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AREA V minute news

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SOME INITIAL PERCEPTIONS

By Harold Margulies, M.D.
Acting Director, Regional Medical Programs Service

My perceptions of the May 6-8, 1970 Airlie House meeting, written several weeks after the event, are greatly influenced by events with which you are familiar.

As a reflection of the tempo of our times, on July 1 a new Administrator will take over the leadership of the Health Services & Mental Health Administration and there has already been Congressional confirmation of the appointment of a new Secretary of the Dept. of Health, Education, and Welfare. In a tangential way these, and a number of less prominent changes in the organization in which we work, sharpen my comments to you about the uncomfortably short period of time we have in which to perform the tasks which lie before us. Further, at this writing we do not yet have a new Bill extending the Regional Medical Program legislation, but the form of the legislation is becoming clearer in the actions and deliberations of Congressional committees.

Despite these distractions, some of my impressions expressed at Airlie House and since then, remain and are clear and unaltered. Foremost of these was the deeply encouraging evidence of a lively awareness, willingness and cooperation I found among the Coordinators reflecting their commitment to make Regional Medical Programs not just successful, but broadly an influential force for constructively altering our health care systems in terms of their quality and availability of care to all people.

Although I had been prepared to find at Airlie House a sense of gloom regarding the almost overwhelming problems which we face, I found instead a mature perception of the character of our challenge and a determination to do what has to be done with whatever tools and resources are available. Fiscal strictures were reviewed soberly, and even those who were dismayed by our limitations exhibited no signs of apathy or unwarranted discouragement.

My staff was wise to forewarn me that I would do well to eliminate empty rhetoric, face reality and report the facts as I saw them. I attempted to do just that. I

(continued next page)

talked about the need to mold Regional Medical Programs into total programs rather than a series of discrete projects; the necessity for Regional Medical Programs to serve as the strong professional ally for Comprehensive Health Planning agencies; the desirability of moving toward the new system of Anniversary Review; and the need to revise certain objectives of Regional Medical Programs to achieve what is most necessary to improve the health care of the Regions they serve separately and in the country as a whole.

In response, the Coordinators raised all of the issues they felt were important, described their misgivings, and left us with few illusions. Even the uncertainties of the new legislation and the question of appropriations were taken in stride with a frankness that matched my own.

Perhaps the most complex subject raised centered on the working relationships which are to be established between Regional Medical Programs and Regional Offices of the Dept. of Health, Education, and Welfare. I felt that the answers to this question were especially difficult to perceive because the Federal-private working arrangement Regional Medical Programs and the Regional Medical Programs Service now have is so unique and, at the same time, so delicate. The introduction of another kind of Federal agency was also regarded with suspicion and reasonable misgivings.

Although I left the meeting convinced that doubts and uncertainties remained, I reaffirmed my opinion that they must be resolved during the coming months and years.

The most sensitive aspect of my role and the role of my staff is a reflection of two basic elements in the Regional Medical Programs. One is the strong thrust we are giving toward increased self-determination of each Regional Medical Program. The other is our desire, apparently shared by the Coordinators, for clearer policies and more effective professional leadership on the part of Regional Medical Programs Service. Certain demands made on Regional Medical Programs Service, including those of better coordination with other Health Services and Mental Health Administration activities, faster and fuller communications, more professional-technical support, and clearer statements of objectives are all reasonable. I promised to meet those demands. I am further determined to meet our national and local commitments by respecting equally the advantages of local efforts to meet local needs, and the need for clear-cut Federal policies which will give coherence to the entire program.

More than ever, I am convinced that the character of medical care in this country will be influenced for generations to come by what we do in the next several years. I have no illusions about the difficulties which lie ahead. Even before I assumed my present position, I had known the Regional Medical Programs well enough to have become confident that they would, if prudently developed, realize their great potential. At Airlie House I learned that my confidence was well placed. The coming year will make all the difference. It will be difficult but thoroughly engaging.

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CCRMP . . . .

at its quarterly meeting July 8 in San Francisco, approved for forwarding to Washington six new operational proposals. Results of the balloting on priority are shown in brackets beside each project, lowest score indicating the greatest priority:

Continuing Education (2.0) by Area VII, San Diego; Family Practice (1.9) and Medical Oncology (2.7) by Area I, San Francisco; Perinatal Crisis (2.1) and Continuing Education (2.5) by Area IV, UCLA; Renal Program (2.6) Area VIII, Irvine;

The Progress Report and Continuation Application for California was approved. A total of $9,700,000 was requested for the eight Areas and the Watts-Willowbrook District RMP.

The Organization and Procedures Subcommittee reaffirmed the current system of Technical Review for proposals. Final right of approval is reserved for CCRMP but its primary function is to assign priorities.

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Date of the next meeting of CCRMP has been rescheduled to Wednesday, October 7 in Los Angeles.

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The Ad Hoc Conference Committee announces that the date of the Regional Conference at Asilomar has been changed to Oct. 28-30.

The use of carryover funds from Area V core program budget to implement five special studies has been OK'd by CCRMP as follows:

Free Clinic Liaison Program - $22,800; San Fernando Valley Health Consortium - $10,000; Respiratory Training Institute - $22,400; Summer Experience for Allied Health Students - $1,800; Comprehensive Health Care for Senior Citizens in ELA - $40,000.

The studies were approved by Area V Advisory Group on May 19 and will be reported in detail in a forthcoming issue of V-Minute News.

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WELCOME ABOARD

Cardiac Committee - Byron E. Mork, M.D., to represent Vocational Rehabilitation.

Library Services - Mrs. Myrtle Humphrey, Librarian with Charles R. Drew Postgraduate School of Medicine.

Changes in the Secretarial Staff at Area V: The newcomers are Miss Cindy Gates and Mrs. Ruth Smith.

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Lee Horovitz, former Executive Director of L. A. County Heart Assn., who has been associated with Area V Cardiac Committee as consultant, is joining California RMP as Associate Coordinator of Area IV (UCLA)

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AREA V REGIONAL MEDICAL PROGRAMS

CALENDAR

August 1970

Monday, August 3		
AREA V	Free Clinic Liaison Program	10 a.m. - 12 noon RMP Conference Room
Wednesday, August 5		
AREA V	Staff Meeting	9:30 a.m. Conference Room
Thursday, August 6		
CCRMP	Staff Consultants	2 - 5 p.m. Vintage Rm. Hilton Inn, S.F. Airport
Tuesday, August 11		
AREA V	Cardiac Coordinating	11:30 a.m. RMP Conference Room
Wednesday, August 12		
AREA V	Staff Meeting	9:30 a.m. Conference Room
Thursday, August 13		
COMP - L. A.	Health Manpower	12 noon Los Angeles
Friday, August 14		
AREA V	Committee Chairmen	11:30 a.m. RMP Conference Room

AREA ADVISORY GROUP MEETINGS FOR 1970

September 8 November 10

COMMITTEE CHAIRMEN'S MEETINGS - AUGUST, SEPTEMBER

August 14 September 11

NOTICE

During the summer months, the Calendar will cover two-week periods and V-Minute News will be published once every two weeks.

ANNIVERSARY REVIEW, AND THE DEVELOPMENTAL COMPONENT . . . .

were explained at the July 14 meeting of the Area V Advisory Group by Paul D. Ward, Executive Director of the California RMP. Over 40 AAG members, committee chairmen, core staff and guests were present to hear Mr. Ward, considered one of the most effective spokesmen for RMP on the national scene.

Mr. Ward traced the origin of the Anniversary Review and Developmental Component to long-standing efforts to decentralize federal government programs and to move some of the decision making to regional levels. The annual or anniversary review--instead of the three or four site visits currently being made--has been adopted by the Administration and the National Advisory Council as a solution to an increasingly heavy work load. The Developmental Component provides a degree of funding about which RMP's may make their own decisions. The amount is not to exceed 10% of the total amount granted to a Region for its core program and its use must give first recognition to national priorities, although the focus may be local. The method differs from the usual RMP practice in that it permits experimental testing of projects on a very small scale providing there is reasonable assurance of continued funding once the development has proved worthwhile.

"This is a legal delegation by the National Advisory Council of its review process to local Regional Advisory Groups," Mr. Ward said. "Once given the right to use these funds, we will be reviewed on a yearly basis as to whether or not the money has been spent wisely or unwisely and whether the greatest amount of benefit has been obtained for each dollar spent. Each yearly review will determine whether the original amount is increased or decreased. We have to produce results that are measureable, tangible, and meaningful to the delivery of medical care services."

A study of RMP's relation to current HEW priorities, Mr. Ward related, had resulted in a consensus that first priority had to be for development of health manpower; a second priority was given to organization and the delivery of health services (associated with preventive measures, prepaid group practice, use of subprofessional and paraprofessional personnel, ambulatory care, and the creation of any kind of model or method which provides needed health services where none previously existed, particularly in disadvantaged areas). A third priority was found in the target groups--children under five years of age, migrant farm workers and their families, and the American Indian.

All 55 RMP's will go on Anniversary Review during the next twelve months but only four or five Regions are considered sufficiently developed to get a Developmental Component. Mr. Ward estimated that California might expect to receive a quarter million of the two million dollars set aside for Developmental Component for the next fiscal year for the whole of the United States.

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V minute news

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Personality Factors, Poor Communication

Blamed for Poor Trustee-Medical Staff-Administrator Relationship

CONCERNED and serious inquiry into the hidden "core" problems that obstruct good working relationships among members of the medical staff, governing board, and administration characterized the activities of 250 physicians, trustees, and administrators attending the medical staff leadership conference at Monte Corona Conference Center, Twin Peaks, Calif., late in April.

The conference, sponsored by the postgraduate division of the University of Southern California School of Medicine and Area 5 of the California Regional Medical Programs, marked the first time that hospital medical staff members, trustees, and administrators in that area had assembled for the express purpose of discussing how they might best work together in the patients' behalf.

Under the guidance of Andre L. Delbecq, Ph.D., associate professor of business, Graduate School of Business, University of Wisconsin,

the conference participants, working in small groups, were asked to decide "in the silence of their own minds" what they believed to be the "problems behind the problems" in their working relationships and to list them in order on a small score card.

Although an indepth evaluation of the results of this particular "class exercise"—and of others in which other questions were asked—was patently impossible within the short time span of the two-day meeting, a swift tally of the replies indicated that personality problems—tendencies to dominate, differences in basic philosophy and value systems—plus ineffective communication were serious obstruction to good working relations in many hospitals. It was suggested that resolution of personality conflicts could be an important prerequisite to constructive handling of the many complex problems facing hospitals today.

COORDINATION NEEDED

At the formal presentations, which alternated with informal group sessions at the conference, attention focused on the particular challenges that medical staffs, governing boards, and administrative personnel must face as their hospitals move deeper into the 1970s.

Thomas E. Tonkin, president of the California Hospital Association, said that the demands of a more sophisticated public are making greater coordination of effort among trustees, physicians, and administrators imperative. He suggested that effective coordination would require a greater sharing by staff doctors of the responsibility for the business development of the hospital. He stressed that in certain crisis situations, such as those that arise during employee strikes when extensive work stoppage is life-threatening to the patients—the medical staff's advice and assistance are essential to a successful resolution of the problems.

Kenneth J. Williams, M.D., director of medical affairs of the Catholic Hospital Association, echoed Mr. Tonkin's comments regarding society's demands for greater coordination among trustees, physicians, and administrators. This can be achieved, he said, only if there is competent management that correlates all of the in-hospital professions and skills.

Traditionally, Dr. Williams said, hospital managements have maintained a "hands off" policy toward the medical staff and its function while the physicians, in turn, have had nothing to do with the hospital's business operation. Because the medical staff influences the quality, quantity, and cost of medical care, it represents, in a sense, the only control mechanism the public has with respect to these factors, Dr. Williams said.

Bringing the medical staff into the management of the institution, Dr. Williams explained, would require recognizing certain long-standing barriers, among them, the physicians' fear that strong management would operate as a threat to clinical freedom; election of staff leadership on the basis of popularity rather than leadership skills; the absence of job descriptions for department chiefs; rotation policies for heads of clinical departments that prevent the development of strong leadership because of limited tenure.

To overcome these barriers, Dr. Williams said, physicians must first become deeply aware of the demands society is placing upon them and then realize that their participation in the hospital's management actually will afford them greater opportunity to exercise their influence within the hospital.

A NEW SPECIALTY PREDICTED

Problems in the field of emergency care were discussed by Ralston R. Hannas Jr., M.D., who predicted that from this department would come the next recognized specialty in medical practice.

The tremendous utilization of emergency departments, Dr. Hannas said, is turning them into outpatient departments in many hospitals. Because of the need for physicians of broad capabilities to care for the wide variety of ills, disorders, and accidents that continually flow into the emergency department, the establishment of a specialty in this area is becoming necessary. He identified several existing specialties that could contribute to the type of training that would be needed for board certification of physicians specializing in emergency care. These included internal medicine, for training in episodic care; psychiatry, for treatment of acute nervous disorders, overdoses of drugs, etc.; pediatrics, for infections and poisoning cases; and

radiology, for diagnosis of signs and symptoms.

LEGAL PROBLEMS

San Francisco attorney, David E. Willett, in discussing legal trends affecting hospitals, identified three situations in which medical staffs and governing boards should exercise extreme care in their decision making in order to avoid litigious action. These were the rejection of an applicant for medical staff membership; dismissal of a member already on the staff; and adequate staffing of the emergency department.

With respect to both the application for staff membership and dismissal from the staff, the courts are especially concerned, he said, that the physicians be afforded the protection of civil liberties provisions under the U.S. Constitution. Therefore, credential committees and medical staff executive committees must make sure that their decisions are not capricious but are based on accurate information, and that their motivation for rejection of an applicant for staff membership, or dismissal of a staff member is in no way questionable.

Attorney Joseph A. Saunders of Los Angeles, speaking at the same session, listed 10 prerequisites for affording "due process" for a rejected applicant to the medical staff. Among these were the right to a hearing with proper notice as to the time of the hearing and notification of the matters that would be in controversy (the reasons for the rejection); the opportunity to present documentary facts in support of his application; entitlement to a hearing by an impartial panel; and notification of the basis on which the decision to reject was made.

Regarding dismissal of a member already on the staff, the obligation to prove dereliction becomes even stricter, with the burden of proof resting on the committee rather than on the physician, Mr. Saunders said. To avoid a possible taint of malice or slander, information acquired in investigation and evaluation of an applicant for staff membership, or of a physician facing dismissal, must be used only within the bounds of committee proceedings. Both attorneys warned that if procedures for dismissal of a physician are faulty, the court may have to decide on matters that properly should be decided by physicians and not by a judge.

The two attorneys also pointed out that, unfortunately, no dismissed physician ever sues merely for reinstatement; he invariably sues for damages as well, on the basis of loss of income, malice, etc.,—litigation that can be very costly for the hospital. They added, however, that even though a hospital might be unable to prevent a dismissed physician from bringing suit, it could, by following carefully the proper procedures for dismissal, avoid the payment of damages. ■