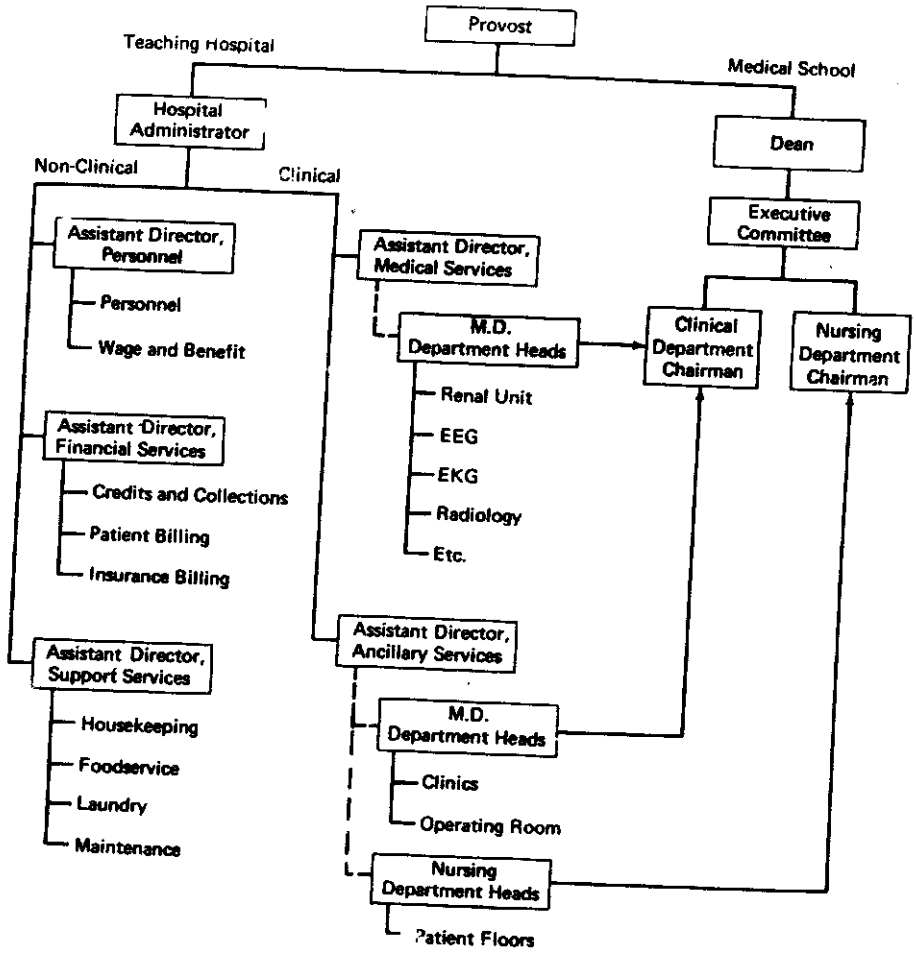
19. THE TEACHING HOSPITAL

Dr. Robert Uric was the head of the Renal Medicine Unit at a large university medical school and teaching hospital. A regional medical center, the teaching hospital had over 1,000 beds and was considered a reasonably prestigious assignment, although no one fooled himself that it was the Mayo Clinic.

There was a steady undercurrent of hostility and competition between the hospital and the medical school. A state school, and state-supported hospital, the two institutions had only one official in common—the provost. From the provost down, the organization split in half with the medical school, its M.D. faculty and nursing faculty on one side, and the hospital administrator, nonmedical hospital employees, and technicians on the other. (See the organization chart.)

SOURCE: This case was prepared by Roberta P. Marquette and Michael H. Smith under the supervision of Theodore T. Herbert. The case is not intended to reflect either effective or ineffective administrative or technical practices, but was prepared as a basis for class discussion.



The physical plant paralleled and accentuated the organizational structure. Designed in the shape of an "H," the medical school ran east-west, ten floors high on the north side, and the hospital ran east-west, eight stories high on the south. They were connected only by the bar of the "H," an officeless corridor connecting the medical school and hospital on each of the first six floors.

A large part of the problem was the unusual nature of the financial arrangements. The physicians, as faculty members, received salaries, but no money for patient services. Patients *were* billed for professional services, but the revenues went into departmental funds which were disbursed at the discretion of the department chairmen. The hospital, on the other hand, turned in every patient-revenue dollar to the state and then had to turn around and beg for, and account for, every penny of operating revenue they got.

Grant monies further complicated the situation, especially in the area

of salaries. Hospital employees were civil service, strictly regulated by job classifications and wage scales; no exceptions were made. The medical school faculty, however, could frequently use grant money to supplement state salary scale, hire people outright at higher salaries, or use the grant money to provide nonsalary perquisites. Because of this, working conditions were also frequently better on the medical school side, and they had money for more equipment, more travel, and even more parties.

The inconsistencies between the operations of the hospital and the medical school were highlighted by the integration of medical school faculty into hospital functions; the situation was aggravated by the reports of technicians, patient-floor employees, and clinical clerks. These hospital personnel worked directly under the physicians and nurses from the medical school faculty, who were also administrative heads of clinical hospital departments, and were in rather good positions to observe and hear of differences between the hospital and teaching sides. (Quained physicians were felt to be necessary in heading clinical hospital departments because of the technical natures of the departments' functions and from medical necessity.)

Assistant hospital directors were in charge of most administrative matters, including administration of wage and benefit programs; department heads (physicians), however, were responsible for supervising departmental activities, evaluating employees, and recommending raises and prc otions. It left the employees in a situation of very divided responsibilities. Further, the general disdain which the physicians felt for hospital administrators left the assistant directors in the position of mere figureheads in the area of clinical services. The hospital personnel, seemingly from the administrators down to the clinic clerks, complained that the physicians were prima donnas who considered themselves the next best thing to being divine. The medical personnel, on the other hand, complained that hospital personnel were civil service, time-serving incompetents.

One exception was Dr. Robert Uric, head of the Renal Unit. Despite the difficulty of his job, and his apparent membership in the faculty group, Dr. Uric was roundly liked by the hospital employees with whom he worked. One reason was that he shared whenever possible the largess of his grant monies with the hospital employees in his Renal Unit. Financially and emotionally, the hospital Renal Unit, not the medical school Department of Medicine, was Dr. Uric's home and favorite child.

The Renal Medicine Unit at the teaching hospital, like many other renal units, received what might be termed stepchild treatment, banished to a subbasement where most of the other faculty and staff could avoid the painful realities of chronic kidney patients. Nevertheless, the Renal Unit *was* a cheerful place. The staff, under Uric's leadership, maintained high morale, remarkably high in view of the hopelessness of many cases and the frequent deaths of patients who spent years visiting the unit and who became, in time, almost members of a large family. The job done by the renal staffers—residents, interns, and technicians alike—was sincerely appreciated

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by the patients and their families and was a source of wonder to those outside faculty and staff who were familiar with the conditions in the dungeon-like Renal Unit. As a matter of fact, Dr. Uric himself was something of a wonder.

On nice afternoons he could be seen strolling the grounds, pop bottle and hero sandwich in hand, trailed by a half-dozen students, teaching Socratic-style among the birch trees and the squirrels. Brown-bagging his lunch was not the least of Uric's peculiarities; many stories circulated, including the tale of his being given a ticket for speeding down one of the steep campus hills on his bicycle. Also, through those who knew someone in the Renal Unit, other stories began to leak out; tales of Friday afternoon parties fueled with grain alcohol and Hawaiian Punch, and worse yet, rumors of a monthly rabbit roast in which experimental animals whose transplants didn't take were put away painlessly and barbecued over a pair of bunsen burners.

Other faculty members found Uric to be a constant source of embarrassment and discomfort. His actions were "undignified"; for a research physician he was entirely too involved with his patients. He actually cried, openly, when his patients died; most unprofessional! Still, he was a fine director of renal medicine, and a remarkable teacher, and he was, after all, an inside joke.

That all changed with Flower Life.

Dr. Uric had several federal grants from the National Institutes of Health (NIH) to pursue research on kidney transplantation. He had begun doing active research within the first year after taking over the Renal Unit. Not the type of man to become fascinated by academic questions, Uric had become almost obsessed with the need for answers when he saw his patients suffering and dying because treatments were not available. He began by solving small, individual problems for specific patients and then generalizing and publishing the solutions. Gaining confidence from his initial successes, Uric applied for, and got, grant money and began working on the larger problems facing patients with chronic kidney failure.

A major problem in transplantation is keeping the kidney properly diffused (alive and full of fluid) between donor and recipient, and Uric was involved in this aspect of the problem. In the course of his work he discovered a fluid that was absorbed much faster than water at the cellular level. Testing showed it to be ineffective as a solution for diffusion, but it occurred to Uric that if plants absorbed it as well as cells it might make a good fluid for cut flowers, extending their life. After finding the right combination of fluid and an acid substance to keep the cut stem end from closing, Dr. Uric decided he did have a substance superior to anything on the market.

As required by the grant agreement, Uric reported his discovery to NIH. They said they didn't want it. Ownership next belonged to the university, and Uric offered it to them. They smiled indulgently and said he could

keep it. Not a man to be easily discouraged, Uric next offered his discovery to a large nursery supply manufacturer. They bought it, named it Flower Life, and began making millions. All of a sudden, NIH had a change of heart and filed suit. The story broke in the newspapers, first locally, then regionally, then nationally; needless to say, Dr. Uric made "fun" copy.

Uric and his peculiarities were no longer a private joke, and the faculty became concerned for the "reputation of the school." At the next Executive Committee meeting, the heads of the clinical departments discussed the situation with the dean and suggested that perhaps Uric should be put in a "less visible" position until things quieted down. The dean agreed. The Executive Committee felt they should move carefully; Uric was, after all, tenured and very popular with the students and house staff. It wouldn't do to let this look like persecution. They finally settled on approaching the provost with a plan to establish a new research chair in medicine. Backed by the dean, and financed by donated money from the chairman's department funds, the plan was approved and Uric was hastily offered the position. At first he refused, but it was made subtly clear that if the university were to be expected to back him in the impending litigation, he would have to help out by surrounding himself with an air of respectability. Uric accepted and was given a big raise and transferred to a beautifully equipped new lab on the tenth floor of the main building; the chief resident on renal medicine, Dr. George Conrad, was placed in charge of the dialysis unit.

The chief resident had a reputation for being a "hard nose." He had gone to medical school at a smaller university and had been very happy to get an internship and residency at a large teaching hospital. An excellent student, Conrad had also applied to Bellevue, the hospital arm of N.Y.U., and to several other major teaching hospitals. This had been his only acceptance, and the evaluation committee had looked long and hard at his application before accepting him. While his grades and aptitude tests showed him to be an extremely bright and an extraordinarily dedicated young man, his reference letters revealed an inflexible and rather ruthless individual. Born and raised in very poor surroundings, George Conrad was determined to become a doctor and surround himself with that safe and apparently impenetrable aura of the physician—financially, socially, and professionally secure. He had an image of the "physician"—wise, aloof, self-controlled, and as close to infallible as a man can get. Somewhat insecure about his origins, Conrad had long ago assumed the facade of what he thought a physician should look like, and by this time it was hard, even for him, to tell whether it was still facade or had become reality.

With Uric's removal, the members of the Executive Committee felt that this man was ideal to assume the responsibility for the unit. They felt Conrad would apply "a strong hand." The assignment was turned over to him by the chairman of the anesthesiology department, a powerful and respected member of the committee. The chairman told Conrad that the

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committee was certain he could handle it, and that they didn't expect to hear of any problems from the unit under his capable guidance. The chairman also suggested that Conrad be firm in asking Uric to stay away from the unit and thereby allow the transition of authority to proceed most quickly.

The Executive Committee expected a period of adjustment, but disruptions of routine exceeded anything they imagined. Employees in the dialysis unit became serious personnel problems with increased absences and constant grievances about impossible working conditions. While these complaints were pouring into the Hospital Personnel Office through grievance procedures, few or no messages were coming through to the Executive Committee or the dean. The hospital administration, unable to alter matters without the concurrence of the department head, in this case Dr. Conrad, waited for appropriate authorization to investigate the matter and attempt to improve conditions.

By the end of the first month the turnovers had started; after three months ninety of the old employees were gone. Dr. Conrad did not believe in becoming involved with patients on a personal basis, and he appeared to feel the same way about subordinates. Interns on rotation through renal medicine complained bitterly about Conrad's attitude toward, and treatment of, them; the roster of residents applying to the service dropped dramatically.

Meanwhile upstairs, Uric's research work was stale, and his disposition matched. He failed to turn in a grant progress report on time, and the granting agency flexed its muscle and canceled the remainder of his funding.

The dean was not happy and the Executive Committee was far from delighted, but everyone still believed it would all straighten itself out. Nobody, however, believed the problem to be serious enough to investigate the effects on the kidney patients and how the patients were doing down in the subbasement. They might have even forgotten that the dialysis unit was down there. When news did come out, its effects were far more damaging than any tales of Dr. Uric's weird habits could possibly have been.

A patient who had been on dialysis (three times a week) for several years had given up her place and gone home to die. A rare blood and tissue type, the woman had been waiting a long time for a transplant. She had seen many other patients die waiting, and had seen still more get transplants while her odds appeared ever slimmer. Sometime after Uric left the unit she had made her decision; the story leaked out after she died.

Shocked by realization of how bad the situation had actually become, the dean and the Executive Committee immediately placed Uric back as head of the Renal Unit; they then began to analyze what had happened, and what could be done to put the Renal Unit—and the hospital's reputation—back together again.