11-20-1968

Correspondence: From Max Michael, Jr. to G. Dekle Taylor on Jacksonville Hospitals Educational Program, Inc. Letterhead, 1968-11-20

Max Michael Jr., MD

Jacksonville Hospitals Educational Program, Inc.
AFFILIATED WITH THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF FLORIDA
2000 JEFFERSON ST., JACKSONVILLE, FLORIDA 32206 904/356-7866

MAX MICHAEL, JR., M.D.
EXECUTIVE DIRECTOR

November 20, 1968

G. Dekle Taylor, M.D.
221 Marshall Taylor Doctors Bldg.
Jacksonville, Florida 32207

Dear Dekle:

Joe and I had a curbstone discussion this morning about the future of DMC and about the proposed survey. I read him some notes that I jotted down, which I'd like to pass on to you. This all comes under the title of "what is the aim of our survey?"

It seems to me that there are several areas we're concerned with.

1. Financing. This is to include sources other than tax funds, and the ratio of private to ward beds. It is my feeling that in this area, much information is readily available. When we come to the item of the relationship of the private to the ward beds, I think we are faced with a complete question mark. We all know perfectly well that tomorrow we could fill up 500 beds with indigent patients, thus this bears careful consideration.

2. The hospital image. How do we go about developing the "private hospital air"? In other words, how can the place be made attractive so that the private patient will willingly come to this institution. We know that in general, patients go where the physician directs. But the physician will not bring his private patients to an institution where the comforts available in others aren't available and where the physicians help and ancillary services are not available. Another item in this is to improve the workings between the administration and staff, and this, of course, is a big item for discussion.

3. Type of hospital. It seems to me that there are three general types to be considered.

a) A general teaching hospital. This is a costly institution. It requires specialized people, specialized techniques and specialized equipment. This is the Massachusetts General or the Johns Hopkins type, where there is a blending of private and of indigent or semi-indigent patients.

b) A general community hospital, such as our Baptist or St. Vincent's. These institutions are costly in the window dressing, but by all means, they are the best income producers. Now we do want some window dressing and the window dressing is not only that in facilities, but is window dressing in people and in their attitudes. The attitudes in the "indigent hospital" are absolutely unacceptable to the private patient. Our friend Wilbur Cohen is obviously striving, as are many others, to see that the indigent patient gets the window dressing of care that the private patient gets - do we approach this?

c) The indigent hospital. This is obviously the least expensive. This is the current image of the Duval Medical Center. This is what one sees at Bellevue and the Philadelphia General, and let's look at what's happened to these institutions. New York University has used Bellevue for many years as its major teaching unit, but they too have gone to construct their own University Hospital. Cornell has pulled out of Bellevue completely. Over in Brooklyn, State University of New York used Kings County exclusively. They now have built their own University Hospital. I mention this to point out that the future of the solely indigent oriented hospital is through, not only as a teaching hospital, but as a patient care area. These may be rambling thoughts, but I put them down to try and focus on what we're after.

With all good wishes.

Sincerely yours,

Max Michael, Jr., M.D.
Executive Director

MMjr/sg

cc: Joe Lowenthal, M.D.