Louisiana's place in American surgery

The following guest editorial is a reprint of the Presidential address made to the Surgical Association of Louisiana at its annual meeting in mid November 1983.

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In the early years of this century New Orleans was a hotbed of medical-surgical activity. Matas was experimenting with intravenous fluids and remaking vascular surgery. Bass grew the malarial plasmodia in artificial media. New Orleans was the first major city to control yellow fever. In 1908, 85 scientific papers were presented at the meetings of the Orleans Parish Medical Society. New Orleans was clearly recognized as one of the world's great medical centers. I believe we must face the fact that this position of preeminence has gradually slipped over the past several decades.

It is my belief that this is due to Louisiana's persistence in following historical precedence and tradition long after modifications were indicated by changes in medical and social sciences. It is the purpose of this address to discuss some of these issues and to suggest changes that might lead to reclamation of our preeminent role.

The history of Louisiana medicine and medical education is intimately bound to the commitment of Louisiana to the provision of health care to its poor. Fig 1 shows our education pedigree. The Charity Hospital of New Orleans began in 1736 from a small legacy of Jean Louis, a New Orleans sailor and boat builder. That institution, after 247 years, has changed buildings and location, but continues, its service uninterrupted, save for a four year period around 1810. It has spawned our other centers of medical education and can be called the "Mother" of all Louisiana physicians.[1]

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Between 1803-1813 there was considerable turbulence concerning the operation of the Charity Hospital. This conflict and the poor quality of care led territorial Governor Claiborne to assume control of the institution and provide some financial support in 1811. Louisiana was admitted to the Union in 1812 and the Legislature officially made the Charity Hospital of New Orleans the Charity Hospital of Louisiana in 1813. The operation and support of the hospital became a state responsibility. Thus, Louisiana was the first state in this country to maintain and operate a general hospital from state funds.[1] Concomitantly and perhaps unconsciously the principle was established that Louisiana would provide medical care for its indigent citizens by supporting specifically designated "charity" hospitals rather than subsidizing such care in private institutions.

TABLE 1

	State Support	Location
Charity Hosp. of LA	1813	New Orleans (Tul.-LSUMC-NO)
LSU-Hospital	1876	Shreveport (LSUMC-S)
University Medical Center	1937	Lafayette (LSUMC-NO)
Lallie Kemp Charity Hosp.	1938	Independence (Tul.)
Huey P. Long Charity Hosp.	1939	Pineville (Tul.)
E.A. Conway Charity Hosp.	1941	Monroe (LSUMC-S)
Wash-St. Tammany Charity	1952	Bogalosa
Wm.-Olin Moss Charity	1956	Lake Charles (LSUMC-NO)
Earl K. Long Charity Hosp.	1968	Baton Rouge (LSUMC—NO)
South LA Medical Center	1979	Houma (Osch.)

Table 1 lists the 10 charitable general hospitals operated by the state today, their location, and the dates they were either opened or began operation with state support. This network has not been the product of any one or

two administrations, but has been produced by the people's representatives over almost two centuries. This commitment to the care of the poor is a heritage in which Louisiana can take great pride. Not only did Louisiana support the first such hospital, but it is safe to say that no other state has dedicated as great a proportion of its resources to the health care of its citizens over such a long period of time. These institutions have, on balance, provided the best care for the most people and have been of enormous benefit to our citizens.

All of the hospitals listed in Table 1, save one, are integral parts of the residency training programs of the two LSUs, Ochsner Foundation or Tulane. As such, they have provided training grounds unequaled in this country relative to the volume of clinical experience. This has been particularly valuable in the training of surgeons who must learn the manual part of their art by executing operations one at a time, learning from each step repetitively until they are largely reflexive. In fact, Louisiana trained surgeons are recognized throughout this country as being technical surgeons without superior.

What then is the evidence that our position in American medicine has declined? Certainly we have not produced the number of academic or scholarly leaders in American medicine and surgery over the past 50 years as produced by Hopkins, Harvard or the University of Chicago. We have not been the fertile centers of clinical or scientific innovations. Where are our centers of monoclonal antibody production or genetic engineering? Where are our centers of bioengineering comparable to the Massachusetts Institute of Technology? Where are our centers of oncology comparable to the M. D. Anderson? Where are our centers of transplantation comparable to University of Minnesota? These are unpleasant facts but this audience knows that they are true and can immediately think of numerous other examples to support the point.

Clearly this is an exceptionally complex problem and probably no one other than a surgeon would attempt to simplify it. Nevertheless, the problem needs to be addressed. It is not that we do not have the manpower or the brainpower, and it is not that we do not have the fiscal or physical resources. Rather, we are not using our resources properly.

It is my contention that the basic cause of this decline has been our traditional separation of public and private care into two clearly defined efforts. This tradition goes to the very roots of our history. Shortly after the founding of Charity Hospital the French Minister (colonial governor) stated publicly that since the charitable hospital was available, "the King would not now or in the future be responsible for the cost of care to paupers in the Royal Hospital."[1] Other than the current experiment in Shreveport, I have been able to find only one example of a

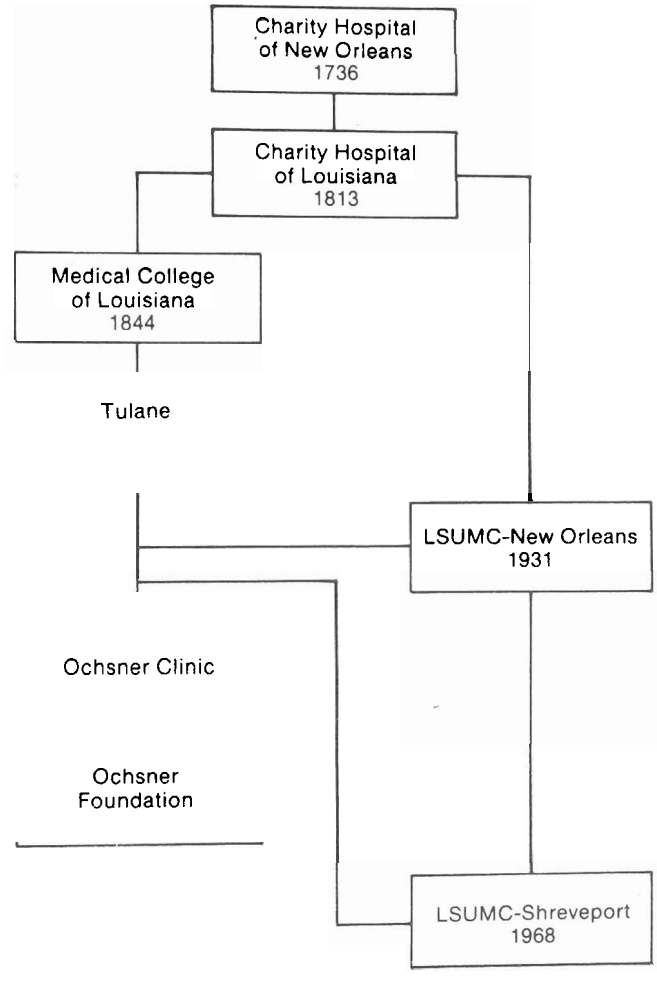

Fig 1. The evaluation of Louisiana's major teaching institutions.

different attitude since 1736. That also occurred in Shreveport. In 1867 the legislature appropriated $10,000 to subsidize the care of the poor at the Shreveport Medical and Surgical Infirmary where physicians were paid a fixed per diem for each patient treated.[2, 3] For unknown reasons that enterprise was soon abandoned and funds for the Shreveport Charity Hospital were appropriated in 1869 under the reconstruction administration of Governor H. C. Warmoth.[4] It may be argued that Ochsner Foundation exists today as a monument to the failure of Ochsner and his colleagues to break this tradition.[5]

I realize some minor exceptions may be taken to those statements. For example, LSUMC-NO has private patients at the Hotel Dieu and Ochsner Foundation has public patients at Houma. Touro Infirmary once had an excellent training program with large public care resources, but so far as I can determine, the public care was financed by Touro and not the state. However, no large scale program has existed where public and private patients are treated in the same place in the same way by the

same people, with public care financed from public funds and private care by private funds.

This separation of private and public care has produced an artificial dichotomy in which teaching and training has taken place primarily in public hospitals while private practice occurs elsewhere without major teaching or training commitments. Thus the trainer and trainee have been separated. This has produced profound effects on the trainees, the teachers, the hospitals and the patients.

The public hospitals have been and still are staffed largely by physicians in training with staff as advisors. Until formal training programs were organized in the 30s these house physicians were virtually autonomous. In 1906 Matas complained to the Board of Administrators of Charity Hospital that only 76 cases were assigned to him during that year while the rest were assigned to the house surgeons. Thus, he had inadequate material with which to teach medical students.[6] In 1912 the Orleans Parish Medical Society petitioned the Governor to make the house staff subordinate to the visiting staff. As late as 1969 when I joined the Tulane faculty, my chief resident felt it a great imposition on his authority when I insisted on being informed about every patient prior to any operation.

In this system of teaching, the trainee has had little opportunity to observe directly how the teacher practices with his own patients. He has not the opportunity to learn the politics and etiquette of practice, nuances of judgment, technical tricks, or many other things that the student can learn from a master surgeon which are virtually impossible to transmit by the spoken or written word. All too frequently he has become overconfident and found himself in dangerous situations without assistance. Further, students of surgery in Louisiana soon come to believe that the study of surgery is solely the study of the practical delivery of health care. And why not? Only a handful of their teachers are engaged in scholarly or research activities. These so-called and misnamed "full-time" teachers are few in number and, as Dr. Rives has so eloquently stated, quite peculiar people.[7] The clinical faculty, the practitioners who are not in environments where scholarly pursuits are encouraged or convenient, are the true role models. So as expected, we produce few teachers and/or investigators who are the soul of our profession.

The system has tended to separate our profession into teachers and practitioners. Paid teachers have been relatively few in number and have had to conduct their own practices largely in private hospitals without their trainees. It is an inefficient use of their time, has not benefitted their trainees and with some notable exceptions has not been very successful. The practitioner, on the other hand, becomes a teacher only when time is sequestered and donated in the teaching setting. As the

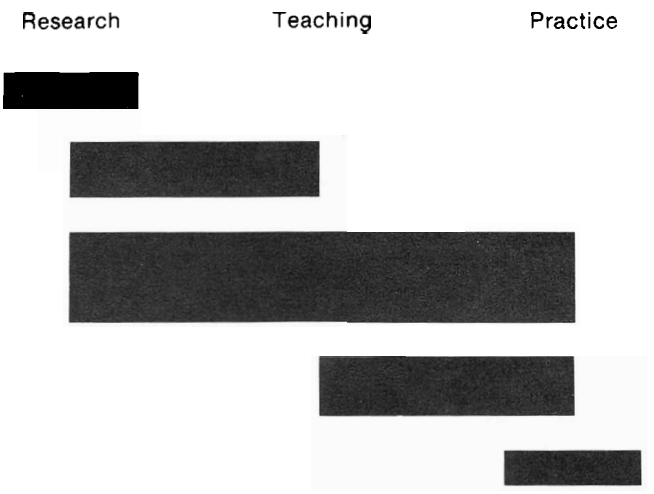

Fig 2. A suggestion as to how a medical center faculty should be constructed. Most faculty should engage in research, teaching and practice, but some few might practice only, while the only duty of others might be investigational, etc.

demands of practice become greater, his teaching and scholarly activities are the first to suffer. It is a system designed to be divisive, to lead to poor communication, town-gown misunderstandings, and decreased scholarly productivity. Great medical centers have faculties as illustrated in Fig 2. Some few faculty do only research or practice, a larger number do research and teach, or they practice and teach, while the largest number perform research, teach and practice. In any event, it is all one continuum without division.

How has the system affected our hospitals? The private hospitals have been purveyors of health care, largely without trainees and without the stimulus or resources for scholarly contributions, but the public hospitals have been most seriously affected. The public hospitals have not had faculty or staff whose careers were based upon the efficiency and proper function of those hospitals. Thus it has been all too easy for the faculty to become demoralized and acquiesce to poor management and planning. By default, the public hospitals have been operated by standard political methods. This is quite clear from their method of financing. Each year our legislature is presented with a request for more money. Much to their credit they generally appropriate more, but the system does not change, and that is due to the fact that in the history of this state the public hospitals have never been funded by a method that relates the allocated funds directly to the services rendered to patients. There has never been a system which allows for depreciation, programmatic development, or long-range planning.

Finally, this system has not served the patients well. Our private patients have not been the beneficiaries of

the frontier, pioneering developments and our poor patients have not received the proper humanistic considerations. Care in public hospitals does not result in higher mortality or morbidity, but it certainly is not provided with the same timeliness, courtesy or efficiency. In fact, "separate and equal" medical facilities like "separate and equal" schools are inherently unequal.

This system is simply not sufficiently productive or efficient for today's world. Many of our great institutions about the country never embraced it and most of those that did have since abandoned it. The Massachusetts General Hospital has always practiced public and private medicine within its walls. The Brigham Hospital's original endowment was for free care but its trustees included private patients before the hospital was ever operational. Johns Hopkins was the first medical system to incorporate the fulltime system, but it never envisioned faculty that did not practice, only faculty that practiced under income restriction. The University of Chicago quickly included private patients into its hospital when the Great Depression arrived and Rockefeller money departed. In fact, there are few if any great centers of medicine in this country that are not involved in both private and public care.

An experiment in reform has been underway at the LSUMC-Shreveport for the past several years. In 1976 the legislature transferred the operation of the Confederate Memorial Medical Center from the Department of Health and Human Service to the Louisiana State University. The name of that hospital was changed to the Louisiana State University Hospital which is the only hospital operated by the University. This made the Dean of LSUMC-S the Chief Executive Officer of the LSU Hospital and the clinical department heads chiefs of their respective hospital services with all the prerogatives of literally operating their services.

In general surgery, faculty members were recruited, with special competence in areas of tertiary care, with the understanding.that they were free to engage in private practice in accordance with the school's practice plan. But, they were expected to confine their practice to the LSU Hospital.

In June 1977 there were no private patients in the LSU Hospital. In 1983 approximately 20% of the census on General Surgery is private. This rate has not been achieved on all services, but over 50% of patients now treated at LSUMC-S have some financial resources.

There have been several consequences of this experiment.

1. The department has been able to recruit an outstanding faculty, mostly young, all altruistic and capable of making scholarly contributions. While there has been the usual academic turnover, faculty has not been lost for financial or academic reasons.

2. The quality of care to the indigent has been improved immeasurably because faculty are always present. Care is provided to public and private patients side by side in the same way. Nursing, housekeeping and support services function more efficiently because of demand. All patients are treated with more humanism since support personnel do not know if they are treating a public or private patient. Practitioners in the field now have faculty to whom they can refer public patients with assurance that when their patients arrive, they will not be returned by inexperienced personnel.

3. The scholarly production has increased considerably. Publications have increased from 5-10 per year to 50-60 per year. Papers were read at six national meetings last year.

4. The Residency Training Program has become very competitive and the application rate has virtually doubled each year. All residents participate in scholarly activity and publications from residents have steadily increased. Two graduates in the past seven years are in academic positions; four have gone to further training or fellowships; one is currently in a research fellowship; and all who have entered private practice have found advantageous positions.

5. Several tertiary care programs have blossomed to benefit all of our citizens: transplantation, burn care, trauma care, oncology and congenital cardiac surgery, to name some.

6. This has been accomplished without town-gown turmoil. Practitioners in Shreveport have not suffered from competition. If there has been opposition in the community to these developments, it has not been visible.

We have an open staff policy and any member of the clinical faculty is encouraged to practice in the LSU Hospital with either public or private patients provided they participate in our practice plan.

7. Roughly 50% of hospital costs are self-generated. Because of the group practice arrangement, the money generated from professional services by the surgical faculty, which goes back into the Institution, is nearly virtually equal to the cost of the department to the state.

In my view this experiment has been a great success. It provides better patient care, improves resident training, encourages scholarly activity and is less expensive to the state. Further, it has been a great stimulus to the health profession in Shreveport, which has probably never been more alive, innovative and vigorous. However, all is not well. This experiment has produced progressive pressure upon state funding and management techniques, which have evolved over many decades, and have not accommodated to these developments as yet.

To oversimplify the situation, an effort is being made to operate the LSU Hospital with the efficiency and productivity of a private hospital. Surely this is in everyone's best

interest. However, to do so requires a degree of flexibility and local autonomy not feasible under current state policies.

Perhaps the most stifling problem relates to the way the state hospitals are funded and how these funds are controlled. State officials really do not know what they are buying when they fund individual hospitals nor do they know what they receive. The system does not recognize the difference in cost of care for a patient with appendicitis as opposed to a ventricular aneurysm. For the system to work, monies allocated must be related to services rendered. Such a system would ultimately result in monies flowing to effective and efficient institutions and away from the reverse. Self-generated funds need to be sequestered from general state funds and used for reinvestment at the local level. Self-generated funds should support the cost of services rendered, and programs continued or discontinued depending upon their productivity. Finally, state hospitals must be administered by state-of-the-art management techniques by properly trained and experienced professionals.

I have four recommendations.

1. Each state hospital used as a teaching hospital should be administered as well as staffed by the parent teaching hospital.

2. The budget of each hospital should be directly related to services rendered to indigent patients, with provisions made for depreciation, modernization and programmatic development.

3. Faculty and staff should be encouraged to practice in the state hospitals with private as well as public patients in accordance with a group practice plan.

4. Self-generated funds from each hospital or teaching group of hospitals should be sequestered in a foundation arrangement to be reinvested into the institution(s) and the departments involved. Capital and programmatic investments should be jointly underwritten by state and self-generated funds in proportion to the purpose of the investment.

As president of this body (Surgical Association of Louisiana), I request that its Executive Board consider these suggestions and seek ways to see them implemented. I suggest that a representative committee be appointed, that their meetings and deliberations be financed by this organization and that they be charged with proposing these or similar reforms to the appropriate elected officials for their consideration.

Louisiana has had a substantial influence in American medicine. We have the resources to exercise an ever greater role in the future provided we can work collectively to modify an ancient system which, however noble its purpose, will not work to our best interest today.

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