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9-683-068

REV: JUNE 2, 2003

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Shouldice Hospital Limited

Two shadowy figures, enrobed and in slippers, walked slowly down the semidarkened hall of the Shouldice Hospital. They didn't notice Alan O'Dell, the hospital administrator, and his guest, who had just emerged from the basement boiler room on a tour of the facility. Once they were out of earshot, O'Dell remarked good naturedly, "By the way they act, you'd think our patients own this place. And while they're here, in a way they do."

Following a visit to the five operating rooms, also located on the first of three levels, O'Dell and his visitor once again encountered the same pair of patients still engrossed in discussing their hernia operations, which had been performed the previous morning.

History

Born on a farm in Bruce County, Ontario, Dr. Earle Shouldice, who was to found the hospital bearing his name, first displayed his interest in medical research at the age of 12. He performed a postmortem on a calf that, he discovered, had died from an intestinal obstruction. After a year of following the wishes of his parents that he study for the ministry, Shouldice persuaded them to let him enroll in medicine at the University of Toronto.

An attractive brochure that was recently printed, although neither dated nor distributed to prospective patients, described Earle Shouldice as follows:

> While carrying on a private medical and surgical practice in the years between the two World Wars and holding a post as lecturer in anatomy at the University of Toronto, Dr. Shouldice continued to pursue his interest in research. He did pioneer work towards the cure of pernicious anemia, intestinal obstruction, hydrocephalic cases and other areas of advancing medical knowledge.
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> His interest in early ambulation stemmed, in part, from an operation he performed in 1932 to remove the appendix from a seven-year-old girl and the girl's subsequent refusal to stay quietly in bed. In spite of her activity, no harm was done, and the experience recalled to the doctor the postoperative actions of animals upon which he had performed surgery. They had all moved about freely with no ill effects. Four years later he was reminded of the child when he allowed washroom privileges immediately following the operations to four men recovering from hernia. All had trouble-free recovery.

Professor James Heskett prepared this case. HBS cases are developed solely as the basis for class discussion. Cases are not intended to serve as endorsements, sources of primary data, or illustrations of effective or ineffective management.

By the outset of the Second World War in 1940, Shouldice had given extensive thought to several factors that contributed to early ambulation following surgery. Among them were the use of a local anesthetic, the nature of the surgical procedure itself, the design of a facility to encourage movement without unnecessarily causing discomfort, and the postoperative regimen designed and communicated by the medical team. With all of these things in mind, he had begun to develop a surgical technique for repairing hernias[1] that was superior to others. He offered his services in correcting hernias for army inductees who otherwise would not qualify for service. Because hospital beds often were not available, sometimes the surgery took place in the emergency department of the Toronto General Hospital, and the patients were transported later in the day to a medical fraternity where they were cared for by medical students for two or three days.

By the war's end, word of the Shouldice technique had spread sufficiently that 200 civilians had contacted the doctor and were awaiting surgery upon his discharge from the army. Because of the scarcity of hospital beds, particularly for an operation that was considered elective and of relatively low priority, he started his own hospital. Dr. Shouldice's medical license permitted him to operate anywhere, even on a kitchen table, and consequently he received authorization from the provincial government to open his first hospital in a six-room nursing home in downtown Toronto in July 1945. As more and more patients requested operations, Dr. Shouldice extended his facilities by buying a rambling 130-acre estate with a 17,000-square foot main house in the suburb of Thornhill, 15 miles north of downtown Toronto. Initially, a 36-bed capacity was created in Thornhill, but after some years of planning, a large wing was added to the house to provide a total capacity of 89 beds.

At the time of his death in 1965, Dr. Shouldice's long-time associate, Dr. Nicholas Obney, was named surgeon-in-chief and chairman of the board of Shouldice Hospital Limited, the corporation formed to operate both the hospital and clinical facilities. Under Dr. Obney's leadership, the volume of activity continued to increase, reaching a total of 6,850 operations in the 1982 calendar year.

The Shouldice Method

Only external types of abdominal hernias were repaired at Shouldice Hospital. Internal types, such as hiatus (or diaphragmatic) hernias, were not treated. As a result, most first-time repairs (called primaries) involved straightforward operating procedures that required about 45 minutes. Primaries represented approximately 82% of all operations performed at Shouldice in 1982**.** The remaining 18% involved patients suffering recurrences of hernias previously repaired elsewhere.[2]

In the Shouldice method, the muscles of the abdominal wall were arranged in three distinct layers, and the opening was repaired—each layer in turn—by overlapping its margins in much the same manner as the edges of a coat might be overlapped when buttoned. The end result was to reinforce the muscular wall of the abdomen with six rows of sutures (stitches) under the skin cover, which was

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[1] Most hernias, known as external abdominal hernias were protrusions of some part of the abdominal contents through a hole or slit in the muscular layers of the abdominal wall which was supposed to contain them. Well over 90% of these hernias occurred in the groin area. Of these, by far the most common were inguinal hernias, many of which were caused by a slight weakness in the muscle layers brought about by the passage of the testicle in male babies through the groin area shortly before birth. Aging also caused inguinal hernias to develop. The other, much less common, external hernias were called "femoral," in which a protrusion appeared in the top inch or so of the thigh. Because of the cause of the affliction, 85% of all hernias occurred in males.

[2] Based on a careful tracking of its patients over more than 30 years, it was estimated that the gross recurrence rate for all operations performed at Shouldice was 0.8%. Recurrence rates reported in the literature for these types of hernia varied greatly. However, one text published around that time stated, "In the United States the gross rate of recurrence for groin hernias approaches 10%."

then closed with clamps that were removed within 48 hours after the operation. (Other methods might not separate muscle layers, often involved fewer rows of sutures, and sometimes involved the insertion of screens or meshes under the skin.)

The typical first-time repair could be completed with the use of preoperative sedation (sleeping pill) and analgesic (pain killer) plus a local anesthetic, an injection of Novocain in the region of the incision. This allowed immediate patient ambulation and facilitated rapid recovery. Many of the recurrences and the very difficult hernia repairs, being more complex, could require up to 90 minutes and more. In some circumstances, a general anesthetic was administered.

The Patients' Experience

It was thought that most potential Shouldice patients learned about the hospital and its methods from past patients who had already experienced them. Although over 1,000 doctors had referred patients, doctors were less likely to recommend Shouldice because of the generally regarded simplicity of the surgery, often considered a "bread and butter" operation. Typically, many patients had their problem diagnosed by a personal physician and then took the initiative to contact Shouldice. Many more made this diagnosis themselves and contacted the hospital directly.

The process experienced by Shouldice patients depended on whether or not they lived close enough to the hospital to visit the facility to obtain a diagnosis. Approximately 42% of all Shouldice patients came from the United States. Another 2% originated from provinces other than Ontario and from European countries. These out-of-town patients often were diagnosed by mail, using the Medical Information questionnaire shown in **Exhibit 1**.

Of every eight questionnaires sent, seven were returned to the hospital in completed form. Based on information in the questionnaire, a Shouldice surgeon would determine the type of hernia the respondent had and whether there were signs that some risk might be associated with surgery (for example, an overweight or heart condition, or a patient who had suffered a heart attack or a stroke in the past six months to a year, or whether a general or local anesthetic was required). At this point, a patient was given an operating date, the medical information was logged into a computerized data base, and the patient was sent a confirmation card; if necessary, a sheet outlining a weight loss program prior to surgery and a brochure describing the hospital and the Shouldice method were also sent. A small proportion was refused treatment, either because they were too fat, represented an undue medical risk, or because it was determined that they did not have a hernia.

If confirmation cards were not returned by the patient three days or more prior to the scheduled operation, that patient was contacted by phone. Upon confirmation, the patient's folder was sent to the reception desk to await his or her arrival.[3]

Arriving at the clinic between 1:00 P.M. and 3:00 P.M. the day before the operation, a patient might join up with 30 to 34 other patients and their friends and families in the waiting room. After a typical wait of about 20 minutes—depending on the availability of surgeons—a patient was examined in one

[3] Patients living within 50 miles from the hospital (about 40% of all patients) were encouraged to come to the clinic on a walk-in basis for an examination, usually requiring no more than 15 or 20 minutes for the physical and completion of an information questionnaire. If the doctor performing the examination diagnosed the problem as an external hernia, the individual could obtain immediately a future booking for the operation. On occasion, when a previously booked patient canceled at the last minute, a walk-in patient, or one selected from a special waiting list, could be scheduled for the next day. At the time of booking, the potential patient was given a specific date for the operation, a letter estimating the total cost of the operation (as required by the Ontario provincial government for all Ontario residents), and information supplied to out-of-province patients.

of six examination rooms staffed by surgeons who had completed their operating schedules for the day. This examination required no more than 15 to 20 minutes, unless the patient needed reassurance. (Patients typically exhibited a moderate level of anxiety until their operation was completed.) At this point it occasionally was discovered that a patient had not corrected his or her weight problem; others might be found not to have a hernia after all. In either case, the patient was sent home.

Following his or her examination, a patient might experience a wait of 5 to 15 minutes to see one of two admitting personnel in the accounting office. Here, health insurance coverage was checked, and various details were discussed in a procedure that usually lasted no more than 10 minutes. Patients sometimes exhibited their nervousness by asking many questions at this point, requiring more time of the receptionist.

Patients next were sent to one of two nurses' stations where, in 5 to 10 minutes and with little wait, their hemoglobin (blood) and urine were checked. At this point, about an hour after arriving at the hospital, a patient was directed to the room number shown on his or her wrist band. Throughout the process, patients were asked to keep their luggage (usually light and containing only a few items suggested by the hospital) with them.

All patient rooms at the hospital were semiprivate, containing two beds. Patients with similar jobs, backgrounds, or interests were assigned to the same room to the extent possible. Upon reaching their rooms, patients busied themselves unpacking, getting acquainted with roommates, changing into pajamas, "prepping" themselves (shaving themselves in the area of the operation), and providing a urine sample.

At 5:00 P.M. a nurse's orientation provided the group of incoming patients with information about what to expect, the drugs to be administered, the need for exercise after the operation, the facility, and the daily routine. According to Alan O'Dell, "Half are so nervous they don't remember much from the orientation." Dinner was served from 5:30 to 6:00 P.M. in a 100-seat dining room on a first-come, first-served basis. Following further recreation, tea and cookies were served at 9:00 P.M. in the lounge area. Nurses emphasized the importance of attendance at that time because it provided an opportunity for preoperative patients to talk with those whose operations had been completed earlier that same day. Nearly all new patients were "tucked into bed" between 9:30 and 10:00 P.M. in preparation for an early awakening prior to their operations.

Patients to be operated on early in the day were awakened at 5:30 A.M. to be given preop sedation and to be dressed in an O.R. (operating room) gown. An attempt was made to schedule operations for roommates at approximately the same time. Patients were taken to the preoperating room where the circulating nurse administered Demerol, an analgesic, 45 minutes before surgery. A few minutes prior to the first operation at 7:30 A.M., the surgeon assigned to each patient administered Novocain, a local anesthetic. During the operation, it was the responsibility of the circulating nurse to monitor the patient's comfort, to note times at which the Novocain was administered and the operation begun, and to arrange for the administration of Demerol to the patient scheduled next on the operating table, depending on the progress of the surgery under way. This was in contrast to the typical hospital procedure in which patients were sedated in their rooms prior to being taken to the operating rooms.

Upon the completion of the operation, during which a few patients were "chatty" and fully aware of what was going on, patients were invited to get off the operating table and walk to the post-operating room with the help of their surgeons. According to Ursula Verstraete, director of nursing:

> Ninety-nine percent accept the surgeon's invitation. While we put them in wheelchairs to return them to their rooms, the walk from the operating table is for psychological as well as

> physiological [blood pressure, respiratory] reasons. Patients prove to themselves that they can do it, and they start their all-important exercise immediately.

Throughout the day after their operation, patients were encouraged to exercise by nurses and housekeepers alike. By 9:00 P.M. on the day of their operations, all patients were ready and able to walk down to the dining room for tea and cookies, even if it meant climbing stairs, to help indoctrinate the new "class" admitted that day.

Patients in their second or third day of recovery were awakened before 6:00 A.M. so they could loosen up for breakfast, which was served between 7:45 and 8:15 A.M. in the dining room. Good posture and exercise were thought to aid digestion and deter the buildup of gas that could prove painful. After breakfast on the first day after surgery, all of the skin clips (resembling staples) holding the skin together over the incision were loosened and some removed. The remainder were removed the next day. On the fourth morning, patients were ready for discharge.

During their stay, patients were encouraged to take advantage of the opportunity to explore the premises and make new friends. Some members of the staff felt that the patients and their attitudes were the most important element of the Shouldice program. According to Dr. Byrnes Shouldice, the 53-year-old son of the founder and vice president of the corporation—a surgeon on the staff and a 50% owner of the hospital:

> Patients sometimes ask to stay an extra day. Why? Well, think about it. They are basically well to begin with. But they arrive with a problem and a certain amount of nervousness, tension, and anxiety about their surgery. Their first morning here they're operated on and experience a sense of relief from something that's been bothering them for a long time. They are immediately able to get around, and they've got a three-day holiday ahead of them with a perfectly good reason to be away from work with no sense of guilt. They share experiences with other patients, make friends easily, and have the run of the hospital. In summer, the most common after-effect from the surgery is sunburn. They kid with the staff and make this a positive experience for all of us.

The average patient stay for comparable operations at other hospitals was thought to be five to seven or eight days, but it had been declining because of a shortage of beds and the tendency to give elective surgery a low priority for beds. Shouldice patients with jobs involving light exercise could return to work within a week after their operations, but those involved in more strenuous work, whose benefits were insured, received four weeks of benefits and recuperation. All self-employed persons returned to work much earlier. In general, typical times for recuperation from similar operations at other hospitals were two weeks for those in jobs requiring light exercise and eight weeks for those in more strenuous jobs, due largely to long established treatment regimens.

The Nurses' Experience

The nursing staff comprised 22 full-time and 18 part-time members. They were divided into four groups (as shown in **Exhibit 2**), with supervisors for the hospital, operating room, laboratory, and central supply reporting to Ursula Verstraete, the director of nursing.

While the operating rooms were fully staffed from about 7 A.M. through the last operation ending in the mid- to late afternoon, the hospital was staffed with three shifts beginning at 7 A.M., 3 P.M., and 11 P.M. Even so, minimal patient needs for physical assistance allowed Shouldice to operate with a much lower nurse-to-patient ratio than the typical hospital. Shouldice nurses spent an unusually

large proportion of their time in counseling activities. As one supervisor commented, "We don't use bedpans." In a typical year, Verstraete estimated that she might experience a turnover of four nurses.

The Doctors' Experience

The hospital employed 12 full-time surgeons, 7 part-time assistant surgeons, and one anesthetist. Each operating team required a surgeon, an assistant surgeon, a scrub nurse, and a circulating nurse. The operating load varied from 30 to 36 operations per day. As a result, each surgeon typically performed three or four operations each day.

A typical surgeon's day started with a *scrubbing* shortly before the first scheduled operation at 7:30 A.M. If the first operation was routine, it usually was completed by 8:15 A.M. At its conclusion, the surgical team helped the patient walk from the room and summoned the next patient. While the patient was being prepared and awaiting the full effects of the Demerol to set in, the surgeon completed the previous patient's file by dictating five or so minutes of comments concerning the operation. Postoperative instructions were routine unless specific instructions were issued by the surgeon. After scrubbing, the surgeon could be ready to operate again at 8:30 A.M.

Surgeons were advised to take a coffee break after their second or third operation. Even so, a surgeon could complete three routine operations and a fourth involving a recurrence (a 60- to 90-minute procedure) and still be finished in time for a 12:30 P.M. lunch in the staff dining room.

Upon finishing lunch, as many as six of the surgeons not scheduled to operate in the afternoon moved upstairs to examine incoming patients between 1:00 and 3:00 P.M. A surgeon's day ended by 4:00 P.M. In addition, a surgeon could expect to be on call one weekday night in ten and one weekend in ten. Alan O'Dell commented that the position appealed to doctors who "want to watch their children grow up. A doctor on call is rarely called to the hospital and has regular hours."

According to Dr. Obney, chief surgeon:

> When I interview prospective surgeons, I look for experience and a good education. I try to gain some insight into their domestic situation and personal interests and habits. Naturally, as in any field, we try to avoid anyone with a drinking or drug problem. Oftentimes these people can hide their illness very well and it can take a while before it is detected. Here, sometimes, recommendations can be of great help. I also try to find out why a surgeon wants to switch positions. And I try to determine if he's willing to perform the repair exactly as he's told. This is no place for prima donnas.

Dr. Shouldice added:

> Our surgeons enjoy operating, but sometimes are less interested in the more mundane office routines that all vocations have. Traditionally a hernia is often the first operation that a junior resident in surgery performs. Hernia repair is regarded as a relatively simple operation compared to other major operations. This is quite wrong, as is borne out by the resulting high recurrence rate. It is a tricky anatomical area and occasionally very complicated, especially to the novice or those doing very few hernia repairs each year. But at Shouldice Hospital a surgeon learns the Shouldice technique over a period of several months. He learns when he can go fast and when he must go slow. He develops a pace and a touch. If he encounters something unusual, he is encouraged to consult immediately with other surgeons. We teach each other and try to encourage a group effort. And he learns not to take risks to achieve absolute perfection. Excellence is the enemy of good.

Dr. Obney assigned surgeons to an operating room on a daily basis by noon of the preceding day. This allowed surgeons to examine the specific patients that they were to operate on. Surgeons and assistants were rotated every few days. Scrub nurses and circulating nurses were assigned to a new operating room every two weeks and four weeks, respectively. Unless patients requested specific doctors, cases were assigned to give doctors a nonroutine operation (often involving a recurrence) several times a week. More complex procedures were assigned to more senior and experienced members of the staff, including Dr. Obney himself. Where possible, former Shouldice patients suffering recurrences were assigned to the doctor who performed the first operation "to allow the doctor to learn from his mistake."

As Dr. Obney commented:

> If something goes wrong, we want to make sure that we have an experienced surgeon in charge, and we don't like surgeons who work too fast. Experience is most important. The typical general surgeon may perform 25 to 50 hernia operations per year. Ours perform 600 or more.

The 12 full-time surgeons were paid a straight salary. A typical starting salary at that time for someone with 5 to 10 years of experience was $50,000. In addition, bonuses to doctors were voted by the board of directors twice a year, depending on profit and performance. The total bonus pool paid to the surgeons in a recent year was approximately $500,000. Assisting surgeons were part-time, and they received 51% of the $60 fee that was charged to patients who received their services.

The anesthetist was hired for $300 per day from a nearby partnership. Only one was required to be on duty on any given day and could supervise all five operating rooms in addition to administering an occasional general anesthetic to a patient with a complex case or to a child.

Training in the Shouldice technique was important because the procedure could not be varied. It was accomplished through direct supervision by one or more of the senior surgeons. The rotation of teams and frequent consultations allowed for an ongoing opportunity to appraise performance and take corrective action.

According to Dr. Obney:

> We haven't had to let anyone go because they couldn't learn, or continue to adhere to, the method. However, a doctor must decide after several years whether he wants to do this for the rest of his life because, just as in other specialties—for example, radiology—he loses touch with other medical disciplines. If he stays for five years, he doesn't leave. Even among younger doctors, few elect to leave.

The Facility

A tour of the facility with Alan O'Dell yielded some interesting information. The Shouldice Hospital comprised two basic facilities in one building—the hospital and the clinic.

On the first-level opening to grade at the back of the building, the hospital contained the kitchen and dining rooms as well as the office of the supervisor of housekeeping. The second level, also opening to grade but at the front of the building, contained a large, open lounge area, the admissions offices, patient rooms, and a spacious glass-covered Florida room. The third level had additional patient rooms, a large lounge, and a recreational area.

Throughout the tour, patients could be seen visiting in each others' rooms, walking up and down hallways, lounging in the sunroom, and making use of light recreational facilities ranging from a pool table to an exercycle.

Alan O'Dell pointed out some of the features of the hospital:

> The rooms contain no telephones or television sets. If a patient needs to make a call or wants to watch television, he or she has to take a walk. The steps are designed specially with a small rise to allow patients recently operated on to negotiate the stairs without undue discomfort. Every square foot of the hospital is carpeted to reduce the hospital feeling and the possibility of a fall. Carpeting also gives the place a smell other than that of disinfectant.
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> This facility was designed by Dr. Byrnes Shouldice. He thought about it for years and made many changes in the plan before the first concrete was poured. A number of unique policies were also instituted. Because Dr. Shouldice started out to be a minister, ministers are treated gratis. And you see that mother and child in the next room? Parents accompanying children here for an operation stay free. You may wonder why we can do it, but we learned that we save more in nursing costs than we spend for the patient's room and board. Children may present difficulties in a hospital environment, but when accompanied by a parent, the parent is happier and so is the child.

While patients and staff were served food prepared in the same kitchen, the staff was required to pick up its food from a cafeteria line placed in the very center of the kitchen. This provided an opportunity for everyone to chat with the kitchen staff several times a day as they picked up a meal or stopped for coffee. Patients were served in the adjoining patient dining room.

According to O'Dell:

> We use all fresh ingredients and prepare the food from scratch in the kitchen. Our kitchen staff of three prepares about 100 breakfasts, 200 lunches, and 100 dinners each day at an average raw food cost of $1.10 per meal.

Iona Rees, director of housekeeping, pointed out:

> We do all of our own laundry in the building with two full-time employees. And I have only three on my housekeeping staff for the entire facility. One of the reasons for so few housekeepers is that we don't need to change linens during a patient's four-day stay. They are basically well, so there is no soiling of bed linens. Also, the medical staff doesn't want the patients in bed all day. They want the nurses to encourage the patients to be up socializing, comparing notes [for confidence], encouraging each other, and walking around, getting exercise.
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> Of course, we're in the rooms straightening up throughout the day. This gives the housekeepers a chance to josh with the patients and to encourage them to exercise.

The bottom level of the clinic housed five operating rooms, a laboratory, the patient-recovery room, and a central supply area where surgical instruments were cleaned and sterilized. This was the only area of the entire facility that was not carpeted, to prevent static electricity from forming in areas where potentially explosive anesthetics might be used. In total, the estimated cost to furnish an operating room was no more than $30,000. This was considerably less than for other hospitals requiring a bank of equipment with which to administer anesthetics for each room. At Shouldice, two mobile units were used by the anesthetist when needed. In addition, the complex had one "crash cart" per floor for use if a patient should suffer a heart attack or stroke during his or her hospital stay.

The first floor of the clinic contained admissions and accounting offices, a large waiting room with a capacity for as many as 50 people, and 6 examination rooms. On the second floor of the clinic, situated in much of what was the original house, was found the administrative offices. A third floor contained 14 additional hostel rooms where patients could be held overnight awaiting the assignment of a room and their operations. At such times when the hospital was particularly crowded, doctors were asked to identify those postoperative patients who could be released a day early. Often these were local residents or children.

Administration

Alan O'Dell, while he walked, described his job:

> I'm responsible for a little of everything around here. We try to meet people's needs and make this as good a place to work as possible. My door is always open. And members of our staff will come in to seek advice about everything from medical to marital problems. There is a strong concern for employees here. Nobody is fired. [This was later reinforced by Dr. Shouldice, who described a situation involving two employees who confessed to theft in the hospital. They agreed to seek psychiatric help and were allowed to remain on the job.] As a result, turnover is low.
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> We don't have a union, but we try to maintain a pay scale higher than the union scale for comparable jobs in the area. For example, our nurses receive from $15,000 to $25,000 per year, depending on the number of years' experience. We have a profit-sharing plan that is separate from the doctors'. Last year the employees divided up $65,000.
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> If work needs to be done, people pitch in to help each other. A unique aspect of our administration is that I insist that each secretary is trained to do another's work and in an emergency is able to switch to another function immediately and enable the more vital workload to proceed uninterrupted. With the exception of the accounting staff, every secretary, regardless of her or his position in the hospital, is trained to handle the hospital switchboard and work at the reception desk. If necessary, I'll go downstairs and type billings if they're behind. We don't have an organization chart. A chart tends to make people think they're boxed into jobs.[4]
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> In addition to other activities, I try to stay here one night a week having dinner and listening to the patients to find out how things are really going around here.

Administrative Structure

The hospital was operated on a nonprofit basis and the clinic on a for-profit basis. Dr. Shouldice and Mrs. W. Urquhart, his sister, each owned 50% of each.

O'Dell, as administrator of the hospital, was responsible for all of its five departments: surgery, nursing, administration, maintenance, and housekeeping. Medical matters were the domain of Dr. Obney, the chief surgeon. Both Alan O'Dell and Dr. Obney reported directly to an executive committee composed of Drs. Shouldice and Obney, Alan O'Dell, Ursula Verstraete (director of nursing), and Mrs. Urquhart. The executive committee met as needed, usually twice a month, and in turn reported to an inside board (as shown in **Exhibit 2**). In addition to executive committee members

[4] The chart in **Exhibit 2** was prepared by the casewriter, based on conversations with hospital personnel.

(except Ursula Verstraete), the board included the spouses of Dr. Shouldice and Mrs. Urquhart, two former long-time employees, and Jack MacKay. The board met three times per year, or when necessary.

Operating Costs

It was estimated by the casewriter that the 1983 budgets for the hospital and clinic were close to $2.8 million and $2 million, respectively.[5]

The Market

Hernia operations were among the most common performed on males. In 1979, for example, it was estimated that 600,000 such operations were performed in the United States alone. Only in the early 1980s had the hospital begun to organize information about either its client base of 140,000 "alumni" or the market in general.

According to Dr. Shouldice:

> When our backlog of scheduled operations gets too large, we begin to wonder how many people decide instead to have their local doctor perform the operation. Every time we have expanded our capacity, the backlog has declined briefly, only to climb once again. Right now, at 1,200, it is larger than it has ever been at this time of year [January].

The hospital relied entirely on word-of-mouth advertising, the importance of which was suggested by the results of a poll carried out by students of DePaul University as part of a project (**Exhibit 3** shows a portion of these results). Although little systematic data about patients had been collected, Alan O'Dell remarked that "if we had to rely on wealthy patients only, our practice would be much smaller."

Patients were attracted to the hospital, in part, by its reasonable rates. For example, charges for a typical operation were four days of hospital stay at $111 per day, a $450 surgical fee for a primary inguinal (the most common hernia) operation, and a $60 fee for the assistant surgeon.[6] If a general anesthetic was required, an additional fee of $75 was assessed. These were the charges that compared with total costs of $2,000 to $4,000 for operations performed elsewhere.

Round-trip fares for travel to Toronto from various major cities on the North American continent ranged from roughly $200 to $600.

In addition to providing free services to the clergy and to parents of hospitalized children, the hospital also provided annual checkups to its alumni, free of charge. Many of them occurred at the time of the annual reunion. The most recent reunion, featuring dinner and a floor show, was held at a first-class hotel in downtown Toronto and was attended by 1,400 former patients, many of them from outside Canada.

The reunion was scheduled to coincide with the mid-January decline in activity at the hospital, when an average of only 145 operations per week were performed. This was comparable to a similar

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[5] The latter figure included the bonus pool for doctors.

[6] At the time this case was written, a Canadian dollar was worth about 80% of an American dollar.

lull in late summer and contrasted with the peak of activity in September, when as many as 165 operations per week might be performed.

It was thought that patients from outside Canada were discouraged from coming to Toronto in midwinter by often misleading weather reports. Vacations interfered with plans in late summer. For many of the same reasons, the hospital closed for two weeks late in December each year. This allowed time for major maintenance work to be performed. Throughout the year, no operations were scheduled for Saturdays or Sundays, although patients whose operations were scheduled late in the week remained in the hospital over the weekend.

Problems and Plans

When asked about major questions confronting the management of the hospital, Dr. Shouldice cited a desire to seek ways of increasing the hospital's capacity while at the same time maintaining control over the quality of the service delivered, the future role of government in the operations of the hospital, the use of the Shouldice name by potential competitors, and the selection of the next chief surgeon.

As Dr. Shouldice put it:

> I'm a doctor first and an entrepreneur second. For example, we could refuse permission to other doctors who want to visit the hospital. They may copy our technique and misapply it or misinform their patients about the use of it. This results in failure, and we are concerned that the technique will be blamed for the recurrences. But we're doctors, and it is our obligation to help other surgeons learn. On the other hand, it's quite clear that others are trying to emulate us. Look at this ad. [The advertisement is shown in **Exhibit 4**.]
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> This makes me believe that we should add to our capacity, either here or elsewhere. Here, for example, we could go to Saturday operations and increase our capacity by 20% or, with an investment of perhaps $2 million and permission from the provincial government, we could add another floor of rooms to the hospital, expand our number of beds by 50%, and schedule the operating rooms more heavily.
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> On the other hand, with government regulation being what it is, do we want to invest more money in Toronto? Or should we establish another hospital with similar design outside Canada? I have under consideration a couple of sites in the United States where private hospital operations are more common. Then, too, there is the possibility that we could diversify at other locations into other specialties offering similar opportunities such as eye surgery, varicose veins, or hemorrhoids.
>
> For now, I have my hands full thinking about the selection of someone to succeed Dr. Obney when he retires. He's 65, you know. And for good reason, he's resisted changing certain successful procedures that I think we could improve on. We had quite a time changing the schedule for the administration of Demerol to patients to increase their comfort level during the operation. Dr. Obney has opposed a Saturday operating program on the premise that he won't be here and won't be able to maintain proper control.

Alan O'Dell added his own concerns:

> How should we be marketing our services? Right now, we don't. We're even afraid to send out this new brochure we've put together for fear it will generate too much demand. We know

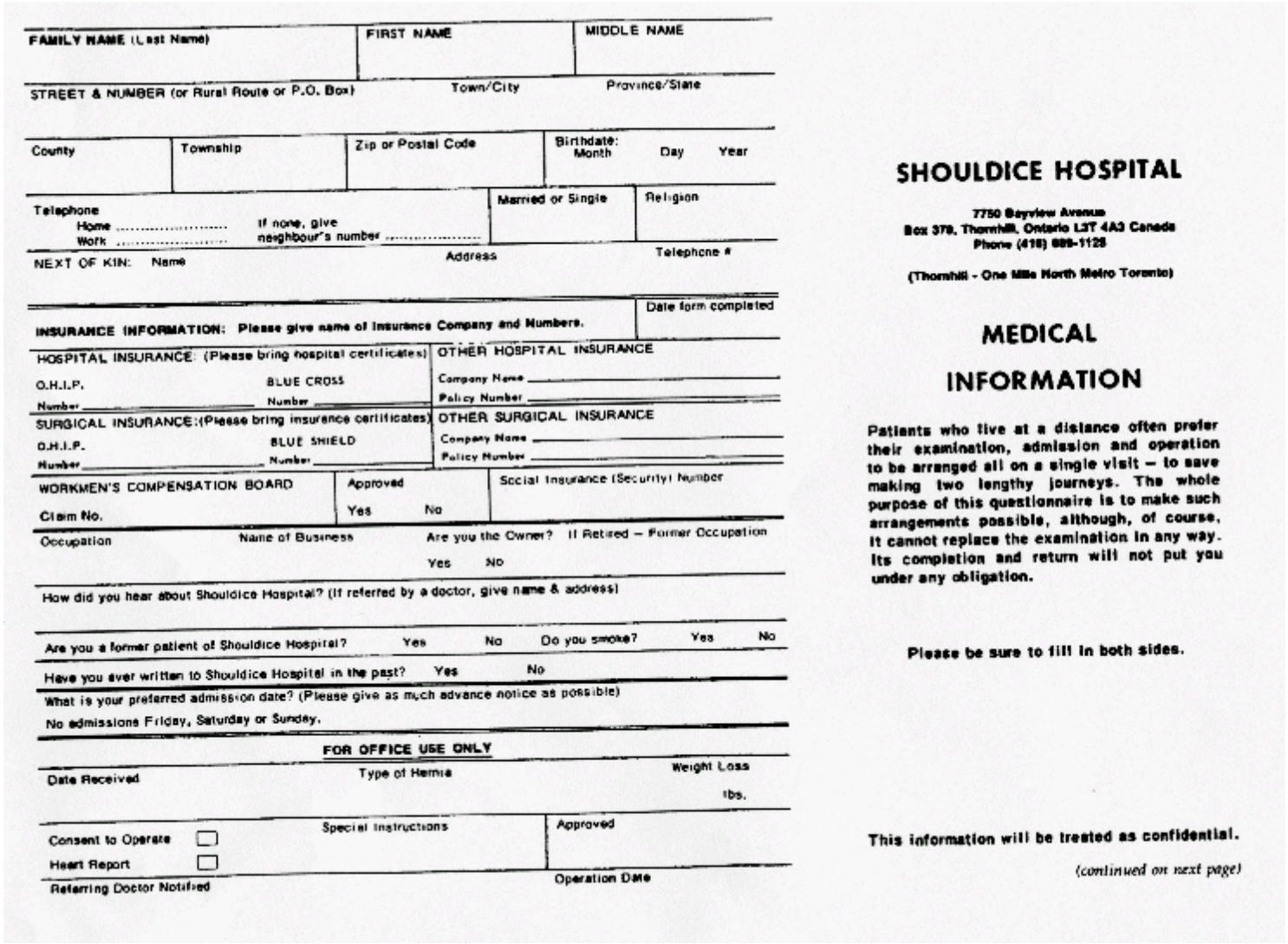
that both patients and doctors believe in what we do. Our records show that just under 1% of our patients are medical doctors, a significantly high percentage. How should we capitalize on that? And should we try to control the misuse of the hospital's name by physicians who say they use our techniques but don't achieve good results? We know it's going on, because we get letters from patients of other doctors claiming that our method didn't work.

On the other hand, I'm concerned about this talk of Saturday operations. We are already getting good utilization of this facility. And if we expand further, it will be very difficult to maintain the same kind of working relationships and attitudes. Already there are rumors floating around among the staff about it. And the staff is not pleased.

We still have some improvements to make in our systems. With more extensive computerization, for example, we could improve our admitting procedures.

The matter of Saturday operations had been a topic of conversation among the doctors as well. Four of the older doctors were opposed to it. While most of the younger doctors were indifferent or supportive, at least two who had been at the hospital for some time were particularly concerned about the possibility that the issue would drive a wedge between the two groups. As one put it, "I'd hate to see the practice split over the issue."

Exhibit 1 Medical Information Questionnaire



FAMILY NAME (Last Name) | FIRST NAME | MIDDLE NAME

STREET & NUMBER (or Rural Route or P.O. Box) | Town/City | Province/State

County | Township | Zip or Postal Code | Birthdate: Month Day Year

Telephone
Home .....
Work .....
If none, give neighbour's number .....

Married or Single | Religion

NEXT OF KIN: Name | Address | Telephone #

INSURANCE INFORMATION: Please give name of Insurance Company and Numbers. | Date form completed

HOSPITAL INSURANCE: (Please bring hospital certificates)
O.H.I.P. Number
BLUE CROSS Number

OTHER HOSPITAL INSURANCE
Company Name
Policy Number

SURGICAL INSURANCE: (Please bring insurance certificates)
O.H.I.P. Number
BLUE SHIELD Number

OTHER SURGICAL INSURANCE
Company Name
Policy Number

WORKMEN'S COMPENSATION BOARD
Claim No.

Approved Yes No

Social Insurance (Security) Number

Occupation | Name of Business | Are you the Owner? Yes No | If Retired — Former Occupation

How did you hear about Shouldice Hospital? (If referred by a doctor, give name & address)

Are you a former patient of Shouldice Hospital? Yes No Do you smoke? Yes No

Have you ever written to Shouldice Hospital in the past? Yes No

What is your preferred admission date? (Please give as much advance notice as possible)
No admissions Friday, Saturday or Sunday.

FOR OFFICE USE ONLY

Date Received | Type of Hernia | Weight Loss lbs.

Consent to Operate ☐
Heart Report ☐
Referring Doctor Notified

Special Instructions

Approved
Operation Date

SHOULDICE HOSPITAL

7750 Bayview Avenue
Box 379, Thornhill, Ontario L3T 4A3 Canada
Phone (416) 889-1128

(Thornhill - One Mile North Metro Toronto)

MEDICAL INFORMATION

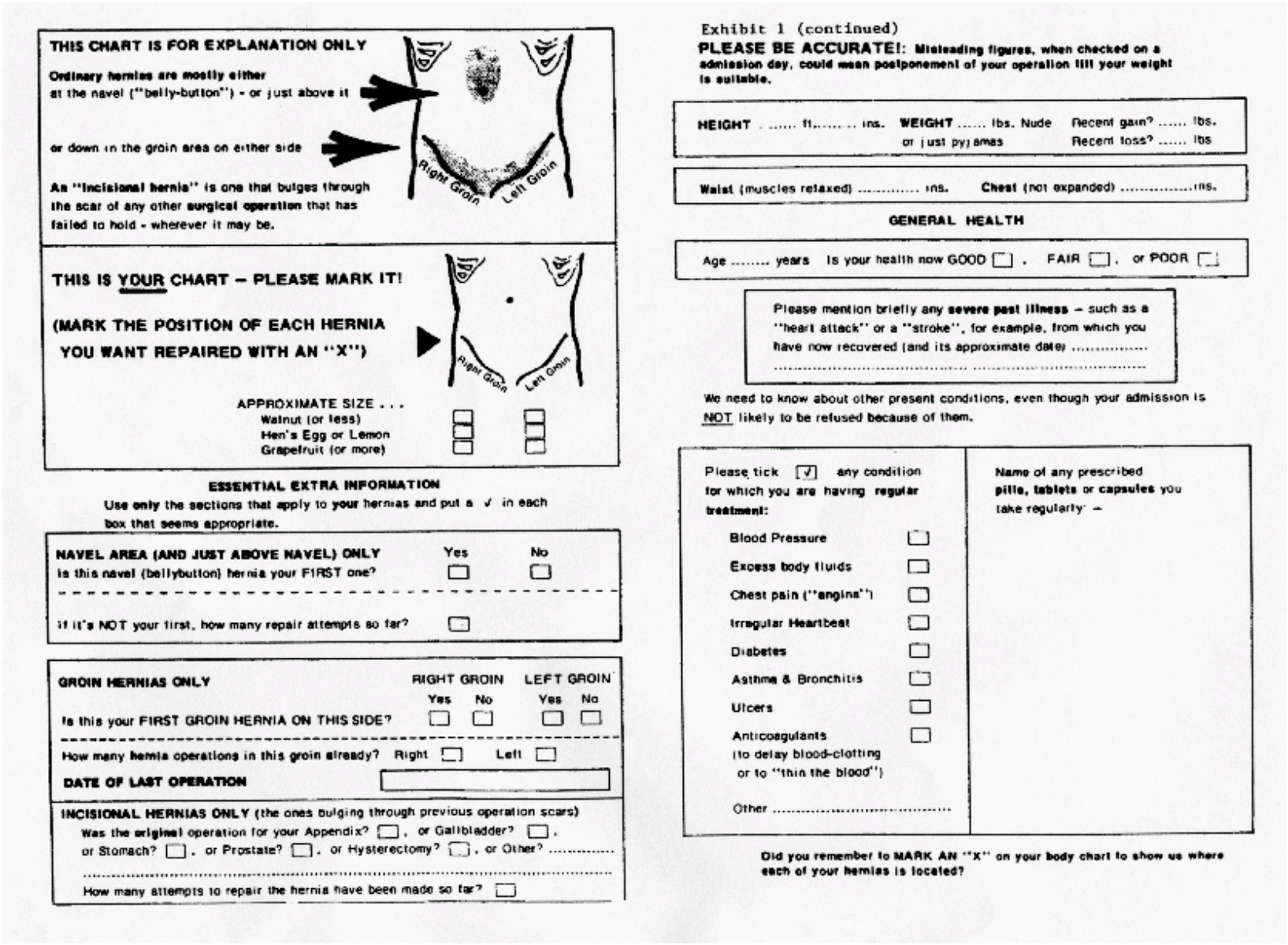
Patients who live at a distance often prefer their examination, admission and operation to be arranged all on a single visit – to save making two lengthy journeys. The whole purpose of this questionnaire is to make such arrangements possible, although, of course, it cannot replace the examination in any way. Its completion and return will not put you under any obligation.

Please be sure to fill in both sides.

This information will be treated as confidential.

(continued on next page)

Exhibit 1 (continued)



THIS CHART IS FOR EXPLANATION ONLY

Ordinary hernias are mostly either at the navel ("belly-button") - or just above it

or down in the groin area on either side

An "Incisional hernia" is one that bulges through the scar of any other surgical operation that has failed to hold - wherever it may be.

Right Groin Left Groin

THIS IS YOUR CHART – PLEASE MARK IT!

(MARK THE POSITION OF EACH HERNIA YOU WANT REPAIRED WITH AN "X")

Right Groin Left Groin

APPROXIMATE SIZE . . .
Walnut (or less)
Hen's Egg or Lemon
Grapefruit (or more)

ESSENTIAL EXTRA INFORMATION

Use only the sections that apply to your hernias and put a ✓ in each box that seems appropriate.

NAVEL AREA (AND JUST ABOVE NAVEL) ONLY	Yes	No
Is this navel (bellybutton) hernia your FIRST one?	☐	☐
If it's NOT your first, how many repair attempts so far?	☐	

GROIN HERNIAS ONLY	RIGHT GROIN Yes	RIGHT GROIN No	LEFT GROIN Yes	LEFT GROIN No
Is this your FIRST GROIN HERNIA ON THIS SIDE?	☐	☐	☐	☐

How many hernia operations in this groin already? Right ☐ Left ☐

DATE OF LAST OPERATION ☐

INCISIONAL HERNIAS ONLY (the ones bulging through previous operation scars)
Was the original operation for your Appendix? ☐, or Gallbladder? ☐, or Stomach? ☐, or Prostate? ☐, or Hysterectomy? ☐, or Other? .....
.....
How many attempts to repair the hernia have been made so far? ☐

Exhibit 1 (continued)

PLEASE BE ACCURATE!: Misleading figures, when checked on a admission day, could mean postponement of your operation till your weight is suitable.

HEIGHT . ..... ft..... ins. WEIGHT ..... lbs. Nude or just pyjamas Recent gain? ..... lbs. Recent loss? ..... lbs

Waist (muscles relaxed) ..... ins. Chest (not expanded) .....ins.

GENERAL HEALTH

Age ..... years Is your health now GOOD ☐, FAIR ☐, or POOR ☐

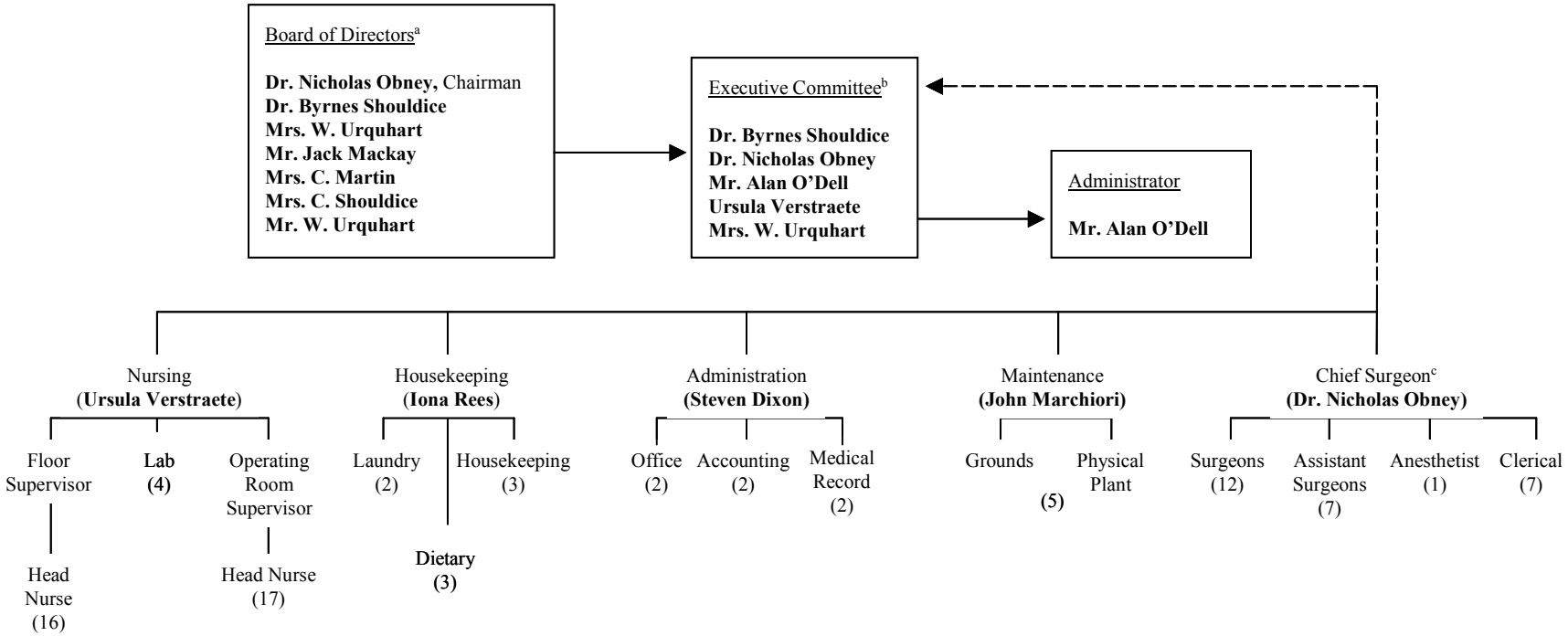
Please mention briefly any severe past illness – such as a "heart attack" or a "stroke", for example, from which you have now recovered (and its approximate date) .....
.....

We need to know about other present conditions, even though your admission is NOT likely to be refused because of them.

Please tick ☑ any condition for which you are having regular treatment:		Name of any prescribed pills, tablets or capsules you take regularly: –
Blood Pressure	☐	
Excess body fluids	☐	
Chest pain ("angina")	☐	
Irregular Heartbeat	☐	
Diabetes	☐	
Asthma & Bronchitis	☐	
Ulcers	☐	
Anticoagulants (to delay blood-clotting or to "thin the blood")	☐	
Other		

Did you remember to MARK AN "X" on your body chart to show us where each of your hernias is located?

Exhibit 2 Organization Chart



[a]Meets three times a year or as needed.
[b]Meets as needed (usually twice a month).
[c]Informally reports to Executive Committee.

Exhibit 3 Shouldice Hospital Annual Patient Renunion, January 15, 1983

Direction: For each question, please place a check mark as it applies to you.

1. Sex Male 41 95.34%
Female 2 4.65%

2. Age
20 or less ___
21-40 4 9.30%
41-60 17 39.54%
61 or more 22 51.16%

3. Nationality

Directions: Please place a check mark in nation you represent and please write in your province, state or country where it applies.

Canada 38 Province 88.32%
America 5 State 11.63%
Europe ___ Country ___
Other ___ ___

4. Education level

Elementary 5 11.63%
High School 18 41.86%
College 13 30.23%
Graduate work 7 16.28%

5. Occupation _____

6. Have you been overnight in a hospital other than Shouldice before your operation? Yes 31 No 12

7. What brought Shouldice Hospital to your attention?

Friend 23 53.49% Doctor 9 20.93% Relative 7 16.28% Article ___ Other 4 (Please explain) 9.30%

8. Did you have a single 25 58.14% or double 18 41.86% hernia operation?

9. Is this your first Annual Reunion? Yes 20 46.51% No 23 53.49%
If no, how many reunions have you attended? ___
2-5 reunions - 11 47.83%
6-10 reunions - 5 21.73%
11-20 reunions - 4 17.39%
21-36 reunions - 3 13.05%

10. Do you feel that Shouldice Hospital cared for you as a person?

Most definitely 37 86.05% Definitely 6 13.95% Very little ___ Not at all ___

Exhibit 3 (continued)

11. What impressed you the most about your stay at Shouldice? Please check one answer for each of the following.

	Very Important	Important	Somewhat Important	Not Important
A. Fees charged for operation and hospital stay	10	3	6	24
B. Operation Procedure	33 (76.74%)	9 (20.93%)	1 (2.33%)	—
C. Physician's Care	31 (72.07%)	12 (27.90%)	—	—
D. Nursing Care	28 (65.12%)	14 (32.56%)	1 (2.32%)	—
E. Food Service	23 (53.48%)	11 (25.59%)	7 (16.28%)	2 (4.65%)
F. Shortness of Hospital Stay	17 (39.53%)	15 (34.88%)	8 (18.60%)	3 (6.98%)
G. Exercise; Recreational Activities	17 (39.53%)	14 (32.56%)	12 (27.91%)	—
H. Friendships with Patients	25 (58.15%)	10 (23.25%)	5 (11.63%)	3 (6.98%)
I. "Shouldice Hospital hardly seemed like a hospital at all."	25 (58.14%)	13 (30.23%)	5 (11.63%)	—

12. In a few words, give the MAIN REASON why you returned for this annual reunion.

Exhibit 4 Advertisement by a Shouldice Competitor