhood, it was probable that, because of years of contentious exchanges between the two institutions, Loyola was hesitant to move into an enclave currently dominated by Mercy, fearing that it would always be negotiating from a position of weakness. There was, in any event, little sentiment at Loyola for such a move as indicated by the vote of the President's Council on possible sites: in favor of the northwest side--11; in favor of the west side medical

²⁶John Sheehan to Samuel Stritch, July 8, 1953, AOC. Chancery Correspondence. Box 5603.

center: 1; in favor of the south side: 1 (Frank Lewis).²⁷ Dr. John Sheehan, as was noted in the board of trustee minutes, was a strong proponent of the Touhy and Carpenter Avenue location.²⁸ Consequently, as 1954 ended, the university felt that it had a firm commitment for the building of a new medical school and a new Mercy Hospital on the northwest side of Chicago.

Race Based Issues

The struggle of the city and its institutions to adjust to the changing demographics affected the decision making processes during the transition era. It is no exaggeration to say that the Catholic Church in Chicago did little to foster racial equality during the era of Cardinal Stritch. In the city churches, there were pastors who spoke openly from the pulpit inciting fear among parishioners about the “colored” moving into their area.²⁹ Steven Avella points out that Stritch, who was born and raised in the South, was ill equipped temperamentally and philosophically to deal with racial issues.³⁰ Cardinal Mundelein, Stritch's predecessor, had started a policy of racial segregation in the Catholic schools of Chicago, and Stritch did not discourage the practice. White pastors in changing neighborhoods, “regularly directed

²⁷Fr. James T. Hussey to Cardinal Stritch, May 15, 1953, AOC. Chancery Correspondence. Box 5602.

²⁸Board of Trustees Minutes, Loyola University of Chicago. November 25, 1952.

²⁹Steven Avella, “Cardinal Meyer and the Era of Confidence” in Catholicism, Chicago Style (Chicago: Loyola University Press), 119.

³⁰Steven Avella, This Confident Church, (Notre Dame: Notre Dame University Press, 1992), 254.

black children to 'colored schools' usually some distance from their homes."³¹ Fr. John Egan, who worked with the archdiocesan Office of Urban Affairs in the 1950's, explained "The situation at that time was that blacks were to be restricted to their own areas where they were living. The pastors, generally speaking, with some few exceptions protected their neighborhood. The church was not only inactive in race relations--they were totally opposed to blacks' moving into their neighborhood."³²

This pattern would not escape the medical institutions. As was discussed previously, it was generally difficult for minorities to attend the medical school in its developmental years.³³ The hospitals also reflected the

³¹Ibid., 258.

³²Fr. Egan interview; segregation problems escalated when the Dan Ryan Expressway was built and thousands of residents were displaced. Public Housing was erected for the displaced Chicagoans, but aldermen could refuse to allow the building of such complexes in their districts. So the new housing went in districts that already had black alderman creating a situation which, Fr. Egan noted, "neither the church nor the city should have allowed."

³³Jews and females also faced discrimination. In an interesting letter Fr. George Warth, S. J., March 18, 1937 George Warth to Mr. J. L. Markley, LUCA, School of Medicine, Office of the Regent. George Warth. Box 3 File 2. "The case of the young lady about whom you wrote is very interesting. I wish I could answer that this matter could be arranged for her. However, it is my honest opinion that this girl should be thoroughly discouraged about following a medical career. It would seem from your letter that she owes it to her mother to remain in some position whereby she could be of financial help. Even if such were not the case she is at present too young to know her mind. Many girls have thought they would like to be doctors and with greater maturity have seen that it was only a childish whim. In the interview by the author with Fr. Baumhart, he commented that Sheehan as dean would personally select the token two females who would be admitted to each class. Loyola was a Catholic institution which also restricted admission to those of Jewish faith during the developmental years; Dean Francis Braceland to Samuel K. Wilson, S. J. November 22, 1941. LUCA.

ethos of the era; Lewis Memorial Hospital administrators did not want black women to have the use of their facilities.³⁴ In a letter to the cardinal the director of the hospital decried the increasing number of black women who sought service in the hospital.³⁵ Mercy hospital followed a similar pattern, “there was the question of admitting Blacks which the sisters didn't want and which is something they did not want known.”³⁶ Cardinal Stritch received a report in 1955 detailing that of the fifteen Catholic hospitals (out of 22) from which information was available only one, Alexian Brothers, practiced nondiscrimination.³⁷ In an address to the Cook County Physicians Association in 1950, incoming president, A. M. Mercer, passionately described some of the harsh realities for blacks in medicine at this time,

Negro Catholics have no personal rights to lose when it comes to their health. They cannot enter a Catholic hospital like other Catholics. They can enter provided they submit in humility to segregation and discrimination.

A white atheist doctor has a much better chance of joining their staffs than a qualified Catholic Negro doctor.

Office of the President. Samuel K. Wilson. Box 4. File 6. Dr. Braceland writes to Fr. Wilson: We are already besieged by an epidemic of Jewish applications for next year. The worst of it is that they are apparently all good students with high aptitude tests.

³⁴Dr. Avella interview.

³⁵Sr. Marguerite de Montmartre to Samuel Cardinal Stritch, January 9, 1954, AOC. Chancery Correspondence. Box 5607.

³⁶Dr. Avella interview

³⁷Avella, This Confident Church, 279.

In 1947, of forty-two accredited hospitals investigated in Chicago, not a single Negro doctor was allowed to treat patients in any of them. I believe medical historians in future years will look back upon the policies of the A.M.A. and the American Hospital Association as they affect Negroes today as barbaric and unworthy of any organization in a civilized Christian nation. It is a paradoxical fact that the two professions in which Christ was engaged: the saving of souls and the healing of the sick are the last in America to eliminate the color barrier.³⁸

Dr. Mercer in his speech goes on to note that there had been some progress in recent years including the addition of John B. Hall, a Black physician, to the faculty at Stritch.

1955-1960

New Leadership at the University

As 1955 began, Dr. Sheehan must have felt secure that finally there were a new hospital and medical school on the horizon. For the present, as in the past, however, this Mercy-Loyola coalition would not run smoothly. Also occurring in 1955 was the ascension of a new university president, Fr. James F. Maguire. Fr. Hussey's devotion to medical education had enabled the Stritch School of Medicine to survive for the ten years of his term. Were it not for his commitment and dogged determination, surely the medical school would only be a memory. The university itself was making the transition from a small operation to a major force having grown to over 8,000 students, almost double its pre-World War II enrollment. Now there would be new leadership, bold new ideas, openness to input from sources outside

³⁸A.M. Mercer to the Cook County Physicians Association January, 1950, AOC. Chancery Correspondence. Box 10712.

the university, and a willingness to raise funds aggressively. Fr. Maguire arrived after serving six years at Xavier University in Cincinnati where he was considered, "the best builder in the school's 125 year history."³⁹ When fifteen years later he would leave the presidency of Loyola to become its Chancellor, that same description could be used to describe his term at Loyola. Born on the west side of Chicago, one of nine children, he had attended St. Ignatius High School in the city. A thoughtful, trim man of great energy and enthusiasm, he was a take-charge administrator and indefatigable fund-raiser who quickly became absorbed in the problems of the medical school.

Mercy - Loyola Negotiations

Negotiations between Mercy and Loyola proceeded slowly over the next several years while the medical college remained "barely within the limits of academic respectability."⁴⁰ Talks proceeded in order to ensure an affiliation that would be mutually beneficial to the hospital and the medical school; however, the hospital made severe demands. It wanted the university to guarantee an 80 percent occupancy rate; furthermore, the hospital feared being over-shadowed or swallowed by the medical center.⁴¹ On the other hand, the medical school sought guarantees concerning control of the clinical teaching program and provisions for research access.

³⁹"Loyola's New Prexy Glad to 'Come Home'. Chicago Daily News August 2, 1955, Section 1, Page 6.

⁴⁰Fr. Baumhart interview.

⁴¹Board of Trustees Minutes, Loyola University of Chicago, March 23, 1957.

Discussions became more acrimonious when in July, 1956 Mercy Hospital hired the well-known hospital consultant from New York, Dr. Anthony Rourke, to represent them in the deliberations. After a review by Dr. Rourke, what had been seven items of discussion turned into a detailed proposal consisting of ninety-four separate negotiable points. For over a year, a negotiating team from both sides made proposals and counter proposals. Eventually, Fr. Maguire reported that he "approved all compromises made."⁴² If he was optimistic, this optimism would soon fade.

Loss of Loyola's Greatest Supporter

Matters became worse in March of 1958 when Cardinal Stritch was abruptly reassigned to Rome to serve as pro-prefect to the Congregation for the Propagation of the Faith. At first Cardinal Stritch hoped for a reversal of his appointment citing his lack of knowledge in the area of his new assignment and pleading poor health. The Vatican was unmoved and Cardinal Stritch agreed to travel to Rome.⁴³ Enroute he became ill, suffering from a blood clot that would force the amputation of his right arm soon after his arrival in Rome. The following month, while recuperating from this surgery, Samuel Cardinal Stritch suffered a major stroke from which he was unable to recover and on May 27, 1958, the Cardinal died. Loyola had lost its greatest supporter and most loyal friend. Of further consequence, there was

⁴²Report on the History of Loyola Medical School. LUCA. Office of the President. James Maguire. Box 1. File 12.

⁴³Skerrett, Kantowicz and Avella, Catholicism, Chicago Style, 115; Avella, This Confident Church, 6.

no guarantee that the new archbishop of Chicago would continue to support the medical school. The position of head of the largest Catholic archdiocese in the country would remain vacant until November 15, 1958 when Archbishop Albert Meyer took office. The death of Cardinal Stritch and the absence of church leadership combined to leave the medical school in limbo for over six months, causing the cancellation of the annual fund-raising banquet.

Two weeks before he left for Rome, Cardinal Stritch held a final meeting with Fr. Maguire and Dean Sheehan in which he startled the participants with the news that the Mercy Sisters decided to remain on the south side and "all possibility of a permanent affiliation as the teaching hospital of the Stritch School of Medicine was out of the question."⁴⁴ This decision put Loyola in a precarious position with the accreditors, and although Mercy would continue for a short time as an affiliate hospital of Loyola, Mercy's action placed the medical school in peril. In retrospect, it seemed evident that the Mercy Sisters had never actively desired a relationship with Loyola, especially one that would threaten their autonomy.⁴⁵ It seemed clear, however, that the most salient reason for Mercy's reversal was the Mercy doctors. As Dr. Matré noted, "it sounded good until the doctors suddenly realized that they had to put their patients there; the doctors, the ultimate source for filling the hospital beds, did not want

⁴⁴James F. Maguire to Albert Meyer, General Collection: Medical School, LUCA. Memorandum 2 Page 4. Box 1.

⁴⁵As Sr. Gwendolyn pointed out, however, in contrast to the Loyola relationship, archdiocesan support of Mercy Hospital never meant any financial provision for the hospital.

patients in a hospital in the north side of the city far away from their homes."⁴⁶ In fact, a survey of the Mercy staff revealed that eighty-six of the one hundred fourteen doctors did not favor the move to Skokie.⁴⁷ The base of support of these physicians had been the south side's white, Catholic communities. In the final analysis, they recognized the best way to serve their constituents was to remain in that part of city where they had been established for many years.

Father John Egan, of the office of Urban Affairs of the Archdiocese of Chicago, attended the meeting during which Mercy Hospital reached the decision to remain near on the south side. The Mercy structure was old and dilapidated; there was no question that they were in need of a new home. The only issues to be decided was where and whether they would build with Loyola. The sisters were becoming increasingly hesitant to move and wary of joining forces with the medical school. Two city projects, the building of the Stevenson Expressway and the Land Clearance Commission, helped convince the Mercy sisters to remain. Fr. Egan reported on the meeting:

So Sr. Huberta, a very wise woman, was at the head of the table and Mr. Doyle (the director of the Land Clearance Commission) was at the other end and I made the pitch that it is very important for the archdiocese, the people of this area and the whole city of Chicago for the hospital to remain on the south side. I explained that when the expressway comes through there, and, of course, it is hard for the sisters to imagine the expressway when there are buildings and

⁴⁶Dr. Matré interview.

⁴⁷Paper titled Tabulated Results from Questionnaire Mailed to Mercy Hospital Staff Regarding the Move of Mercy Hospital to Skokie Area. Sr. Gwendolyn's Personal Files.

everything else there, but I said when the expressway comes through Mercy Hospital will be available within forty-five minutes to every area of metropolitan Chicago. It will be a most strategic place. Sister Huberta believed the expressway would come and said that she would be happy to stay if there was property that they could afford to expand on because they needed radiation labs, a new hospital, and parking.

Fr. Egan knowing that this land was owned by the Land Clearance

Commission asked Phil Doyle how much the two blocks of land from the hospital to Michigan Avenue would cost the sisters. Mr. Doyle offered the land for approximately sixty-five cents a square foot. Fr. Egan continued his story

So I figured it out and said to sister for those two blocks it would cost you \$250,000. They were all stunned. They said that in that event we would certainly love to have it if that is all it is going to cost us. The deal was made; they could stay there and from then on I got the finest treatment at Mercy Hospital. ⁴⁸

The loss of a teaching hospital would, however, place the medical school in a severe dilemma: how to rally the faculty, alumni and the city around an institution which appeared to be on the brink of losing its accreditation. The faculty by 1957 had also reached the end of its patience with hallow university promises. They had grown weary of the continual assurance that a new medical school building was imminent. When Lad Grapski came to the medical school in 1948, he had been told that a new building was coming soon, but now ten years later that vision was no closer.⁴⁹ Because the dean and university administrators believed that the current

⁴⁸Fr. Egan interview.

⁴⁹Mr. Grapsky interview.

building was only temporary, much needed repairs were delayed. This made it increasingly difficult to attract new faculty and retain current faculty. Meanwhile, the deficit continued to expand; in 1957, Cardinal Stritch contributed \$230,000 to sustain the medical school.

Cardinal Stritch was deeply saddened that his great hope of a unified Mercy and Loyola would never come to fruition. During his eighteen years as the archbishop of Chicago, he worked tirelessly to broker an effective relationship between these two Catholic institutions. It was certainly a great disappointment for him to leave Chicago with the viability of Loyola Medical School and Catholic medical education in the city in doubt. However, at that very important final meeting with the medical and administrative leaders from the university, he proposed that the school erect their own university hospital in conjunction with the medical school on the northwest site, and he admonished Fr. Maguire to "investigate the possibility of outstanding business and professional men incorporating a hospital to form with the university medical school--a new medical center."⁵⁰ Even as his final days in Chicago drew to a close, Samuel Cardinal Stritch was charting the course for the future of the medical school.

Soon after Archbishop Meyer assumed office, he was visited by Fr. Maguire, who presented detailed memoranda explaining the history of the medical school, its search for new quarters, its overall financial needs, long standing record of archdiocesan support, and the urgency for action in light of

⁵⁰James F. Maguire, S. J., to Albert G. Meyer, General Collection: Medical School, Nov. 24 , 1958. LUCA. p.1. Box 1.

the impending review of the medical school by the American Association of Medical Colleges and the American Medical Association.⁵¹ Boldly, Fr. Maguire broached the suggestion that the new archbishop spearhead a fundraising drive for a new medical center using the following terms:

It is our conviction that with archdiocesan initiative and promotion a Cardinal Stritch Memorial Medical Center would have great appeal to the faithful of the archdiocese. It would also, they feel, because of the sustained dramatic impact of his Eminence's appointment to the Roman Curia, his illness, surgery, death and funeral, appeal to Chicagoans of other faiths.

It is the feeling of these men that through a memorial that corresponds to His Eminence's generally known concern for a great Catholic medical center in the archdiocese, Cardinal Stritch can in death greatly aid "in working out a plan which will correspond with his hopes and prayers." The University Trustees share the opinion of the members of the President's Council that the faithful generally and citizens of all faiths will consider a Cardinal Stritch Memorial Medical Center to be the most fitting memorial to a spiritual leader whose annual "Cardinal's Dinner" evidenced his consuming interest in medical education under religious auspices.⁵²

After giving much thought to the needs of the medical school and the needs of the Catholic community at large, Archbishop Meyer informed Fr. Maguire that the diocese would not lead an appeal for a new medical center and would no longer support the "Cardinal's Dinner," because of the archbishop's commitments to the parish expansion project and to the construction program for elementary and secondary schools. He did not wish totally and suddenly to abandon the medical school, recognizing full well that this would mean a certain end to the school. So after additional

⁵¹Ibid.

⁵²Ibid., 9.

discussions with Fr. Maguire, Archbishop Meyer agreed to continue to support the medical school for the next five years with an annual donation of \$230,000. This was the amount given in the final year of Cardinal Stritch's leadership in Chicago. The university was relieved, but it was evident that new sources of income, and a new hospital affiliation arrangement had to be procured. Time was running out. In March of 1959, Loyola received its evaluation by the accreditation agencies. Again, they found problems in several areas including the lack of a teaching hospital and a limited number of full-time clinical faculty. Since, in the view of the accreditors, the medical school continued striving to improve itself; it was once again awarded a conditional three year (rather than the optimum seven year) approval with the accreditors again insisting that the medical school improve its clinical teaching arrangements.⁵³

The Faculty and Alumni Committee on Medical School Planning

With limited resources and few options available, Fr. Maguire sought input from the broader university community as he searched for solutions to the increasingly vexing medical school dilemma. In May of 1959, the university president revealed to the general faculty of the Stritch School of Medicine that Mercy had decided to continue on the south side and announced the appointment of a committee of faculty and alumni to receive

⁵³John Sheehan, "Annual Report of the Dean of the Medical School 1958-59", Office of the President Annual Reports Collection: 1958-1959, LUCA. Box 2. File 3.

and study proposals for the future of the medical school.⁵⁴ This was the first time that university administrators reached out beyond their small circle to elicit input from the faculty and alumni at large to address medical school issues. Many faculty had in recent years expressed frustration with the slow pace of progress in establishing a new facility. With Mercy no longer in the picture, the university would now concentrate on the possibility of building its own medical center with a medical school and a hospital. Fr. Maguire recognized that to achieve this he would need the support of the faculty at the medical school. Hence the Faculty-Alumni Committee for Medical School Planning was organized. It was co-chaired by Dr. John Madden, Chairman of the Department of Neurology and Psychiatry, and Dr. James Callahan, Chairman of Bone and Joint Surgery. The twenty person committee was charged with evaluating proposals from the faculty, alumni and other interested parties with two objectives:

1. To present to the Loyola University Board of Trustees a realistic plan for securing funds to guarantee the long-range operation of the medical school at a level which would assure the accrediting agencies that adequate educational and research programs could be maintained.
2. To demonstrate to the satisfaction of the University Board of Trustees that within one year an affiliation agreement satisfactory to accrediting agencies can be arranged between the medical school and (a) an existing hospital, in the Chicago area, or (b) a projected new

⁵⁴Board of Trustee Minutes, Loyola University of Chicago. April 6, 1959,

hospital, the erection of which would be assured within the next three or four years.⁵⁵

The committee held a series of meetings from June to September of 1959 and reached five main conclusions:

1. The university should achieve operational budget balance by organizing at once a) an Annual Medical Alumni Fund, and b) an annual civic benefit dinner for the medical school.
2. The university should attempt to interest a group of business and professional men to serve as the board of directors to build and operate a teaching hospital that will conform to the standards of the medical accrediting association.
3. The board of directors of the teaching hospital should approach foundations, corporations and individual donors for the funds required for the teaching hospital.
4. In the very near future the university should solicit from foundations and prospective large donors the funds required for the construction of a basic science (medical school) building.
5. The desirability of erecting the proposed medical center on property now owned by the university on the northwest side was confirmed; the basis for selecting this area has already been

⁵⁵Maguire Medical Alumni Reports. Excerpts from Remarks by James F. Maguire and Dean Sheehan on the Recent History and Future of the Stritch School of Medicine, p. 15, LUCA. Box 15. File 11.

presented to the alumni, and they noted "There is still a possibility that another site, not on the south side or in the west side may prove to be desirable."⁵⁶

The final product of this committee gave Fr. Maguire a mandate to solicit funds from alumni, corporations and foundations for the purpose of erecting a teaching hospital. It was now an accepted fact that Loyola needed its own facility. However, their solutions proved in part to be unrealistic. Large donors and benefactors were willing to serve on the board of directors but they expressed no interest in purchasing or supplying the financial resources for erecting a hospital. Two other recommendations: soliciting alumni and promoting an annual banquet (to replace the highly successful Cardinal's Dinner), would prove to be financial successes.

The committee's fifth recommendation, directing the building of the proposed medical center on the property currently held by the university near Skokie or "on another site," was prophetic. The possibility of surplus government land at Hines Hospital in Maywood becoming available had recently surfaced. Not yet a certainty in 1959, this land would eventually catapult Loyola into the modern era of medicine. Loyola's future partner on this journey was not mentioned in the committee's conclusions. For several decades Loyola's ally in the pursuit of a high caliber medical program had been the Archdiocese of Chicago. With the passing of Cardinal Stritch, the

⁵⁶James Maguire to Albert Meyer, Sept. 23, 1959, LUCA. The Medical Alumni Report #4. Final Report and Recommendations of the Faculty Alumni Committee on Medical School Planning. p.3, Box 15. File 15;

new priorities of Cardinal Meyer, and medical education expenses and demands increasing exponentially, the medical school was in need of a new partner which could satisfy its financial needs. Fortunately for Loyola, the federal government was waiting in the wings.

CHAPTER VI
LOYOLA MEDICAL EDUCATION IN THE MODERN ERA

The Maywood Connection

On May 5, 1959 the Chicago American hypothesized that because of Mercy Hospital's decision to remain in its present location, the Stritch School of Medicine probably only had three alternatives: to go it alone in the Skokie area, to join Mercy Hospital in the south side, or to expand at their present West Side Medical Center location.¹ The college, however, had another very promising option. It was a well kept secret that, as early as the fall of 1958, Fr. Maguire and Dean Sheehan became aware of another parcel of land. There was the possibility of property adjacent to Hines Veterans' Hospital becoming available to Loyola University if it agreed to construct a medical school there in conjunction with the existing veterans' hospital. It would be necessary, however, for Loyola to erect an additional hospital within five or six years to "provide care for and medical training with women and children."² The possibilities were tremendous, but there were many unknowns. For the sixty to eighty acre property to be available, Congress needed to act on their plan to

¹"Mercy Hospital Plans Upset Stritch School," Chicago American May 5, 1959, Section 1, p. 3.

²James Maguire to Albert Meyer, November 24, 1959, LUCA. General Collection: Medical School. Box 1 .

allow for disposal of excess V. A. property. Federal and state agencies would have priority over a private institution (such as Loyola) in acquiring surplus property; and there would likely be interested groups who would oppose the transfer of public land for Catholic hospital and medical school purposes.³

Father Maguire noted that this location (close to the Eisenhower Expressway and at the gateway to the rapidly growing western suburbs) was ideal for Loyola to construct a medical center, but first he had to raise the money. A consulting firm had compiled a list of twenty-four people who might be interested in donating \$5-6 million of the \$18 million believed to be necessary for construction. Despite extensive canvassing, Fr. Maguire found little interest among this group.⁴ The administration continued to vigorously search for funds. Large benefactors were reluctant, but the medical school's recently inaugurated appeal to the alumni, the Loyola Medical Loyalty Fund, had raised over \$140,000 from November, 1959 and June, 1961 placing, "it second only to Harvard medical alumni who, in 1959, contributed \$176,000."⁵

³James F. Maguire, S. J to John L. Keeley. December 11, 1978, LUCA. James F. Maguire. Chancellor Emeritus Correspondence 1978-1990.

⁴Board of Trustees Minutes, Loyola University of Chicago, March 25, 1963.

⁵Notes for Executive Committee Meeting, Stritch School of Medicine Dinner, September 15, 1960, LUCA. Office of the President. James Maguire Box 23. File 9.

In June of 1961 Fr. Maguire informed Cardinal Meyer that Loyola would build a medical center on the property at Hines Hospital.⁶ This correspondence with Cardinal Meyer was the official notification of Loyola's proposed course of action; more importantly, it was the symbolic end to the Loyola dependence on the archdiocese. Loyola's new partner would be the federal government.

The Hines Property

The acreage that Loyola Medical School now pursued had an interesting history dating back to 1915 when some farsighted businessmen erected a grandstand, constructed a two mile oval (made of wooden planks), and entertained an estimated 150,000 people with the newest craze--speedway racing. The winning race time was an impressive ninety-eight miles per hour. The needs of World War I and the subsequent gas and rubber shortages ended the racing and changed the purpose for the land. Edward Hines, Sr., a wealthy local lumber man, bought the site and built a hospital to honor his son and serve the needs of the World War I wounded. Edward Hines, Jr. was born and raised in Chicago, attended Yale University, enlisted in the Army and was only twenty-one years old when he fell ill and died in France. Devastated by the death of his son, the senior Hines donated \$1,190,000 of the original \$1,600,000 building costs. The federal government and the newly

⁶James Maguire to Albert Meyer June 29, 1961, LUCA. Office of the President. James Maguire Collection. Box 4. File 34.

formed Veterans' Bureau later took over the hospital and opened it to returning war wounded in 1921.⁷

The land surrounding the veterans' hospital found a different and varied use. On April 25, 1926 the famous aviator, Charles A. Lindbergh, taxied down a runway (located on the land that is now Loyola University Medical Center) and headed for St. Louis to complete the first airmail flight on the Chicago to St. Louis route. ⁸ Since 1919 when the U.S. Post Office decided that the winds from Lake Michigan made landings in that vicinity too hazardous for their small airmail delivery planes, they had been landing on the vacant land near Hines Hospital. Hangars were built and the Maywood location soon became the repair and maintenance hub for the entire United States airmail fleet.

Loyola and the Hines Property

Forty years later this parcel of land would be released by the government to become the site for Loyola's modern medical center. By the end of the 1950's, Loyola was positioned (although still precariously) for a movement into the modern age of medicine. The university had shrugged off the odds and remained accredited (albeit conditionally), and its financial stability had been ensured (at least for the near term) by Cardinal Meyer. In addition, at the head of the university was Fr. James Maguire, a successful

⁷Allard, Loyola Orthopedics, 65-66.

⁸Ann T. Serb, "The Historic Ghosts of Loyola's Medical Center," Loyola Magazine, (Spring, 1991) : 16-18.

fund-raiser who did not hesitate to beg for medical school funds, and who was also willing to accept the risk of indebtedness to build the university. In addition, the dean, Dr. Sheehan, was a consummate salesman; Fr. Baumhart stressed Dr. Sheehan's importance:

without Dr. Sheehan there would never have been a medical center--by far the single most influential person in persuading Fr. Maguire and the board of trustees, all of whom were Jesuit at the time, to pursue the present course. To start the medical center was an incredibly risky thing, the biggest in the history of the university. . . .and he persuaded them to do it.⁹

The Kennedy Administration

Fr. Raymond Baumhart explained how the Veterans' Administration land finally and officially became available to Loyola,

Jack Gleason, a Catholic from Chicago, became the head of the Veterans Administration while John Kennedy was president, and he persuaded the president that it would be a way of strengthening the V.A. hospitals in the United States if each of them would be linked closely with a medical school. Kennedy bought that idea and the first transfer of land after that was to Loyola Medical School which was to get the 62 acres in unincorporated Cook County.¹⁰

On February 6, 1962 Loyola made formal application to the Secretary of Health, Education and Welfare for the transfer of acreage at the Hines Veterans' Hospital for the purpose of erecting Loyola University Medical Center. This land, valued at \$4,778,000, was deeded to Loyola for one dollar. ¹¹

⁹Fr. Baumhart interview.

¹⁰Ibid.

¹¹Board of Trustees Meeting, Loyola University of Chicago, Feb. 6, 1962.

Thus after nearly fifty years of instability, Loyola began the process that would enable it to provide patient care, research and medical education in a state-of-the-art facility. Construction began in 1965. The medical school opened in January of 1967 and the 451 bed hospital commenced operations on May 21, 1969. In addition, the Loyola University Dental School would move there and the State of Illinois' Madden Mental Health Center would open on the thirty-one acres adjoining the medical center.¹²

There would be many years of struggle before Loyola would achieve financial security at their new home. In fact, John Sheehan noted in his 1967 annual report, "the wisdom of choosing to build Loyola University Medical Center at Hines has been amply attested to. There is another major consideration--the attractiveness to the state of Illinois of these facilities in the event absorption by the state should prove advisable."¹³ The size of the financial risk to the university cannot be overestimated. The original estimate of \$18 million quickly became unrealistic. Construction delays forced the cost of the project to rise from \$21 to \$35 million before building even began. By 1970 after both the medical school and the hospital opened, the assets of the rest of the university were \$45 million; the assets of the medical school were also \$45 million. By building a medical center the size of the university's assets doubled. The university invested as much money as it

¹² John J. Madden M.D. for whom the Madden Mental Health Center is named was a distinguished Chicago neuropsychiatrist who served as chairman of the Department of Psychiatry and Neurology at Loyola University's Stritch School of Medicine from 1941-1962.

¹³Fr. Baumhart talk to the faculty at Stritch School of Medicine, January 15, 1993.

had accumulated in its first ninety years of existence.¹⁴ When the hospital opened in 1969, the beginning was slow and difficult. That year the hospital was losing over \$15,000 a day. It would continue to lose money until fiscal 1975 when the total accumulated deficit reached \$7.7 million.¹⁵

Replacing Dr. Sheehan

In addition to the overwhelming financial concerns, Fr. Maguire was now forced to deal with the festering question of leadership at the medical center. In early 1968 at Father Maguire's behest, a team of three outside doctors reviewed the center's progress. They advised Fr. Maguire that because of the personality of John Sheehan (who was serving as both the dean of the medical school and vice-president of the medical center) the medical center was having difficulty filling key clinical positions, and it probably would not open on time. In the summer of that year (1968), management consultants from Touche Ross reviewed the situation and informed Fr. Maguire that Dr. Sheehan was without key people. Possible recruits were avoiding Sheehan because no one could work with him.¹⁶ Delays in the opening of the hospital would put the university in serious financial jeopardy. So Fr. Maguire came to the reluctant conclusion that Dr. Sheehan would have to be replaced. This was a very difficult decision for the university president. Personally, he had great respect for Dr. Sheehan, but Fr. Maguire elected to put the needs of the

¹⁴Ibid.

¹⁵Fr. Baumhart interview.

¹⁶Dr. Matré interview; Fr. Baumhart interview.

university ahead of all other considerations. In Fr. Maguire's view, "John Sheehan was a genius. He saw so many possibilities that he hesitated to have a subordinate make a decision. We needed to get things moving; the project was stalled and the hospital was not going to open."¹⁷ Feeling he had little alternative in October, 1969, Fr. Maguire offered Dr. Sheehan a new position as his advisor on medical center matters and asked Fr. Raymond Baumhart to become acting vice-president of the medical center. Fr. Baumhart, who had earned doctorate in business from Harvard, had served as dean of the business school for the past four years; he brought to the medical center the business acumen and administrative skills necessary at this critical time. Informed on a Friday, the shattered Dr. Sheehan now suddenly cleaned out all of his files over the weekend leaving his successor and Loyola with only the information contained in one small manila folder. He never returned. His strong-willed commitment to the medical school had sustained the school through his eighteen year tenure. However, his autocratic manner was not suited to the present management job. In an intriguing analysis, Fr. Baumhart noted, "he was not a modern egalitarian . . . in a way in Catholic colleges and universities because they are Catholic and (because the Catholic church is so authoritarian) it is easier to abuse authority than in other places because people expect authoritarianism in a Catholic college or university."¹⁸ A bitterly disappointed Dr. Sheehan refused later efforts to by Loyola

¹⁷Fr. Maguire interview.

¹⁸Fr. Baumhart interview. Dr. Sheehan relocated to California where he worked for the Veterans Administration.

administrators to, as Fr. Baumhart described, “come and see what a great thing has happened from his original vision.”¹⁹

Government's Role in the Medical Center Development

In the 1948 “Questions and Answers” pamphlet printed to publicize the Loyola University Fulfilment Fund, a question was asked, “Is either State or Federal aid available to help pay the cost of constructing and equipping a Medical and Dental building?”²⁰ The 1948 answer was an emphatic no! In the approximately twenty years that lapsed before Loyola would build its medical center, that answer would be changed to an emphatic yes! The final cost estimates of the medical complex reached \$34 million--the federal government's share was nearly one half.²¹ Portions of the federal money came from The Hill-Burton Act which allowed \$4 million for hospital construction and the National Institute of Health gave a \$2 million matching fund grant for the construction of research areas. Thus the delay in building until the 1960's proved to be fortuitous. The book, Beyond Flexner, helps explain how serendipitous the years of building delays turned out to be:

Throughout recent decades, the undergraduate medical education enterprise has generally been subsidized with revenues obtained by medical schools for other purposes, such as biomedical research and recently patient care. The major exception to this history of subsidization was of a brief period of direct federal support for

¹⁹Fr. Baumhart interview.

²⁰Questions and Answers, The Fulfilment Fund, March, 1948 AOC. Chancery Correspondence. Box 10694.

²¹James Maguire to Albert Meyer, Nov., 1964, LUCA. Office of the President. James Maguire. Box 4. File 34.

medical schools during the 1960's and 1970's, a period in which the instruments of public policy were used to help expand the number of U.S. schools and to increase the nation's supply of health manpower. Recently, however, federal policy has retreated from the task of subsidization of medical schools.²²

The reason for federal intervention was a fear that America was falling behind other countries in its scientific capabilities, hence the willingness of the government to support research efforts and construction costs ancillary to those research expenditures. There was also a perceived need for additional physicians.

Loyola would also benefit greatly from its close affiliation with the veterans' hospital. Besides enabling department faculty at Loyola University Medical Center to have joint appointments with Hines, there was an additional patient base and increased research facilities. There were also important financial benefits as the two institutions' close relationship enabled them to share, rather than purchase individually, some highly specialized and expensive equipment.

The state also contributed to the center's growth and development increasing its aid from \$400,000 in 1970 to \$1,377,000 in 1977.²³ Inadvertently, the mishandling of Cook County Hospital by the Cook County Board proved to be a bonanza for the burgeoning medical center. In the beginning there

²²Janet Perloff, "Trends in the Financing of Undergraduate Medical Education" in Beyond Flexner (New York: Greenwood Press), 127.

²³Notes given to the author by Fr. Raymond Baumhart for his talk to the McGaw Hospital Medical Staff, Dec. 7, 1977.

were few full-time clinical faculty members and physicians willing to move their patients to the new Loyola Medical Center. However, the discontent of many key Cook County clinicians at their hospital enabled Fathers Maguire and Baumhart to hire department heads for medicine, radiology, anesthesiology and surgery. These physicians brought staff, patients and “built departments out there which have really made the medical center what it is today.”²⁴

Changes at the Medical Center in the Modern Era

Accreditation was always a nemesis for the medical college; Loyola moved from secret probation in 1962 to conditional accreditation as a “developing school” in 1966 to finally in May, 1973 to full accreditation and placement on the regular cycle of seven-year visits by the accrediting agencies. ²⁵ The medical college had arrived, and it was official!

Patients and prestige enabled the medical center to expand its clinical faculty from fewer than twenty when it opened to over 450 in the 1990’s. Loyola’s financial stability was improving with the assistance of the federal government, increasing alumni donations and the hugely successful Alumni Award Dinner (which replaced the Cardinal’s Dinner in 1960). Financial security for the medical school, however, was achieved with the development of the Loyola Medical Practice Plan which is a corporate arrangement between the doctors and the university. Although revised

²⁴Dr. Matré interview.

²⁵Fr. Baumhart talk to the McGaw Hospital Medical Staff, Dec. 7, 1977.

several times since the 1970's (and currently in the process of another revision), physicians worked full-time at Loyola and contributed approximately 25 percent of their earnings to their department to support education and research, and 25 percent of their income to the medical school; the remaining 50 percent went to the physician. As Dr. Matré pointed out, "that helped the medical school go from being \$5 to \$6 million in the red to a balanced budget to an eventual surplus. Income in the last decades at the hospital has been able to support the whole university."²⁶ In the late seventies and through the early nineties, hospitals generated large surpluses which were used not only for the medical school but for other purposes. Therefore, in a new phenomena for Loyola, the university was able to benefit from the surpluses being generated by health care. Because of these surpluses, "The medical school has long since paid all of its debts with big dividends."²⁷ It is ironic that the medical school, which for many years had a negative image for financially depleting the university, was now the major source of surplus funds and a benefactor for the entire university system. The tide of prosperity would ebb somewhat in the 1990's as medical centers nationwide were forced to adapt to new problems.

The Medical Center in the 1990's

There is often rapid change in medicine and health-care and Loyola is positioning itself to be able to adjust quickly to the nuances of change.

²⁶Dr. Matré interview.

²⁷Fr. Baumhart interview.

Recently, the medical center announced its intention to establish itself as a subsidiary corporation of Loyola University with a separate board of trustees. This is intended not to isolate the medical center from the university but to enable it to act more expeditiously in the competitive health-care environment. Jim Whitehead, Dean of Students at the Stritch School of Medicine, noted, "Separate organizations are necessary so it can respond to managed care; flexible enough to change with the times and not anchored to an institution that is somewhat inflexible such as higher education."²⁸ This new corporation does not include the medical school and does not change the medical center's ultimate connection to the university. In addition, the medical center has recently shaped affiliations with West Suburban and Provident Hospitals and provided an added base of primary care physicians to dovetail with the specialists and sub-specialists housed at the medical center.

One indication of the need for change is the decrease in net income at the medical center which fell from \$49.95 million in 1992 to \$32.48 million in fiscal 1993.²⁹ As Crain's Chicago Business pointed out, the medical center is now the major source of income for the university, contributing, in 1992, 61 percent of its net income. In addition to a national trend of shorter hospital stays and increasing amounts of outpatient rather than inpatient surgeries, income has been effected by local community hospitals now offering high-margin, delicate surgeries and procedures that were once only available at the

²⁸ James Whitehead, interview by author, Maywood, Illinois, October 4, 1994.

²⁹Crain's Chicago Business, November 15-21, 1993, Section 1. Page 1.

university hospital. Faced with the decline in income, the medical center has inaugurated cost cutting measures that will eliminate 430 hospital positions. After years of unprecedented growth, a reduction in force is painful both psychologically and operationally for the institution.

Mr. Whitehead stated the situation clearly:

It is the same for almost every organization in the country, you have to increase productivity. It is a turbulent time. It is a delicate surgical procedure to remove middle management. It has to be done very carefully and appropriately and there is a lot of pain involved. These are very difficult times at the medical center because it is change and it is a different way of planning how the job is to be done in health care and education.³⁰

Curricular

Loyola recently began implementing radical curricular changes with a problem-based focus designed to better prepare students for the changing medical environment. New changes include:

1. A movement away from the former didactic lecture system; the new curriculum structure would decrease lectures by 30-40 percent and give students increased opportunity for individual learning, small group activity, case-study learning, and computer-based instruction. For the majority of medical schools in the country, curricular change has been a very slow evolution; the importance of moving away from the didactic lecture was a major component of Flexner's Report in 1910.

³⁰Mr. Whitehead interview.

2. A new structure for class time as formal lectures would be limited to the morning leaving more time for independent study and active learning.

3. In order to give students increased patient exposure, there would be opportunities for clinical study during the first year of medical school.

All these changes are designed to teach students how to continue to learn on their own once they leave the medical school environment.

This new curriculum requires a new learning environment. The university has appropriated \$375,000 for plans and a study of a new medical school building better suited to take advantage of computer technology, and flexible individual and co-operative learning options. Only twenty-eight years young, the current medical school building is considered obsolete.

What is the Present Status of the Medical School?

Loyola Medical Center has continued to grow since it first opened in 1967. The university built the Mulcahy Outpatient Clinic (1981), the Russo Surgical Pavilion (1987), and added a \$30 million cancer facility which opened in 1994. Besides its physical growth, Loyola today is recognized as a premier medical facility performing over 300 heart transplants and more open-heart surgeries than any other facility in Illinois. It has one of the best cardiac-care programs in the state of Illinois, and its fourteen bed burn center serves a four-state region. Although there were many who doubted that it was possible, the university unquestionably has achieved its goal of building a world-class medical center.

There have also been significant changes in the demographics of the student population. There is a large increase in the number of minority students, and females comprise 41 percent of the 1994 admitted class. One of the first areas to show significant change when Loyola and the federal government formed a partnership was the number of Catholic students. In 1965, 85 percent of the student population was Catholic. By 1980 that number had already dropped to 55 percent.³¹

Loyola, Mercy and the Archdiocese

Loyola's financial relationship with the archdiocese ended in 1963. Although Cardinal Meyer had offered to continue his annual donation of \$230,00 for five years, Loyola's Annual Award Dinner proved so successful that Fr. Maguire informed the cardinal that after 1963, it was no longer necessary. ³² Since then the medical school has operated without any assistance from the Chicago diocese. The Annual Award Dinner has continued to be the major fund raising event for the medical school. In 1994, this one event raised over \$750,000 for the medical center.

Mercy Hospital rebuilt and expanded in the new parcel of land purchased from the Chicago Land Commission dedicating a twelve story multi-million dollar facility in September of 1967. It also developed a new

³¹Lester Goodchild, "The Mission of the Catholic University in the Midwest, 1842-1980. A Comparative Study of the Effects of Strategic Policy Decisions Upon the Mission of the University of Notre Dame, Loyola University of Chicago, and Depaul University," (Ph.D. diss. University of Chicago, 1986) 681.

³²Fr. Maguire interview.

relationship with the University of Illinois Medical School, which according to Sr. Gwendolyn, current C.E.O. of Mercy Hospital, has been very harmonious and beneficial for both parties.³³ The hospital has recently been involved in a controversy with the current leader of the Chicago archdiocese, Joseph Cardinal Bernadin. The dispute is the result of Mercy's current intention to affiliate with the University of Chicago Medical School, and the cardinal expressed disapproval of a Catholic hospital forming an alliance with a non-Catholic medical institution. Always protective of their autonomy, there is no indication that the Mercy Sisters feel the necessity to receive the cardinal's approval before affiliating with any hospital of its choosing.

Additionally, there seems to be no interest by Loyola in resuming any relationship with Mercy Hospital. Sr. Gwendolyn stated that they talked four or five times with Loyola "in terms of a possible association again, but it was quite obvious that they are interested in the western suburbs and could not give us what we are really after in our needs for medical education." ³⁴ In an interesting note of historical revision, current brochures on the medical center that include historical information note that Loyola Medical School used Cook County Hospital (Mercy Hospital is not even mentioned) as its main clinical facility for the many years before it permanently moved to Maywood.

³³Sr. Gwendolyn interview.

³⁴Ibid.

Jesuit Tradition

One facet of the medical school's culture that has not changed over the decades is the Jesuit foundation. Loyola is one of only four remaining Catholic medical colleges--all Jesuit and--its literature and edifice speak loudly to a commitment to the Jesuit tradition of knowledge and service to humanity. From the school's inception there were few priests (usually only the regent) at the school, but it was the Jesuit's express purpose to provide a Catholic medical education. This tradition continues today as a conscious part of the program. It is more than the statue of St. Joseph that greets the hospital visitor, or the seminar in values in medicine; it is a conscious effort to select students "who want to be a physician because they want to help people. They have a mission beyond their own self-interest."³⁵ Jim Whitehead believes that it is also reflected in the actions of the medical school and medical center administration. There is a Catholic culture which is based on Jesuit principles for which the school does not apologize "if anything we celebrate it."³⁶ As Dr. Matré noted, many who teach at Loyola are not Catholic, but the feeling is that anybody who joins that institution, in any kind of a position, "should be someone who understands and is committed to the Jesuit tradition of the whole person. Faith in God is part of our education; you may be a Moslem or a Jew, but it is always a factor."³⁷

³⁵Mr. Whitehead interview.

³⁶Ibid.

³⁷Dr. Matré interview.

Summary

Loyola's current prominence in the local, regional, and national medical community is unquestioned. That it survived many years to arrive at this state is a story in which the school should take great pride. This research describes the growth and development of the Loyola School of Medicine with particular reference to the period from 1940-1960. This era, often called the transition era of American medical education, was when Loyola as well as all American medical schools were going through a critical and difficult time. It was a time during which the existence of Loyola's medical school was threatened, and certainly its future was determined. To provide a perspective to the Loyola medical school story, it was necessary to review the history of medicine from its earliest times to the present and to relate how medical schools, in general, fared during this transition era.

This dissertation has been divided into six chapters: Chapter I and II dealt with the development of the modern medical school in America from colonial times until the present and made particular reference to the early reform movement. Chapter III is concerned with the problems of Chicago medical schools particularly Loyola in the early twentieth century. This chapter traces the early development of the Loyola medical school, its administration and curricular problems. Chapter IV treats the transition era at Loyola, the difficulties of the World War II period, financial hardships, and the rescue by Samuel Cardinal Stritch, after whom the school was ultimately named. In addition to finances, the key difficulty for the medical school was

the continuous and unsatisfactory efforts to bring about the critical university hospital relationship with Mercy Hospital of Chicago. Also in this chapter is recorded Loyola's valiant effort, eventually abandoned, to develop its own university hospital at the West Side Medical Center.

Chapter V provides an account of the continual efforts of the medical school to cope with its pressing problems during 1950-1959. In this decade, representing the last half of the transition era, the medical school undertook an ambitious fundraising campaign, continued the exasperating chore of trying to work out satisfactory agreement with Mercy Hospital, and coped with the death of Cardinal Stritch, the school's most faithful and inspirational patron.

Chapter VI provides an account of the Stritch School of Medicine and its progress from 1960 to the present. During this period, the school embarks on an ambitious task of developing and financing its own university hospital. Not the least of the barriers in these efforts was the procurement of a site. Through a series of fortuitous circumstances, a large tract of land in an excellent location (in Maywood, a western suburb) was obtained at almost no cost. In 1961, Loyola took possession of the site near Hines Veterans Administration Hospital and began construction. The new medical school was completed in 1967 and the university hospital in 1969. After a long and agonizing battle, the Loyola University Medical Center had finally become a reality. While the medical school is currently grappling with financial and other problems common to all medical schools, there is no question that the achievement of the modern medical center and school was a reality which

seems, in light of its history, almost miraculous. Fr. Maguire would agree that Loyola's survival and eventual rise to prominence had assistance from a higher source. He related when asked how he coped with the tremendous financial risk connected with building the medical center, that he had a "great faith in the power of prayer." ³⁸

Furthermore, there were truly many who contributed to the success of Loyola's medical school; however, a few unquestionably stand out: the persistence of Fr. Hussey (an early president), the risk-taking of Fr. Maguire (a later president), the efforts of Dean John Sheehan, the patience and generosity of Cardinal Stritch, the philanthropy of Frank Lewis and finally the administrative skill of Father Baumhart, medical center vice-president and later president of the university.

Together these leaders fashioned a most unusual saga of persistence and of unremitting effort of individuals stirred by a common objective-- Catholic medical education. In this ideal, they were devout in their beliefs and for these beliefs they faithfully strove.

Significance of the Study

This study investigated the endurance of one of the few remaining Catholic medical colleges in the country. It is an import story of Catholic institutional survival. Faced with few resources other than strong leadership and persistence, Loyola struggled to remain viable through the transition era and rose to prominence in the modern era of medicine.

³⁸Fr. Maguire interview.

Of particular interest for this dissertation were the complex and difficult issue that enveloped the school from 1940-1960. The private papers of Dr. James Smith, the chancery correspondence of Cardinal Stritch, the archival records of Fr. Maguire and Fr. Hussey, and interviews with some of the principals proved invaluable in understanding the complexities of a Catholic institution fraught with financial, accreditation and affiliation difficulties forced to balance the importance of Catholic education with the realities of transition era medicine in a post-war society. By better understanding where Loyola University Medical School came from and the struggle that ensued, the reader can truly appreciate the heights to which it has risen!

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VITA

The author, Lucy Shaker, was born in Oak Park, Illinois during her father's tenure as dean of Loyola University School of Medicine. Ms. Shaker received her Bachelor of Arts degree in History from Marquette University and a Master of Arts in Curriculum and Instruction from Concordia University. During her years as a college student, Ms. Shaker worked as a research assistant in the department of physiology at Marquette University Medical School and participated in the publication of several articles on the effects of exercise in laboratory animals. She has taught in both elementary and middle schools. In addition, Ms. Shaker has developed learning assistance programs for high school math students. In 1988 she entered Loyola University of Chicago's doctoral program in Higher Education. As part of that program, Ms. Shaker completed an administrative internship at Northeastern University's Chicago Teachers' Center. Ms. Shaker remained at the Teachers' Center for several years working on grant writing, staff evaluation and teacher development before taking leave to complete her dissertation.

APPROVAL SHEET

The dissertation submitted by Lucy Shaker has been read and approved by the following committee:

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee which reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

April 5, 1995

Date

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