EVE 6
Annual Alumni Day of the Associated Alumni of
The Mount Sinai Medical Center
Saturday, May 1, 1976
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Friedman: I welcome you all to the 1976 Scientific Session of The Mount Sinai Medical Center Associated Alumni. As physicians, our very raison d'être is the daily care of patients. Our scientific session was proposed by the practicing physicians of this Medical Center. It is designed to be diagnostic, analytic, prophetic, and we fervently hope, therapeutic. Please make note of your questions and save them for the discussion which follows.

Our first speaker, Dr. Robert S. Siffert, is Director of the Department of Orthopedics. He will begin the session with an analysis of care, past and present.

Siffert: Good morning! Doctors, perhaps more than lawyers, like to talk shop. The big subject today is that medical care has gone to the dogs. It's not like the good old days, the days of the "Giants" of Mount Sinai, the days when nurses got up from their desks when the doctor arrived on the floor, and the patient's call button received immediate attention.

We boast that medically we are capable of out-treating the staff at any hospital in town, yet we complain that our own patients are not receiving the type of care we envision for them. They are unhappy about the housekeeping services and the food, and neglect and the discourtesy, long waiting for diagnostic tests, and the many inefficiencies.

The department store bureaucracy of a modern medical center not only makes us unhappy because our patients are unhappy, but because we are thwarted in our efforts to render what we consider this quality medical care.

Try to define quality care. About thirty years ago in the handicapped children's program of the Health Department, we approached this problem in an attempt to restrict reimbursement to those hospitals which rendered acceptable quality care. Using a more primitive audit system than is available today, we came to the conclusion that there was a direct correlation between good patient care and a number of very specific factors. Among these were concepts of standards, including the presence of qualified personnel, efficient management, and continuity. Standards were considered practical only if they could be measured and evaluated by direct audit or by hospital survey.

In the simplest form, it was assumed that if certain features of patient care were present, patients would be better off than if these features were absent. These ingredients, which are just as valid today, include prompt medical evaluation and evolution of a treatment plan on the admission of the patient to the hospital, the treatment team consisting of a board-qualified staff and a board-acceptable training program, active involvement of a team of nurses, social workers, rehabilitation experts, and other medical and paramedical specialists, and an administration sensitive to the objectives of patient care, serving as a means whereby these might be accomplished.
Each institution evolved a method suited to its personality, problems and restrictions, different from all others, yet potentially capable of being effective. It was soon obvious that goals and objectives, when clearly identified, could be accomplished by many different techniques. It was amazing how often a poor administration was a self-serving bureaucracy unresponsive to the advice of physicians and patient needs, while an administration that was inventive, served as a mechanism whereby quality of patient care could be accomplished.

Research and evaluation determine the effectiveness of programs and serve as a guide for introduction of new and innovative approaches. Commissioner of Health of New York, Lowell Bellin, stated that the directions of national and local health policy always emanate from health administrators, implying that the quality of these services is in direct relationship to the concern and efficiency of the administration.

Emphasizing the need for quality medical guidelines and a means of accomplishing realistic goals in today's world, Dr. Eli Ginzberg described administrators as a link in the chain that depends upon leadership by key professionals in an environment of availability of resources. Since resources are not as available as they used to be, greater and more imaginative care must be exercised in priority programming and in choosing those alternatives which best meet our current needs.

Over two years ago, Dr. Irving Leopold [Chairman of Ophthalmology at Mount Sinai, 1965-74], then President of the Medical Board, appointed an ad hoc committee on goals and priorities to explore ways in which doctors at Mount Sinai might develop leadership in improving the quality of medical care and the morale. The GAP Committee, as it was called, concluded, as did Walter Menninger, that the secret of the care of the patient is caring for the patient. The element of caring is an essential ingredient of quality health and it is the responsibility of physicians, as the most authoritative members of the treating team, to keep these criteria paramount, implying similar commitment by nurses, technicians, paramedical personnel, aides, and others who come into contact with the patient during this hospital stay.

The patient's emotional response to how well he is being cared for is, in part, a response to the concern and humanity of those around him. Every illness and therefore every outcome in terms of achieving the patient's expectations, has a huge emotional component. Lack of concern for anxiety of the patient in a frustrating and strange setting further increases the obstacles towards accomplishing both physical and emotional fulfillment of the desired objectives for each patient.

These were the concerns of the GAP Committee, which felt that greater authority to address itself to fundamental problems relative to patient care and evaluation of existing programs, as well as evolution of better approaches, should properly be the concern of all the physicians in the Hospital and of the Medical Board itself. Accordingly, one year ago, the ad hoc committee was made a standing committee of the Medical Board with these charges and its name was changed to Hospital Operation and Practices, or HOP. The optimistic HOP replacing the pessimistic
Siffert: GAP was purely fortuitous. The HOP Committee, therefore, with an unlimited charge to explore problems relating to patient care at all levels within the Hospital, will attempt to catalyze physician participation with the objective of priority and realistic program development of highest quality and at maximum administrative efficiency.

Since we are not administrators, statisticians, financial experts, or auditors, the specific charge developed by the committee itself was to explore: What can we as physicians and professionals do to improve patient care and esprit de corps in an environment of increasing administrative and fiscal restrictions, an unproductive work ethic, social pride in being impersonal if not outright impudent, and a general social, obstructionist philosophy towards work components of motivation, ambition, efficiency, and creativity?

In exploring our professional role, the dialogue that had been developed in the GAP Committee permitted regular meetings between administrators, physicians, nurses, and social workers and key practicing physicians. It was amazing how simple it became to express a concern, not through channels, but directly to the Director of the Hospital or the service, receive a commitment for action, and see a non-red-tape solution in record time. The mechanism can work.

It is now the goal of this forum to further the physician's contribution in setting quality care guidelines, in communicating these directly to our administrative authorities who are willing and able to act. As a watchdog group, the HOP Committee will attempt to coordinate the charges and the goals of the various committees of the Medical Board concerned with patient care in an attempt to present practical approaches based on practical priorities. The administration, on the other hand, has committed itself to make available staffs of administrative departments including records, patient services, volunteers, nursing administration, ambulatory care, and other programs to accomplish these goals and to evaluate them periodically.

As a mechanism to assure that the priorities established are realistic, an operational research program has been developed on the Ear, Nose, and Throat Service on Housman 6. With the assistance of a participant observer, personnel on the floor have evolved a team approach to communicate with each other the objectives of treatment of each patient and an overall management regimen. Techniques developed, it is hoped, will become a model for introduction to other services. The project is serving to measure the efficiency and coordination of hospital services in general, to document inefficiencies, and to make recommendations for better administrative coordination.

Finally, since management of patients is the name of the game at Mount Sinai, a quality care program becomes essential as a model for medical students. Although teaching basic science, research, and academic information is the responsibility of all of us as members of the faculty, translation of this information into care of the patient as a whole is the responsibility of the clinical faculty. A quality care program, therefore, is essential not only for better patient
Siffert: management, but for training of our future physicians. It is the responsibility of the medical staff and the alumni of Mount Sinai to establish quality care standards and to work with administration and other professional and paraprofessional services towards this accomplishment in a realistic environment consistent with growing restrictions and social obstacles.

Medical leadership, through its board and its committees with the support of the trustees and in coordination with medical school faculty and administration, are the goals of our efforts. We think we can do it. Thank you. [Applause]

Friedman: Thank you very much, Dr. Siffert. I now know what all that committee work has been, both through GAP and HOP.

I also want to emphasize to you that this is a day in which you can directly communicate with the administration and with the President of the Medical Center and the Board of Trustees. That communication will be available to you in the question-and-answer period following these discussions.

Our next speaker is also actively involved in the committees associated with patient care. Dr. Leonard Stone is an Associate Attending in Medicine. He has participated in many other committees and many other aspects of care of patients at the Mount Sinai Medical Center. Dr. Stone!

Stone: Bob, I think you've superbly presented the broad concepts of our problems in patient care.

I would like to say a few words about the nitty-gritty problems that we have worked with other the years. When I was asked to say something about the activities of the Patient Care Committee, I decided to do some brief historical research. I discovered that in 1956, at a time when there was great unhappiness about patient care, when everyone talked about his patients preferring Harkness Pavilion [at Columbia-Presbyterian Medical Center] or New York Hospital or even Doctor's Hospital because there was such unhappiness here, Harry Rosenwasser, who was then President of the AAS [Association of the Attending Staff], appointed a committee on patient care; Joel Hartley was his chairman. The committee sent out questionnaires to the medical staff and sent detailed reports to the Medical Board. Some of the early ones are--vary from eleven to fifteen pages of single spaced enumeration of all the deficiencies in medical care. And I think it might be of interest, sometimes, to look at some of these because some of these are not so different, although the problems, certainly, today, are not what they were then.

Joel worked tirelessly with this committee and there was a great deal of input and, I must say, in the early years, not much impact. During Dr. [Alexander] Gutman's tenure as Chairman of the Medical Board, the committee became an ad hoc committee of the Medical Board and several years later finally we became a standing committee of the Medical Board. At that time, the so-called voluntary staff, which has membership of the committee, was expanded. We enlisted full-time members of the clinical departments, the Director of the Department of Nursing, Miss Venger, later was Mrs. Kinsella and now Gail Weissman, have come
Stone: to every one of our meetings or had one of their senior members of the department join us.

Miss [Rehr?] of Social Services, has worked with the committee through the years since its inception. Later, we added members of the house staff to the committee. More recently Dr. [Elliot] Greenburg of Radiology, Dr. [Edwin] Bottone of Microbiology, have joined us so that we can have direct communication with laboratory members. For some years we had hoped to have a member of the Board of Trustees with us. Bob Kriendler was with us a short time but unfortunately he became ill and had to drop out. Now we're fortunate in having Mrs. [Jane] Aron, whose incisive comments, whose suggestions have been very helpful and for us it's nice to have a pipeline to the Board of Trustees so that they are aware of what our problems are.

What's been the charge of the committee? The charge has been to seek out problems of medical care and to recommend methods of implementation, of improvement. [Unintelligible] when we can have innovative ideas for changing our programs of patient care. The mechanism of action has been threefold: (1) the standard procedure for Medical Board committees. We have monthly meetings, we send our minutes up to the Medical Board either for information or with occasionally items earmarked for action. However, our major impact has been by cross-the-table discussion, where there are problems with admitting or where there are problems of nursing or problems of administration. We've sat, we've had heated meetings, we've battled these things out and this has been the mechanism of whatever improvements we've been able to accomplish. Another mechanism has been invitation of people. For example, when we had problems with Radiology, we invited the radiologists. We discussed-- we told them what our complaints were, what our unhappiness was, and we worked together in an effort to improve it. If we had a discussion on radiation safety in women, we invited the hospital radiation officer, the Director of Radiology, and we sat and hammered out the problem.

What are other areas of concern? The early years, food and housekeeping were problems and fortunately we haven't had a talk about them recently. We worked out, at the request of the Medical Board, a definition of patient death, which was a problem particularly now with transplantation. [Unintelligible] that we worked out and finally presented to the Medical Board for approval.

Currently, what are our headaches? Admitting has been one of our big problems and I think we've made considerable advances. I think all of you remember the days when you called the admitting office and you felt like you were calling an Arab Consulate. [Laughter] Things have changed. They are more courteous; they're friendly. The waiting area that looked like a section of a bus terminal after years of pressure has been expanded. The room is fair sized, it has a nice decor.
Some years ago Bernie Simon [Professor of Surgery] came back from a meeting on the West Coast and it had been at a small hospital where, he pointed out, they had routine laboratory studies, cardiograms and x-rays done on the way into the hospital. We tried to institute that here. At Mount Sinai things move slowly. It took us about a year and a half to get the blood count and a urinalysis. A six channel took another year. A twelve channel was two years. Subsequently, electrocardiograms were added and then routine chest x-rays. Unfortunately, it has meant transporting a patient to x-ray, having him wait there, get his films, then get another transporter to get him back to the floor. That is all being changed. The suite is being reorganized and we hope in the near future that all of the laboratory procedures, electrocardiogram, chest x-ray, is done in the admitting suite and, hopefully within an hour, and then the patient expeditiously taken back to the floor.

Radiology has been a big headache. Problems were: scheduling of appointments, long waits, questions of courtesy in the department, delays in retrieval of films, and delays in receiving reports. We have had multiple meetings with the Department of Radiology and with Administration, and last year we set up a series of standards as to what we felt this should be. How long should it be before you get an IVP [intravenous pyelogram] done when you request it? When should the films be available? How soon should you get the report? These were worked out with Elliott Greenberg and we worked out something that was to our mutual satisfaction.

Things have improved. We haven't reached Utopia yet, but the department is undergoing now some organizational changes in its working personnel. The often illegible hand-written reports are being replaced again by typewritten reports except for those few instances in which a check-off in a box--no abnormality--is sufficient. And the department is also exploring new techniques, particularly the question of computerized reading.

Pathology has been a problem. As you know, post mortem reports come months, and sometimes, years afterwards. [Unintelligible] Dr. [Stephen] Geller is acting director, we invited him to a meeting, we sat and expressed our discontent and unhappiness and following our discussion of the problems, we've arrived at what we hope is going to be a whole new era. Starting July 1st, post mortem reports are going to be signed out within a month of the time that they are done.

We are unhappy about the standardization of floors in the institution. If you go to a floor in Mount Sinai, it would be nice if you go and pick up a consultation form and know where to find it, to find an x-ray request form, to find a glove to do a rectal exam. And each floor sometimes has been like a different institution. We set up a program for this. We had the drawers color coded, a chart on each floor showing where everything is, some three and a half, four years ago. It went very well for a while and then fell apart. We are now in the process of getting this organized again. In the new era, when the Director of the Hospital has come to every one of our meetings when he's been in town, we're very optimistic.
Stone: I could go on with a number of other things we've been interested in but I think I've given you an example of some of the major areas of concern. I might mention, incidentally, also T & I [Traffic and Information], which Mr. [Samuel] Davis [Director, MSH, 1975-81] is going to take care of. This has been one of our big headaches. As you know, waiting for a transporter to take a patient from the floor to scanning or to EEG and then the long wait after it's done to get somebody to take him back to the floor, has been a big headache. I understand that this is all going to be reorganized. Hopefully, we'll put in a plug for decentralization, because many of us think that in this great big hospital, a central pool of transporters isn't the way to do it, and, hopefully, if each department-- major department-- has its own people who can identify with the department, take people back and forth, it might solve a lot of the problem. And then we won't find blood specimens under the counter in Murphy's Bar.

I'd like to conclude with a feeling that we haven't solved all our problems, but I think we've made a dent over the years. I am optimistic, particularly with the help of our new administration, that one of these days patient care at Mount Sinai is going to be what it can and should be. [Applause]

Friedman: Thank you very much, Leonard, and I'm very pleased to hear that we are making progress. Some of it isn't so obvious, but I think it will become obvious in short order.

We're very happy to have with us the new Director of the Mount Sinai Hospital who has been described as a young, enthusiastic, dedicated individual, who has had a substantial amount of directorial experience both in this state and in other states. He has been very much involved in his, so far, short stay with us, in the affairs of administration of the Hospital and particularly in the direction of patient care. He will talk to us about the current thrust of patient care and his interpretation of dreams.

Davis: Thank you, Dr. Friedman.

I really struggled, (a) as to what my topic was all about, and (b) how was I going to get started, and fortunately last night I had a dream. And I dreamt I was the son of the shah and my father was giving me a twenty-first birthday party, and we had a magnificent feast, and we had a little wine. And after the feast, my father took me to a section of the palace where I had not been in many years, and -- you heard the story -- and there in that section of the palace had been created a smaller palace for me. And he took me through the doors and there were fifty members of my harem, a gift from my father for my twenty-first birthday. And I stood in the entrance to the harem and I was just awestruck, overwhelmed. One of the more aggressive of the harem members came up to me and said, "Don't you know what to do?" And I said, "Yes, but where do you begin?" And that's a little bit like the dreams, or the nightmare, of tackling all of the problems we've got and trying to tackle them simultaneously and trying to tackle them in a way that you folks will feel is responsive.
Davis: So, I guess, there is only one way of getting at it and that's Lenny Stone's way. Some of you may remember Archie and Mehitabel and may remember Archie's line that an optimist is a guy who hasn't got very much experience. Well, Dr. Stone has got a lot of experience, Dr. Siffert has got a lot of experience, and I've got a lot of experience and in spite of that experience and in spite of the problems of New York and in spite of the kind of inputs we're getting, I'm optimistic. There are times -- I'm not a frustrated doctor, that's not my problem -- there's times I'm a frustrated administrator, but I think the job is doable.

We did an article for your alumni magazine on patient care and I'm not going to go through all of the details in that article because you'll have a chance to read it, but one of the opening lines in that paper was: “Why did you come to Mount Sinai, New York? Aren't you overwhelmed, how can you possibly try to manage this monster?” Well, apart from being an optimist, I really think it's an exciting challenge to be able to deal with the problems of patient care in as complex and as important an institution as this.

I think the dream of the harem is really about what my job is. My job, I think, like the dream, has got five parts. The parts are attitudes, data, systems, and equipment, and finally, organization. My conscious wishes, as opposed to those in my dream, are also about attitudes, data, systems, equipment, and organization. What kind of attitudes do we want to see? We'd like to see them be congenial, collegial, directed at patient care, and mostly trusting. And how do they get to be trusting? Well, I think, you've got to be straight. I think you've got to be direct and most of all, I think you've got to be predictable. There's a great expression in the Midwest: You've got to know where you're coming from. And that kind of predictability then builds trust. You've got to be visible. You've got to be around. You've got to be seen. You've got to be available.

I've got to tell you a story. Some of you know that we've been making rounds all times of day and night and weekends. Gail Weissman, our Director of Nursing, members of the administration, walk around the Hospital and one morning at four o'clock, I saw this cleaner shuffling down the corridor at the B-1 level, and I walked up to him and I said, "Hi, I'm Sam Davis, I'm the new Director of the Hospital." He looked up at me, he said, "You've got to be kidding." He just didn't believe it. Well, you gotta believe it. The attitudes that we're trying to project are not going to be validated by what we say, they're going to be validated by what we do. I hope that we have begun to establish the attitudes, or demonstrate the attitudes, that are very real.

With respect to data, we need to know what your attitudes are. We need to know what patient attitudes are. We've got to stop dealing with impression. We've got to stop waving one patient questionnaire and saying that's really what patients think. We need to know what patients think. We need to know what patients think on a unit by unit basis and we need to know what patients think from time to time. Shortly after I got here, Dr. Chalmers [Thomas Chalmers, Dean and President, 1973-83] had just come back from a management course for deans at MIT and he said, "Look, you're going to be making all these management changes. Don't you think you need some baseline data?"
Davis: Don't you think you need to know what is the affect of these changes?" And I said, "Yeah, but I really don't know how to get it." And I thought about it for a couple of days and as frequently is the case in the life of administrators, sometimes you get lucky. And I got a call from the Columbia Business School asking did we want a free market study. And I said I sure did and would they help us design a questionnaire to survey not only patients but also physician's attitudes. That would give us baseline data to measure whether indeed, we're progressing in the way we would like to.

I guess I'm not too comfortable with the department store analogy to this institution. And certainly from what I've seen in department stores since I've returned to New York, I'm less happy with that analogy. It is my hope from a systems standpoint we can begin not to function as a department store and not to function as a bureaucracy, but to function in a decentralized and responsive way. I won't tread on Gail Weissman's material. She will be talking about decentralization of nursing responsibility.

One of the things we've got to do is to begin to deal with facts and data in a systems approach. We need to know what is an adequate level of nursing staffing. We need not to deal with an impression which says: I think we've got enough nursing/I don't think we've got enough nursing. We've got to come up with very clear standards, as Dr. Siffert suggested, share these standards with you, get them validated or invalidated by you, but get to the point where medical staff agrees on what appropriate staffing levels are and move to them. That's what the productivity game is all about. And that's why we are in the midst of a very detailed and systemic study of all of the departments in the institution to establish agreed upon standards of staffing and agreed upon standards of performance, with those standards validated by you through your departments, through your committees.

Similarly, the attitudinal survey material has got to be validated and measured by you and so these attitude surveys of patients and physicians will be reviewed with Dr. Siffert's committee and will be reviewed with Mrs. Aron's committee, which is a Patient Care Committee of the Board. Dr. Stone had a good line shortly after I got here when I said, "You know we really have a proliferation of patient care committees." He said, "Yeah, the problem is so big, that if you fire enough bullets at it, you're likely to hit it." And I think that's exactly right. And so the information that we generate and the validation that we're seeking will be worked through all these of established organizations.

We've got some major problems with respect to space productivity, apart from people productivity problems. I figured out yesterday that if we could reduce the amount of waiting time of medical staff and employees on the elevators, we could probably free up a couple of million dollars of very precious resource. That's productivity. If we could shorten the number of steps taken by all of us to get from one place to another, if we could shorten the amount of time it takes to get the bloods from Murphy's Bar to the laboratory, our lives would not only be easier, there would be more time for the amenities that we all seek in patient care. And so we have just started an analysis of how space is used in the
Davis: institution and what is the flow between those spaces, and begin to look for ways of more productively aligning the space in this huge institution, which you might know has three million square feet.

Finally, we have tried to develop an organization which is alternatively called "Davis' dream," "Davis' nightmare," matrix organization, program resource, and really, all this new organization structure is a means of shortening the number of steps required to get a decision made. We have eliminated the entire layer of assistant directors in the administration. We have made it possible for physicians, for chairmen, for attendings, for people in this organization to deal directly with each other without going through an intermediary. The answers will be quicker. They may be "no", but the answers will be quicker. And it's entirely consistent with the overall thrust, which is to be responsive to your concerns for patient care. In spite of the times in New York, in spite of the weather outside, in spite of the financial crisis, I've got to tell you that after nine months more experience, I'm still an optimist. Thank you. [Applause]

Friedman: Thank you very much, Sam. And if you fulfill your promise, we have another committee of physicians who will tell you how to get started with that harem. [Laughter]

One of the focal points of patient care is nursing. We are privileged to have with us, not just another pretty face, but the Director of Nursing who has done a great deal to get closer to the ideal of patient care, Mrs. Gail Kuhn Weissman, who will talk about "Bedside Nursing: Rediscovering a Lost Art."

Weissman: Thank you, Dr. Friedman.

I've taken a different approach than to just tell you what we're trying to do here at Mount Sinai today with the Nursing Department and to better patient care. I thought it was rather important, and, actually, it came to my attention through being challenged at a recent Medical Audit Committee on why nurses had set certain outcome criteria for their outcome audit. What it brought to mind is that we as nurses had been very remiss in keeping our other colleagues in the health care professions up to date on where nursing thinks they're at today or where they're going to.

The reason that I thought I would start with this, before I got into the actual changes we are trying to implement here at Sinai, is that it gives you a perspective on the kinds of problems that are going on within the profession before the nurses ever reach Mount Sinai's door. I was a little overcome with the title "Bedside Nursing: A Rediscovered Art", because that is not the way nursing is going throughout the nation. I felt much more comfortable with "Patient Care, Our Primary Concern". Why? I would say that first I would like to share with you -- and it's a brief paragraph -- the Nurse Practice Act in the United States. At this time it is probably in the medium someplace. There are acts more restrictive and there are nursing practice acts much more broad that allow nurses to practice in a variety of other ways. This statement reads:
The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.

The period prior to World War II -- and I'm really going back a little -- the nursing education programs began to emphasize not the practice of nursing in hospitals; they started to place an emphasis in the public health area. With the onset of World War II, it brought most of the nurse's focus back into hospital care and after the war it was found that there were not enough prepared professionals to provide the care that needed to be given. It was at this time that a lot of emphasis was put on delivering care through others. At that point, the professional nurse was elevated into roles of management, and management was the aspect of their job that was rewarded. And it was, in a way, the idea wasn't necessarily bad, except that it was ludicrous in how it came about: That the nurses were being prepared for the caring of patients, with nothing in their educational background that prepared them in the field of management. And it is still true until this day in their basic preparation programs, there is very little management preparation.

In the last fifteen years in the nursing education, there has once again been an emphasis on the outpatient or the public health area, and especially true in the last six to seven years, there has been a concept called primary nursing or nurse practitioner.

The concept that I elicit from my colleagues in the educational fields is that they were looking at the increased specialization within medicine, and that there were fewer physicians going into the general practice area; that they felt that the nursing profession could be a complementary colleague, and be responsible for the health care of a group of families, possibly moving from hospital to home, and in the next ten to fifteen years their practice would more resemble that of the family physician of yesterday, with more of the emphasis on health care than on the technical aspects.

Now, the reality of everything, the education program is emphasizing health care and health emphasis when we, as hospitals, are still the largest employers of professional nurses. The concepts I've spoken about -- there are pilot programs throughout the United States where nurses are practicing in the health care areas in which they are carrying case loads usually in conjunction with a private physician's practice. They do have admission privileges at some hospitals. Arizona is doing a lot of work in this area, as well as Hawaii.

Since we are the major employers of nurses -- hospitals are the major employers of nurses -- and the nurses are primarily focusing on health rather than the care of the acutely ill patient, the new graduates that we obtain each year to provide our bedside care to our patients are confronted with a lot of frustrations as well as we as the leaders. And how do we make the transfer of their skills -- they come with a great
Weissman: deal of knowledge -- into practice? It's gone from health maintenance to the care -- versus the care of the acutely ill.

We've also been confronted in the last decade with the changing financing of health care and the need to keep all of our beds filled. This is a -- hospital services are quite costly, and by keeping our beds at full maximum, it's been very difficult to allow nurses to specialize within the institution, or to keep our patient care units a pure service. With the rapid expansion of knowledge, our nurses have been confronted with that there is more to know than one person can know and there's more skills to know than one person can master.

On the other front, in the State of New York, the profession is supporting a bill that will have the entry level into the profession at the baccalaureate level. The bill is in [the] Senate now and if it is passed, this will be the degree requirement by 1985. Part of the reason for supporting such a bill is to close the gap in education and knowledge between medicine and nursing and some of the other health care areas where the entry level degree is at a more institutional level.

Part of this is that we found that we had a big gap in coming to grips with planning patient care because our goals were so diverse by having this big breach in educational backgrounds. To provide the changes here within Sinai, as Mr. Davis spoke to, we've embarked on a decentralization of the Nursing Department, first at upper management level, in which there is now an assistant director of nursing for each pavilion or division that's comparable to the major program chairman in the Department of Medicine. And they, in turn, plan program and how the program is to be implemented within each pavilion. At the unit level, rather than having the traditional assistant supervisor cover a multitude of floors, which they were damned if they did or damned if they didn't, and never available to anyone when you felt that they should be there, we've now provided an opportunity for clinical supervisor per patient care unit with a management team on a twenty-four basis. We also were confronted with -- and I'm sure you're well aware of it -- when patient complaints came in on evenings or nights and we would try to investigate the problem, we could never find out who was on. It was never "their job' or "I wasn't on duty". Now we are looking at the units as a continuum. Now this is not a new concept. I think, most of us who have practiced for a while had worked in that situation. There was a big drift away from it, and now we're trying to reconsolidate responsibility and authority to the people who work on the unit.

In addition, we're attempting to provide some degree of specialization in clinical practice. I'd like to reemphasize, just as in medicine, one nurse can't know everything about every disease entity. But this conception of specialization, because of our high-bed occupancy, has been a little difficult to address. But we're attempting a concept called primary care, which it is our ultimate hope that with the results of the productivity and some additional staff, that we will be able to have nurses follow case loads rather than following assignments. As assignments are made today, Nurse A (as opposed to Nurse B) could have Mrs. Jones, Mr. Smith, et cetera, and tomorrow the patient she may care for may be Mr. Brown, Mr. Whoever. Primary care would allow a professional nurse to carry basically a caseload in which they would work in conjunction with one of you in carrying out
Weissman: and implementing the medical regime prescribed, and those aspects of professional nursing that would need to be followed through to get the care delivered to the patient.

This does not mean that they will always be the person that would give the care. It might also be given through others because it would be a very costly operation to completely replace all of our nursing personnel with professional staff. But they would be held responsible for why it is or is not accomplished.

The problem-solving approach is basically the process by which professional nursing is practiced now. It is not called problem-solving. You'll hear the nurses refer to it as the nursing process. I think to put it in lay terms, the best way that I can explain it, it is the old problem-solving approach that all of us learned in our schools. The integration of the technical skills has been rather difficult. We have made Mount Sinai, basically, a critical care teaching center. We had tremendous difficulty in recruiting nurses for our critical care areas. And in approaching the problem, we found that there was a desperate need in the city for nurses skilled in this area. We are giving this educational program through our School of Continuing Education, which came out of our former School of Nursing that we closed, and now have the students from City College affiliating here.

The optimistic side -- I don't want to paint it bleak, but the nurses are not coming with any technical skills -- is that the Critical Care Association is the fastest growing professional nursing association in the United States today. Of course, it is causing the American Nurses Association a little concern, but I think it does illustrate that they possibly went a little too fast in their goal for providing a health care professional nurse rather than a nurse that would meet the wide variety of patient care needs. Thank you. [Applause]

Friedman: Thank you very much, Gail. As Dr. Stone mentioned, we do have what we consider to be our own pipeline to the Board of Trustees. He is our next speaker, Mr. Alfred R. Stern, who is Vice Chairman of The Mount Sinai Medical Center and he has been involved with multiple aspects of problems associated with the Medical Center, but particularly will voice his concerns about patient care today. Mr. Stern?

Stern: Thank you, Dr. Friedman.

I was very please to note the optimistic views taken by so many speakers before me and I want to know, want you to know at the outset of my brief remarks that I am equally optimistic. So, now all we have to do is to get the job done.

I have to talk about patient care in terms of the area of concern that I have in one of my jobs as a Trustee of Mount Sinai, particularly that of development and fund raising, because this is where I've spent most of my time and my energy and therefore, it is the biggest single concern I have personally as a Trustee. And as you can imagine, it involves a lot of the things that are being talked about this morning and will continue to involve them as we move into other areas of fund raising besides the kind of thing we have been doing over the past few years: raising the
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large capital funds which built this building and did a lot of other things of a capital nature.

We, I think, are pleased with the success so far. We've done, I would guess, pretty well you would have to say, measuring our efforts against the efforts of other institutions. You know that we've been after a large drive of $152 million. We have had all kinds of help from everybody. The participation of members of the Board, the doctors, friends of the institution, have made this drive a success, not to forget the state and federal governments, which have done a good share in making it possible for us to succeed. To give you some brief numbers, the doctors have so far given about $2 million, which is a considerable amount of money from any institution. I think it is one of the largest sums ever raised by an institution from its medical staff. The Trustees have also given a tremendous amount of money, and it's their job to do so. That's really one of the main reasons why they're around. And the total Trustee giving so far has been about $33 million. We've received, of course, the balance from other sources. But that's all very fine, and we can pat ourselves on the back and be optimistic and really say, "Where are we going from here?" Some of you are very much aware of the fact that there were budget cuts instituted in this institution just recently with respect to the budget for the next fiscal year. It was a deep cut, which everybody regretted having to do, but was obviously necessary to keep us going.

We, therefore, have to begin to think about raising money for other uses, besides the capital funds drive. We need to worry about endowment, we need to worry about scholarship, and we need to worry about our ability to reconstitute the cuts and to move forward in a way which Tom Chalmers would want to do, and all the administration and, of course, all of you. And that's a job that we are going to undertake in the very near future.

It will cause us to have to broaden our base of support considerably over the kind of support that we have had in the past. The gifts we were looking at, to the extent we could find them, were gifts of $100,000 or more. Gifts of $5,000 and $10,000 when you're after $152 million don't really become efficient in terms of the time you spend to raise that kind of money. Now, however, we're after, as I say, a broad basis of support, and it's critical to us that we do find people who can give relatively small sums, large to them but relatively small in the light of what we've already raised.

In order to get this kind of money, we're going to need a review of and a concern about and a continued effort toward a better patient care because it's going to be a major source of this revenue, from the source of patients past, patients in particular. And their view of this institution is going to be critical to us, to all of us, because we will think that directly you will be beneficiaries of the kind of monies we're going to be able to raise, since it will most likely all of it will go into some form of program that you will be concerned with and benefitted from.

The image of our constituency towards this institution is therefore most critical, and those people who have a chance to view it first hand, the patients, are those who not only with their own personal reactions, but their word-of-mouth, spread a good view of our institution to the public we seek to reach or a bad one. And it's just vital to us
Stern: that that image is one which we can all be pleased with and will result in dollars. There is a quid pro quo for that pleasure, in my opinion, which we must recognize, at least as far as the work I'm concerned is going.

The assumption, it seems to me, speaking as a lay person at this meeting, is that the medical care is going to be fine. They've become impressed with the fact that the medical care at Mount Sinai is of a very high level. And that's one of the reasons they come here. But if they find themselves depressed about other aspects of their care, once they've recovered and forgotten the pains and travail they've been through, they're memory is very good about the other problems, most likely more than the fact of what kind of medical care they got because that's behind them, but they do have an impression and they talk. If you think our ex-patients don't talk, talk to any of them and you'll know they do. In any institution that is true. So their word-of-mouth and talk about us is critical and this kind of view, which we have to bear in mind -- all of us in our own jobs, you particularly in yours, the nursing group does understand it, people who run the elevators must understand it, people, as Sam Davis just indicated, who clean the floors -- everybody has got to understand that they play a part in this very vital thing and keep in mind the fact that the dollars will flow directly in proportion to the kind of job that's done in this particular area, at least in my opinion.

Then there are other things that I could tell you about that have to do with doctors who have problems of administration of after-care. The paper work that you have to go through and the view that's taken of the way you handle that by the patient is very important. I'll just give you a small example of one of the things, and it wasn't in the institution, I'm glad to say, one of the things that happened to an employee of my company, where he had to have an operation and he got the bill from the physician, from the surgeon, and I think it was about $2500 and he didn't have $2500 and he had to pay the bill. He had all the usual kinds of medical insurance and Blue Cross, et cetera. But, of course, by the time all that gets through the doctor wanted his money. So he borrowed $2500 from the bank and he paid the bill off. And then he proceeded to go through the normal channels of getting his reimbursement worked out. The biggest thing he had to face was to get the information from the doctor signed off which would indicate that, in fact, he did have this operation and all the paper work you're aware of and have to cope with all the time. He couldn't get this information from the doctor. He called up the doctor, he called up the doctor's nurse and secretary and carried on, he couldn't get it.

Finally he turned to the company, because by this time he was paying a considerable amount of interest and it was bothering him terribly and also being very costly to him. The company proceeded to try to get the doctor to come forward with this rather routine piece of paper which was vital to the collection process. We couldn't get it from the doctor either. Finally, we went to the hospital and after almost eighteen months of work, we succeeded in getting the necessary papers from the hospital which enabled this man, through our normal claims department, to get reimbursed. And by that time, of course, he had paid a relatively high interest rate for eighteen months on $2500.

Now, this is a bad example and I am sure all of you would say, "Well, that's the kind of thing that doesn't happen around here." I don't really know whether it does or not
Stern: but the point is that we must be aware of it, because leaving aside the question of the money involved, the discussion about that doctor and the affiliation with the hospital is bad for us, very bad, and something you have to watch.

So I just point that out to you. It isn't only while they're here. It isn't only the question of the kind of care they get that influences them, but it's also the question of how they're treated just generally as patients. And we must keep these things in mind.

Of course, the other problem that I'd like to bring to your attention with respect to fund raising is a rather difficult one which you face when you are asked to cut your budgets and have to find money to replace the lost funds that the institution has heretofore been giving you. And you seek to take advantage, as you should, of your doctor-patient relationships to see whether you can't raise money. And the doctors in this institution have done a very good job. On the other hand, from the point of view of our overall development, these forays into the fields of fund raising by the individual physician, which are very necessary and vital, and without which a lot of money would not be raised, have to be coordinated, in my opinion, more than they have been in the past between the central development office of the Medical Center and the individual doctors or the departments in the institution. It's difficult because you get these ideas and you go forward with them and it looks like you're going to be successful and you're jealous, and rightly so, about your ability to get this money, and you don't want to reveal your sources to someone else who might move in against you. I recognize the competitive nature of it. But at the same time, I think, we all have to be aware that there's a big job to be done and a lot of money to be raised and the coordination of this effort, it seems to me, is terribly important.

In conclusion, I want to say, as I said at the outset, that I'm optimistic. The problems that we have in all areas that have been discussed today still lead me to believe that we can get the job done and that we can, in my particular area of interest, raise the money that you're going to need and will spend wisely. I think we have to continue to work together to do this, and I think that the problems that I've raised, in some respects, are undoubtedly problems that you have and which should be discussed, and I want to thank you very much for all you've done in the past and tell you that I hope we can do as much for you as you've done for us. Thank you. [Applause]

Friedman: Thank you very much, Mr. Stern.

The President and Dean, Thomas C. Chalmers, is involved also at all levels of the running of the Medical Center. He is involved in teaching and very much involved in patient care. He will be our final speaker and round out the program. Dr. Chalmers?

Chalmers: The title you gave me, I think, is "Presidential Views." I think the best way to approach such a title is to recognize that I must tell you a little bit about my concepts of presidential duties if I am to tell you about my presidential views. I want to make these views in special reference to this very interesting program that we've had this morning.
Chalmers: I think there are four or five reasons for having a president of a medical center. The first is commonly thought of throughout the country as being fund raising. And one of the reasons why I was delighted to come to Mount Sinai rather than to any other institution as a medical center president was that fund raising seemed to be something I wouldn't have to worry about here, and that was a great relief because it's not something that I envisage myself as being very good at. So I'm just terribly grateful to Al Stern and all of the Trustees who work with him because they've done a superb job from that standpoint and made my life very easy.

The second function of a leader in an institution like this is to be a talent scout, and to be sure that the institution acquires the best possible people to do the job. And one of the wonderful parts about Mount Sinai is that so many superb physicians were here, the reputation was such that it would not be hard to overcome any disadvantages of needing further good people, and in the two and a half years that I've been here, I think we've been extremely fortunate in recruiting very good department chairmen and, as you saw this morning, I think, we've been very fortunate in recruiting a new management team for the Hospital. One of the great aspects of Mount Sinai was that its Director, when I came, was renowned throughout the country for his skills in the important aspect of reimbursement and, what I think he would be free to admit, his concentration on the outside aspects of running a great medical center. And now, I think, we've accomplished a great coup in acquiring someone who clearly enjoys the inside aspects of running a great medical center and clearly enjoys setting up administrative systems that will work. He's a little uneasy and I'm a little uneasy, everybody's a little uneasy, because they are new and somewhat experimental, but on the other hand, I'm especially delighted because they're new and somewhat experimental because I think that's the only way you really get things done in the world that are important. And that's the only way you can do them with excitement and pleasure in accomplishing them, if there is an element of the new and the different. And I learned all about matrices and other modern techniques of management at MIT in my one week conversion to an administrator. Incidentally, I've forgotten it all except -- because I haven't had to do it myself, but I still can appreciate the advantages.

And I think that we at Mount Sinai are going to be recognized throughout the world, not only for the superb-ness of our medical care, but also for the fact that we've solved the enormous problem of running a large, tremendous institution that has extremely complicated factors involved in it and takes a great deal of vigorous and enthusiastic hard work and imagination to do.

So, the good president has to be an excellent talent scout and recruit good people to accomplish the jobs that need to be done. He also has to be a good delegator. When good people come they've got to be given authority and responsibility and they've got to be allowed to make the decisions or they won't stay. They've got to have the pleasure of the responsibility falling on them and I think that is a primary function which I have, which is to ask what's going on and to show an interest in what's going on, but to defer to the better judgment of the man who is doing the job unless there is some particular reason why he should be dissuaded or argued with, but I haven't found that to happen very often around here because the people working in the institution are so competent. The president may have to, once in a while, lend an
Chalmers: ear to discouragements or conflicting viewpoints, but there again, his main function is just listening, not deciding.

The biggest job that I think anyone in my position has is that of being responsible for the long-term planning, the dreaming, the blue sky kind of thinking, the questioning about whether some of the basic concepts what we have are correct and then the talking and thinking about methods of testing them. In the long run, if we're going to have superb medical care at Mount Sinai ten to twenty years from now, we've got to think in terms of attracting the best kind of college student into our school because a reasonable percentage of them will stay.

We don't really know how to do that except by the seat of our pants. We're using a technique of clinical judgment in selecting medical students. We've got to systemize it, we've got to do research in comparing, in some way connecting what we consider to be a good doctor ten years or twenty years after he gets into the practice of medicine and what kind of a person he was when he was in college and applying to schools, so that we can choose that kind of a person to come to our school. We have to worry more about the curriculum and set up some studies which will help us to determine which curricular changes are useful and which ones are bad. And again, the reference point should not be the happiness of the student, the happiness of the faculty, although both are important -- good Lord, any dean has to appreciate that or he's a failure -- but the real concern has to be how to teach them things that will stick with them and things that will make them good doctors ten to twenty years after they graduate.

I can remember when I was practicing medicine in Cambridge, Mass., that it was not really easy to distinguish between the fellow who had graduated from Harvard Medical School thirty years ago and the fellow who had graduated from a school called P & S, which existed before World War II in Boston -- a diploma mill to which the people went who couldn't get into a legitimate medical school, and from which some of the practicing doctors thirty years later were fully as good as the graduates of Harvard Medical School.

So, we have to work on curriculum. We have to work on better ways of choosing -- or at least we have to work on maintaining good ways of choosing house officers for Mount Sinai, because they clearly are going to be our doctors on our staff of the future. And we have to be thinking constantly about the milieu in which we are going to maintain excellence in our staff after they finish their house staff training and settle here. It's very easy to sit back and say anyone who practices in an environment of an academic institution, anyone who teaches medical students, is bound to stay good. That's why a lot of us stayed around medical centers, so that we would have to do that. But I think we also have to be concerned with our graduates from the house staff and from the Medical School who don't stay in immediate contact with the teaching institution, but who go out into the community or into far-away communities, and we have to maintain an interest in them equally strong, both to help maintain the quality of their care and also to use them in conducting research to find out how better to do the job, in turning them out. How better to avoid any problems they may have ten to twenty years later by doing a better job earlier.
Chalmers: But I think these are all very exciting goals and I want to just close by saying how pleased I am to have heard this morning's session, because it sounds like progress is being made in adjusting and correcting details of patient care in this great hospital. And I think we can all be proud of the people we've heard from this morning and the interest that they're showing in accomplishing the job. Thank you. [Applause]

Friedman: Thank you very much, Dr. Chalmers.

Before we go on to the question-and-answer period, I would like to reemphasize the fact that I appreciate that all of our speakers came this morning and devoted their time, efforts and energies toward elucidating the problems related to patient care. These people on our panel and other individuals who are like them, are truly involved in The Mount Sinai Medical Center and its progress, and it's only this type of caring and the caring of all of you and of all the physicians and people who participate in the Medical Center that will produce the kind of patient care that we are all looking for. So, I thank you again and I thank everybody for coming.

I will entertain any questions to our panelists that you may have. Sir? Dr. Ginzburg.

Ginzburg: I'm Dr. Leon Ginzburg. I think most of the people know me. [Laughter] I want to ask a question as a man who has been around here for more than fifty years and maybe interject a few remarks.

Friedman: A man who is as philosophic as you, may.

Ginzburg: You know, it's a very interesting phenomena and as an example of the perversity of human nature, the more efficiently one gets a job done, the less gracious he is likely to be about it. Let me illustrate. When I first came here in the Twenties, medicine was really a sham. Since we couldn't treat disease very well, we treated the patient, and nobody, but nobody since -- nowhere have I ever seen the amount of regard with which the patient was handled. People made rounds on Saturdays, on Sundays. You couldn't do very much, but at least that made the patient feel better.

Nowadays, we've come a long way, and I'll tell you we've come a long way, and we do a great many things very efficiently. And yet when you say to one of the very efficient group, "Why don't you treat this patient like a person, as well as a case?" the answer is, "What do they want anyway? An egg in every beer?". Or to bring us more up to date -- this is a 1920 phrase -- "What do they want anyway? A dab of caviar with every glass of champagne?"

Now, an attitude like that isn't, it doesn't exist just in the hospitals and in medicine. No segment of society can have a level of ethics and morals much different from the level that is attained by the rest of the society. And I think there is a pretty general opinion at present the modes and mores in society could to some extent be improved.

It's a very interesting thing that Mr. Stern said. In attempting to gain the good graces of the populace, one of the things to impress upon the medical men and other people
Ginzburg: If we don't act in the way we should, in the final analysis it's going to affect us personally, generally, psychically, and in the pocketbook. The last is a very potent reminder of the necessity for doing things.

I think another thing that is going to make me as popular as a polecat at a picnic is: In the Groves of Academe you get a point of view, a bird's-eye view, which is likely to be a little different from the worm's-eye view that is gotten by the people who are working in what, for want of a better name, we might call the asphalt jungle. It's town and gown. It's still going on here. It's less than it was. I think recently on the surgical side the latest appointment was magnificent, and I think it's going to a great extent to alleviate that. Yet this man was not primarily a product of the Groves.

You know, this past period we've gone through, "produce or perish", where a great deal of the literature that appeared was largely ad majorem gloriam mei, rather than ad majorem gloriam dei, [laughter] was not one calculated to improve the relationship between certain individuals and their doctors. I think it's a thing to remember. I have maintained for years that we should have professors of practical surgery, or clinical surgery, and professors of research.

One other thing, and here I get a little personal. When one reaches the age of sixty-five, or did -- it used to be sixty-two for surgeons, then later sixty-five, and now, recognizing the partisan tradition, and recognizing some changes, I'd have to say sixty-eight or seventy -- but at that point, at the appointed moment, one immediately returns to the womb. Apparently, one loses one's intelligence, one's warmth, one's insight. Despite of the fact, that's about the time you first start learning what it's all about. In this country, oh, yes, you can get these accolades of a senior citizen and social security, but there doesn't seem to be any rule around here, in this country -- not just this hospital -- for entities called elder statesmen. There are a few around, but not very many. A good many people, like good wines, improve with age, and others just turn into vinegar. But that doesn't mean that you have to say that all old wines are all vinegar.

And like everything else, I think it would help a lot in general if we stopped making great generalizations and came down to, after all, what is the function of the physician: the management of individual cases, events and people. [Applause]

Friedman: Thank you very much, Dr. Ginzburg. I hope that you will continue to be our superego for many years to come.

Are there any other comments? Dr. [Albert] Cornell?

Cornell: As another member of the Committee on Patient Care, and I participate, myself, only because from a doctor's point of view I realize that [unintelligible] have to do. I don't think--I'm not saying this to be pedantic, because I'm leading up to a question.

It is, especially with Medicare--you see a patient in consultation, and you put down, you send a copy of the report to the [unintelligible]. It is a bit harder to take care of the paperwork.
Cornell: But I was going to ask Mr. Stern, I was curious as to why it did take a year and a half. I mean, I know you had the problem. But why did the surgeon--how come they couldn't get--I was just curious about the problem--his problem. Why couldn't you get the information? What was it? No answer? No excuse? What was the reason?

Stern: I'd like to be able to answer that question, Dr. Cornell. I don't really know. I only heard of this from the Personnel Department as an example of a problem. And I never, unfortunately, knew that I was going to come here. Therefore, I would have been more prepared to answer the question. But I do know that he tried, and it's my point of view that he just gave up in some respects. If he'd gone to the company back a long time -- I really don't know, or I'd answer it.

Cornell: I was going to give a partial answer.

Stern: Good.

Cornell: The only reason -- I don't say this is it -- sometimes it's the secretary.

Now sometimes it's like getting the information from Medicare, or someone to help the party out. We spend a lot of our time trying to deal with Medicare, and lately you're dealing with a computer number, and you just - In the old days you could call up and tell the man, the analyst, and say, "Well, this is a deserving case, and we should take care of it."

I'm just wondering whether it's really in the doctor's office, or whether--but I didn't mean to spend a lot of time on it.

Klingensteini: [Percy] I have listened with great interest to all the wonderful talks that were given in connection with modern patient care. I have no doubt that the patient care at Mount Sinai is not surpassed by any institution in the United States.

I noted that Dr. Stone's committee has been in existence since '56, and I wonder, really, whether they have made very many improvements, when I listen to patients who have been here in Mount Sinai Hospital. It's very disconcerting to sit at the dinner table and hear a lady state that she was in the admitting room for two hours, and then had to have persuasive powers to get somebody to take her grip up to the room.

I can speak from a little personal experience that I had recently here at Mount Sinai. My professional care was absolutely phenomenally brilliant. Fortunately, I don't know whether I should have had, but I did have nurses around the clock, and I think the expense amounted to $109 each day. If it hadn't been for that--and these are the things that Mr. Stern alluded to, that patients carry away with them after they are discharged -- if it hadn't been for that, I can assure you that my fare, in terms of food, would have been much less noteworthy. I'm not going to beat the food, but I can tell you, unless you have a nurse who can heat up a little bit of soup, which comes up ice cold -- and it's not vichyssoise in the summertime, I can tell you that -- you are absolutely devoid of that type of thing.
Klingenstein: My wife was here recently, and I don't know what people's customs are with respect to breakfast, but most people, I would say, enjoy a piece of toast. Well, the bread comes up wrapped in cellophane -- I don't know how old it is -- and she asks that it be toasted. Well, there was no toaster on the floor. How long had the toaster been out of existence? Well, that was problematical. She finally bought a toaster and donated it to the Hospital, so that she could get a piece of toast in the morning.

Now, I say this in particular reference to what Mr. Stern had to say. You know, there's an old expression that you sell your daughter with the cook, the waitress, and the laundress. And that's true of your hospitals. You sell it with the minutiae. You don't sell it with: they have a complete body scan, to the cost of some half a million dollars at the Mount Sinai Hospital. They sell it with the niceties. And I can tell you that patient care represents, if I may paraphrase Wordsworth's saying, with the little, unremembered acts of kindness and love, which I think are missing too frequently. Thank you. [Applause]

Friedman: Thank you very much, Dr. Klingenstein. And to answer those questions, we'll have Dr. Stone talk about some of it, and then we'll let Mr. Davis talk about the toaster.

Stone: Percy, what I'm delighted to see is that you have recovered and you look so well. Too, obviously, if the problems were solved, neither our committee nor the large committee would ever have to meet again.

However, I'd like to point out that the two hours you spent here in the old days were spent just waiting. Now, at least, you have a blood gas, and you have some chemistries and an x-ray and a cardiogram. So the time isn't totally wasted.

Many of the things you complain about are things that we didn't go into today, that we've talked about and Mr. Davis spoke about. There are big attitudinal problems. There's a big sociologic problem. It's not all that simple, the problems of getting our personnel to have an attitude of compassion and an attitude of interest. I'm not sure how we solve this, but it's something that everybody worries about, and has been concerned about.

I don't know. Maybe Sam can tell you something about this.

Davis: I thought you'd never ask. [Laughter]

I've really got to start out by saying that I really agree with what you said. There's no point in trying to wipe it away and say it doesn't exist, because it's very much there. Sure, it's endemic to New York City. Sure, it's endemic to large organizations, but it doesn't have to be. And it seems to me that the excitement of this job is to be able to turn around again in a period of time, and hear you folks say, "Yeah, it's better." And that [includes] the kind of little amenities that simply are not present, but which really set the tone for this institution to become a little more pleasant than we have. I could talk about systems, and I could talk about productivity, and I could talk about theory, that is, the theory of application, but I really think you're quite right, unless we can reintroduce all of this.
Davis: One of the nice things about Dr. Siffert's committee and Dr. Stone's Committee is that it doesn't only focus on the [Local] 1199 folks, and it doesn't only focus on the management folks; it also focuses on all of us in this room, in discussions about attitudes towards patients among physicians, the confidential discussions about patient information in the elevators. I think we, all of us, have got a major job ahead of us.

What also turns me on is that we're beginning to talk a little bit about [unintelligible]. We're hoping and are developing mechanisms such as Gail described, so that nurses on a unit, for example, can be responsive to the kinds of concerns you describe, rather than a nurse on the unit calling the associate director, who calls the super-associate director, who calls the director, who calls me, who calls the associate director, who calls the assistant director, who calls the housekeeper. By that time the patient is discharged.

So that I think, I think it starts with attitudes, and it starts with availability, and it starts with a declaration of purpose. And that kind of thing begins to deal with the little things while we're dealing with the existing things.

I hope that next year we'll have some real progress to add to this report. [Applause]

Friedman: You didn't mention the toaster, Sam. Sir?

Grossman: Mr. Chairman, lest I be redundant, my name is Sidney Grossman, of the vintage of Dr. Leon Ginzburg and Dr. Percy Klingenstein.

Dr. Ginzburg said something extraordinarily pertinent, and struck, as far as I am concerned, directly between the eyes, the fact that, as of my retirement on September 1, 1975, I found myself in a predicament, much of which he described. And I think it would be of great avail if there were facilities offered to individuals who perhaps chronologically are on the shelf, so to speak, but physiologically may be still very competent.

As I say, I finished my office association, in which I made this Center as my life's professional work, in September of 1975, finding myself traumatically hurt over the fact that I retired, and not because of factors concerning such things as malpractice, a decrease of revenue in the office, income tax bracket, nursing involvement in the office, and so forth, the vintage of doctors who are no longer referring patients because they have either retired or died off!

I looked at other sources, feeling that I still had capabilities for doing something. I asked first in this institution for an opportunity to serve, and was told a very honest answer, to the effect that money is not available for a position that I might seek. I applied to the United States Government, through the means of the United States Navy, to the HEW, to the Veterans Administration, and received letters that my qualifications were all very satisfactory, but in view of the fact that I had reached this particular age, I could no longer service these places.
Grossman: I applied to an emergency clinic out in New Jersey, where I live. I was told by them that they were most delighted to have me, please fill out the application; they want me as soon as I can have it approved. Within a month's time I had a letter back that the overseers of the particular county regret very much, but after age seventy they no longer are permitted to employ anybody.

Now, I ask again, as Dr. Ginzburg did in a very, very philosophical way, that these things be given thought, and that one who has the capacity -- and with all due modesty, I think I have -- not be placed upon the shelf, and whose talents, if they be such, gathered over a space of some fifty-odd years, still have a place where they can be employed.

And it was the traumatic experience of hearing Dr. Ginzburg speak that provoked me to say the few things that I have. [Applause]

Friedman: Thank you very much, Dr. Grossman. Dr. Siffert?

Siffert: I'd like to just talk about if for a moment, if I may, because that, certainly, is a question and a problem that comes to everybody's mind, and is touching more and more people today, and it is something that has not been overwhelmed by study, and perhaps we're not aware of some of the concerns. But the active members of the staff are just as concerned as you are, not so much because of the fact that we ourselves will be in that position in the not-too-distant future, but also that we are losing a tremendous amount of very good talent and very good, capable leadership.

There has been a good deal of discussion of this, the very point of thinking about the age, that if you reach a certain age, you are cut off. The surgical chiefs have met on many occasions to try to evolve some kind of a solution to this.

Now, a person at a certain age may not be as competent in some areas as he was; yet he may have gained increased competence in other areas. And the question is: How can you best use a man, not on the basis of what he has lost, but what about his positive capabilities?

I must say that this is not only of concern about people who reach retirement age, but also of concern to this institution, and all institutions that I know of, because just because a man is young does not necessarily mean that he has great talent; and a full reevaluation of where a man could be best used -- not where are his weaknesses, but where are his strong points? -- and on the other hand, where can a medical center, a medical school, and a hospital use those particular talents?

So I think what you are bringing up is very, very germane to what the problem is, and I must say that there is a great deal of concern and interest about that in the Medical Center. [Applause]
Stone: I'd just like to mention briefly that there is an organization whose name is HANYS; Muldave, of the neurologists, has been very active in using people who have been active in teaching hospitals to make rounds in hospitals in the outlying areas and teach house staff. They have made a regular schedule, regular commitment, they are paid for these rounds, and the house staffs are getting an opportunity to see people with training and background that they would never see in these small community hospitals. The question arises whether this is the kind of thing that could not be expanded.

Ginzburg: Let me clarify something. I wasn't advocating that people should be kept on in their professional positions regardless of age. I think it's very important that there be changes. As you get older, you tend to get fixed ideas, and also acquire a lot of brilliance in youth that is intentional kind.(?) And I'm not expecting anybody to be continued. I'm doing pretty well professionally. That doesn't bother me.

The trouble we forget—as I said many years ago, there was a question of succession here in the hospital. The miners didn't pick John L. Lewis to be President of the Miners' Union because he could pick more coal per hour than anybody else in the Union. He was elected for certain other qualities...

[End of Track 1 of tape]

Stone: I can't conceive of anything more tragic in the world than Mount Sinai diminishing the excellence or quality of the highly specialized physicians that it turns out. So that I think our first goal should be to turn out superb cardiologists, gastroenterologists, surgeons, and specialized surgeons.

Now, that doesn't mean that that should be the only thing we do, I think that any medical school does best when it has a mix of students among it, as any hospital training program does best when it has a mix. So that we should be, like everybody else, turning a little more attention to the general internist and the general pediatrician. And I think we can do that without changing the way the Hospital functions very much.

What I do feel very strongly about, and will fight against, unless it's rammed down our throats by the Congress, is that I do not believe that at any time, now or in the future, there should be physicians who vigorously and all day long take care of pregnant women, deliver babies, take care of the newborn, take care of the children, and then be an adult internist.

In other words, I think we should fight with everything we can the misguided trend of the return towards the general practitioner. And, agreed that everybody has to have a primary care physician, and that the internist -- and even the cardiologist -- has to expend a fair amount of his time as a primary care physician, and does a very good job at it.
Stone: But we make a little progress, I think, when we talk to the people who insist that we must be turning out more primary care physicians, about who they send their wives to when they are pregnant, and who they have to take care of their children, and who they go to when they have a pain in their chest, and they think they may have a heart attack. I think this is a political tactic thing that is bound to pass over, and we'll come back to our senses and find a middle road which will lead to the ideal mix.

One of the problems in this country that makes it very different and difficult is that we're told all the time that Britain has solved the problem; that they have general practitioners who are happy on the outside, and they have specialists in the hospital. But the patient is saved by the fact that when he gets sick enough to go to the hospital, he is taken care of by a highly trained specialist, whereas in this country, especially in the outlying areas, the general practitioner who takes care of the diabetic coma, can operate to remove the gallbladder, and take care of the meningitis in the child -- and there's no way in which he can be stopped from doing that, even though his training is no longer adequate to do it, because he hasn't been able to keep up.

Obviously in this country we have to strive to find some way to have specialists giving primary care, and possibly develop non-M.D.'s who take care of the very minor things and the more prevention aspects of medical care, as well as, maybe, well-adult checkups, which don't have to be done by M.D.'s. If we did that, then we would have some protection against the physician doing the wrong thing, or doing something which he wasn't paid for, because the non-M.D. certainly would not be able to take care of a sick person.

Most of all, I think this is the place that should be turning out superb cardiologists, superb physicians, and superb specialized, highly skilled [word inaudible], and we shouldn't let the present fad stop us in any way from continuing to do that. [applause]

Friedman: Jerry, as a superb graduate surgeon, you can understand that viewpoint. Are there any other questions? We have five minutes until lunch. Sir?

Jacoby:[John] Dr. Friedman, I would like to see an inclination that this hospital [unintelligible]. We have a lot of models, private practice models, the clinic—the old clinic; I even remember the old [unintelligible] models with the [unintelligible], and few doctors were prepared [unintelligible]. And now they're trying to bring everyone under the service [unintelligible] supervisor.

But I found myself investing in a supermodel, and I just wondered, you know, we were talking about malpractice, and not being approved. What's happening to the human factors? Are people working more in groups, or are there -- is Mount Sinai viewing this [unintelligible] -- Dr. Ginzburg's suggestion that the patient isn't being cared for?

The team approach has left out the personal touch. The idea of science, the idea of getting a brain scan and there's nobody at your bedside explaining to you that you are getting a brain scan. So how can the future, in terms of the team, in terms of
I wonder if Mount Sinai is working as well as the physician practices on the outside, as well as trying to keep the [unintelligible] on the inside. I wonder this practice is retaining [inaudible].

Chalmers: Certainly, one of the ways of solving the problem is by physicians working together, so that the patients can get the best of care in all specialties. That does require an extra effort to give the patient the feeling that he has a doctor, a personal physician.

But certainly, I think, as models of how to deliver compassionate personal care in an era of specialization -- we should be doing research in that, and trying to find better ways, and trying to evaluate how we're doing.

You're a graduate of Mount Sinai School of Medicine. Other than Dr. Frank, are there any other graduates of the Mount Sinai School of Medicine back for Alumni Day?

Well, I think it's very exciting that we have two here, and we look forward to a geometric progression of the graduates returning.

Stone: This has nothing to do with patient care, but Dr. Chalmers has brought up something that's close to my heart. As I look around, although I'm not very young, and, I guess, not very old, I find very few of my contemporaries, who took their residencies around 1966, are here. It seems that, I agree with Dr. Ginzburg with regard to patient care, it alerts anybody--my [?] inpatient care.

However, when I look around at the younger doctors who have graduated from residency programs, I doubt if [unintelligible]. And, frankly, the institution does not seem to attract a certain fraternal desire, wherein the elders have a certain revered place, and you have a succession of hierarchies in which you emulate a certain Mount Sinai attitude towards patient care which was present in the 1950s, and probably ended when I ended my residency. [Laughter]

So I was wondering what was being done to create this particular tradition, which we no longer have. What we had at Mount Sinai Hospital was a tradition that was very strong, and which was real. With the coming of the Medical School, we're in a transition era, and I don't think we have the tradition that built the culture to fall back upon. And I think that the fact that there are so few people here is a mirror of this particular problem.

I was wondering what is being done, indirectly this does influence patient care, but what is being done in building a tradition, other than the one that exists now, which, frankly, I think is pretty much devoid?

Friedman: Dr. Siffert, how would you like to try to answer that question?
Friedman: Well, one of the things that we're doing -- and I discussed this at great length with Dr. [David] Coddon, who is going to be taking over after this year -- is that we are making an effort to bring into the orbit of the Alumni Association the medical students, the graduating medical students, the house staff, and many other individuals in the institution who have not heretofore been active. This is a major goal for the coming year.

As far as tradition is concerned, tradition is a feeling that is engendered by the institution and carried down from one generation to the next, and I think that this kind of feeling will be engendered when we are all working together as unit in this institution, not only directed toward patient care, but this feeling of brotherhood and fraternalism which I think the institution can foster. I don't know the exact answer, but I think we all have thought about this. Dr. Lyons, as the archivist, do you have a statement to make regarding tradition, historically?

Lyons: We have no past tradition of any medical school. It's entirely a different direction. But, generally, I think one can make a conclusion on having seen what's happened to other places, just as in all human behavior, there are those values. I am certain that this particular period, in which students are concerned with other things, and don't have an attachment to the university, will change. And they will also start to take over the Alumni Association. The only reason for that: they will be here, and the others won't. And it will soon, before long, become an organization of graduate medical students.

I don't have any such despair that the medical students have not been part of the alumni. I can remember even my own case, and those of my friends, I don't think I ever went to an Alumni Day of my medical school, and yet I felt close to it, and in subsequent years I went when I had an opportunity, and I think the same thing will happen in the Medical School.

Friedman: Dr. Frank, as a more recent graduate, would you like to say a few words about your feeling about your role in the Alumni Association, and the institution, not so much from the traditional point of view, but your current attitude?

Frank: Thank you for the opportunity.

I find myself, as a recent graduate from medical school and as a present member of the house staff. One of the concerns that some of us feel about the institution has been [inaudible] addressed by the more senior members of [inaudible] Dr. Klingenstein.

I think it's interesting to note that the program this morning calls special [inaudible] Dr. Chalmers passing remark about medical students and house staff, had the house staffs not mentioned the maintenance of [inaudible] care of patients.

Nurses are busy with the management--to do with patients, with their care. The house staff probably as much as anybody spends time with the patients. I think it's [inaudible]. I've found, day after day, I go in and spend time with the patients on the
Frank: ward service and on the private service, and take a few minutes to talk to them about what's happening to them, what the doctor has in mind for them, what tests he ordered, and why.

Yesterday I had a patient admitted. He and his wife had some question and he said, "You're the first one to stop and take a few minutes to tell me why I'm here, and what it's all about."

I mean, this tradition that we talked about -- Dr. Ginzburg said that in the old days not much could be done, and so we spent time on the patient. I think today a lot can be done, but still we have to spend time with the patient. If there is surgery being done, the patient has to have that explained to him, as well as an explanation where [inaudible].

I would like to say that the Alumni Association, I think, will have to readdress itself to younger colleagues, such as myself. Not one of us was in any way [inaudible] a part of the program here this morning. I think if the Alumni Association continues to do its job, and the Hospital continues to give a good care of patients -- and it's inconceivable [inaudible]

...desirous, and the house staff--most of the members of the house staff are trying to deliver good patient care. [Applause]

Friedman: I think, with those remarks, we will consider that to be the renaissance, and I hope that, as Dr. Lyons says, that if we're in the valley now, this will take us up to one of the peaks that we're looking for.

Dr. Wolf, would you like to say a few words?

Wolf: Just a small collection. [Laughter]

I'd like to point out that every patient, every patient, signs informed consent before a patient comes to surgery. Responsibility of the house staff (?) to get that signed.

Friedman: Thank you very much. Dr. Ginzburg?

Ginzburg: May I end on a note of pride and joy, like Beethoven's Ninth Symphony? [Laughter]

I'd like to point out that Dr. Kammers (?), who is probably the oldest living Mount Sinai alumnus, has come here in the rain to attend this meeting. [Applause]

And I would also like to point out that we have here Dr. Sam Karellitz, who was the Chief of Medicine to the 3rd General Hospital of Mount Sinai [in World War II]. And I would like to, with great pride, remind everybody that the Mount Sinai Hospital unit, as Dr. Klingenstein had to say to me, was the only non-university hospital that had a general hospital overseas. In other words, we were of university caliber, intellectually and in action, long before we received the imprimatur of the
Ginzburg: Hospital [medical school?]. And the Third General Hospital goes back to World War I. [Applause]

Friedman: In concluding the program, I want to tell you something. Whenever I come to these programs, I really learn a hell of a lot. And I learn a lot of history, and a lot of philosophy from people like Dr. Ginzburg.

I hope that you'll all join us for lunch, and that you'll all be with us tonight for the Annual Cocktail Party. Thank you very much for coming. [Applause]