venous heparin, isoproterenol and other supportive measures are effective in the great majority of patients. We are reluctant, therefore, to advise embolectomy in patients without refractory systemic hypotension, which we believe is the single most reliable indication. However, because clinical experience varies and can be interpreted in different ways, the indications for pulmonary embolectomy cannot be categoric. The decision must be based upon clinical judgment with consideration of the clinical and hemodynamic state of the patient as well as the magnitude of the embolic obstruction. Although pulmonary embolectomy may occasionally be lifesaving, it is not indicated in the great majority of patients with major pulmonary embolism.

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Promises! Promises! or What Can We Do in the Last Forty-Two Seconds of Play?

The staff physician in a teaching municipal hospital finds himself in the horns of a dilemma. Since 1963, we have seen the most remarkable burst of health legislation in our history, with some 32 major laws involving health programs enacted by Congress; historically significant advances made on many fronts, to mention but a few: basic research, preventive medicine, therapeutic and diagnostic procedures; and finally, the advent of improved private health insurance (Medicare and Medicaid) which provides for sound medical care to more than 80 percent of our population. Federal expenditures for health programs alone will reach an estimate of $13.9 billion and public and private health and medical care expenditures will reach $50 billion for 1968. The development of medical knowledge has outpaced the capability of the medical professions to deliver successfully their services. The curve is not on its plateau nor is it in decay—it curves upward, perhaps spelling trouble!

The growth data of most municipal hospitals falls far behind: In 1940 in one major teaching municipal hospital (Boston City Hospital) there were 1593 beds in the main hospital. The professional staff looked after the acutely ill patients with 102 interns, 42 residents, and 281 visiting and consulting physicians and dentists. An administration staff of six was expected to look after their own problems. The interns received room, board and laundry, but no salary to pay for the lowly frankfurt or hamburger which cost five and ten cents respectively. The resident usually averaged $100 per month and he was much sought after (both sexes intended). The staff physician, save for those in a so-called "hazardous specialty," received no salary. Nevertheless, all of these posts were keenly sought after. The broad spectrum of patient care, with unique opportunities for teaching and research, was the nectar.

Today, this prototype hospital has 1114 beds and 98 basinets, having lost one-third of the beds of 1940, is staffed by 87 interns, 288 residents, and 58 fellows (three times the 1940 number); 693 staff physicians and dentists (two and a half times the 1940 number); and is administered by a commissioner of the Department of Health and Hospitals and his staff of some 26 commissioners, deputy and assistant deputy commissioners. The increased staffing is the response to one of many costly surveys and the merger of the city’s Health and Hospital Departments.

What has gone into this hospital’s bricks, mortar and maintenance since 1940? Some $11,315,000 was spent on major projects (minor ones not included) and the bulk of dollars came from municipal funds. In the past ten years, the hospital budget has gone from $14,400,600 to approximately $42,000,000. Nevertheless, only $500,000 per year has gone into maintenance, repairs and construction, with but minimal Federal participation. Too little for too long!—thus adding an unnecessary burden to the present administration and staff. This is a typical story throughout the U.S.A. in 1969.

But what does all this mean for our future? Our “alumni body” of patients is no longer made up

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overwhelmingly of the poor and the disenfranchised. Along with the more fortunate, an "economic prescription," (a necessity for optimal medical care), in the form of third party payments, is presently available to the majority of our patients. The cash flow from these sources is estimated in many millions of dollars yearly. All of the revolutions, so ably defined by the distinguished British economist, Barbara Ward, namely; equality—material change—population increase and scientific contribution, are knocking on the front door of all of our hospitals.

Is the staff ready to assume their responsibilities in the faces of these revolutionary changes? My title "Promises! Promises!": pessimistic, on the one hand, to the reported material promises from the municipal authorities and trustees or "What Can We Do In The Last Forty-Two Seconds Of Play?": optimistic on the other hand, suggests a chauvinistic acceptance once again of a meaningful relationship between staff—administration—trustees and the municipality officers, despite many frustrations. The staff has a good professional product, namely, acutely ill patients seeking help; good production, packaging and distribution by loyal staff and paramedical personnel; and improving cash flows into administration, which will be properly directed in significant amounts to the staff from patient care. However, archaic physical plants, unbelievable road blocks in the processing of urgent matters and the hardships of decentralization face the staff too, almost daily.

The business iconoclast questions—"Could private industry or a hospital with an authority management do better?"

On the more positive side—the medical staffs work very hard for changes to come. "Ad hoc" committees put in innumerable hours working with devoted administrators, trustees, deans' offices, and the municipal staff. Effective patient management, significant teaching and research, still prevail in most municipal hospitals despite odds. The number of geographic full-time physicians increases almost inversely with the (damaged) newspaper image of these institutions. The hospital parking facilities with its disarray of parked cars, usually the worse for their stay, attests to the increased numbers of devoted personnel. An attractive upper limits salary scale should be drawn up based on hospital and/or school rank, for the geographic full-time staff member. An appropriate and efficient method for the collection and distribution of third party payments to the responsible staff members must be instituted.

A competent, professional full-time business counselor should be employed to process and collect fees for professional services, implement proposed plans for appropriate salary support for staff members, and serve as general business counsel to the staff in their increasingly complex and time-consuming relationships with administration, medical schools and community. The staff should be free to devote most of its time to patient care, teaching and/or research—the subjects he knows best.

This leads me to my concluding remarks. A distinguished Harvard football team recently demonstrated what could be done in the last 42 seconds of play. Some may leave for "greener pastures" before the game ends, emulating those in the stadium who rushed out to cocktails or to catch trains, thinking the game was over. Those who remain in the municipal hospital setting should find the final moments exciting, for several institutions are on the brink of adopting plans for municipal hospital—city government—medical school and community interrelationships. The combined impact of new patient groups, new career goals for the medical staff and personnel and changing student and faculty interests is resulting in a proliferation of community hospital programs crying out for medical staff leadership.

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